Data Entry User Guide

Use this guide to help navigate the Data Entry Platform.

For questions and suggestions, email us at:
NPRQI@austin.utexas.edu

Version 1.0, 4/25/2023

Contents

Data Entry User Guide

Welcome - We are excited to have you join NPRQI! This Data Entry Platform was developed specifically with small community and rural hospitals in mind – no specialized training or technology is needed to work with the platform. The data entry format is well organized and straightforward. Let us help you start your journey to measure, reflect, and improve delivery of pediatric emergency care.

Where to Begin?

Logging in to the NPRQI Data Entry Platform

Check with the Pediatric Team Lead at Your Site

The Pediatric Team Lead or Site Administrator for your organization registered Users for NPRQI. If you are listed as a User, you will receive secure login credentials.

Obtain Secure Login Credentials and Password

All NPRQI registered users will receive an email invite from Clario (tap.support@bioclinica.com) with secure NPRQI login credentials. All passwords will expire after 90-days and users will be prompted to reset their secure password. **To prevent this email from being blocked by your organization's firewall, let your Information Technology (IT) department know to "whitelist" the Clario email address**.

Sample Login Page

CLARIO.
THE BEST OF ERT & BIOCLINICA

Sign in with your email address

someone@example.com

Password

Forgot Password   Sign in

Terms of Use   Privacy Policy

Bioclinica helpdesk:

What is the Next Step After Login?

Complete Required Trainings

Trainings

When Users login for the first time, they will be prompted to complete two brief training videos. These videos must be completed prior to beginning data entry:
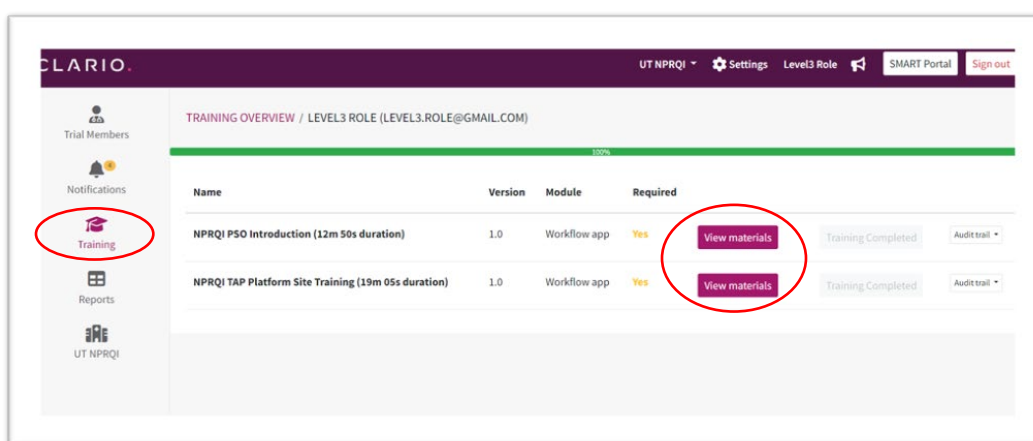
1. NPRQI Patient Safety Organization (PSO) Introduction (~ 13 minutes)
2. NPRQI TAP Platform Site Training (~20 minutes)

How Do I Select Charts?

Selecting Charts To be Entered

Selection Process

NPRQI recommends collecting charts from the following sources:
1) Query your site's electronic medical heath record (EMR) searching by age, complaint, or date of visit
2) Review your site's ED log book

3) Request your site's IT department provide a selection of charts

NPRQI recommends that EDs include all pediatric patients as defined by your facility.

Methods of Chart Sampling

Organizations will need to determine how they will select their patient records to be entered into the Data Entry Platform. **Best practice is to enter a minimum of 30 charts (assessment/Inter-facility Transfer (IFT) bundles) every 90-days.**

Preferred Technique	Definition	Example/Strategy
All	Inclusion of all records	All pediatric patients seen in the ED • *Recommended for low volume sites*
Systematic	Inclusion of ever Nth patient	• Every 5th patient seen in the ED
Stratified	Specific subgroup selected	• Look at certain populations (e.g., head trauma or respiratory complaints) • *Recommended for sites focused on a single clinical presentation*

Note: Other methods like random and convenience sampling are not ideal as they can create bias in the sampling process.

How Do I Create Subject IDs?

Creating Subject IDs

Process

It is recommended that Sites create Subject IDs ahead of time for each patient chart.

Format

Each Subject ID format will be: **user's first initial, user's last initial, + 4 digits**. *Note: Do not use the actual patient record ID for NPRQI data entry.*

How Do I Maintain a Log of Subject IDs?

▤ **Tracking Subject IDs**

Subject ID Crosswalk

Each site must maintain a cross-walk (internal log) of Subject IDs associated with each patient encounter entered into the Data Entry Platform. **Note: Each site must follow their own internal policies for management of Protected Health Information (PHI).** Below is a sample Subject ID log:

	Name of person who will enter this chart	Create Subject ID using User's initials + 4 digits	Patient identifiers from electronic health record		
A	**B**	**C**	**D**	**E**	**F**
BUNDLE(S)	**User Name**	**SUBJECT ID**	**MRN**	**Date of Birth**	**Date of Visit**
	Liza Hinojosa	LH0001	83998763	xx/yy/zzzz	xx/yy/zzzz
	Liza Hinojosa	LH0002	48299861	xx/yy/zzzz	xx/yy/zzzz
	Liza Hinojosa	LH0003	99811722	xx/yy/zzzz	xx/yy/zzzz
	Liza Hinojosa	LH0004	47936502	xx/yy/zzzz	xx/yy/zzzz
	Liza Hinojosa	LH0005	30184412	xx/yy/zzzz	xx/yy/zzzz
	Alice Smith	AS0001	12938274	xx/yy/zzzz	xx/yy/zzzz
	Alice Smith	AS0002	12305123	xx/yy/zzzz	xx/yy/zzzz
	Alice Smith	AS0003	85773922	xx/yy/zzzz	xx/yy/zzzz
	Alice Smith	AS0004	92018347	xx/yy/zzzz	xx/yy/zzzz
	Alice Smith	AS0005	48392713	xx/yy/zzzz	xx/yy/zzzz

Where Do I Find Helpful Tools for Data Entry?

⚙ **Additional Resources and Helpful Tools**

NPRQI Record Entry Form (Data Abstraction Form)

This form illustrates all the data entry fields in the Data Entry Platform and required elements. This document helps users know what questions are asked in the platform. Some users prefer to print this document out ahead of time to support data collection.

ICD-10 Codes

Don't know what code to use? Use this resource to find the most common pediatric diagnosis codes.

Clock Conversion Chart

The data platform requires you to enter time on a 12-hour clock. You need to convert to 24-hour (military time). Use this chart easily convert military time to regular time.

Data Collection Reference Guide (Data Dictionary)

This resource helps explain the questions in the data platform and the answers available for selection.

Data Elements for Clinical Bundles

Measures for specific clinical areas of focus (clinical bundles) require complete and accurate data on key variables. This resource explains which data elements are required to calculate the numerator and denominator for clinical bundle measures.
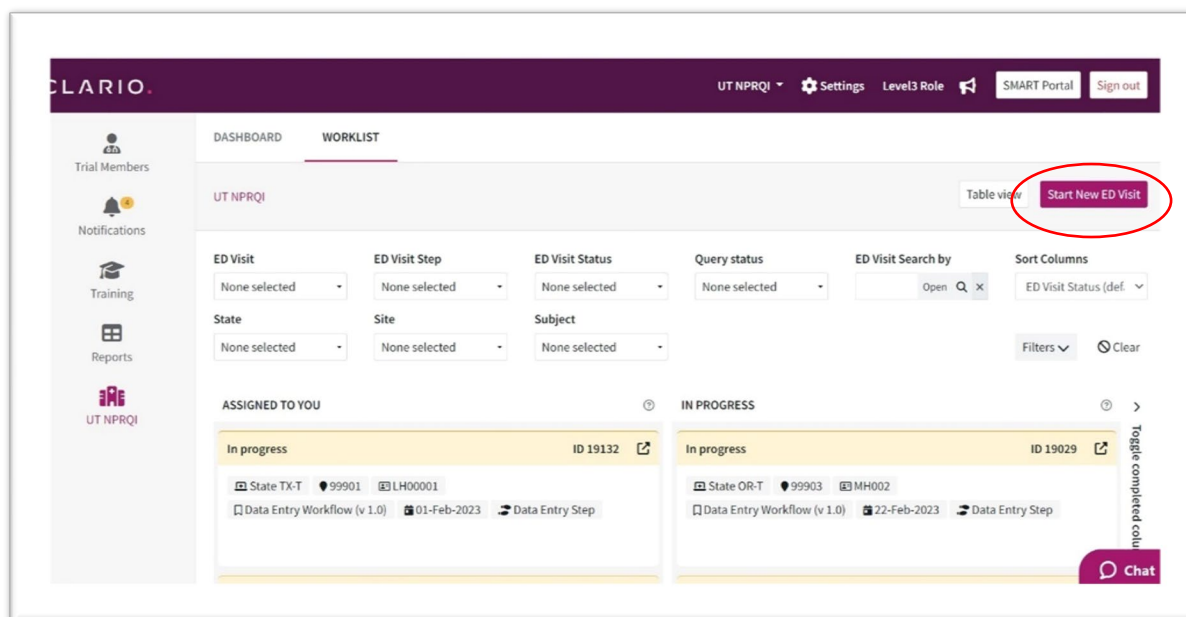
How Do I Start Data Entry?

▶ **Start Data Entry Here**

UT NPRQI/Start New ED Visit

Data entry begins with selecting **UT NPRQI** from the menu options on the left side of the screen, then select **Start New ED Visit**.

1) UT NPRQI
2) Start New ED Visit

Start New ED Visit

3) From the Worklist Tab begin by selecting **Start New ED Visit**
4) Select **Start New ED Visit** from the next screen

Trial Layer Group

5) Select **State.**

State

6) Select your site's state from drop down menu (e.g., Oregon)

Site

7) For EDs entering data, your site will show in the drop down menu. **Select your site/site CLMS ID#** (e.g., 99903 OR-T). Network Users will see a list of EDs in their network that have agreed to share their data. Network Users will select the site they wish to enter data.

Subject

8) If entering a new patient record, select **Add New** under Subject**.** In the Enrolled Subject ID Field, enter assigned Subject ID from your site's internal log then select **Create** (no data required for Enrollment Date Field).

   Note: If resuming data entry for a patient record already in progress, use drop down menu on the Start New ED Visit screen to find associated Subject ID and click on record to resume data entry. Users can also find records already in progress on the Worklist Tab on the UT NPRQI screen under Assigned to You or In Progress sections. Click on Data Entry Step for that record to resume data entry.

ED Visit

9) Select **Data Entry Workflow** from drop down menu.

ED Visit Date

10) Click on **ED Visit Date** field and use digital calendar to enter month, date, and year of patient visit to the ED.

Select Start

11) Click **Start** at bottom of screen.

Select Start Step

12) Click **Start Step** at top right corner.

Enter Data

13) On the ED Visit Steps screen, select **Enter Data.**

Welcome Page for Record Entry

This page will have a brief message and display the patient data entry tabs used to enter chart information.

How Do I Navigate The Patient Tabs?

Helpful Tips:
1. Begin each patient record by selecting the **Patient Demographics Tab**.
2. Tabs that have <u>missing data</u> will remain **red**.
3. To view additional tabs use the right arrow (>) at the end of the row of tabs.
4. If you need assistance or have questions about data entry, use the **Chat** feature in the bottom right hand corner of the screen. Support staff will be able to answer your questions.
5. All data is automatically saved for each tab.
6. Once data entry is complete click **Save and Submit** at the top right hand corner of the screen.

Patient Demographics

When entering age, be sure to <u>select units first</u> (months/years) on the drop down menu. **When entering the age of the patient in years please round down to the nearest round number.**

Clinical Inclusion Bundles

Users can assign a patient to a clinical quality bundle based on chief complaint. Patients can be in more than one clinical bundle (e.g., head trauma and vomiting, or head trauma and seizure).

See **Data Elements for Clinical Bundles** for information on data elements used to calculate the quality measures for each clinical bundle.

Triage

Triage is when the patient is first evaluated by ED staff. Questions are divided into sections that mirror where the information might be in a patient's chart. The clock in the data entry platform is set for military time. Use the **Clock Conversion Chart** to quickly convert regular time to military time. No second's value is needed.
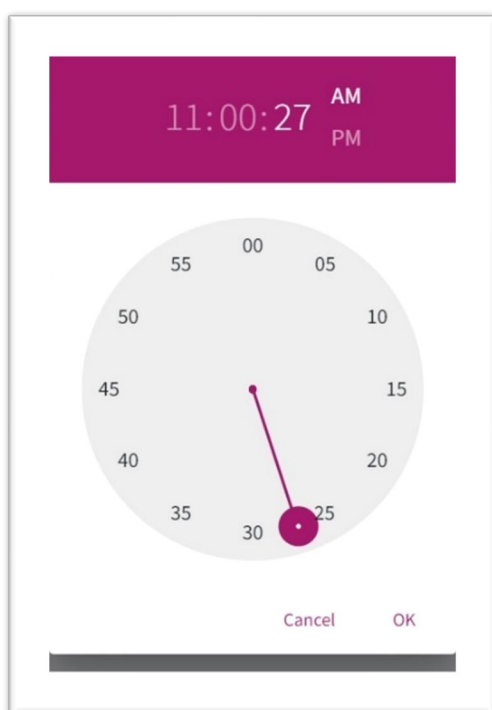
Initial Vitals

This is the first set of vitals obtained on the patient whether in triage or the exam room.

Vital Sign Reassessment

Any vital sign that is obtained more than once is considered a reassessment. **If vital signs were repeated multiple times use the first reassessment.**

Diagnosis

The discharge diagnosis is the final assessment by a clinician which can be different from the chief complaint or presenting concern by the patient. NPRQI will only collect **the first THREE characters of**

the ICD-10 code. For example, if the ICD-10 Code is J45.01, only enter J45. If you are unable to find the ICD-10 Codes in the medical record, please click here to find the most common pediatric diagnosis codes.

Disposition

This describes what happened to the patient when they left the ED. The clock in the data platform is set to military time. Remember to convert your site's 12 hour time format to military time prior to entering this data. Use the **Clock Conversion Chart** to quickly enter this data. **No seconds value is required.**

Safety Screenings

Safety screenings can be used for patients to assess behavioral health risks or exposure to violence or harm.

ED Fluids and Medications

This section focuses on fluids and medications given to the patient during their stay in the ED. Other fluids such as saline, oral rehydration, etc. are listed within medications. For each medication you will provide the type or class of medication, medication name, route it is given as well as date and time given. Remember to convert your site's 12 hour time format to military time prior to entering this data. Use the **Clock Conversion Chart** to quickly enter this data. No second's value is required.

Note: Up to 10 medications and fluids may be entered. Enter 1st medication or fluid given then include medications and fluids relevant to clinical condition in order to accurately capture key metrics.

Airway Interventions

Airway interventions are any type of respiratory support that includes oxygen or other types of ventilation. Remember to convert your site's 12 hour time format to military time prior to entering this data. Use the **Clock Conversion Chart** to quickly enter this data. No second's value is required.

Imaging Studies

This section asks about any imaging studies that were performed during the ED stay. This includes ultrasound, X-rays, CTs and MRI studies. This information may be located in the order section of the chart or as an actual report from the study.

Laboratory Studies

This section focuses on any type of laboratory studies that may have been performed during the patient's stay in the emergency department. This includes point of care (rapid) tests. Information may be in the order section or results section of the patient's chart.

Consultations

This section focuses on any consultations sought during the patient's stay. A consult would be a provider with a specialized expertise (pediatric, infectious disease, etc.). The consult can occur via different modalities (phone call, tele-health, in-person). This information could be found in the order section, nursing notes, or provider assessment notes.

Behavioral Health

This section will be dependent on other patient information previously entered. This section is for patient's that presented with a behavioral health chief complaint, had a concerning behavioral health screening, or a behavioral health diagnosis. Questions focus on safety of the patient during the stay and at discharge. This information may be found in nursing notes, orders, discharge instructions or the mental health section of a chart.

Transfers

This section will be dependent on other patient information previously entered.

How Do I Save and Submit Data?

Save Your Entry and Submit

AutoSave

In the ED environment, things can change quickly. If users need to leave in the middle of data entry, data is automatically saved! Users can log back in and resume data entry as time allows.

Save and Submit

When all patient data has been entered, select **Save and Submit.** If you have missed any data entry fields, your screen will appear as below.

Missing Data

If a screen shows missing data entries, click on each of the highlighted elements to complete data entry. Then click **Save and Submit**.

Missed data will be displayed here.

Once missing data entry is complete click **Save and Submit**.

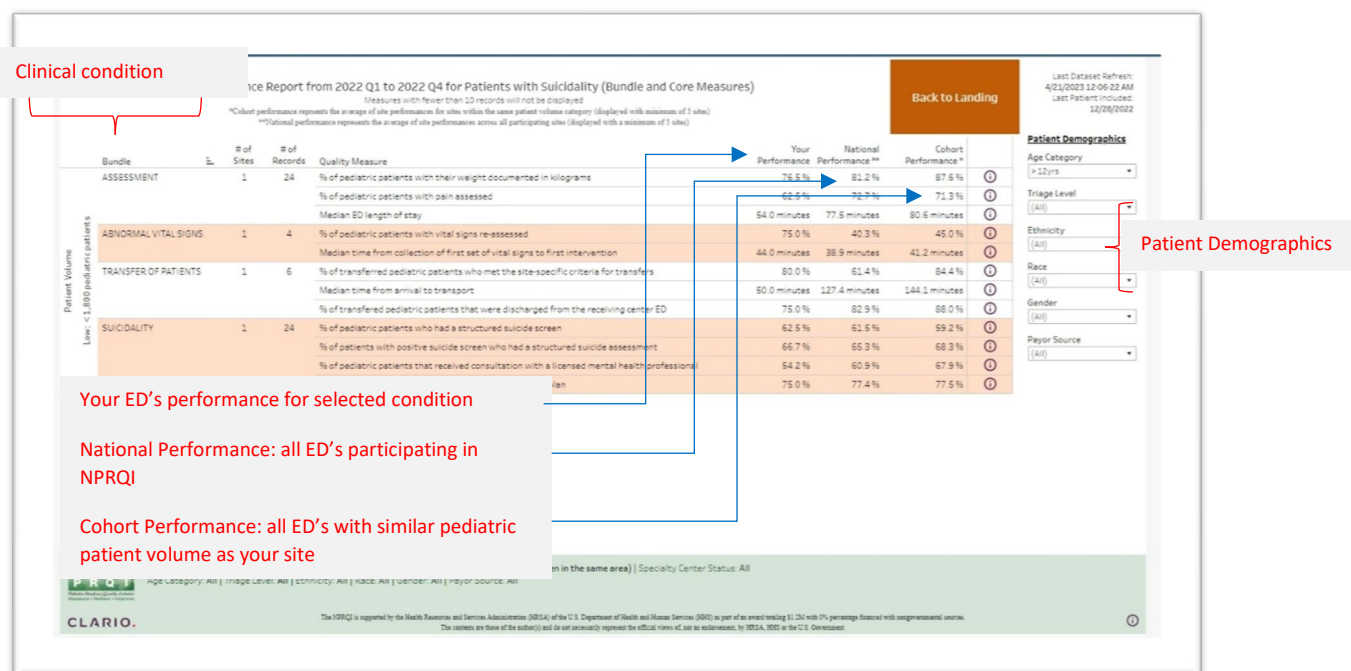Once all data has been submitted, click **Save and Submit**.

NPRQI

How and When Can I View My Site's Dashboard?

Data Visualization (guide coming soon)

Your site's performance measures will only be displayed once a minimum of 10 records have been entered with required data points . Refer the **Dashboard User Guide** to learn how your site can visualize pediatric patient data. <u>Note:</u> The more records a site enters, the better organizations can view trends and measure their site's delivery of pediatric emergency care. See illustration below to see what the NPRQI Dashboard will look like:

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Advanced Features of the Data Entry Platform

**Landing Page Menu Icons**

Trial Members

This screen will show information about users for your site: user email, ED state and site name, user access level, user status, and audit trail (login history). "Active" status indicates user is actively enter data into the platform.

Notifications (important for Level 3 Users)

This screen displays the log of all administrative reports that have been requested. **Note: Only Level 3 Users will have access to the reports function.** Refer to the **Data Reports and Downloads** for details on specific reports.

The **megaphone icon** in the top right corner will inform users about important announcements to the platform. When a number appears next to the megaphone, users can click on the icon to see software updates that have happened or will be happening that may impact access to the platform.
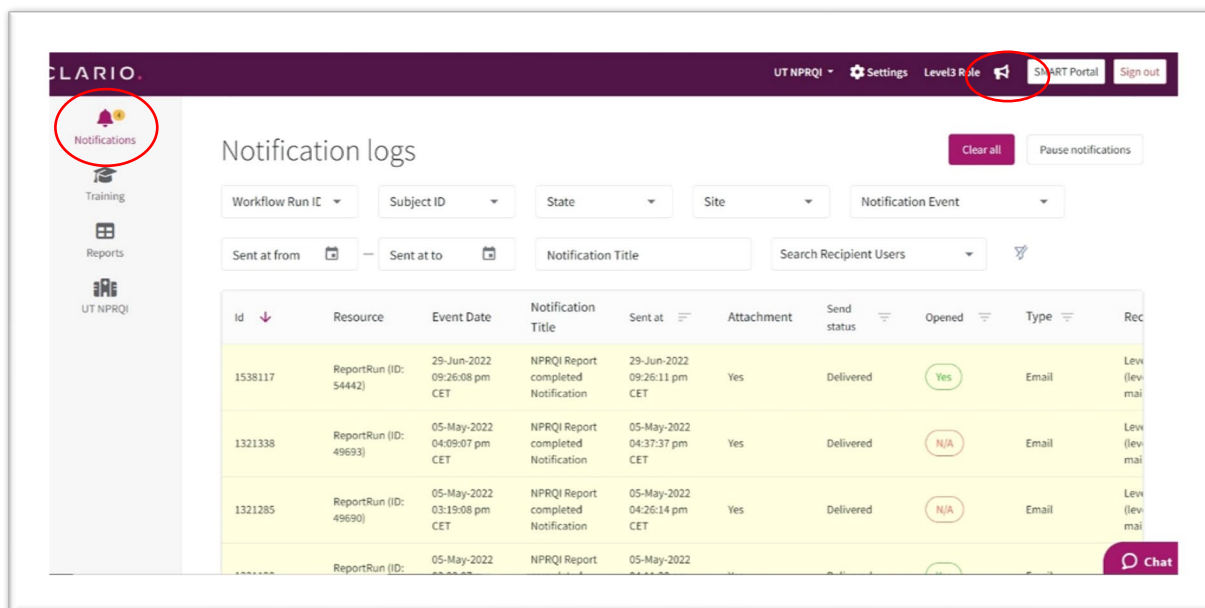
Training

When Users login for the first time, they will be directed to the Training screen. Training videos must be completed before data entry can begin. Users can click on **View Materials** to watch each video.

NPRQI PSO Introduction (~13 minutes) will provide an overview of the Patient Safety Organization protections (PSO) for NPRQI data entry activities and your organization's role in protecting this patient information.

NPRQI Data Entry Platform (~20 minutes) will walk users through the data entry process.

Training certificates can be printed out using the **Audit Trail** drop down.

Training certificates can be printed from here
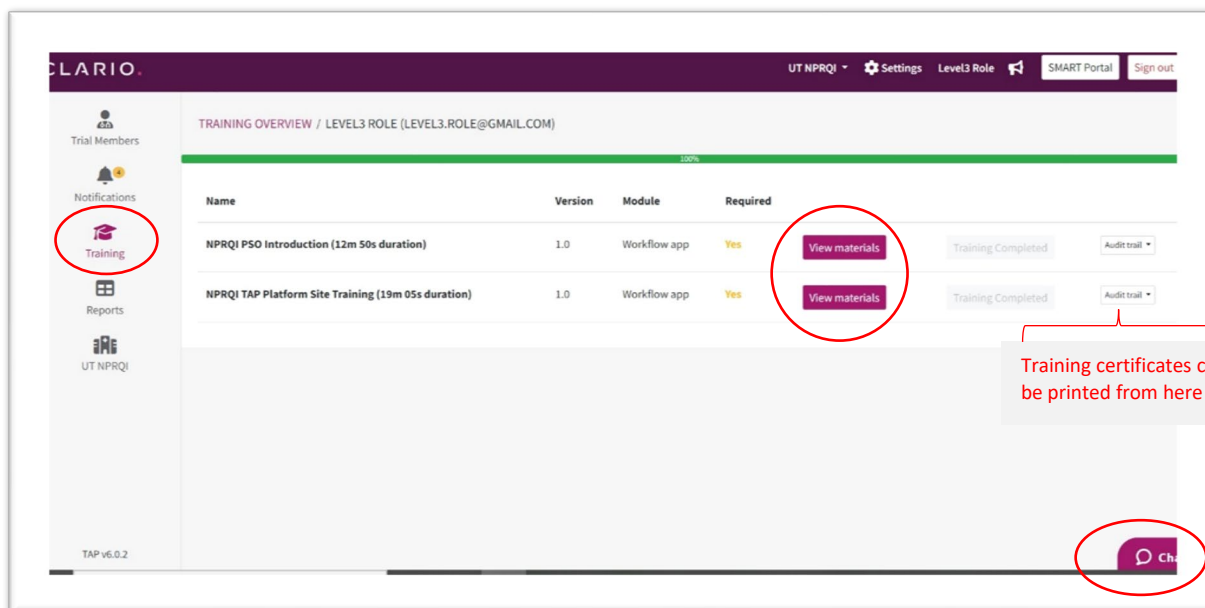
Chat Support

When Users need support with data entry, they can click on the **Chat feature** in the bottom right hand corner of each screen to communicate with live tech support staff.

Reports (important for Level 3 Users)

The reports function is only accessible to <u>Level 3 Users</u>. Administrative Reports can provide sites information on registered Users, frequency of data entry, and data entry date/time errors. See the **Data Reports and Downloads** for details on each report.

Worklist and Dashboard Tabs

👀 **Orientation of the Worklist and Dashboard Tabs**

Charts Assigned to You

This section will show charts the user has in progress which have <u>not been completed</u>, as indicated by the **"Data Entry Step"** status. Users can click on the record with "Data Entry Step" to complete data entry for that record.

Charts In Progress

Charts in this section have been entered by other users at your site. If records in this section are <u>pending additional data entry</u> they will have **"Data Entry Step"** indicated.

Note: *Level 2 and 3 Users must approve data entered by a Level 1 User.* Data entries waiting for approval will be located here. Charts awaiting approval will have **"Data Entry Complete"** indicated. To approve a chart, click on the "Data Entry Complete" portion for this record.

Charts you have entered for your site are listed here.

Charts others have entered at your site are here. Charts Level 2 and 3 User need to approve are also located here.

Dashboard Tab

The Dashboard Tab provides a less granular view of the Worklist Tab (screen above). Here you will find charts assigned to the user and charts currently in progress by other users at your site.
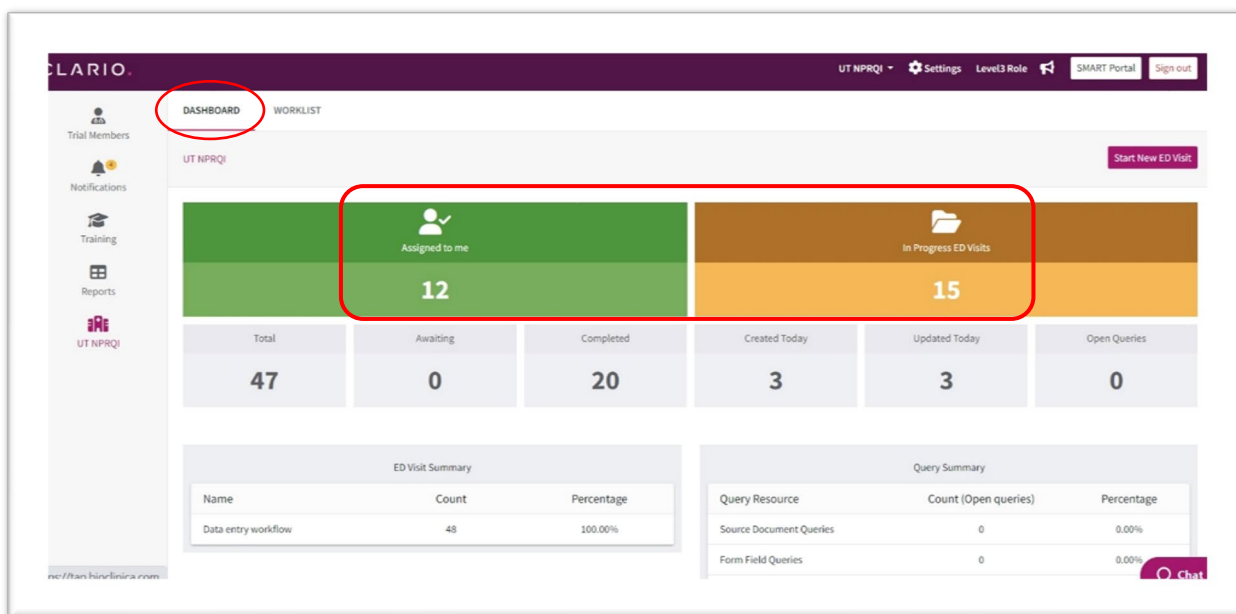
How Do I Reassign A Record?

**Reassign Records or Find Records to Submit**

Reassigning Records

On occasion a record will need to be reassigned if the original user is unable to complete data entry. To reassign a record, go to the Worklist Tab and locate the record to be reassigned from either the section *"Assigned to You"* – *In Progress* (left side of screen) or under the section *"In Progress"* (right side of screen).

To reassign your record or reassign another user's record complete the following steps:

1) Find the record from either the section "Assigned to You" – In Progress (left side of screen) or under the section "In Progress" (right side of screen). Click on the "**Data Entry Step**" for the record you want to reassign.
2) On the next screen, click on the **User's email** and select **"Reassign and Keep Form"**. This keeps the current data in the record. If you need to redo the information for the record select, "Reassign and Reset Form". This will keep the record ID but wipe the data that has been entered.
3) The record will now be linked to the User ID (email) that has been selected. The new assigned User can continue with entering data in record by selecting **"Enter Data"**.

Images below illustrates these steps:
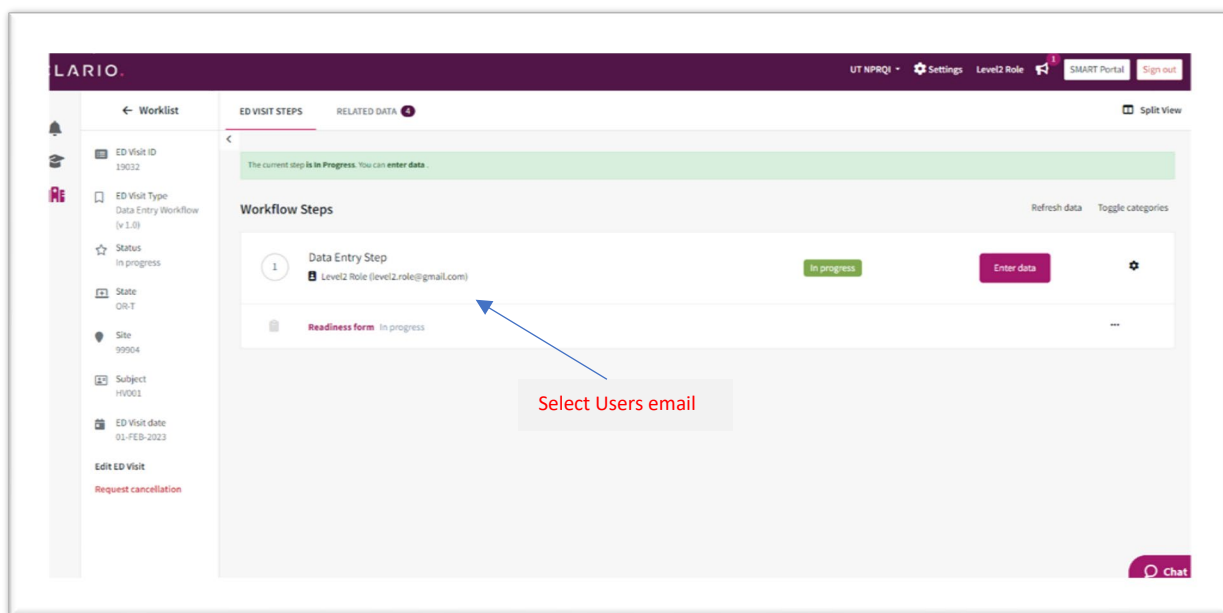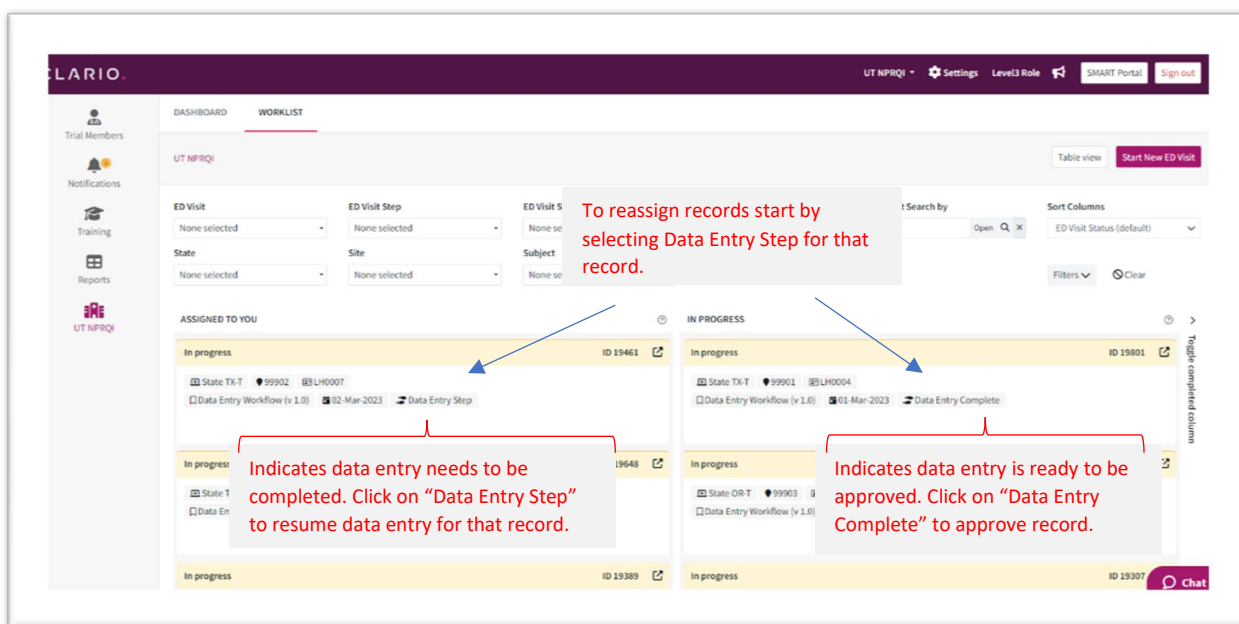
Other Users will be displayed here. Select the User you wish to reassign the record to by clicking **Assign**

Assign User

| User	OOO until	Role	Assigned Cases	
Level3 Role		Level 3	0	Assign

Remove assignment

Select **Reassign and keep form** to keep data in record.

Reassign step

You are about to change the user assignment associated with an in-progress form. Do you want to reset the form or continue from its current state?

Reassign and keep form   Reassign and reset form   Cancel

User assigned to this record can now enter data for the reassigned record by selecting "Enter Data".
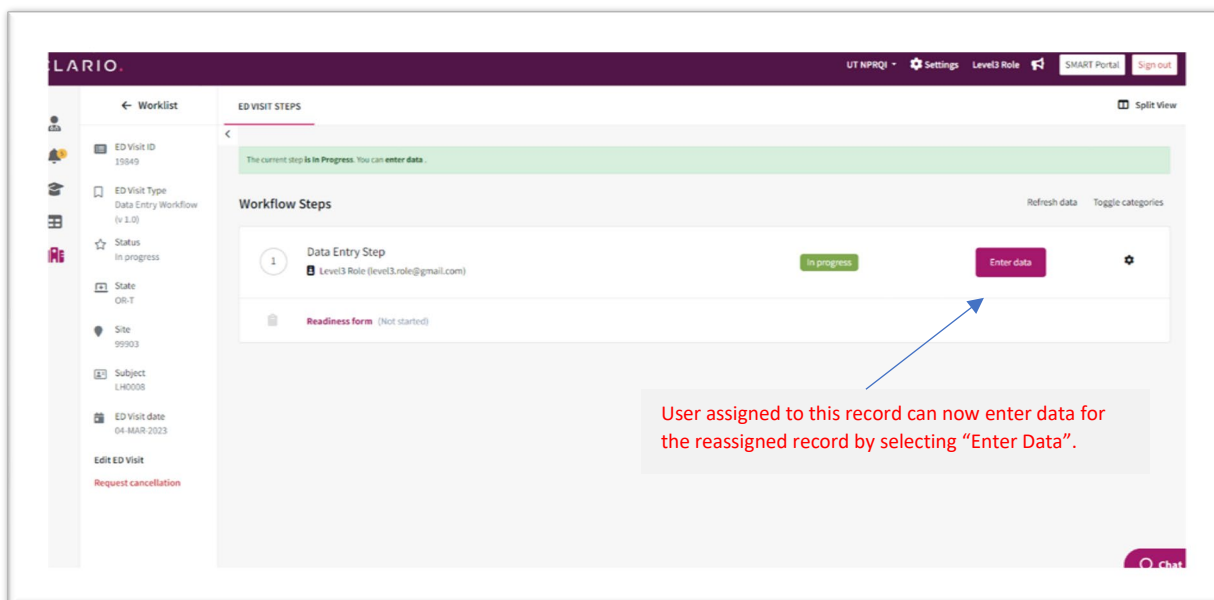
How Do I Submit Records for Level 1 Users?

Submitting Records for Others

Level 2 and 3 Users will need to submit records for Level 1 Users. To do this, go to the Worklist Tab and locate the record to be submitted under the section *"In Progress"* (right side of screen). Records waiting to be submitted will indicate "Data Entry Complete". Click on **Data Entry Complete**.

Begin by selecting **Data Entry Complete** to submit record.

In progress   ID 14869

State TX-T   99902   MV005

Data Entry Workflow (v 1.0)   27-Oct-2022   Data Entry Complete

Click on **Complete ED Visit** to submit record for a Level 1 User.

This screen indicates data has been submitted for the Level 1 User.
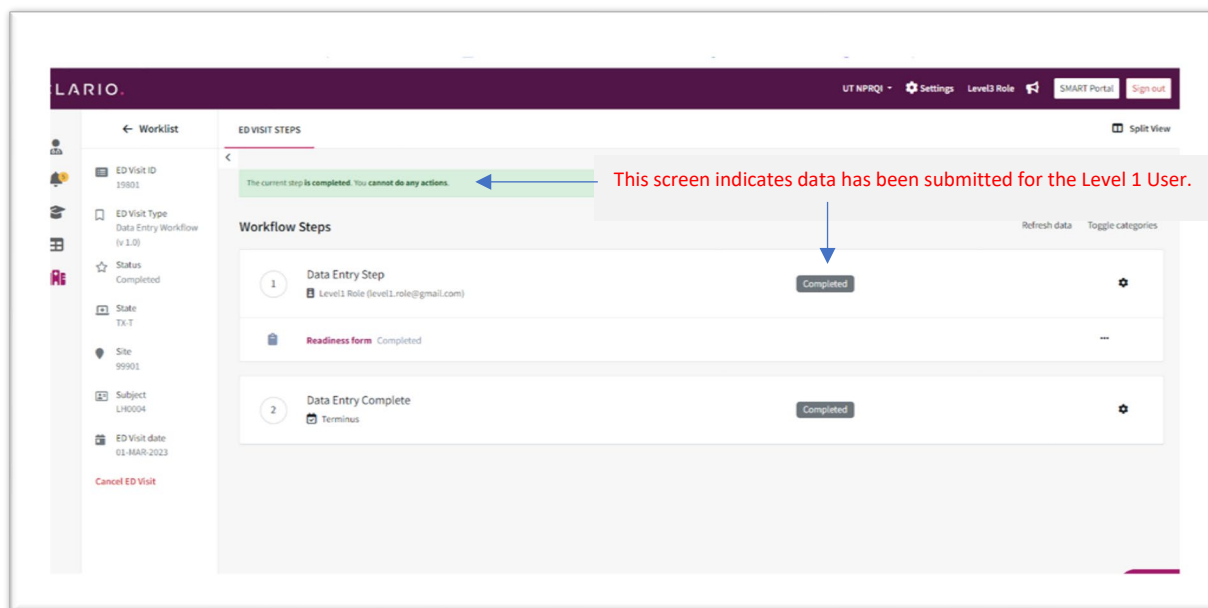
Data Reports and Downloads

Note: Data Reports are only accessible to Level 3 Users.

Administrative Data Reports

How Do I View and Download Administrative Reports?

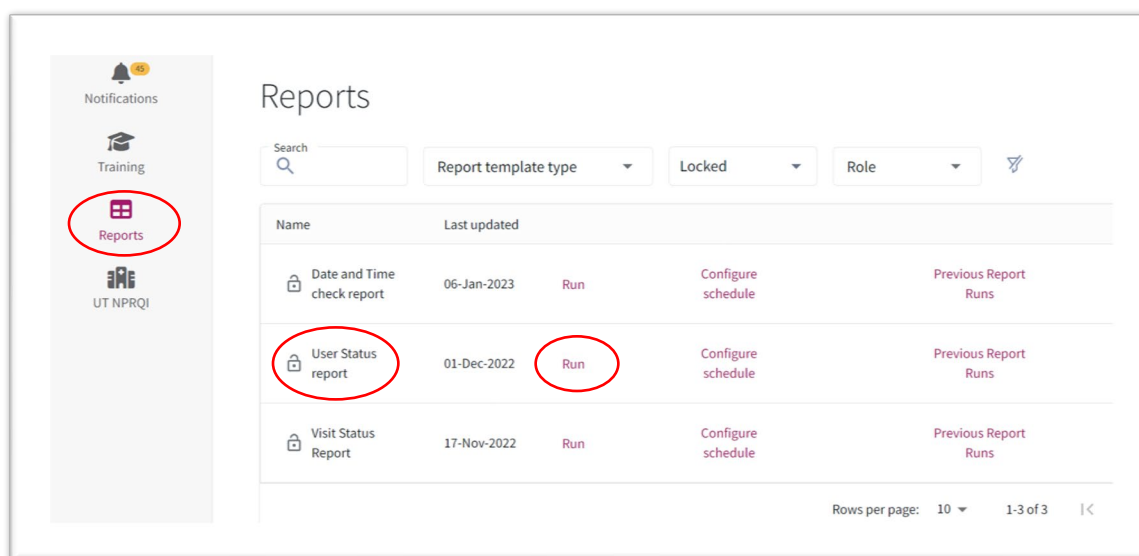Level 3 Users will have access to several administrative reports:

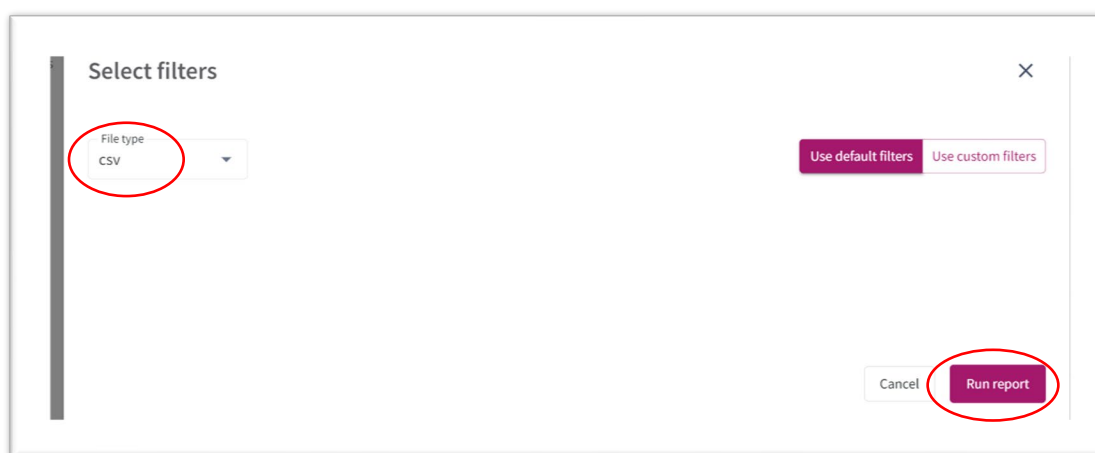| Report	Information provided
User Status	Informs sites about approved Users, assigned access level for Users, and completion of training for each User.
Visit Status	Informs sites about the number of patient charts/records that have been initiated or completed in the Data Entry Platform.
Date and Time Check	Allows a site or User to quickly check for errors in the date and time values entered into the Data Entry Platform.

User Status Report

How to Access and Download

The following workflow will outline how the **User Status Report** can be viewed/downloaded:

- Log into the NPRQI Data Entry Platform
- From the landing page, select **Reports** from the menu on the left
- From **User Status Report** option, select **Run**

- When prompted with Select Filters screen, select:
  - **File type** (csv or xlsx)
  - **Run Report**

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After selecting Run Report, the **User Status Report will be emailed** to the user requesting the report. User Status Reports may also be customized using the Custom Filters feature or Configure Schedule feature to receive regular reports on a designated schedule.

The **Report Runs** tab, on the Reports screen, will list previous reports that have been generated for your site. Sites can download previous reports by clicking the "download" button on the right side of the screen.

Sample User Status Report:

How to interpret the User Status Report:

Column B: Site ID	Your Site's CLMS#
Column C: Hospital Name	Your hospital's name
Column D, E, F: Trial Member First Name, Last Name, and email address	Registered user for data platform
Column G: User Status	Indicates if User has actively logged into platform **Active**= logged in to platform with secure credentials **Invited**= login credentials sent but has not logged into platform
Column H: Trial Member Role	Indicates User's permissions for entering data into the platform *Level 1 user must have Level 2 or 3 user submit data on their behalf
Column I: User's Last Activity	Indicates User's last date of login into the data platform
Column J: Trial Member Training Completion	Indicates what percent of required training is complete (2 trainings are required before entering data) 50=1 training completed 100=both trainings completed

To see the history of reports that have been run select the Reports Run Tab:
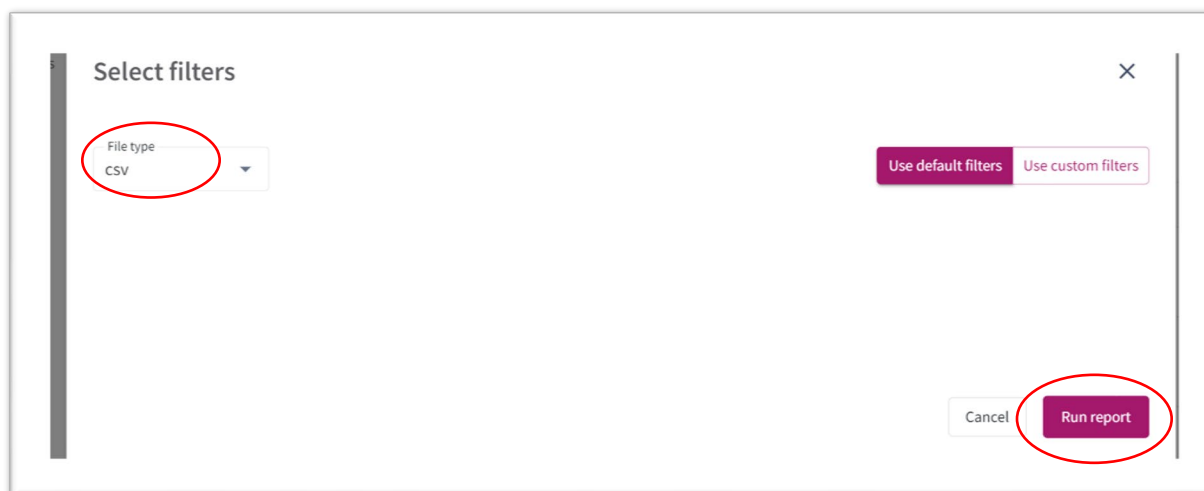

Visit Status Report

How to Access and Download

The following work flow outlines how the **Visit Status Report** can be viewed and downloaded:

- Log into the NPRQI Data Entry Platform
- From the landing page, select Reports from the menu on the left
- From **Visit Status Report** option, select **Run**
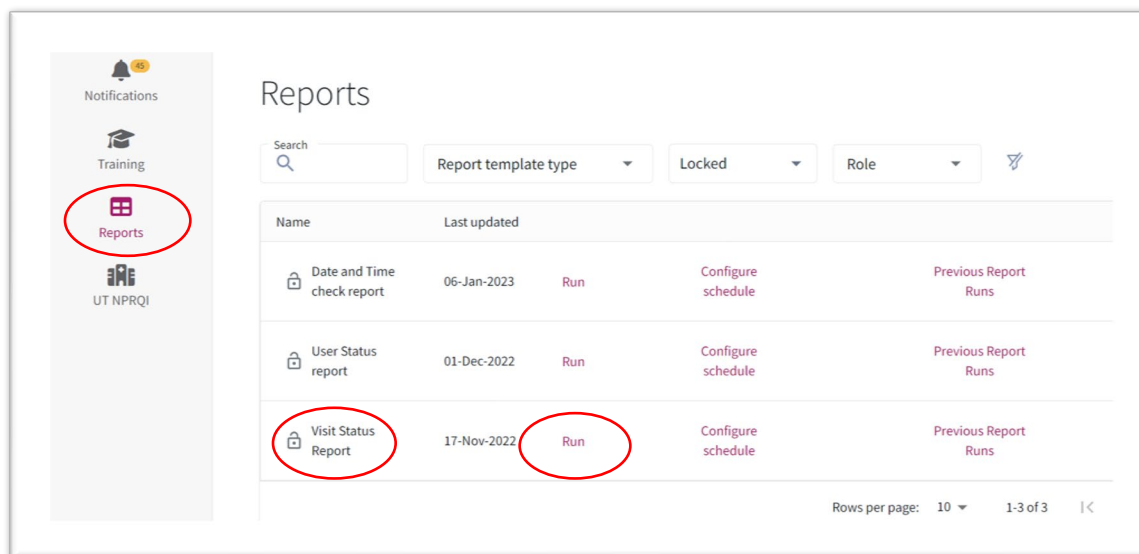
- When prompted with Select Filters screen, select:
  - **File type** (csv or xlsx)
  - **Run Report**

After selecting Run Report, the **Visit Status Report will be emailed** to the user requesting the report. Visit Status Reports may also be customized using the Custom Filters feature or Configure Schedule feature to receive regular reports on a designated schedule.

The Report Runs tab, on the Reports screen, will list previous reports that have been generated for your site. Sites can download previous reports by clicking the "download" button on the right side of the screen.

Sample Visit Status Report:

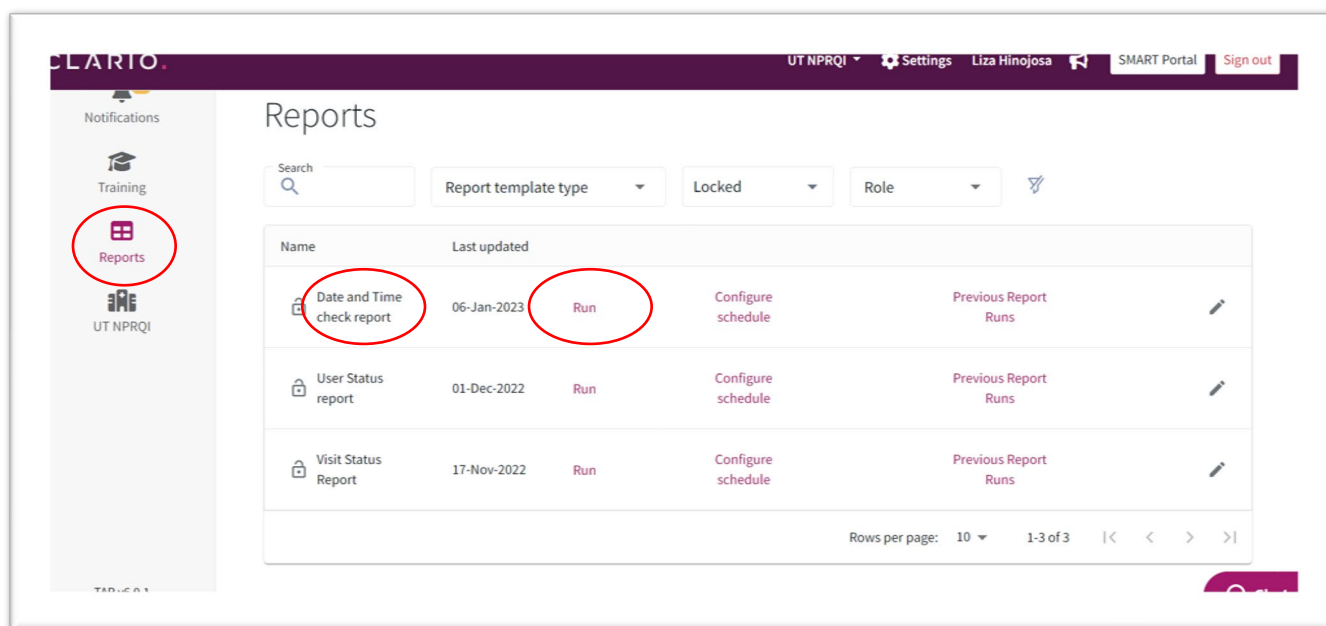| Study Name	Site Identifier/CLMS#	Hospital Name	Person Identifier	Visit ID	Visit Date	Date of record creation	Date and time of last record update	Record completed at (where applicable)	Current Step	Visit Status
UT NPRQI	10000	Test Site 1	LH0001	11850		07-JUN-2022 12:49:41 UTC	07-JUN-2022 13:31:3	07-JUN-2022 13:31:	Data Entry Complete	Approved
UT NPRQI	10000	Test Site 1	LH0002	11851		07-JUN-2022 13:49:36 UTC	07-JUN-2022 14:57:0	07-JUN-2022 14:57:	Data Entry Complete	Approved

How to interpret the Visit Status Report:

Column B: Site ID — Your Site's CLMS#

Column C: Hospital Name — Your hospital's name

Column D: Personal Identifier — Subject ID associated with User that completed record entry

Column E: Visit ID — Automatic ID number generated for each record

Column F: Visit Date — Date patient was seen in the ED

Column G: Date of Record Creation — Date patient record is initially entered into the data platform

Column H: Date and Time of Last Record Update — Date record was last updated

Column I: Record Completed — Date record is completed

Column J: Current Step — Indicates where in the workflow Status of record

Column K: Visit Status — Indicates if record is approved or pending approval
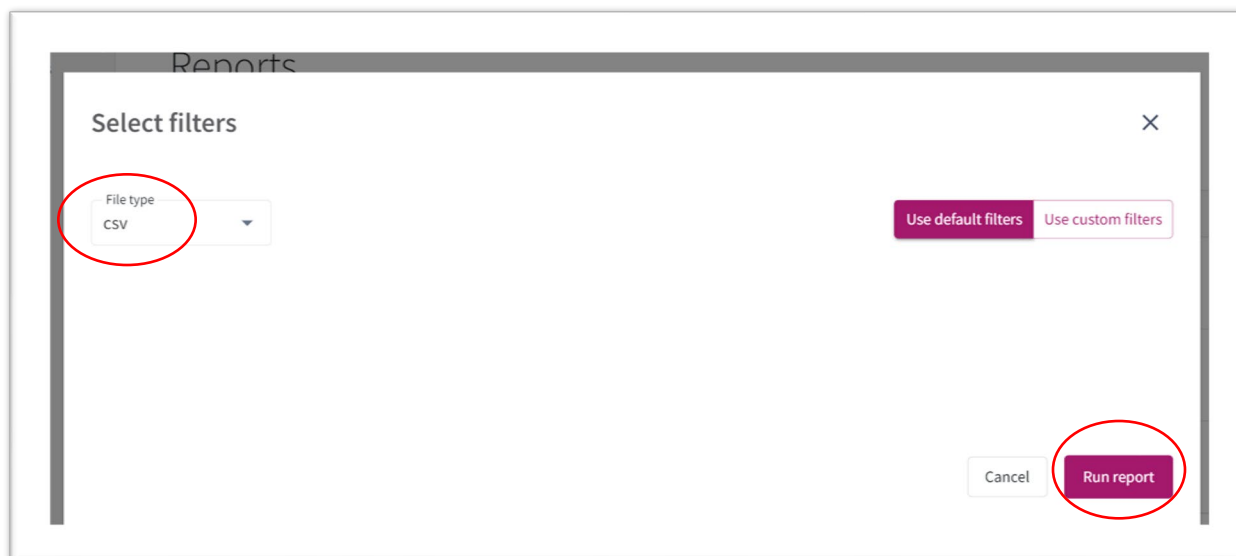
Date and Time Check

How to Access and Download

The following work flow outlines how the **Date and Time Check Report** can be viewed and downloaded:

- Log into the NPRQI Data Entry Platform
- From the landing page, select Reports from the menu on the left
- From the **Date and Time Check Report** option, select **Run**

- When prompted with Select Filters screen, select:
  - **File type** (csv or xlsx)
  - **Run Report**

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After selecting Run Report, the **Date and Time Check Report will be emailed** to the user requesting the report. Date and Time Check Reports may also be customized using the Custom Filters feature or Configure Schedule feature to receive regular reports on a designated schedule.

The Report Runs tab, on the Reports screen, will list previous reports that have been generated for your site. Sites can download previous reports by clicking the "download" button on the right side of the screen.

Sample of Date and Time Check Report:

How to interpret the Date and Time Check Report:

Column A: Site ID	Your Site/ED CLMS#
Column B: Visit ID	ID number automatically generated within the platform for each patient record
Column C: Visit Date	Date of Visit as entered in the initial chart description. Each Medication Date is in Column H. Each Medication Time is in Column I **Make sure that each Medication Date/Time is AFTER the Triage Date and Time**
Column D and E: Date and Time of Triage	Note that the date and time variables are separated into two columns. To calculate Length of Stay, compare Date/Time of Disposition to Date/Time of Triage
Column F and G: Date and Time of Disposition	**Date/Time of Disposition is AFTER Date/Time of Triage.**
Column H and I: Date and Time of Medication Administration	Each Medication Date is in Column H Each Medication Time is in Column I **Make sure that each Medication Date/Time is AFTER the Triage Date and Time**
Column J and K: Date and Time of Oxygen Support	Oxygen Date is in Column J Oxygen Time is in Column K **Make sure that Oxygen Date/Time is AFTER the Triage Date and Time**