LAW ENFORCEMENT FEATURES IN ECS

ELECTRONIC CHART SYSTEM

www.american-data.com

1-800-464-9942

AMERICAN DATA

ECS Integrated Components for Law Enforcement Facilities

Are you looking for healthcare software to serve and support a law enforcement environment at a fraction of the price of other systems? American Data's ECS is an integrated electronic medical record developed to serve law enforcement facilities. ECS understands the need for a user-friendly and affordable program with the necessary tools to monitor and track the health care needs of inmates, starting with the booking process all the way through release. ECS provides electronic nurse's notes and assessments, medication and treatment administration records, mental health notes and assessments, and much more. Additionally, our guided access screens make navigating ECS simple for any staff member. ECS is customizable and can include specific electronic assessments and reports your facility requires.

Booking Process

Nursing Services

Physician Services

Medication Management

Mental Health Services

Data Importing/Interfacing

24/7 Support Line

ECS Cloud Hosting Solution

14 Day Appraisal

14 Day Appraisal Pg 1 | 14 Day Appraisal Pg 2

14 DAY APPRAISAL

Inmate Name: _____ **JCA #:** _____ **D.O.B.:** _____ **Sex:** _____

Date 14 Day Appraisal Completed: _____ ○ 14 Day Appraisal Not Completed (specify reason below)

Comments: _____

GENERAL INFORMATION

Blood Pressure: _____ Pulse: _____ Respiration's: _____ Temperature: _____

O2 Saturation: _____ Weight (lbs): _____ Height (inches): _____

Inmate Status (at time of appraisal)

☐ Cooperative ☐ Lethargic ☐ Alert & Oriented ☐ Appropriately Dressed ☐ Poor Hygiene

☐ Limited Cooperation ☐ Restless ☐ Disheveled ☐ Good Hygiene

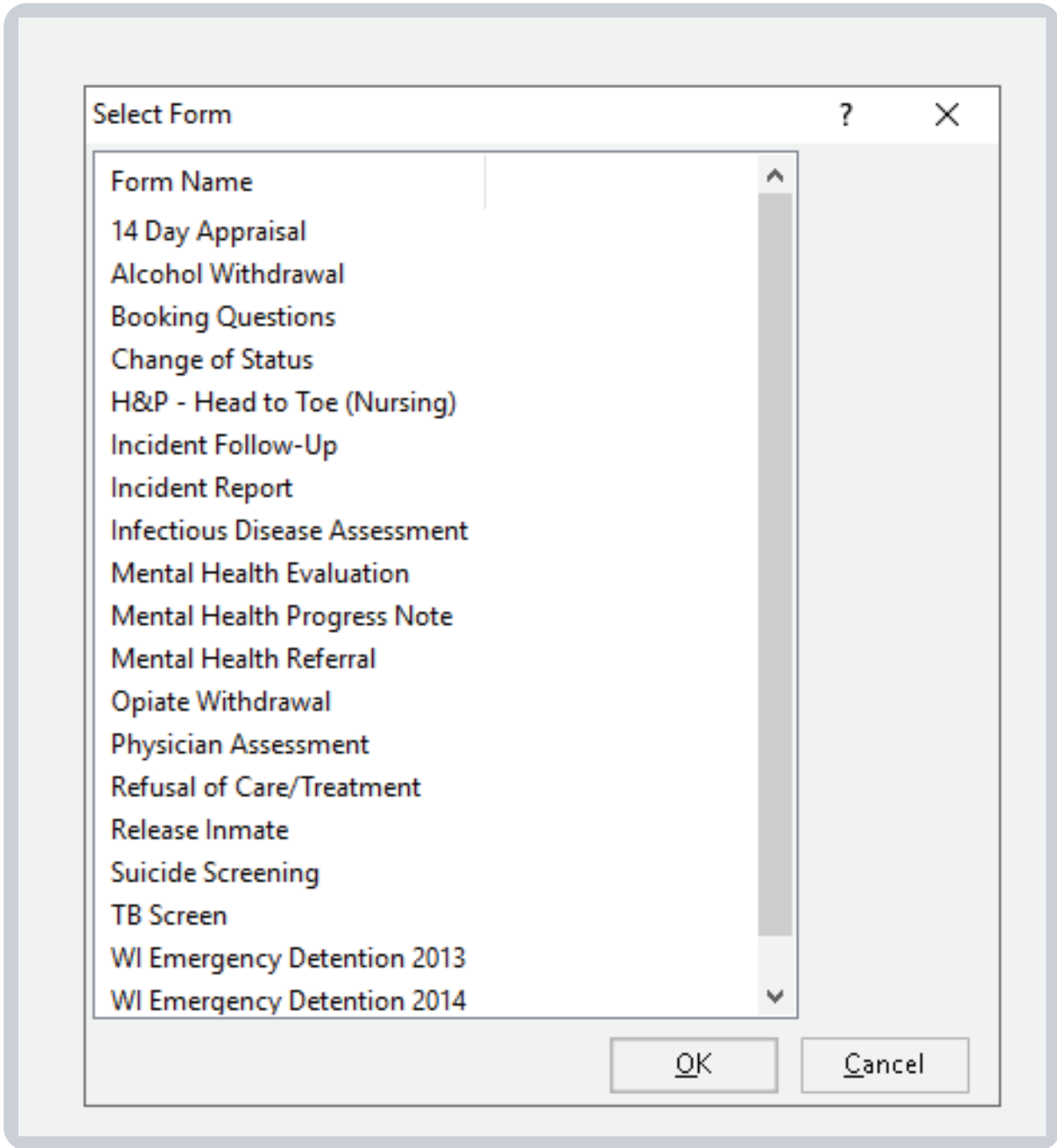
Language: ☐ Speaks English ☐ Limited English Speaking ☐ No English, Needs Interpreter

Additional Comments: _____

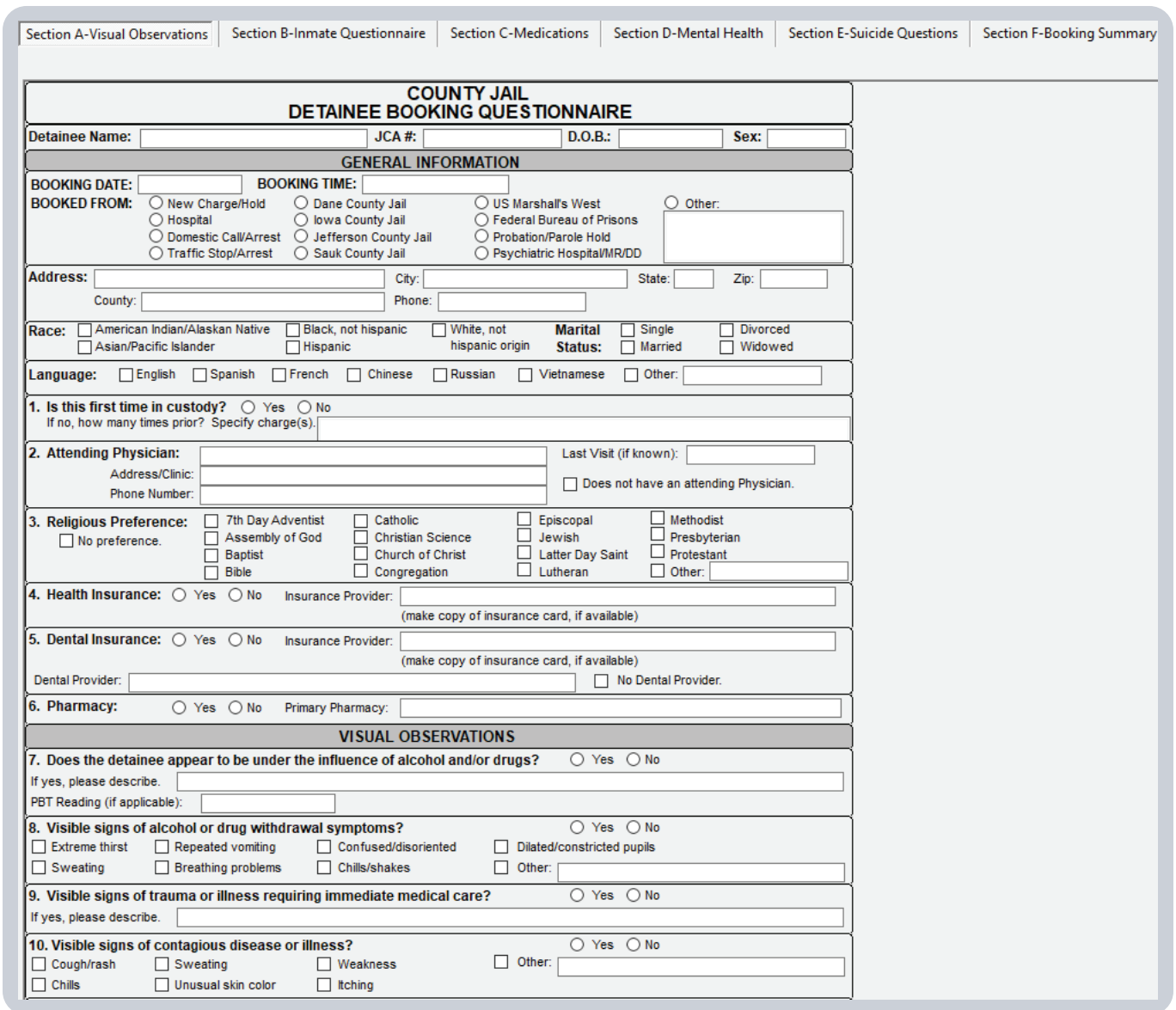
REVIEW OF SYSTEMS

Eye Problems:	○ No ○ Yes ☐ Glasses ☐ Contacts	Comments:	
Ear/Nose/Throat Problems:	○ No ○ Yes	Comments:	
Asthma:	○ No ○ Yes Peak Flow:	Comments:	
Chest Pain/Pressure:	○ No ○ Yes	Comments:	
Heart Disease:	○ No ○ Yes	Comments:	
High/Low Blood Pressure:	○ No ○ Yes	Comments:	
Diabetes:	○ No ○ Yes	Comments:	
Seizure Disorder:	○ No ○ Yes	Comments:	
Respiratory Problems:	○ No ○ Yes	Comments:	
Skin Infections/Sores:	○ No ○ Yes	Comments:	

Preloaded customizable forms and assessments integrated with charting



Booking Questionnaire



Section A-Visual Observations | Section B-Inmate Questionnaire | Section C-Medications | Section D-Mental Health | Section E-Suicide Questions | Section F-Booking Summary

COUNTY JAIL
DETAINEE BOOKING QUESTIONNAIRE

Detainee Name: _____ **JCA #:** _____ **D.O.B.:** _____ **Sex:** _____

GENERAL INFORMATION

BOOKING DATE: _____ **BOOKING TIME:** _____

BOOKED FROM:
- ○ New Charge/Hold
- ○ Hospital
- ○ Domestic Call/Arrest
- ○ Traffic Stop/Arrest
- ○ Dane County Jail
- ○ Iowa County Jail
- ○ Jefferson County Jail
- ○ Sauk County Jail
- ○ US Marshall's West
- ○ Federal Bureau of Prisons
- ○ Probation/Parole Hold
- ○ Psychiatric Hospital/MR/DD
- ○ Other:

Address: _____ City: _____ State: _____ Zip: _____
County: _____ Phone: _____

Race: ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black, not hispanic ☐ Hispanic ☐ White, not hispanic origin

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Russian ☐ Vietnamese ☐ Other: _____

1. Is this first time in custody? ○ Yes ○ No
If no, how many times prior? Specify charge(s). _____

2. Attending Physician: _____ Last Visit (if known): _____
Address/Clinic: _____
Phone Number: _____
☐ Does not have an attending Physician.

3. Religious Preference: ☐ No preference.
☐ 7th Day Adventist ☐ Assembly of God ☐ Baptist ☐ Bible ☐ Catholic ☐ Christian Science ☐ Church of Christ ☐ Congregation ☐ Episcopal ☐ Jewish ☐ Latter Day Saint ☐ Lutheran ☐ Methodist ☐ Presbyterian ☐ Protestant ☐ Other: _____

4. Health Insurance: ○ Yes ○ No Insurance Provider: _____
(make copy of insurance card, if available)

5. Dental Insurance: ○ Yes ○ No Insurance Provider: _____
(make copy of insurance card, if available)
Dental Provider: _____ ☐ No Dental Provider.

6. Pharmacy: ○ Yes ○ No Primary Pharmacy: _____

VISUAL OBSERVATIONS

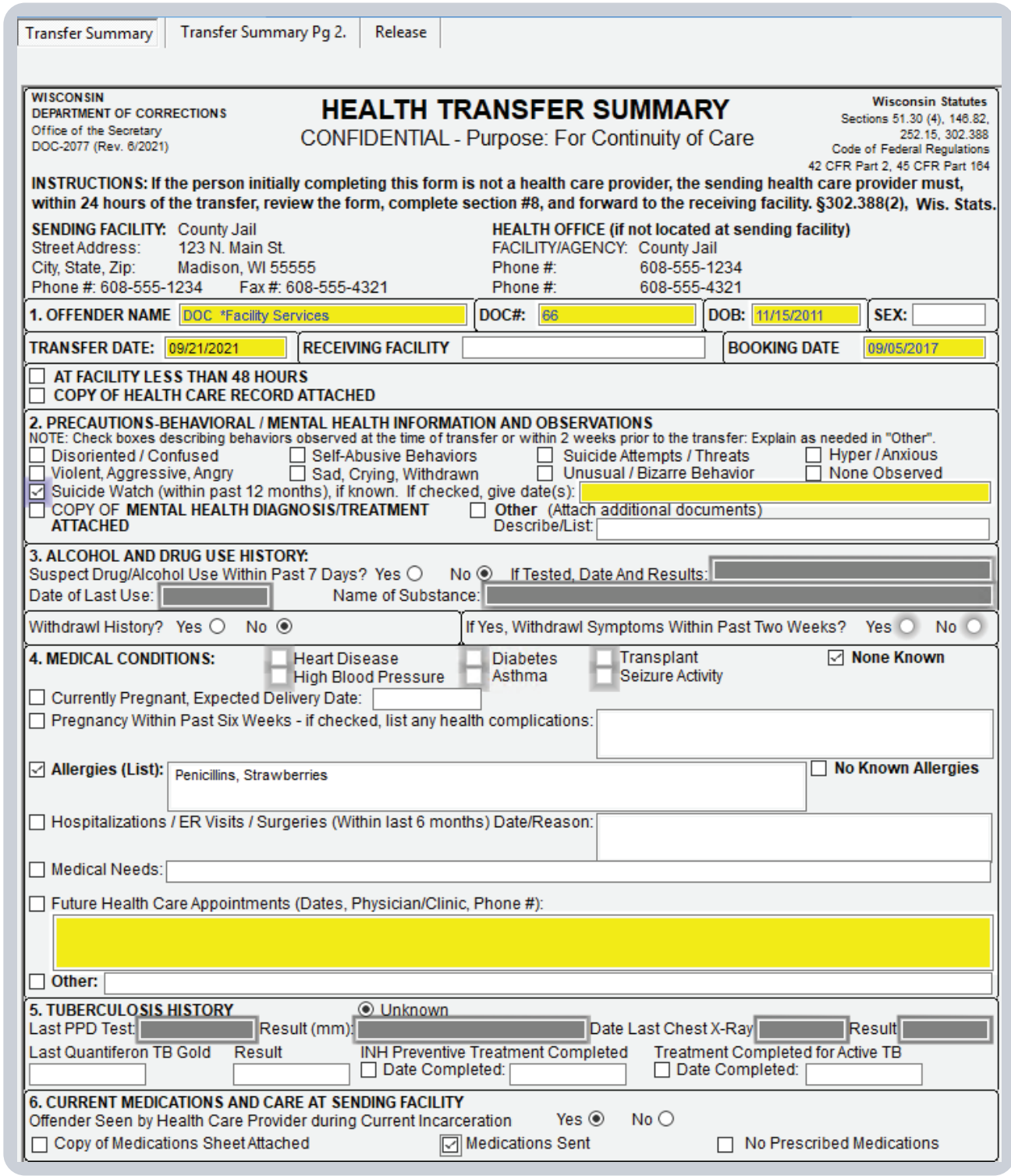
7. Does the detainee appear to be under the influence of alcohol and/or drugs? ○ Yes ○ No
If yes, please describe. _____
PBT Reading (if applicable): _____

8. Visible signs of alcohol or drug withdrawal symptoms? ○ Yes ○ No
☐ Extreme thirst ☐ Repeated vomiting ☐ Confused/disoriented ☐ Dilated/constricted pupils
☐ Sweating ☐ Breathing problems ☐ Chills/shakes ☐ Other: _____

9. Visible signs of trauma or illness requiring immediate medical care? ○ Yes ○ No
If yes, please describe. _____

10. Visible signs of contagious disease or illness? ○ Yes ○ No
☐ Cough/rash ☐ Sweating ☐ Weakness ☐ Other: _____
☐ Chills ☐ Unusual skin color ☐ Itching

Health Transfer Summary



Transfer Summary | Transfer Summary Pg 2. | Release

WISCONSIN
DEPARTMENT OF CORRECTIONS
Office of the Secretary
DOC-2077 (Rev. 6/2021)

HEALTH TRANSFER SUMMARY

CONFIDENTIAL - Purpose: For Continuity of Care

Wisconsin Statutes
Sections 51.30 (4), 146.82, 252.15, 302.388
Code of Federal Regulations
42 CFR Part 2, 45 CFR Part 164

INSTRUCTIONS: If the person initially completing this form is not a health care provider, the sending health care provider must, within 24 hours of the transfer, review the form, complete section #8, and forward to the receiving facility. §302.388(2), Wis. Stats.

SENDING FACILITY: County Jail
Street Address: 123 N. Main St.
City, State, Zip: Madison, WI 55555
Phone #: 608-555-1234 Fax #: 608-555-4321

HEALTH OFFICE (if not located at sending facility)
FACILITY/AGENCY: County Jail
Phone #: 608-555-1234
Phone #: 608-555-4321

1. OFFENDER NAME DOC *Facility Services | **DOC#:** 66 | **DOB:** 11/15/2011 | **SEX:**

TRANSFER DATE: 09/21/2021 | **RECEIVING FACILITY** | **BOOKING DATE** 09/05/2017

☐ **AT FACILITY LESS THAN 48 HOURS**
☐ **COPY OF HEALTH CARE RECORD ATTACHED**

2. PRECAUTIONS-BEHAVIORAL / MENTAL HEALTH INFORMATION AND OBSERVATIONS
NOTE: Check boxes describing behaviors observed at the time of transfer or within 2 weeks prior to the transfer: Explain as needed in "Other".

☐ Disoriented / Confused ☐ Self-Abusive Behaviors ☐ Suicide Attempts / Threats ☐ Hyper / Anxious
☐ Violent, Aggressive, Angry ☐ Sad, Crying, Withdrawn ☐ Unusual / Bizarre Behavior ☐ None Observed
☑ Suicide Watch (within past 12 months), if known. If checked, give date(s):
☐ COPY OF **MENTAL HEALTH DIAGNOSIS/TREATMENT ATTACHED** ☐ **Other** (Attach additional documents) Describe/List:

3. ALCOHOL AND DRUG USE HISTORY:
Suspect Drug/Alcohol Use Within Past 7 Days? Yes ○ No ◉ If Tested, Date And Results:
Date of Last Use: Name of Substance:

Withdrawl History? Yes ○ No ◉ | If Yes, Withdrawl Symptoms Within Past Two Weeks? Yes ○ No ○

4. MEDICAL CONDITIONS: ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Asthma ☐ Transplant ☐ Seizure Activity ☑ **None Known**

☐ Currently Pregnant, Expected Delivery Date:
☐ Pregnancy Within Past Six Weeks - if checked, list any health complications:
☑ **Allergies (List):** Penicillins, Strawberries ☐ **No Known Allergies**
☐ Hospitalizations / ER Visits / Surgeries (Within last 6 months) Date/Reason:
☐ Medical Needs:
☐ Future Health Care Appointments (Dates, Physician/Clinic, Phone #):
☐ **Other:**

5. TUBERCULOSIS HISTORY ◉ Unknown
Last PPD Test: Result (mm): Date Last Chest X-Ray Result
Last Quantiferon TB Gold Result INH Preventive Treatment Completed ☐ Date Completed: Treatment Completed for Active TB ☐ Date Completed:

6. CURRENT MEDICATIONS AND CARE AT SENDING FACILITY
Offender Seen by Health Care Provider during Current Incarceration Yes ◉ No ○
☐ Copy of Medications Sheet Attached ☑ Medications Sent ☐ No Prescribed Medications

Refusal of Care/Treatment

Refusal of Care/Treatment

REFUSAL OF CARE / TREATMENT

Inmate Name: _____ **JCA #:** _____ **D.O.B.:** _____ **Sex:** _____

Criteria for Refusing Care

The inmate must meet all of the criteria below.

1. Inmate is age 18 or older.
2. Inmate exhibits no evidence of:
   * Altered level of consciousness
   * Alcohol or drug ingestion that would impair judgement
3. The inmate understands the nature of the medical condition, as well as risks and consequences of refusing care/treatment.

Acknowledgement of Information

Inmate must initial items below.

A. _____ I have been advised that medical care on my behalf is necessary, and that refusal of care and assistance could be hazardous to my health, and under certain circumstances, including disability or death.

OR

B. _____ I acknowledge that I may have a medical problem which may require additional medical attention, and that County Jail or an ambulance is available to transport me to the hospital. Instead, I elect to seek alternative medical care and/or refuse further evaluation, treatment and/or transport.

Describe treatment being refused:

Release of Liability

Inmate must initial items below.

A. _____ By signing this form, I am releasing County Jail, of any liability or medical claims resulting from my decision to refuse care against medical advice.

Signatures

I have read and understand the Acknowledgement of Information and Release of Liability.

Signature:_____ **Date:**_____

* If you change your mind, or your condition changes, call 911 in an emergency, go to the ER, or call your private physician, if appropriate.

Staff Completing Refusal of Care: _____ **Date of Refusal:** _____

Signature:_____ **Date:**_____

Signatures on Assessments

BOOKING SUMMARY

42. Booking Summary

Is request needed for mental health services? ☐ No ☐ **Yes - Place Request**

Jail supervisor notified? ☐ No ☐ Yes Who was notified?

Special Precautions: (check all applicable)

- ☐ Constant Supervision
- ☐ Active Supervision (every 15 minutes)
- ☐ 30 Minute Watch (not to be used for Suicide Risk Watch)
- ☐ No Special Precautions Needed
- ☐ Clothing Removed
- ☐ Bedding Removed
- ☐ Other:

Does the detainee have any other non-emergency health related concerns to report? ☐ No ☐ Yes (specify below)

Is request needed for sick call? ☐ No ☐ **Yes - Place Request**

Person Completing Questionnaire:

Specify Name | Badge Number | Date | Time

43. Inmate Acknowledgment

I acknowledge the information provided by me to the Jail was to the best of my knowledge and ability, in providing accuracy and truth without pursuasion.

Detainee Signature

Date

☐ Check this box if inmate refuses to sign at the booking process.

Comments:

If detainee refuses to complete the booking process or sign at booking, further attempts to complete the form and/or signature should be attempted and documented below.

Second Attempt Completed By:

Specify Name | Badge Number | Date | Time

Third Attempt Completed By:

Specify Name | Badge Number | Date | Time

Suicide Screening

Suicide Screening

SUICIDE SCREENING

Detainee Name: DOC *Facility Services **JCA #:** 66 **D.O.B.:** 11/15/2011 **Sex:**

To your knowledge, does the detainee have a history of suicidal behavior? ○ Yes ○ No

If yes, please describe.

Has detainee been hospitalized in the past year for a suicide attempt or feeling suicidal? ○ Yes ○ No

How many times? How long in hospital?

When and where?

What method was used?

What was going on that caused suicidal feelings?

Did detainee let anyone know they were feeling suicidal? ☐ No ☐ Yes Who?

What treatment did the detainee receive?

What is the name of MD/mental health professional who approved the hospitalization?

Has the detainee ever had thoughts of suicide and not been hospitalized? ○ Yes ○ No

What were the circumstances?

How close did detainee come?

Has detainee been treated for depression? ☐ No ☐ Yes

Have any family members been treated for depression or related issues? ☐ No ☐ Yes

Have any family members ever attempted or committed suicide? ☐ No ☐ Yes

Is detainee thinking of hurting and/or killing themselves currently? ○ Yes ○ No

Why?

Has detainee thought about how they would do it? ☐ No ☐ Yes

Does the detainee have a plan or method in mind? ☐ No ☐ Yes How?

Has detainee thought about "when" they would do it? ☐ No ☐ Yes When?

Has detainee ever tried to kill themselves when in jail or prison before? ☐ No ☐ Yes

How?

Is there anyone to contact who may be able to help? ☐ No ☐ Yes Who?

What can the jail better do to help detainee feel better and get through this hard time?

Summary

If yes, would you like to initiate a suicide watch? ☐ **Yes - Initiate Suicide Watch** ☐ **No** Date: Time:

Reason:

Precaution Level:

☐ 15 Minute
☐ 30 Minute
☐ 1 Hour
☐ Ferguson Gown
☐ Uniform
☐ Holding Cell
☐ General Population

Additional Instructions:

Special Precautions: (check all applicable) ☐ No Restrictions necessary at this time.

Clothing:

☐ No restrictions.
☐ Ferguson Gown and undergarments
☐ Ferguson Gown no undergarments
☐ Uniform, no undergarments
☐ Ferguson Gown, night time only

Property (may have):

☐ No restrictions.
☐ No personal property allowed
☐ Pencil (potential weapon)
☐ Toothbrush and toothpaste

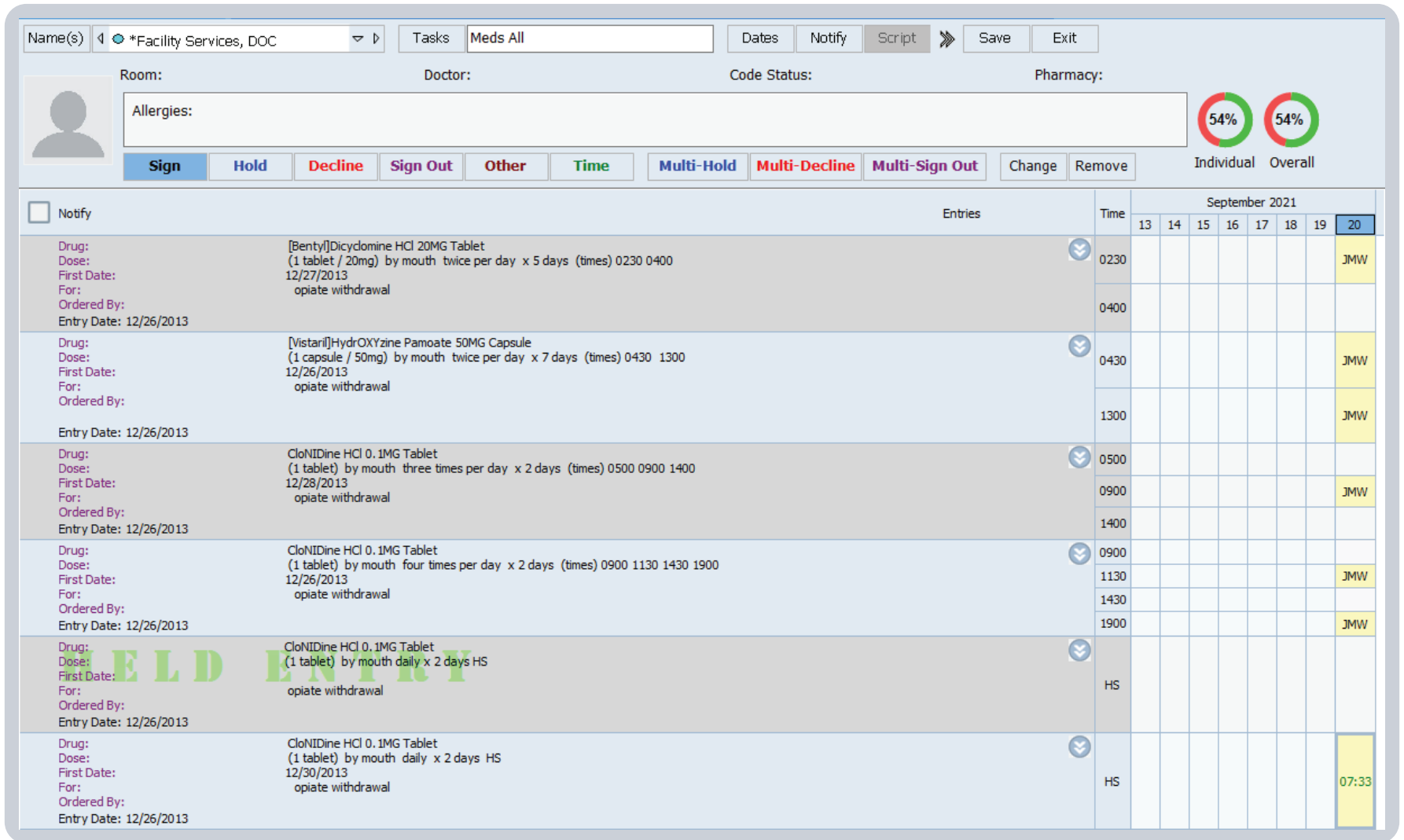
Linens:

☐ No restrictions.
☐ Ferguson blanket
☐ Linens:

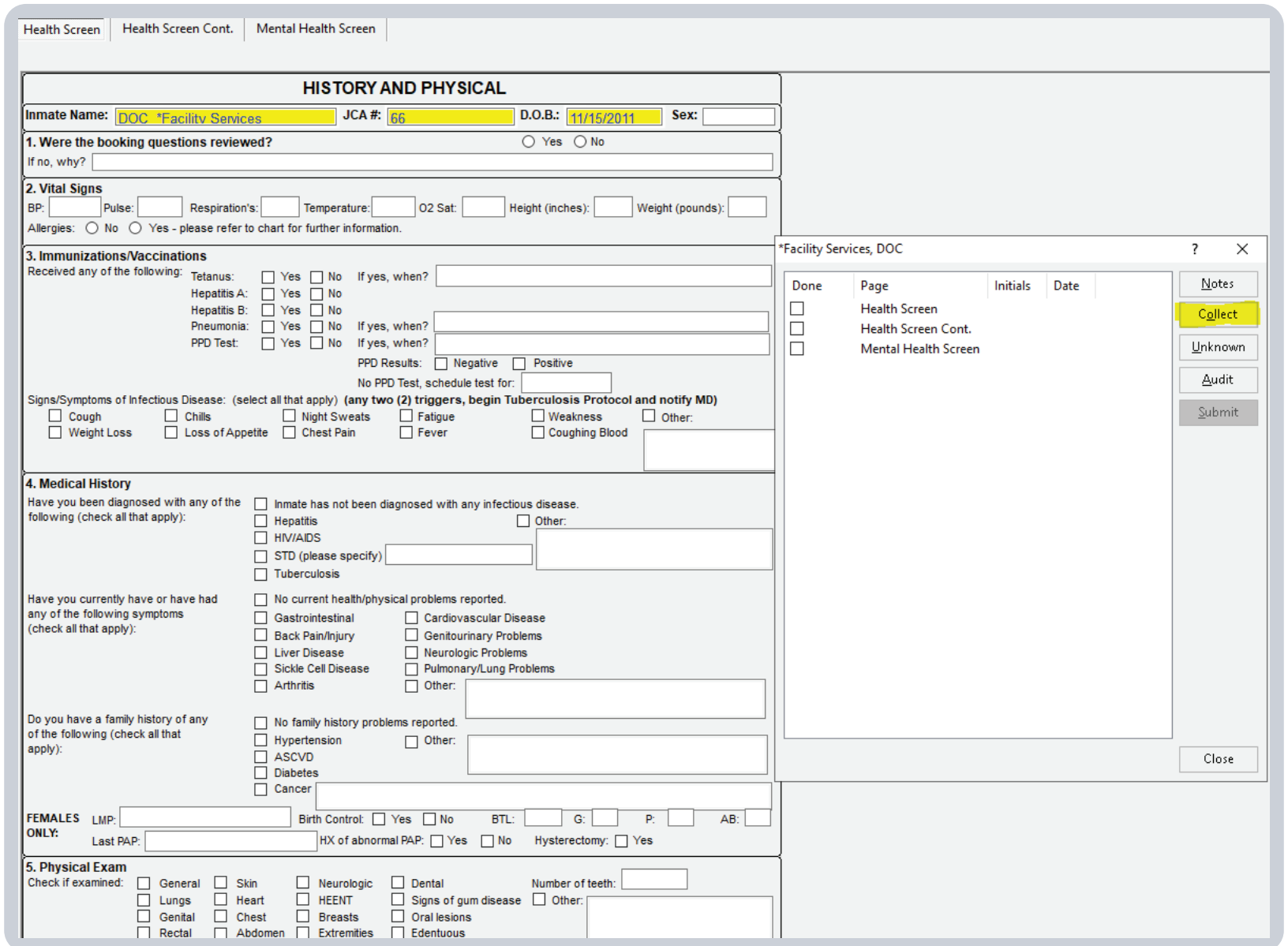
Privileges:

☐ No restrictions.
☐ POD day/holding cell lights out
☐ Multi-purpose room without supervision
☐ Multi-purpose room with supervision

Medication Administration Record



Head to Toe Assessment



Customizable workflow display with personal access screens

Nurse	Assessments	Charting	Log/Watches	Other	Chart Review	Send Message
Main Menu	Start an Assessment	Nurse Note	Active Watches	Appointment Schedule	View Chart	Write Internal Memo
	Change Assessment	Diagnosis Information	Medical Watch	Edit To Do List	Reports	View Messages
	Continue Assessment	Personal Information	Sick Call Request	Physician Orders		
	Delete Assessment	To Do List	Sleep Log (start/end)	MAR/TAR		
	View Assessment		Sleep Log Follow Up			
			Suicide Watch			

Nurse Notes

Nurse Note

PURPOSE FOR NOTE:	VITAL SIGNS	ACUTE NOTE (MISC.):	SKIN STATUS:		RESPIRATORY:	CARDIOVASCULAR STATUS:	GI/DIGESTIVE:	GU/URINE STATUS:	MUSCULOSKELETA
new or sudden onset/change	BP:	Lab results:	no skin issues	Location:	Respiratory Complaint:	Circulatory Complaint:	GI/Digestive Complaint:	Urinary Complaint:	Musculoskeletal c
ongoing change in condition	Ortho BP:	Fever:	NEW Skin Impairment:	Treatment:	Respiration Characteristics:	Pulse Characteristics:	Abdomen:	Urinary/Renal pain:	Musculoskeleta
follow-up	Pulse:	Mood:	Surgical Wound:	Dressing:	Nasal discharge:	Chest Pain:	Bowel Sounds:	Urine Clarity:	Movement/limi
progress note	Respirations:	Behavior:	Abrasion/Bruise:	Depth:	Cough:	Edema:	Vomitus:	Voiding Concerns:	Swelling:
	Temp:	^ Additional behavior	Rash:	Size:	Lung Sounds:	Circulation:	Stool Output:	Peritoneal Concerns:	Precaution
	Weight (lbs):	Infection/ABT:	Blister:	Color:	Mucus:	Cardiac Implant/Device:	Oral/dental:	Catheter:	Positionin
	Height (inches):	Isolation:	Wound:	Drainage:	Oxygen:	Peripheral Pulse:	Swallowing:	Urine sample:	Exercise/RC
	Pulse Oximetry:	Medication:	Pressure Area:		Nebulizer:	Anti-anginal:	Colostomy:		Assistive Dev
	Blood Glucose:	COVID-19:	Other skin issue:		Trach:	Diuretic/BP Med:	Feeding Tube:		
	Pain (0-10):				Suctioning:	Positioning:			
	Pain (descriptor):								
	Fluid Intake (mL):								
	Fluid Output (mL):								

Active Inmate Watches and Treatments

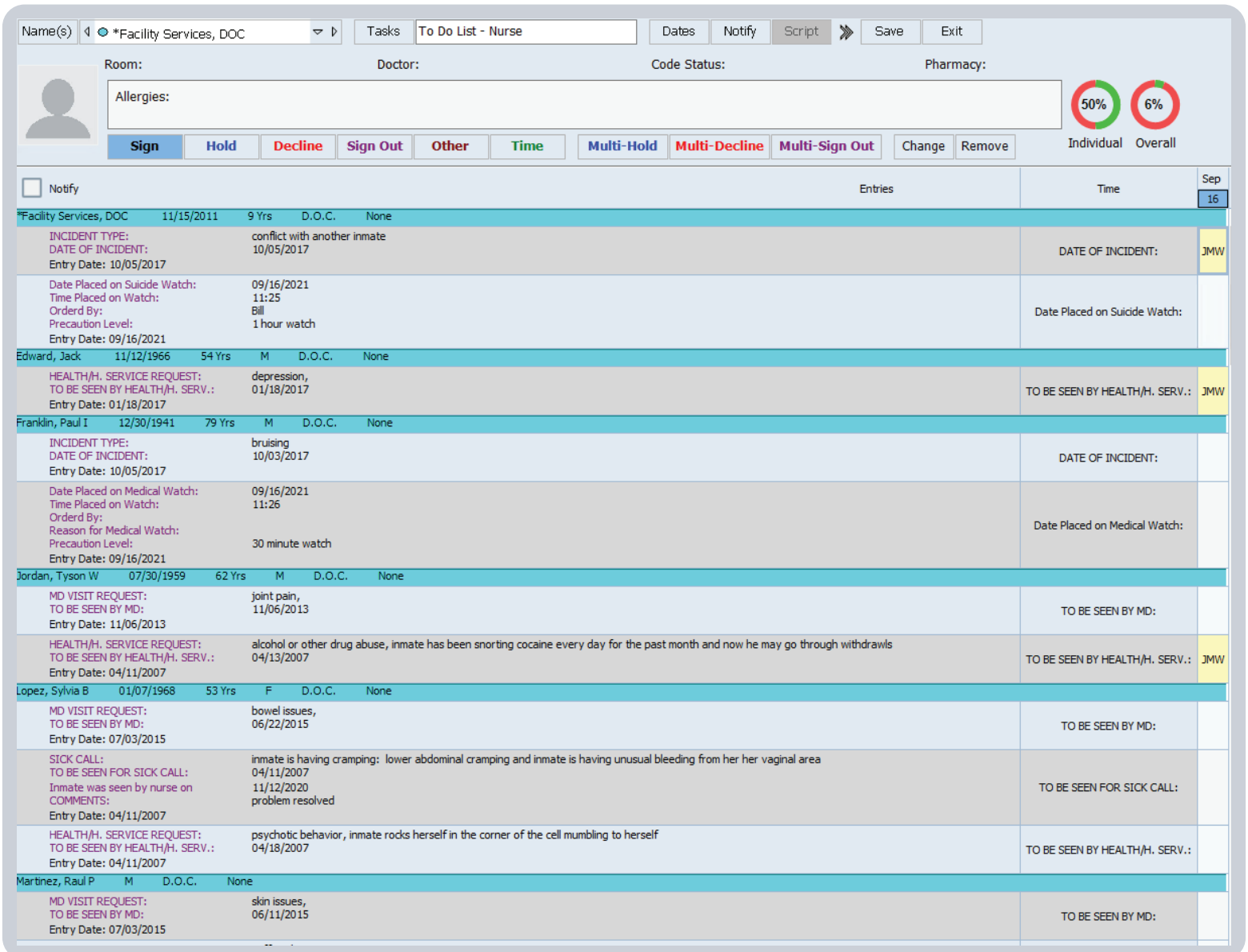
Active Inmate Watches and Treatments

09/16/2021

D.O.C.

Inmate	Sleep Log Order	Suicide Watch	Medical Watch	Active TB TX
*Facility Services, DOC		1 hour watch		
Edward, Jack		1 hour watch General population		
Franklin, Paul I		1 hour watch General population	30 minute watch	
Martinez, Raul P			1 hour watch	
Rogers, Hillary K	2 Hour		1 hour watch	
Smith, Liz		15 minute watch Ferguson Gown		
6	1	4	3	

To Do List


Name(s)
*Facility Services, DOC
Tasks
To Do List - Nurse
Dates
Notify
Script
Save
Exit
Room:
Doctor:
Code Status:
Pharmacy:
Allergies:
Sign
Hold
Decline
Sign Out
Other
Time
Multi-Hold
Multi-Decline
Multi-Sign Out
Change
Remove
50%
6%
Individual
Overall
Notify
Entries
Time
Sep
16
*Facility Services, DOC 11/15/2011 9 Yrs D.O.C. None
INCIDENT TYPE: conflict with another inmate
DATE OF INCIDENT: 10/05/2017
Entry Date: 10/05/2017
DATE OF INCIDENT:
JMW
Date Placed on Suicide Watch: 09/16/2021
Time Placed on Watch: 11:25
Orderd By: Bill
Precaution Level: 1 hour watch
Entry Date: 09/16/2021
Date Placed on Suicide Watch:
Edward, Jack 11/12/1966 54 Yrs M D.O.C. None
HEALTH/H. SERVICE REQUEST: depression,
TO BE SEEN BY HEALTH/H. SERV.: 01/18/2017
Entry Date: 01/18/2017
TO BE SEEN BY HEALTH/H. SERV.:
JMW
Franklin, Paul I 12/30/1941 79 Yrs M D.O.C. None
INCIDENT TYPE: bruising
DATE OF INCIDENT: 10/03/2017
Entry Date: 10/05/2017
DATE OF INCIDENT:
Date Placed on Medical Watch: 09/16/2021
Time Placed on Watch: 11:26
Orderd By:
Reason for Medical Watch:
Precaution Level: 30 minute watch
Entry Date: 09/16/2021
Date Placed on Medical Watch:
Jordan, Tyson W 07/30/1959 62 Yrs M D.O.C. None
MD VISIT REQUEST: joint pain,
TO BE SEEN BY MD: 11/06/2013
Entry Date: 11/06/2013
TO BE SEEN BY MD:
HEALTH/H. SERVICE REQUEST: alcohol or other drug abuse, inmate has been snorting cocaine every day for the past month and now he may go through withdrawls
TO BE SEEN BY HEALTH/H. SERV.: 04/13/2007
Entry Date: 04/11/2007
TO BE SEEN BY HEALTH/H. SERV.:
JMW
Lopez, Sylvia B 01/07/1968 53 Yrs F D.O.C. None
MD VISIT REQUEST: bowel issues,
TO BE SEEN BY MD: 06/22/2015
Entry Date: 07/03/2015
TO BE SEEN BY MD:
SICK CALL: inmate is having cramping: lower abdominal cramping and inmate is having unusual bleeding from her her vaginal area
TO BE SEEN FOR SICK CALL: 04/11/2007
Inmate was seen by nurse on 11/12/2020
COMMENTS: problem resolved
Entry Date: 04/11/2007
TO BE SEEN FOR SICK CALL:
HEALTH/H. SERVICE REQUEST: psychotic behavior, inmate rocks herself in the corner of the cell mumbling to herself
TO BE SEEN BY HEALTH/H. SERV.: 04/18/2007
Entry Date: 04/11/2007
TO BE SEEN BY HEALTH/H. SERV.:
Martinez, Raul P M D.O.C. None
MD VISIT REQUEST: skin issues,
TO BE SEEN BY MD: 06/11/2015
Entry Date: 07/03/2015
TO BE SEEN BY MD:

Contact Us

Schedule your Demo Today!

American Data takes care of your facility by offering software that far beats the price of competitors. Scan the QR code or call **1-800-464-9942** to schedule a demo today!

Our Annual Price: $295/Bed

AMERICAN DATA

info@american-data.com | www.american-data.com | 1-800-464-9942