*Los Angeles County EMS Agency*

# SITUATION REPORT INSTRUCTIONS

## PURPOSE

The Los Angeles County Situation Report is designed so that each participant in the EMS system has the opportunity to provide feedback and input into the EMS System. This form is intended to provide hospitals and providers with a standardized method of documenting and reporting any unusual situation.

A Situation Report assists the EMS Agency, provider agencies and hospitals in constantly upgrading the delivery of emergency medical services in Los Angeles County and potentially improving patient care.

## PROCEDURE

Each of the three sections of the form -- GENERAL INFORMATION, NOTIFICATION and DOCUMENTATION -- should be completed as fully as possible. If information required on the report is unknown to an individual writing the report, assistance should be obtained from his/her base hospital Prehospital Care Coordinator, provider agency EMS Coordinator, receiving hospital Emergency Department Manager or appropriate supervisor.

## DISTRIBUTION

Distribution of report copies is dependent on the nature of the situation and is generally determined by the party or agency/hospital initiating the report. In general, whenever completing a Situation Report involving prehospital personnel, a copy of the form should be submitted to the individual's employer.

The Reporting Party shall retain the original copy. Spaces are provided at the bottom of the Situation Report (canary and pink copies) to indicate specific recipients of the form, such as:

- Base Hospital
- Receiving Hospital
- Provider Agency
- Individual

Examples of situations requiring submission of the EMS Agency copy include, but are not limited to:

- Exemplary performances
- Actions identified in Reference No. 214 of the Prehospital Care Policy Manual
- Patient outcomes requiring review
- Poison Control Center issues

When applicable, forward EMS Agency copies to:

Los Angeles County EMS Agency
**SITUATION REPORT**

Send Email

## GENERAL INFORMATION

DATE OF SITUATION: ____/____/____ TIME: _____ ☐ AM ☐ PM SEQUENCE NO. _____
(attach copy of EMS Report Form)

☐ CONFIDENTIAL

CALL LOCATION: _____ SITUATION LOCATION: ☐ ON SCENE ☐ AT HOSPITAL ☐ ENROUTE ☐ OTHER

PT. NAME: _____ MEDICAL RECORD # or D.O.B.: _____

| PERSONNEL INVOLVED | AGENCY/FACILITY | DISCUSSED WITH INDIVIDUAL(s) |
|---|---|---|
| ____ | ____ | ☐ YES ☐ NO |
| ____ | ____ | ☐ YES ☐ NO |
| ____ | ____ | ☐ YES ☐ NO |
| ____ | ____ | ☐ YES ☐ NO |
| ____ | ____ | ☐ YES ☐ NO |

## NOTIFICATION

NAME AND TITLE OF ON DUTY SUPERVISOR, PCC, or PARAMEDIC COORDINATOR NOTIFIED (if applicable): _____

DATE OF NOTIFICATION: ____/____/____ TIME: _____ ☐ AM ☐ PM

NAME: _____ TITLE: _____
(Please Print)

SIGNATURE: _____ REPORT DATE: ____/____/____

AGENCY/FACILITY: _____

## DOCUMENTATION

☐ ISSUE or ☐ COMMENDATION:

- ☐ Airway
- ☐ AMA
- ☐ Base Contact Criteria
- ☐ Destination
- ☐ Dispatch
- ☐ Documentation
- ☐ Equipment
- ☐ Hospital Diversion
- ☐ Interpersonal Issue
- ☐ MCI
- ☐ Medication
- ☐ Patient Assessment
- ☐ Patient Transfer
- ☐ Patient Treatment
- ☐ Patient Report
- ☐ Poison Control Center
- ☐ Policy Clarification
- ☐ Scope of Practice
- ☐ Standing Field Treatment Protocols
- ☐ Supply/Resupply
- ☐ Other _____

ACCOUNT OF SITUATION (Use additional paper if necessary):

☐ Isolated Event ☐ Recurring Problem

PROPOSED RESOLUTION:

☐ For Information--No Action Necessary ☐ Resolution Documentation Attached

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