304 INCIDENT REPORTING

I. POLICY:

A. All incident reports shall be entered into the District's software reporting system (www.emergencyreporting.com) immediately upon return of an incident.
B. Any incident that involves the provision of patient care, to include refusal of care, shall be documented using the SOAPE format. A separate narrative and individualized information will be entered for each patient. Patient narratives will only be entered in the "Patient Narrative" section of the reporting program.
C. Any medical incident that involves the establishment of "Command" for mitigating extenuating circumstances (e.g.: multiple patient alarms, extensive extrication, etc.) shall have a Command narrative completed utilizing the PAST format. This information will be entered in the NFIRS narrative section of the program.
D. All incidents shall:
   1. Be entered into Emergency Reporting.
   2. Be recorded in the incident logbook.
   3. Have an Information Release form completed.
   4. Have any Patient Refusal forms attached to the Information Release forms.

II. RESPONSIBILITIES

A. Incident Commanders (IC) are responsible for ensuring that incident reports are completed per the procedures outlined in this guide. Incidents of a critical nature are expected to have the reports completed by the IC.
B. Primary care givers for medical/trauma patients are responsible for completing medical reports.
C. Duty Officers are responsible for monitoring report completion to include compliance with the procedures outlined in this guide.
D. Duty Officers are responsible for ensuring accurate logbook entries are made.
E. The Battalion Chief or his/her designee will monitor the quality of all reports and make recommendations for improvement as required.

III. GUIDELINES:

A. As a general rule, all incident reporting shall occur immediately after the incident.
B. Any incident involving critical patient status, a fatality, high dollar loss, a Fire District accident, significant environmental exposure, increased media or public interest, or any other incident that the shift leader or on-call officer determines early documentation is necessary, shall be completed by required personnel prior to leaving the station.
C. Any incident report may be started by someone other than the responsible party. However, the primary patient care-giver and or incident commander is ultimately responsible for the entire report and its contents.
D. All incident narratives must be completed by the person(s) responsible for the report. Always identify yourself as the report writer in the narrative section.
E. Only the information contained in the Information Release Form may be disseminated to the public or media unless authorized by the Fire Chief.

SOAPE

(S) SUBJECTIVE AND SCENE INFORMATION:

- Dispatch information – type, time, location, etc.
- En route updates – via dispatch, other fire, other agencies, etc.
- Weather (as applicable)
- Personnel and apparatus
- Verbal report – What have I got? What do I need? Who is in command? What am I doing?
- Size-up – walk around, crew updates, witness information, area of involvement, etc.
- Identify yourself as the report writer
- Age of the patient, gender, race, weight in Kg, chief complaint, scene description, history of the event, pertinent medical history of the patient, patient physician, medications, allergies, other extenuating circumstances, history of smoking, if known.

(O) OBJECTIVE INFORMATION:

- This information you find on your complete head-to-toe physical examination. Level of consciousness/psychiatric status, skin vitals, vital signs (baseline, B/P, pulse, respirations), H.E.E.N.T., neck, spine, thoracic, abdominal, pelvic, lower extremities, upper extremities, neurological including motor and sensation, note placement of medical alert tags.

(A) ASSESSMENT:

- The patient diagnosis. May include more than one.

(P) PLAN/EVALUATION:

- Additional resources
- Pertinent times: ambulance arrival, extrication complete, etc.
- Safety Action
- Evaluation/observation/reassessment
- Post incident status – security measures, CCSO on scene, etc.
- Plan of treatment. Record of your patient care and its results. Record whether the patient's condition improved, continued to decline, stabilized, etc.

PAST

(P) PREARRIVAL:

- Dispatch information – type, time, location, etc.
- En route updates – via dispatch, other fire, other agencies, etc.
- Weather
- Personnel and apparatus
- Identify yourself as the report writer.

(A) ARRIVAL:

- Time(s)
- Verbal report – What have I got? What do I need? Who is in command? What am I doing?
- Size-up – walk around, crew updates, witness information, area of involvement, etc.

(S) STRATEGY/TACTICS:

- Additional resources
- Identified strategic goal (offensive/defensive, containment, etc.)
- Tactical operations
- Pertinent times: fire under control, roof collapse, etc.
- Safety Action
- Evaluation/observation/reassessment

(T) TERMINATION:

- Time
- Post incident property status – security measures, CCFMO on-scene, etc.
- Conclusion – estimated dollar loss, extent of damage, etc.
- Injuries/death
- Origin/cause/circumstance