| NOR-CAL EMS | 5003 | Transition from MCI to Medical Disaster |
|---|---|---|
| Nor-Cal EMS Policy & Procedure Manual | | Hospital |
| Effective Date: 01/01/2021 | | Next Revision: 01/01/2024 |
| Approval: Jeffrey Kepple MD – MEDICAL DIRECTOR | | SIGNATURE ON FILE |

## AUTHORITY:

Health and Safety Code Division 2.5, California Code of Regulations, Title 22, Division 9

## PURPOSE:

To provide guidelines to assist responding agencies and Operational Areas (OA) in formulating a response to best serve the greatest number of casualties with resources available to them.

## DEFINITIONS:

1. A **Multi-Casualty Incident (MCI)** exists when current personnel and equipment are not adequate to care for all the victims involved. A normal level of stabilization and care cannot be achieved until additional resources are available.
2. A **Medical Disaster** exists in the wake of a disastrous event, when the health care system is overwhelmed, resulting in an exorbitant number in need that the emergency management system cannot function with the resources available.

## CONSIDERATIONS:

1. Depending on the disaster-type, early communication of findings and concerns allows prompt contact with resources infrequently needed (ie, Disaster Management Assistance Teams (DMAT), CAL-MAT, Office of Emergency Services (EMS), National Guard, State, and Federal infectious disease teams, etc.).
2. Medical disasters include inconceivable situations where regional planning and resource coordination cannot be fully comprehended, requiring a multi-agency approach. These events include—but are not limited to—situations involving:
    A. Large scale vehicle accidents (ie, passenger trains, etc.)
    B. Hazardous material incidents affecting entire communities or towns (ie, air and water contamination, etc.)
    C. Environmental events (ie, wildfire, earthquakes, volcanic eruptions, etc.)
    D. Mass violence (ie, political upheaval, etc.)
    E. Bio-terrorism (ie, anthrax, Ebola, etc.)
    F. Weapons of mass destruction (WMD) (ie, is a nuclear, radiological, chemical, biological, or other device that is intended to harm a large number of people).
    G. Extreme weather conditions (ie, severe heat/cold, etc.)
    H. Highly infectious disease outbreak (ie, COVID-19, MERS, SARS, etc.)

**CONSIDERATIONS** *(Continued)*:

3. Despite these examples, many disasters are unknown to responding units until their arrival. A focused, and decisive scene size-up is imperative for early identification of both an MCI and medical disaster.

**RESPONSE:**

1. Initial response:
    A. A focused scene size-up is imperative when a potential disaster incident exists. Responders are required to maintain situational awareness to quickly identify evidence of an underlying disaster event (ie, colored plume coming from a tanker/ truck, a significant number of symptomatic or unresponsive victims.
    B. Communicate findings to the designated control facility (CF) immediately.
2. Scene Communication
    A. The nearest CF should be contacted immediately as outlined in the *Revised 10-2020 Region III MCI Plan Manual 1*.
    B. Scene priorities after CF contact include:
        i. Establishing an estimated number of actual and potential victims. Update this number as the incident progresses.
        ii. Quickly identify when the breadth and complexity of the event begin to overwhelm the OA—leading to prolonged patient scene times. These concerns shall be immediately translated to IC.
        iii. The IC shall then notify the Medical Health Operational Area Coordinator (MHOAC) who will contact NOR-CAL EMS and the Regional Disaster Medical Health Specialist/Coordinator (RDMHS/C) to organize further resource needs ***(See Figure 1, below)***.
    C. After IC communication, responders will continue to transport all immediate patients from the scene to appropriate and available facilities.
3. Agency Responsibilities
    A. Regional Disaster Medical Health Specialist/Coordinator (MHOAC):
        a. The MHOAC will notify NOR-CAL EMS and the RDMHS/C and assume responsibility for its 17-programmatic functions ***(see Figure 1, below).***
    B. Regional Disaster Medical Health Specialist/Coordinator (RDMHS/C):
        a. The RDMHS/C in conjunction with the MHOAC and NOR-CAL EMS decide to establish Field Treatment Sites (FTS) to care for the remaining affected victims or the involved community.

**RESPONSE** (*Continued*)**:**

b. The primary purpose of an FTS is to facilitate the stabilization of casualties for evacuation from the disaster site to a more definitive facility. FTS care is directed primarily to the moderately and severely injured or ill with the potential of surviving until they are evacuated to a definitive care facility, mobile field hospital, or other capable medical field treatment center.

c. The following considerations determine the need to establish an FTS:

- With the request for an FTS, it is assumed that an influx of casualties during 24 hours will be greater than the surge capacity of the local medical services.
- There is an expanded need for triage, medical stabilization, and subsequent evacuation of casualties.
- Further medical resources are required due to the extent of injuries and the volume of those involved. These resources include physicians, advanced practice providers, nurses, supplies, etc, as required for mass treatment and throughput of large numbers of affected or injured patients.
- Alternate Care Sites (ACS) should be considered by the OA if long-term support is needed or the community medical services infrastructure is affected.
- If long-term support is needed and the community medical services infrastructure is affected, the OA should consider establishing an Alternate Care Site (ACS), per the guidelines established by California Department of Public Health (CDPH) (California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies: Volume II: Government-Authorized Alternate Care Sites.)

4. Field Treatment Sites (FTS) and Alternative Care Sites (ACS) Considerations

A. Due to the limited availability of transportation, evacuation of casualties from some FTS may not begin until 72 hours after the disaster occurs.

B. Supplies from outside the disaster area may not reach some FTS for 12-48 hours after the disaster occurs.

C. Water, power, and other resources will be extremely scarce, limiting the type of medical field treatment feasible at an FTS.

D. ACS generally requires a minimum of 48 hours to make available.

5. Resource Considerations During a Medical Disaster

   A. These events involve an entire community region, and/or county—likely disabling normal medical service operations. FTS should be considered to support an incident as to not directly impact the function of the community medical service infrastructure.

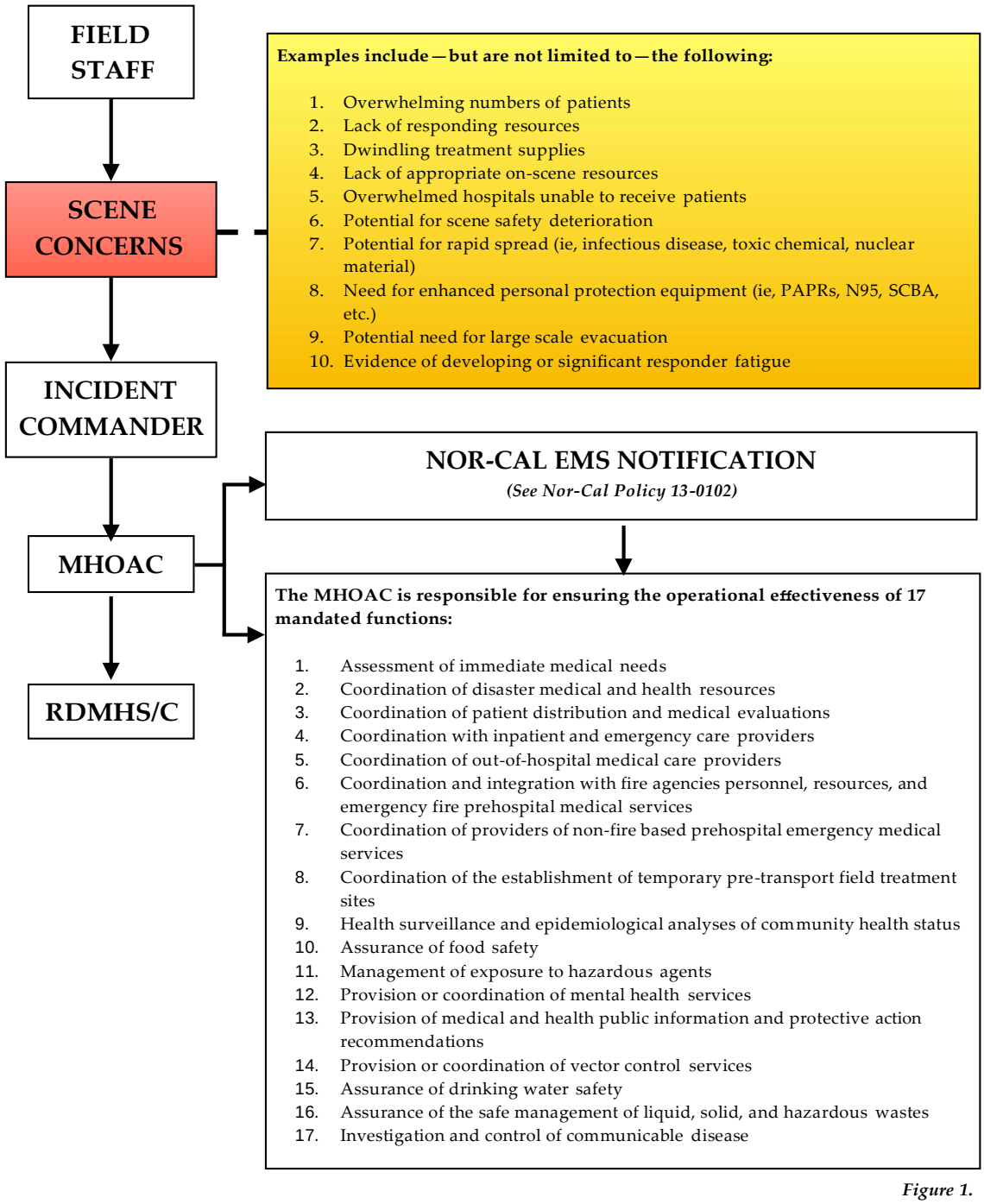


*Figure 1.*