NOR-CAL EMS	1304	Multi-Casualty Incident
Nor-Cal EMS Policy & Procedure Manual		Treatment Guidelines
Effective Date: 01/07/2021		Next Revision: 01/07/2024
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

1. To establish a minimum standard for management of a Multi-Casualty Incident (MCI) through an appropriate operational structure, using the Incident Command System (ICS) and the Revised 10-2020 Nor-Cal EMS/SSV Region III MCI Plan Manual 1.
2. To define roles and duties of responding personnel.
3. To establish standard approach to triage.
4. To facilitate effectiveness of multi-agency response.
5. To provide guidelines for MCI documentation.

POLICY

To provide guidance for the treatment and transport of victims of an incident meeting classification of a Mass-Casualty Incident (MCI).

DEFINITIONS

1. A **Multi-Casualty Incident** 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. These incidents include, but are not limited to, mass trauma or medical (ie. Overdose, infectious disease outbreak, etc.) and/or hazardous materials exposure.
    a. Within the Nor-Cal EMS region, a Mass Casualty Incident is defined as an incident with potential to significantly impact/overwhelm prehospital or hospital resources, including:
        i. Five (5) or more IMMEDIATE and/or DELAYED patients from a single incident, or
        ii. Ten (10) or more MINOR patients from a single incident, irrespective of the numbers of IMMEDIATE and/or delayed.
    b. MCI declaration is ultimately at the discretion of the EMS provider(s) on scene or the base/ modified base hospital.
2. A **Control Facility (CF)** is the facility responsible for the dispersal of all patients during Multi-Casualty Incidents.

INITIAL RESPONSE:

1. Response:

    CF notification should occur as soon as there is information that an MCI my exist. If this occurs at the time of dispatch or while responding to the incident, the CF should be contacted and advised of an *"MCI Alert."* Information concerning the location, approximate number of victims, and a description of the incident should be provided to the CF. The CF can be contacted by a dispatch center or prehospital responders.

    For general guideline purposes MCI's may be called for any incident that overwhelms the local response system. CF's may have different activation criteria, as they are located in counties outside those overseen by Nor-Cal EMS, but will activate an MCI alert at the responders' request.

2. The first medical unit on scene will:
    a. Ensure personal safety.
    b. Report to the Incident Commander (IC)/designee or temporarily establish the ICS if it is not operational.

c. Establish radio communications with appropriate the Control Facility (CF) and provide an assessment of the situation, including the following information, if available:

   i. Confirm or cancel the MCI alert.

   ii. Confirm the incident location (address or cross streets).

   iii. Approximate number of victims.

   iv. Type of MCI (Trauma, Medical, HazMat) **Note**: If this is an active shooter/mass violence incident, DO NOT REPORT ACTIVE SHOOTER OVER THE RADIO.

   v. Approximate number of transport resources at scene and requested. Advise need of alternate methods of patient transfer including helicopter, busses or alternate transport vehicles.

   vi. Provide an incident name.

d. Establish a medical branch, initially responsible for R-A-C-I-N-G:

(R) Resources:	Ensure all needed resources have been requested based on the the MCI type (trauma, medical, hazmat, etc.) and number of victims.
(A) Assignments:	Assign personnel, including a Triage Unit Leader and begin triage.
(C) Communications:	Determine the medical tactical channel, command net, air operations (if needed), etc in coordination with the IC.
(I) Ingress/Egress:	Determine the staging location best routes in and out of incident in coordination with the IC. Notify dispatch of all relevant information.
(N) Name:	Clarify the incident name with the IC and notify dispatch and the CF.
(G) Geography:	Establish triage, treatment, and transport areas.

Note: In MCI situations, the "first-in" ambulance on scene is committed to the incident for the duration. "First-in" personnel will initiate triage utilizing all equipment and supplies within their unit; consequently, the "first-in" ambulance should be the last to depart the incident.

COMMAND STRUCTURE

1. The overall command is under the direction of the Incident Commander (IC) who is responsible for resource management and the safety of those on scene. The choice of command type will usually be made based upon the number of jurisdictions involved, complexity, and size of the incident.

   a. Single Command: This is a system wherein a single individual, determined by the impacted jurisdiction, is given the lead role as IC. This individual is initially the most qualified at the scene. As the incident progresses in size/ scope, the IC may be turned over to a higher ranking or more qualified individual. Some incidents may require advisory (liaison) staff to assist the IC, comprised of agency officials from fire, law enforcement, EMS, public works, etc). (*see figure 1*)

   b. Unified Command: This is a system where a group of officials from the major agencies involved share the lead incident command responsibilities. These officials may include fire, law enforcement, EMS, public works, etc. (*see figure 2*).

Basic ICS Organizational Chart

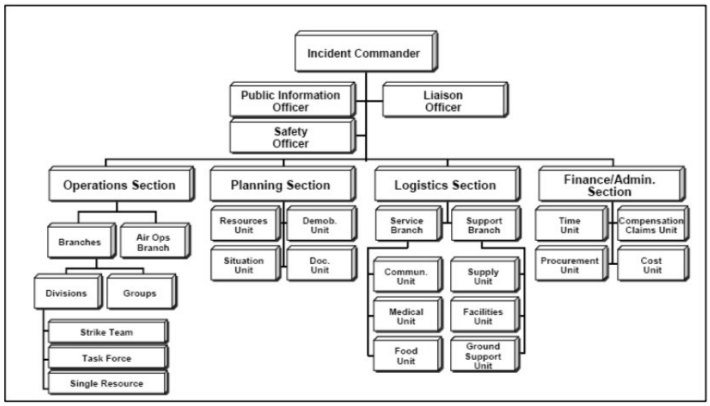

Figure 1

Sample Unified Command Organizational Chart

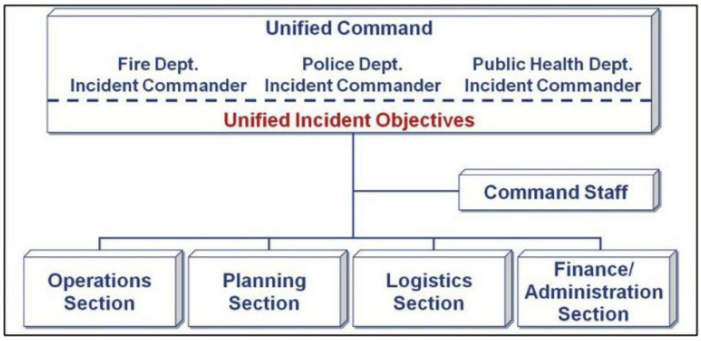

Figure 2

COMMAND STRUCTURE (*Continued*):

2. The IC may designate the following roles: Triage Unit Leader, Treatment Managers assigned to the immediate and delayed treatment areas, the Medical Transportation Unit Leader to determine patient destination from the scene to the surrounding facilities, and other ICS positions as the IC deems appropriate.
3. Responding units should report to the staging area for assignments by the medical group supervisor.
4. Equipment, supplies and personnel will be brought to the staging area. They will be inventoried and dispensed as needed.
5. Law enforcement personnel should secure the scene.
6. Appropriate position identification vests shall be utilized on scene:
    a. Transport providers shall carry a minimum of two (2) position vests (Triage Unit Lead and Medical Group Supervisor) on all initial response units.
    b. Additional position vests should be available form supervisor/battalion vehicles and/or disaster/ MCI support units.

TRIAGE

1. The S.T.A.R.T. method of triage will be used.
2. Victims should generally be treated where they lie, if this is not possible due to safety or other concerns, patients should be relocated to a designated triage area.
3. Triage should take no longer than 30-60 seconds per patient. DMS All Risk Triage Tags should be used whenever possible for treatment and tracking purposes (*see figure 4*).

START 'RPM' Method for Triage of Non-Walking Wounded Patients

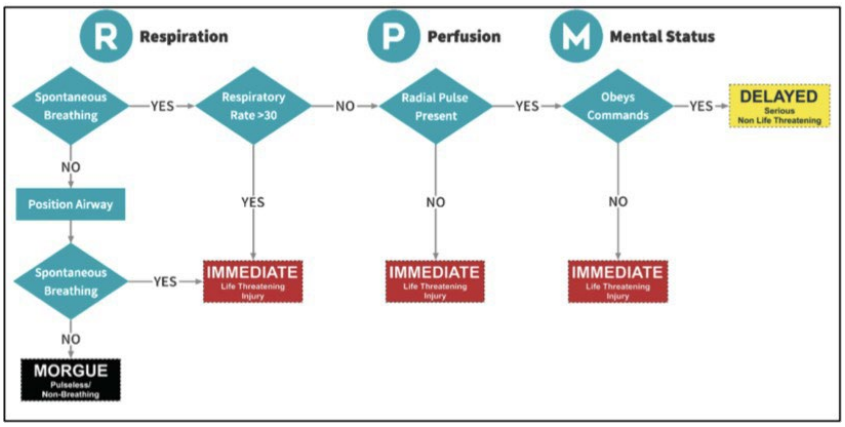

Figure 3

4. Initial treatment will be limited to airway positioning and hemorrhage control.
5. Patients will be designated as follows, per the START 'RPM' Method (*see figure 3*):
    a. Black (Morgue): those who have deceased or those who have sustained catastrophic life-threatening injuries and have a low probability of survival. CPR will not be initiated for cardiac arrest victims unless adequate resources are available to commit to the resuscitation effort. Refer to Determination of Death and Do Not Resuscitate policies (Confirm and add policy #)
    b. Red (Immediate): those with life-threatening injuries, but have a sufficient probability for survival and require immediate treatment and transport. Any patient who has a tourniquet or hemostatic dressing applied shall be deemed Immediate, regardless of the START RPM algorithm. Field to facility target: 30 minutes.
    c. Yellow (Delayed): those who have sustained serious injuries but can wait for immediate treatment. Field to facility target: 2 hours.
    d. Green (Minor/"Walking Wounded"): Ambulatory with minimum or no medical aid needed. Field to facility target: 6 hours or as soon as practical.

Figure 4

TREATMENT AREAS

Once they have been triaged, patients will be sent to the appropriate treatment area. Continuous triage and patient evaluation should occur in these areas until the patient is transported. Personnel assigned to the treatment area should at all times function within their scope of practice and under medical control (see medical control section).

During an MCI, there will be three designated areas for treatment. These areas should be located in a safe space, large enough to handle the number of victims easily with adequate access for rescue vehicles. Whenever possible, this area should be distant to morgue area (*see figure 5*). During hazardous material or infectious disease incidents, these areas should be established (See Hazardous materials and infectious disease section):

1. RED ZONE (IMMEDIATE ZONE): After initial triage, a set of vital signs should be taken and documented on the patients triage tag. Immediate preparation for transport is imperative—one scene treatment should not delay transport (emphasis on ABCs only). If available, MDs and RNs should be assigned to the immediate treatment areas. When there is a physician on scene, refer to Interaction with Physician or Other Provider Policy #16-0105.
2. YELLOW ZONE (DELAYED): If adequate personnel are available, these patients should be triaged again once arriving via assessment and vital signs to ensure that there has been no deterioration. These patients may require ALS and BLS treatment while transporting resources are focused on immediate patients. MD's and RN's should be assigned to the immediate or delayed treatment areas (see Provider Policy #16-0105).

Sample MCI Scene Designated Areas

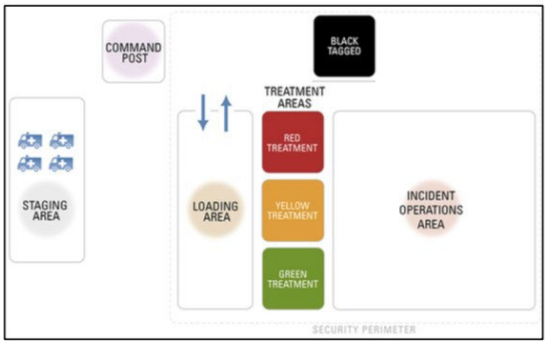

Figure 5

3. GREEN ZONE (MINOR): These Minor treatment areas should be kept away our out of visual range from the Immediate and Delayed treatment areas if possible. Minor patients should receive a vital sign assessment and BLS treatment as time and resources allow.
4. BLACK ZONE (MORGUE): This zone should be distant of the red, yellow, and green zones whenever possible. Movement of these patients should not occur without consultation of law enforcement.

MEDICAL CONTROL

1. When there is a physician or other provider on scene, refer to Interaction with Physician or Other Provider Policy #16-0105.

TRANSPORTATION

1. Transport crews will remain with their vehicle in the staging area until called up by the Medical Transportation Unit Leader or designee.
2. IMMEDIATE patients with the highest acuity level should be transported first to the mostappropriate available medical facility. Patients may be transported by a lower level of trained personnel as determined by the Medical Transportation Unit Leader in cooperation with the managers of the treatment areas based on available resources and personnel.
3. Unless absolutely necessary due to insufficient resources, two (2) IMMEDIATE patients should not be transported in the same ambulance: One (1) IMMEDIATE and one (1) DELAYED or MINOR patient is acceptable. This is to ensure appropriate care is given when required without overwhelming a prehospital provider with two patients that may deteriorate.
4. If required, patients may be transported via BLS units and/or non-traditional transport resources (e.g. buses, vans, etc.).

TRANSPORTATION *(Continued):*

5. Transport destination will be determined by the CF after being advised by the Medical Transportation Unit Leader of the number of patients, including their level of severity (red, yellow, green) that are ready for transport. Transporting crews will then be informed of their transport destination by the Medical Transportation Unit Leader and the CF will notify the receiving facility of the number of patients, category, and ETA. The CF will control patient distribution so that no one facility is overloaded. UNITS SHOULD NOT CONTACT THE RECEIVING FACILITY ON THE MED-NET RADIO—Should communication by necessary, alternate means are required (landline, separate channels, etc). An accurate log of patient names, triage tag numbers, transporting unit numbers, triage category, destination, time of transport, and ETA is required.

HOSPITAL COMMUNICATION

During an MCI, it is imperative that EMS hospital communications are appropriate, effective, and kept to a minimum to ensure an organized coordination of resources.

The CF is responsible of determining and advising patient destination, as well as notifying receiving facilities of incoming patients. Patient reports are not to be given to receiving hospitals. Should hospital contact be deemed necessary, alternate means of communication should be used to avoid interference with designated MCI communication.

Note: Prehospital providers shall function under standing order when possible. If base hospital consultation is necessary, the following guidelines should be followed.

1. On-scene base hospital consultation should only be made following approval fo the Medical Group Supervisor or Patient Transportation Unit Leader.
2. During patient transport, base hospital consultation should only be made due to extenuating circumstances or if there is a clear radio frequency or other appropriate method of communication not being utilized by the MCI incident.

DOCUMENTATION

1. The minimum required documentation during the course of an MCI is a triage tag. Prehospital personnel are required to complete a PCR for each patient they transport after the completion of the MCI.
2. Prehospital personnel should record enough information on the triage tag to facilitate the completion of their PCR.
3. The Nor-Cal EMS approved Prehospital Patient Tracking Worksheet shall be utilized to track all patients (See “Forms” folder at www.norcalems.org).
4. A MCI Evaluation Form shall be submitted to Nor-Cal EMS within seven (7) working days by the following (See the “Forms” folder at www.norcalems.org):
    a. Control Facility (CF)
    b. Receiving Facility (RF)
    c. Transportation Unit Leader
5. Nor-Cal EMS will evaluate the incident details/documentation and determine if additional formal after-action review/follow-up is necessary.

HAZARDOUS MATERIALS AND/OR SUSPECTED INFECTIOUS DISEASE OUTBREAK:

In the event of a hazardous material or suspected infectious disease outbreak, assurance of personal safety is paramount. If personal safety cannot be ensured, responding units are to stage at a safe distance until appropriate resources and/or personal protective equipment (PPE) can be acquired through notification of the CF. Additionally, in coordination with hazardous material and/or public health resources, decontamination areas are required in addition to the standard MCI organizational management discussed above.

ACTIVE SHOOTER / MASS VIOLENCE INCIDENTS:

As with any hazardous material or suspected infectious disease outbreak, personal safety is essential. Staging until appropriate law enforcement arrival is required. With any suspicion of an active shooter and/or mass violence incident (riot, explosive device, etc.), the CF should be contacted during response without delay.

MCI COMMUNICATION CONCERNS:

The Nor-Cal region is expansive—encompassing a large rural population spread over a diverse landscape. Consequently, communications during any MCI incident has great potential to be hindered by remote regions and mountainous terrain, lacking communication towers and cell service. Operational areas are required to plan for potential communication barriers and ensure appropriate options are available to resources should an MCI incident occur in areas with limited or no radio reception.