



Operational Policy		3304
Effective December 1, 2017		Expires March 31, 2019
Policy: Multiple Patient Incident Management	Approval: Medical Director Reza Vaezazizi, MD	Signed
Applies To: PSP, EMT, AEMT, PM, MICN, BHP, EMS System	Approval: REMSA Director Bruce Barton	Signed

PURPOSE

The purpose of this policy is to establish a flexible medical management and documentation strategy for multiple patient incidents (MPI) and multiple casualty incidents (MCIs) to improve patient outcome and decrease patient scene time. Management should include focus on triage of the patients, utilizing REMSA Trauma Triage Indicators and transport to the appropriate receiving facility for the patient’s injuries. An MCI may be activated when there are ten (10) or more patients requiring transport or if deemed necessary by Incident Command.

AUTHORITY

[California Health and Safety Code - Division 2.5: Emergency Medical Services \[1797. - 1799.207.\]](#)
[California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services](#)

Multiple Patient Incident (MPI) Management

1. Multiple Patient Incidents (MPI) are incidents where more than 1 patient but less than 10 patients require transport. Incidents with multiple patients that are not determined to be a Multiple Casualty Incident (MCI) by the Incident Commander are also defined as an MPI.
2. MPI incidents shall be named using a naming convention consistent with the incident’s geographic location.
3. MPI incidents shall be managed with an Incident Commander and a designated MedComm role.
4. **COMMUNICATIONS:**
 - a. Early Trauma Base Hospital notification is essential to managing MPI incidents fluidly.
 - b. All Base Hospital communications must be done by the designated MedComm personnel member.
 - i. MedComm role must be filled by a paramedic whenever possible.
 - c. The assigned Medical Communications Coordinator (Med Com) shall initiate contact as soon as possible with the closest most appropriate Trauma BH.
 - i. Med Com’s initial contact shall include:
 1. Identifying self as Med Com.
 2. Name and location of the MPI Incident.
 3. ETA to closest hospital and Trauma Center to establish a point of reference.
 4. Scene description including any special circumstances.
 5. Number of patients that will likely require transport.
 - ii. Med Com’s second contact to the Trauma BH shall include:
 1. Current patient count by Patient Status (Immediate, Delayed, or Minor).
 2. Transportation destination considerations: Pediatrics, Burn, Trauma.
 - a. The Trauma BH will coordinate patient destination with Med Com.
 - b. Receiving centers should be determined utilizing REMSA Trauma Triage Indicators as the primary determinant for destination. Wherever possible patients meeting trauma triage criteria should be transported to trauma receiving centers.
 - d. Transporting ambulances shall notify the receiving hospital as soon as possible, and shall include:
 - i. Incident Name/Location Incident
 - ii. Patient number from patient count at incident location
 - iii. Patient Status (Immediate, Delayed, or Minor)
 - iv. Chief Complaint/Major Injury
 - v. Mechanism of Injury
 - vi. Glasgow Coma Scale (GCS)

- vii. Patient's Vital Signs
- viii. Estimated Time of Arrival

5. PATIENT TRANSPORTATION:

- a. Treatment and transportation should be according to the seriousness of the patients' injuries whenever possible.
- b. Receiving centers should be determined utilizing REMSA Trauma Triage Indicators as the primary determinant for destination. Wherever possible patients meeting trauma triage criteria should be transported to trauma receiving centers.

6. DOCUMENTATION:

- a. A REMSA Approved ePCR must be completed for each patient involved in the response.

Multiple Casualty Incident (MCI) Scene Management

7. The Incident Command System (ICS) as defined by FIRESCOPE will be utilized at all MCIs. Its Multi-Casualty organizational module is designed to provide for the necessary supervision and control of essential functions required during an MCI. The primary functions will be directed by the Medical Group Supervisor, if activated (otherwise Operations), who reports to the Multi-Casualty Branch Director, if activated, or directly to the Incident Commander (IC). Resources having direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators. The required functional positions under the Medical Group Supervisor (Operations) are:
- a. Triage Unit Leader: Supervises triage personnel, who perform the actual triage of patients. Once triaged, directs movement of patients to the Treatment Area, usually via backboard or litter carried by litter bearers. Once all initial triage is complete, secondary patient assessment utilizing a comprehensive physical exam (e.g. PHTLS/ITLS trauma assessment) shall continue until all patients have been transported from the incident.
 - b. Medical Communication Coordinator: Maintains communications with the Base Hospital (BH)/Coordinating Facility. Responsible for reporting location, mechanism, and approximate number of immediate, delayed, and minor patients, requesting hospital availability and determining patient transportation and destination decisions.
 - c. Treatment Unit Leader: Supervises personnel assigned to treat patients in the three treatment areas. Assumes responsibility for treatment, preparation for transport, coordination of patient treatment and directs movement of patients to the loading area. Responsible for the continued triage and assessment of patients as the incident evolves.
 - d. Ambulance Coordinator: The Ambulance Coordinator reports to the Patient Transportation Unit Leader, manages the Ambulance Staging Area(s), and dispatches ambulances as requested.
 - e. Patient Transportation Unit Leader: The Patient Transportation Unit Leader is responsible for the coordination of patient transportation and the maintenance of records relating to the patient's identification, condition, and destination.

****More than one functional position may be assigned to a single responder****

8. S.T.A.R.T.: This system allows first responders to triage patients in sixty (60) seconds or less, based on three physical assessments: ventilation, perfusion, and mental status.

Deceased: No ventilation present even after attempting to position airway.

Immediate: Ventilation is present only after positioning the airway.

or Respirations over 30 per minute.

or Peripheral Pulse absent and Cap Refill over 2 seconds.

or Mental Status depressed, i.e., patient fails to follow simple commands.

Delayed: Any patient who does not fit the Immediate or Minor categories.

Minor: These patients are separated from the general group at the start of the triage by requesting those who can walk to go to an assigned area.

9. RESPONSE

The first on-scene responder unit will complete a rapid size-up of the incident, declare the incident an MCI by notifying their dispatch agency of this, request additional personnel and equipment as necessary, initiate the ICS, and begin triage of victims using the START system and approved triage tags.

- a. Incident Command will be established by the appropriate jurisdictional public safety agency. In the absence of public safety agency on scene, the transport provider agency should institute ICS as necessary.
 - i. Incident Command will be responsible for the management of all incident operations.
 - ii. The IC will assign the Medical Communications Coordinator position as soon as feasible in the incident, preferably to a paramedic.
- b. Prior to arrival at scene, all responding personnel/units will contact the IC or his/her designee on the assigned radio channel to request assignment or staging instructions. All personnel shall remain with their vehicles until otherwise assigned.
- c. The IC has the authority to change assignments as he/she sees fit.
- d. All on-scene providers will follow legal orders of/from the IC.

10. COMMUNICATIONS

- a. All responding units will be informed of the channel and will use it for all incident radio communications.
- b. Responding units will not contact a BH prior to arrival on-scene.
- c. The assigned Medical Communications Coordinator (Med Com) shall initiate contact as soon as possible with the closest most appropriate Trauma BH.
 - i. Med Com's initial contact shall include:
 1. Identifying self as Med Com.
 2. Name and location of the MCI Incident.
 3. ETA to closest hospital and Trauma Center to establish a point of reference.
 4. Scene description including any special circumstances.
 5. Number of patients and request for MCI bed availability.
 - a. The Trauma BH will use the ReddiNet to notify other hospitals of MCI by sending a general notification and initiating an MCI. (Consider out-of-county hospital(s) for receiving facilities based upon incident location.)
 - b. For MCI's with greater than 10 patients: ReddiNet polling for bed availability should be initiated by the Trauma BH.
 - c. Receiving hospitals will acknowledge the MCI notification and respond with bed availability promptly as needed.
 - ii. Med Com's second contact to the Trauma BH shall include:
 1. Receiving bed availability from the BH using the ICS-MC-308 form.
 2. Current patient count by Patient Status (Immediate, Delayed, or Minor).
 3. Transportation destination considerations: Pediatrics, Burn, Trauma.
 - a. The Trauma BH will coordinate patient destination with Med Com.
 - b. Receiving centers should be determined utilizing REMSA Trauma Triage Indicators as the primary determinant for destination. Wherever possible patients meeting trauma triage criteria should be transported to trauma receiving centers.
 - c. Receiving hospitals will monitor and use the ReddiNet.
 - iii. Med Com's subsequent contacts to the Trauma BH shall be consistent with the ICS-MC-306 form.
 1. Patient Triage Tag Number
 2. Patient Status (Immediate, Delayed, or Minor)
 3. Chief Complaint
 4. Patient Info: Age/Sex
 5. Hospital Destination
 6. Ambulance Company & Unit ID Number
 7. Off Scene Time
 - a. The BH will track patient destinations via use of the ReddiNet or ICS-MC-306 form.

- b. Receiving hospital will “Arrive” each patient via ReddiNet when each arrives in the ED, and add all pertinent patient information as appropriate.
- d. Transporting ambulances shall notify the receiving hospital as soon as possible, and shall include:
 - i. Incident Name/Location Incident
 - ii. Triage Tag Number
 - iii. Patient Status (Immediate, Delayed, or Minor)
 - iv. Chief Complaint/Major Injury
 - v. Mechanism of Injury
 - vi. Glasgow Coma Scale (GCS)
 - vii. Patient’s Vital Signs
 - viii. Estimated Time of Arrival
- e. Base and receiving hospitals shall utilize the ReddiNet to manage patient destination assignments from all MCIs.

11. PATIENT TRANSPORTATION

- a. The IC or his/her designee will designate an ambulance staging area.
- b. Prior to arrival at MCI scene, each ambulance will contact the IC or his/her designee on assigned radio channel and request assignment or staging instructions.
- c. Treatment and transportation should be according to the seriousness of the patients’ injuries whenever possible.
- d. Receiving centers should be determined utilizing REMSA Trauma Triage Indicators as the primary determinant for destination. Wherever possible patients meeting trauma triage criteria should be transported to trauma receiving centers.
- e. The Transportation Unit Leader will notify the Med Com of departing units.
- f. The Transportation Unit Leader will copy the information from the triage tag onto the ICS-MC-306 Form and confirm the destination with the ambulance crew.
- g. During large MCIs where patient transport demands tax ALS ambulance availability and/or negatively affect the operation and continuity of the EMS system, patients may be transported by Basic Life Support (BLS) ambulance.
 - i. Patients should be prioritized with higher acuity patients going via ALS ambulance and lower acuity patients going via BLS ambulance transports whenever possible.
 - ii. Based upon available personnel, a non-transport paramedic (ALS First Responder) should be considered for the provision of care to patients triaged as immediate during transport in a BLS ambulance.
 - iii. Once the decision to utilize BLS ambulance has been made by the IC, those BLS ambulances that present the best estimated time of arrival (ETA) to the scene will be used.
- h. During extreme circumstances where ambulance resources are exhausted or where alternative transportation resources, such as buses, will provide the most expedient transport or enhance patient safety, use of those resources are authorized as determined by the IC.
 - i. The IC is responsible for assuring patient safety when alternative transportation options are utilized.
 - ii. Minimum staffing shall be two (2) Emergency Medical Technicians (EMTs), supplied with radios and BLS equipment if vehicles, such as buses, are used to transport patients triaged as Minor.

12. DOCUMENTATION

Patient identification, assessment, treatment, and disposition will be documented on the triage tags. Only the Cal Chiefs-approved triage tags shall be used. The triage tag will be handled as follows:

NOTE: For non-contaminated incidents, remove the “contaminated” portion of the triage tag. If a contamination hazard exists, all EMS personnel shall coordinate with the IC or his/her designee for briefing.

- a. As patients are triaged, one half of the appropriate triage category (immediate, delayed, and minor) will be removed from the tag and retained by the triage personnel.

- b. Once the triage is complete, triage personnel will deliver the retained category halves of the triage tags to the Triage Unit Leader to retain accountability.
- c. The category half remaining on the triage tag must remain with the patient for the identification of the individual patient triage category.
- d. The transport portion affixed to the top of the triage tag (below the Personal Property Receipt) will be removed by the Transportation Unit Leader and documented with transport destination and mode of transportation with appropriate unit identifier.
- e. Following the conclusion or resolution of the incident, the IC will be responsible for completion of all MCI documentation. Documentation should be attached to the ePCR for the incident, which may include:
 - i. ICS-214 (For each personnel assigned to a functional position)
 - ii. ICS-MC-305 form (Multiple Casualty Branch Worksheet)
 - iii. ICS-MC-306 form draft version (Multiple-Casualty Recorder Worksheet)
 - iv. ICS-MC-308 form draft version (Multiple-Casualty Hospital Resource)
 - v. ICS-MC-310 form draft version (Multiple-Casualty Ambulance Resource Status)
 - vi. ICS-MC-312 form (Medical Supply Receipt and Inventory Form)

****All documentation will be turned into the provider's continuous quality improvement (CQI) department.****

13. TRAINING

The Riverside County EMS Agency approved MCI Training Program for initial and biennial recurrent training is required for all:

- ALS Providers
- BLS Providers
- Base Hospitals