

Multi-Casualty Incident Policy

I. PURPOSE:

The purpose of this policy and procedure is to describe the roles and responsibilities of EMS personnel and other related emergency response agencies during Multi-Casualty Incident's (MCI's). It is designed to provide prehospital personnel with the necessary information to successfully manage such incidents.

II. INDICATION:

An MCI is where the number of patients cannot be fully managed by the on-scene personnel (in many parks this policy is implemented at five or more patients).

III. INITIAL MULTI-CASUALTY SCENE SIZE UP:

Relayed to dispatch by the first EMS provider on the scene.
Includes the following items only:

1. Mobile unit, provider level (Paramedic/Parkmedic/EMT/EMR) and identification (radio call sign)
2. Exact Location/ Environment/ Elevation
3. Type of Incident
4. Hazards
5. Estimate of Casualties (Color Code/Triage designation if known) triage category
6. Request additional help as needed

IV. MULTI-CASUALTY PATIENT REPORT:

To be called in by the Incident Commander or designee to base or designated disaster control facility, once patients are ready for transport. Information is to be utilized to help determine patient destination. **Do not include specifics on physical exam, nor requests for additional therapy, unless transport will be delayed.**

1. Mobile unit, provider level (Paramedic/Parkmedic/EMT/EMR) and identification (radio call sign) Triage Tag number
2. Patient Profile (Age and sex ONLY)
3. Color Priority Code/ Triage destination
4. Primary Injury (chief complaint)
5. Destination unless redirected by Base Hospital
6. Transporting Unit and Type (air/ground)
7. Departure Time/ETA

V. DEFINITIONS:

Acuity – severity of illness or injury

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Dispatch Leader- Reports to the IC and is responsible for taking the initial MCI report from the IC and then relaying that information to the Base Hospital. Dispatch also helps organize requested resources, coordinate transportation and identify potential hazards or access route limitations. (Appendix F)

Extrication Leader- Reports to the IC, facilitates movement of triaged patients from the scene of the incident to designated color-coded treatment areas. Responsible for initial C-spine precautions and patient safety during extrication. Assignment of this role is dependent on need for significant extrication and sufficient manpower. (Appendix C)

Futility – when a patient's condition is so critical that their chance of survival despite maximal intervention is remote.

Incident Commander (IC) - The first rescuer on scene and individual in charge of the overall incident, responsible for commanding and coordinating the disaster site response in its entirety and requesting additional resources as needed. The Triage Leader, Extrication Leader, Treatment Leader, Transport Leader and Dispatch all report to the IC. (Appendix A)

Incident Command System (ICS) - A nationally recognized approach to MCI's using common terminology and procedures. It is a modular organization providing the framework for agencies to respond in a coordinated effort to incidents regardless of size.

Jump START– A complementary triage system to START designed to be used with children (defined as shorter than the NPS Pediatric Resuscitation Tape and/or Broselow tape, generally 8 years old or less). (Appendix H)

Multi-Casualty Incident (MCI) - any incident with five or more patients, or when the number and acuity of patients overwhelms the rescuer's ability to provide care in the usual manner.

NOTE: It is recommended to categorize all incidents with five or more patients as an MCI. This allows responders to practice MCI procedures and protocols on a more regular basis, even in situations where their system is not truly overwhelmed.

Patient- A person with a medical complaint needing assessment, medical care and treatment.

Resource and Personnel Request Log- Form kept by the IC which helps keep accurate data on time of request, E.T.A., and actual time of arrival of resources and personnel requested of Dispatch. (Appendix K)

START Triage –

A specific triage system (Simple Triage and Rapid Treatment) designed for very large-scale disasters. Adult patients are each given a triage tag (METTAG) and assigned to a severity group (Minor/Green, Delayed/Yellow, Immediate/Red or Morgue/Black) representing acuity on the basis of a 30 second or less assessment of airway, respiratory rate, capillary refill (or radial pulse for Jump START) and mental status only. (Appendix G). Categories currently are:

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Immediate/Red- designated for patients who are critically ill but potentially salvageable if given top priority for treatment and transport.

- When using the START triage system, this includes patients requiring airway maneuvers but who are still breathing spontaneously, respiratory rate greater than 30, altered mental status, or capillary refill greater than 2 seconds.
- When NOT using the START/Jump START system, this category would include patients with respiratory distress, shock, altered mental status, multi-system trauma, severe chest or abdominal pain or tenderness, suspected spinal cord injury, hypothermia, fractures with vascular compromise and significant burns.

Delayed/Yellow- designation for delayed care. This category includes patients with significant injury who will require further care and transport to the hospital but whose injuries are unlikely to result in immediate loss of life or limb.

- Using START triage, this would include any patient who does not meet the criteria for either the green, red or black categories.
- When not using the START/Jump START system, this category would include patients with isolated femur fractures or dislocations with normal circulation, mild chest pain or abdominal pain or tenderness with normal vital signs, possible neck or back injuries without neurological deficit, and a history of loss of consciousness but normal mental status.

Minor/Green- designation for ambulatory patients with minor complaints such as simple closed fractures and lacerations and abrasions with bleeding controlled, aka the “walking wounded”.

Deceased/Black- designation for patients who are dead or determined to have no reasonable chance of survival despite airway intervention.

NOTE: Any patient who is non-ambulatory (e.g. requiring C-spine precautions) is triaged as a Delayed/Yellow patient unless triaged as an Immediate/Red patient or Deceased/Black.

Transport Leader- Reports to the IC, responsible for the coordination, with dispatch, of patient transportation by ambulance or helicopter and maintenance of records pertaining to patient identification number (METTAG), injuries, mode of transport, and destination. Transport Leader may also need to fill the role of Extrication Leader if manpower is limited. The Transportation Leader will also be in contact with the Base Hospital to provide the Multi-Casualty Patient Report. (Appendix E)

Transportation Log- Form kept by the Transportation Leader which helps keep accurate data on each patient’s Triage Tag number, age, gender, chief complaint, priority, destination, ambulance and time of departure. (Appendix J)

Treatment Leader- Reports to the IC, assumes responsibility for treatment of patients in each of the color-coded treatment areas. If more assistance is available, the Treatment Leader may *coordinate* patient treatment by overseeing personnel who are each assigned a specific color

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coded treatment area. The Treatment Leader also directs movement of patients to the loading location(s) for transport. (Appendix D)

Triage- To sort.

- The separation of large numbers of patients into smaller groups for the purpose of organization and estimation of the severity of illness/injury.
- The prioritization of care based on either acuity or need to provide the most benefit for the greatest number of patients.

Triage Leader - Reports to the IC, triages patients on-scene using START Triage and Jump START Triage in order to assign them to one of four color coded areas for further care. When triage is complete, the Triage Leader and triage personnel may be reassigned, as needed, by the IC. (Appendix B)

Triage Tag (METTAG)- Cards designed to be used with the START/Jump START system, but may be used with any triage system. One tag is placed on each patient. Each tag has a number by which patients may be identified and has removable color strips corresponding to the severity group. Tags may also be used to help identify patients who are related, when determining destination of transport (e.g. “pt found in red car” may be documented on the Triage Tag comments area so unconscious mother and daughter both end up in the same hospital). (Appendix I)

Victim- Person who is involved in an event or incident who has no medical complaints.

VI. PROCEDURE:

1. “Size Up.” The first rescuer on scene shall make a rapid assessment of scene safety, the number and acuity of patients and a “reasonable overestimation” of the number of resources needed. This information shall be conveyed immediately to dispatch.

NOTE: When there are five or more patients: Triage Tags and the MCI call-in format will be used. EMS Providers are to follow treatment protocols for communication failure.

2. If overwhelmed, the rescuer shall either take a purely command role as IC or shall begin triage based on START/Jump START criteria, stopping only to make simple life saving interventions such as opening an airway or controlling bleeding. Bystanders and Minor/Green patients should be utilized to help when needed (e.g. hold pressure on a wound, comfort a child).

3. If not overwhelmed, the rescuer shall address each patient individually. Triage (including the assignment of color) shall be performed on the basis of a routine primary and secondary survey and consideration of specific injuries and vital signs. Treatment shall proceed according to standard treatment protocols.

4. Patients shall be separated into distinct treatment areas according to color designation when practical, based on number of patients/rescuers and geography.

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5. As additional rescuers arrive on scene, a reassignment of the Incident Commander may be made based on rank, experience, and medical training.

6. The Incident Commander, using the incident command system, shall either assume responsibility for, or delegate someone to be responsible for, the following roles as needed depending on the size and complexity of the incident:

- Operations Section Chief
- Triage Leader
- Extrication Leader
- Treatment Team Leader(s) (green, yellow, and red)
- Transportation Leader
- Dispatch Leader

Depending on the scope and duration of the MCI, these individuals may be present as well:

- EMS Branch Director
- Staging Area Manager
- Communications Officer
- Public Relations Officer
- Morgue Coordinator
- Food Supplier
- Law Enforcement/Traffic Group Supervisor
- Fire Suppression Group Supervisor
- Liaison Officer (outside agencies)

Responsibilities and checklist for each of the leaders are provided in Appendix B-F. Importantly, each individual must know who reports to them and to whom they report. If there is not enough manpower to cover each role, the IC may need to assign multiple roles to each available person. (Appendix L).

7. Base contact should be made as soon as possible and prior to patients being transported. Early notification of base hospital allows them to initiate their MCI plan and will assist with patient distribution to the available hospitals in an effort to avoid relocating the disaster to one hospital.

8. The Treatment Leader or each treatment color group leader shall try to reassess each patient at least every fifteen minutes. Patients who are re-triaged and determined to be a higher priority or lower priority than their initial assessment, shall be re-tagged with a new Triage Tag, noting the time, and initials of the person making the assessment. That person is then responsible for making sure the patient is moved to the appropriate color treatment area.

9. Performing CPR should NOT be done unless adequate manpower allows for immediate treatment of all critical Immediate/Red AND Delayed/Yellow priority patients.

10. All Immediate/Red priority patients should be transported from the scene first, Delayed/Yellow priority next, and last Minor/Green priority patients. Each transport unit should

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contain two patients, except in unusual circumstances. Depending on the number of patients in each group, there may be an occasion for a Delayed/Yellow priority patient to accompany either an Immediate/Red priority, or a Minor/Green priority patient. Attempts should be made to keep family members together and dispatched to the same hospital. Some Minor/Green priority patients may be “Treated and Released” (TAR) or released “Against Medical Advice” (AMA). Minor/Green priority patients can be transported by van or bus to an appropriate medical facility.

VII. USING THE JUMP-START ALGORITHM (Appendix H):

Step 1 – All children who are able to walk are directed to the area designated for Minor/Green patients, where they will undergo secondary (more involved) triage. At a minimum, secondary triage should consist of the respirations, pulse and mental status components of the Jump START algorithm. Infants who are developmentally unable to walk should be screened at the initial site (or at the secondary triage site for Minor/Green patients if carried there by others), using the Jump START algorithm. If they satisfy all of the physiologic “delayed” criteria (i.e., fulfill no “Immediate/Red” criteria) and appear to have no significant external injury, infants may be triaged to the Minor/Green category.

NOTE: Children with special health care needs are often chronically unable to ambulate. These children can be triaged similarly to infants who are developmentally unable to walk. Respiratory and circulatory parameters remain unchanged, although those with chronic respiratory problems may routinely have elevated respiratory rates. Neurological status may be difficult to judge due to lack of knowledge of a given patient’s baseline function. A caregiver with knowledge of the children involved would be of invaluable assistance in this case, usually in the secondary triage stage. If a caregiver is unavailable, err on the side of caution and triage as if baseline function is normal for age.

NOTE: Be on the lookout for information about special needs children; there is a trend favoring brief medical data cards to be stored in the driver’s area of buses and other vehicles routinely transporting children with special health care needs.

Step 2A – Nonambulatory pediatric patients are initially assessed for presence/absence of spontaneous breathing. Any patient with spontaneous respirations is then assessed for respiratory rate (see **Step 3**). Any patient with absolute apnea or intermittent apnea (periods of more than 10 secs) must have their airway opened by conventional positional techniques, including (limited) BLS airway foreign body (FB) clearance *only* if there is an obvious FB. If the patient resumes spontaneous respirations, an Immediate/Red priority is given and the triage officer moves on.

Step 2B – If upper airway opening does not trigger spontaneous respirations, the rescuer palpates for a pulse (carotid, radial, brachial or pedal). If there is **no** pulse, the patient is tagged as Deceased/Black and the triage officer moves on.

Step 2C – If there is a palpable pulse, the rescuer gives 5 breaths (about 15 sec.) using mouth-to-mask/barrier technique. This is the pediatric “jumpstart.” One mask (with one-way valve) should be available on every potential first-in EMS unit. If necessary, an inverted adult mask

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may be used for a child. Ventilatory face shields such as those marketed for CPR classes and public use may also be used. Cross-contamination is a minimal issue, as this is already occurring because triage personnel do not change gloves between patients. Also, children are somewhat less likely to have dangerous transmissible diseases and the number of children satisfying the criteria for a ventilatory trial will be relatively small. If the ventilatory trial fails to trigger spontaneous respirations, the child is classified as Deceased/Black. If spontaneous respirations resume, the patient is tagged as Immediate/Red and the triage officer moves on without providing further ventilations. The child may or may not still be breathing on arrival of other non-triage personnel. Appropriate intervention can then be determined based upon the resources available at the designated treatment site.

Step 3 – All patients at this point have spontaneous respirations. If the respiratory rate is roughly 15 – 45 breaths/min proceed to **Step 4** (assess perfusion).

If the respiratory rate is less than 15 (slower than one breath every 4 seconds) or faster than 45 or very irregular, the patient is classified as Immediate/Red and the triage officer moves on.

Step 4 – All patients at this point have been judged to have “adequate” respirations. Assess perfusion by palpating pulses on an (apparently) uninjured limb. This has been substituted for capillary refill (CR) in the adult START Triage because of the variation in children’s CR with body and environmental temperature.

If there are palpable pulses, the rescuer assesses mental status (**Step 5**). If there are no pulses, the patient is categorized as an Immediate/Red patient and the triage officer moves on.

Step 5 – All patients at this point have “adequate” ABC’s. The rescuer now performs a rapid “AVPU” assessment, keeping in mind the apparent developmental stage of the child. If the patient is **A**lert, reponds to **V**oice, or responds appropriately to **P**ain (localized stimulus and withdraws or pushes it away), the patient is triaged in the Delayed/Yellow category.

If the child does not repond to voice and responds inappropriately to pain (only makes a noise or moves in a nonlocalizing fashion), has decorticate or decerebrate posturing, or is truly **U**nresponsive, an Immediate/Red priority is given and the triage officer moves on.

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Appendix I Medical Emergency Triage Tag METTAG

FRONT

BACK

CONTAMINATED

Personal Property Receipt/
Evidence Tag 731252

Destination _____
Via _____ 731252

TRIAGE TAG

S L U D G E M
Subdural (Cerebral) Contusion Deterioration Unconscious Epilepsy Malignant

AUTO INJECTOR 1 2 3 4 5

Sex	No.	Primary Dose
Sex	No.	Secondary Dose

Solution _____

Blunt Trauma	
Burn	
C-Spine	
Cardiac	
Crushing	
Fracture	
Laceration	
Potential Injury	

Age _____
 Male Female

Other: _____

VITAL SIGNS

Time	B/P	Pulse	Respiration

Time	Drug Solution	Dose

CONTAMINATED

EVIDENCE

MORGUE

Pulseless/Non-Breathing

IMMEDIATE Life Threatening Injury	IMMEDIATE Life Threatening Injury
DELAYED Serious Non-Life-Threatening	DELAYED Serious Non-Life-Threatening
MINOR Walking Wounded	MINOR Walking Wounded

EVIDENCE

Comments/Information

Patient's Name _____

RESPIRATIONS Yes No **R**

PERFUSION + 2 Sec - 2 Sec **P**

MENTAL STATUS Can Do Can't Do **M**

Move the Walking Wounded **MINOR**

No Respiration After Head Tilt **MORGUE**

Respiration - Over 30 **IMMEDIATE**

Perfusion - Capillary Refill Over 2 Seconds **IMMEDIATE**

Mental Status - Unable to Follow Simple Commands **IMMEDIATE**

Otherwise **DELAYED**

ISSUED BY: _____

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PERSONAL INFORMATION	
NAME	
ADDRESS	
CITY	
PHONE	
COMMENTS	RELIGIOUS PREFERENCE

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This is an example of a METTAG used in California. Any similar tag is appropriate for use.

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Appendix A Incident Commander Checklist

Responsibilities: Overall scene management and coordination. Initially the IC will play every role in an MCI. As resources arrive, the emphasis changes from “doing” to “managing”.

Time

Completed:

Checklist:

1) Scene assessment, Scene safety

2) Notify dispatch:

Mobile Unit/EMS Provider Identification

Location/Environment/Elevation

Nature of incident

Estimated number of casualties: _____

3) Rescue people in immediate danger

4) Request additional resources:

EMS/Ambulance Number: _____ ETA _____ 2nd Request Time _____

Fire Unit/Personnel Number: _____ ETA _____ 2nd _____

Law: Number: _____ ETA _____ 2nd _____

Heavy Equipment: Number: _____ ETA _____ 2nd _____

Helicopter: Number: _____ ETA _____ 2nd _____

5) Determine radio frequencies/channels to use for MCI communications

On-site communications: _____

Off-site communications: _____

Interagency communications: _____

6) Assign patient treatment and staging area (may be same place)

Location: _____

7) Inform dispatch of the location of treatment and staging area

8) Separate Minor /Green patients. Number: _____

9) Use non-injured as additional resources as needed

10) Begin duties as Triage Leader

11) Assign Triage/Extrication Leader(s)

12) Assign Treatment/Transportation Leader(s)

13) Reassess scene and resources

14) Reassign personnel resources on scene as they become available

15) Request additional resources

16) Assign additional resources based on reports from Branch Leaders

17) Maintain overall scene management

18) Release personnel/resources no longer required

19) Scene Wrap-Up, Documentation

20) Debriefing

21) Critical Incident Stress Debriefing (CISD)

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Incident Commander

I report to:

1) _____ Position: _____ Time: _____

These people report to me:

1) _____ Position: _____ Time: _____

2) _____ Position: _____ Time: _____

3) _____ Position: _____ Time: _____

4) _____ Position: _____ Time: _____

5) _____ Position: _____ Time: _____

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Appendix B Triage Leader Checklist

Responsibilities: Using START and Jump START triage, classify patients by their conditions in order to prioritize extrication, treatment, and transport. Re-assess patients for change in condition, injury severity, and transport priority every 15 minutes if possible or until moved to treatment areas. Update Incident Commander periodically.

Time

Completed:

Checklist:

- 1) Receive briefing from Incident Commander
- 2) Receive from Incident Commander the radio frequencies/channels to use for MCI communications
 - On-site communications: _____
 - Off-site communications: _____
 - Interagency communications: _____
- 3) Rescue patients in immediate danger
- 4) Separate Minor/Green patients if not already done by Incident Commander
- 5) Use non-injured as additional resources as needed
- 6) Verify patient count is correct. Number: _____
- 7) Request additional resources from Incident Commander if needed
- 8) Initial triage using START and Jump START Triage (triage patients where they lie)
- 9) Begin and maintain Transportation Log
- 10) Inform Incident Commander of number of patients and classification
 - Immediate/Red: _____
 - Delayed/Yellow: _____
 - Minor/Green: _____
 - Deceased/Black: _____
- 11) Inform Extrication Leader of patient locations and extrication priorities
 - Immediate/Red > Delayed/Yellow > Minor/Green > Deceased/Black
- 12) Area search for hidden/ejected patients
- 13) Repeat area search for hidden/ejected patients
- 14) Inform Incident Commander of deviations from initial estimates
- 15) Reassess patients every 15 minutes as time allows and additional resources arrive
- 16) Compare Transportation Log with Transportation Leader
- 17) If authorized by Incident Commander, assist Treatment Leader in patient assessment, treatment and reprioritization
- 18) Inform Incident Commander of personnel/resources no longer required

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Triage Leader

I report to:

1) _____ Position: _____ Time: _____

These people report to me:

1) _____ Position: _____ Time: _____

2) _____ Position: _____ Time: _____

3) _____ Position: _____ Time: _____

4) _____ Position: _____ Time: _____

5) _____ Position: _____ Time: _____

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Appendix C

Extrication Leader Checklist

Responsibilities: Coordinate extrication of patients from vehicles/structures and transport to treatment/staging area. Update Incident Commander periodically.

Time

Completed:

Checklist:

- 1) Receive briefing from Incident Commander
- 2) Receive from Incident Commander the radio frequencies/channels to use for MCI communications
 - On-site communications: _____
 - Off-site communications: _____
 - Interagency communications: _____
- 3) Receive treatment/staging area location from Incident Commander
- 4) Confer with Triage Leader to obtain locations and priorities of patients
- 5) Request additional resources from Incident Commander if needed
- 6) Extricate patients in order of severity and transport to treatment/staging area
 - Immediate/Red
 - Delayed/Yellow
 - Minor/Green (ambulatory patients once extricated)
 - Deceased/Black
- 7) Assist Triage Leader in area search for hidden/ejected patients
- 8) Coordinate vehicle removal
- 9) Coordinate site cleanup
- 10) Inform Incident Commander of personnel/resources no longer required

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Extrication Leader

I report to:

1) _____ Position: _____ Time: _____

These people report to me:

1) _____ Position: _____ Time: _____

2) _____ Position: _____ Time: _____

3) _____ Position: _____ Time: _____

4) _____ Position: _____ Time: _____

5) _____ Position: _____ Time: _____

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Appendix D

Treatment Leader Checklist

Responsibilities: Treatment of patients and/or supervision of patient care personnel. Update Incident Commander periodically.

Time

Completed:

Checklist:

- _____ 1) Receive briefing from Incident Commander
- _____ 2) Receive from Incident Commander the radio frequencies/channels to use for MCI communications
- _____ On-site communications: _____
- _____ Off-site communications: _____
- _____ Interagency communications: _____
- _____ 3) Obtain treatment/staging area location from Incident Commander
- _____ 4) Arrange patients by priority within treatment/staging area
- _____ 5) Provide medical care and treatment within your scope of practice
- _____ 6) Request additional resources from Incident Commander if needed (i.e. Parkmedic).
- _____ 7) Prioritize patients for transport
- _____ Immediate/Red > Delayed/Yellow > Minor/Green > Deceased/Black
- _____ 8) Reassess and reprioritize patients as time allows using START/Jump START Triage
- _____ 9) Consider assigning priority group supervisors for Immediate/Red and Delayed/Yellow patients
- _____ 10) Inform Incident Commander of resources/personnel no longer required

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Treatment Leader

I report to:

1) _____ Position: _____ Time: _____

These people report to me:

1) _____ Position: _____ Time: _____

2) _____ Position: _____ Time: _____

3) _____ Position: _____ Time: _____

4) _____ Position: _____ Time: _____

5) _____ Position: _____ Time: _____

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Appendix E

Transportation Leader Checklist

Responsibilities: Coordinate staging of transport vehicles and transportation of patients from the scene. Communicate with coordinating hospital for patient destinations. Update Incident Commander periodically.

Time

Completed:

Checklist:

- _____ 1) Receive briefing from Incident Commander
- _____ 2) Receive from Incident Commander the radio frequencies/channels to use for MCI communications
- _____ On-site communications: _____
- _____ Off-site communications: _____
- _____ Interagency communications: _____
- _____ 3) Obtain estimate of casualties and number of transport units requested from the Incident Commander
- _____ Immediate/Red: _____
- _____ Delayed/Yellow: _____
- _____ Minor/Green: _____
- _____ Deceased/Black: _____
- _____ 4) Assess staging area and ensure one-way traffic flow
- _____ 5) Estimate ambulance transportation needs (Immediate/Red and Delayed/Yellow patients)
- _____ Estimate: 2 patients = 2 emergency personnel = 1 ambulance
- _____ Patients: _____
- _____ EMT's: _____
- _____ Units: _____
- _____ 6) Begin and maintain Transportation Log
- _____ 7) Request additional resources from Incident Commander if needed
- _____ 8) Contact coordinating hospital and give initial report:
- _____ Location of incident/patients
- _____ Total number of patients
- _____ Number of patients in each priority category
- _____ Estimated time of departure for first patient
- _____ 9) Contact hospital prior to departure of each ambulance for patient destination
- _____ Mobile Unit/EMS Provider Information
- _____ Triage Tag (METTAG) Number
- _____ Age, Gender
- _____ Color Priority Code
- _____ Primary Injury
- _____ Transporting Unit and Type (air/ground)
- _____ Departure Time/ETA/Destination
- _____ 10) Compare Transportation Log with Triage Leader
- _____ 11) Inform Incident Commander of personnel/resources no longer required

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Transportation Leader

I report to:

1) _____ Position: _____ Time: _____

These people report to me:

1) _____ Position: _____ Time: _____

2) _____ Position: _____ Time: _____

3) _____ Position: _____ Time: _____

4) _____ Position: _____ Time: _____

5) _____ Position: _____ Time: _____

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Appendix F Dispatch Leader Checklist

Responsibilities: Work with Incident Commander to obtain needed personnel and resources. Initial notification of mutual aid agencies and coordinating hospital. Update Incident Commander periodically.

Time

Completed:

Checklist:

- _____ 1) Notify administration per NPS policy
- _____ 2) Initial dispatch of units to scene (if number of patients is known)
- Considerations: 1 rescuer per patient
 1 ambulance per 2 patients (maximum 3 units until
 accurate number of patients is obtained)
 Fire service
 Law enforcement
- _____ 3) Inventory resources and personnel so ETA's can be given to Incident
 Commander if resources requested
- _____ 4) Receive report from Incident Commander
- Suggestions: Number of patients and triage priorities if possible
 Number of additional resources needed
 Recommended route to scene (hazards and limitations)
 Location of incident command post
 Location of treatment/staging area
- _____ 5) Receive from Incident Commander the radio frequencies/channels to use
 for MCI communications
- On-site communications: _____
 Off-site communications: _____
 Interagency communications: _____
- _____ 6) Determine closest landing zones
- _____ 7) Notify County EMS Communications for large incidents (i.e. > 20 patients)
 for mutual aid coordination
- _____ 8) Request helicopter units as soon as possible
- _____ 9) Request additional resources as soon as possible
- _____ 10) Contact Incident Commander for any delay in arrival of resources
- _____ 11) Assist with Base Hospital communications as needed

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Dispatch Leader

I report to:

1) _____ Position: _____ Time: _____

These people report to me:

1) _____ Position: _____ Time: _____

2) _____ Position: _____ Time: _____

3) _____ Position: _____ Time: _____

4) _____ Position: _____ Time: _____

5) _____ Position: _____ Time: _____

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Appendix J

Transportation Log (Kept by Triage Leader and Transportation Leader)

Incident Location _____

	Triage Tag (METTAG)	Age	Sex	Complaint/Comments	Priority	Unit ID	Destination
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							

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Appendix K

Resource/Personnel Request Log (Kept by IC, all other Leaders optional)

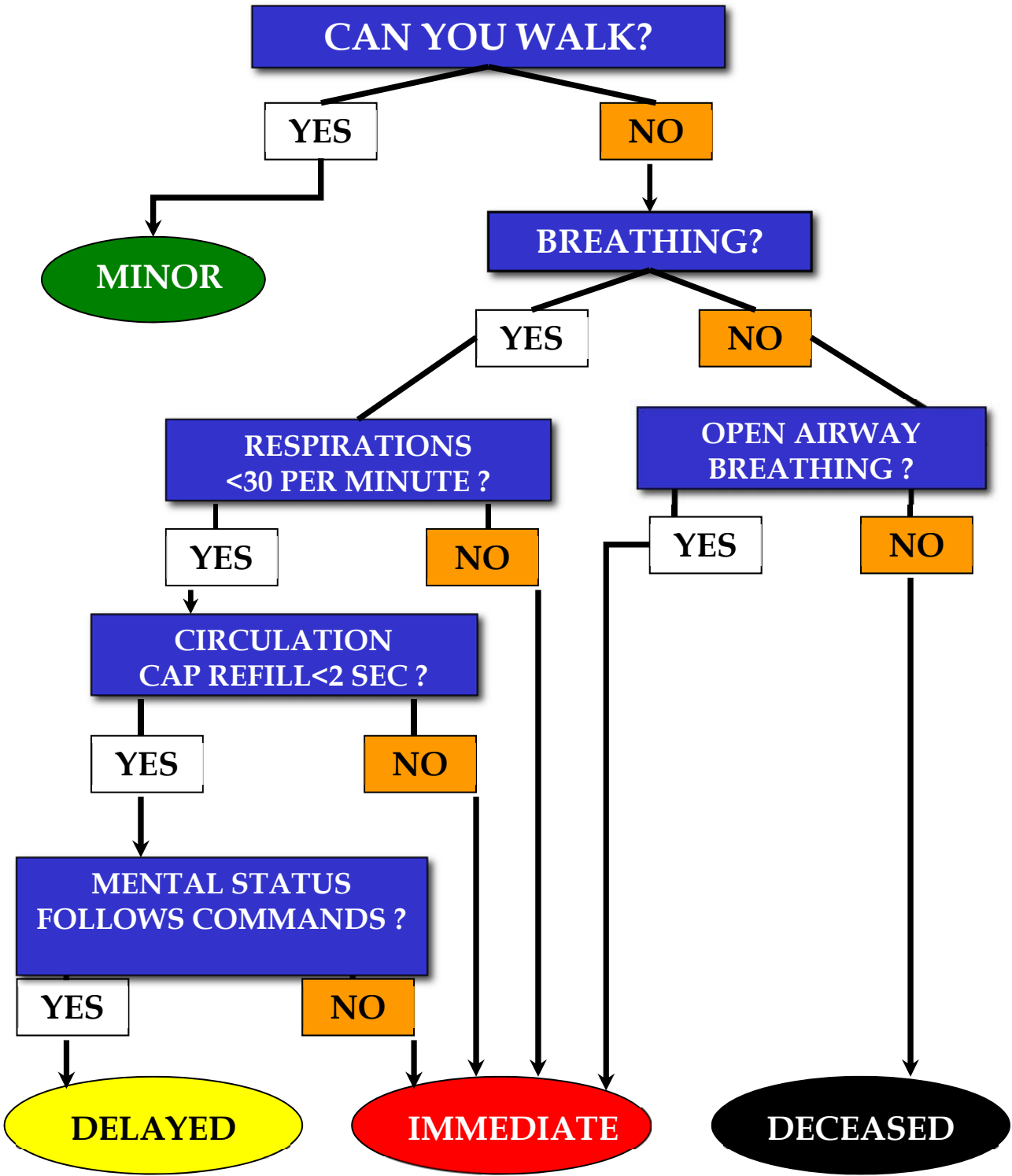
Incident Location _____

Date	Time	Request	Call-Back	E.T.A.	Arrived

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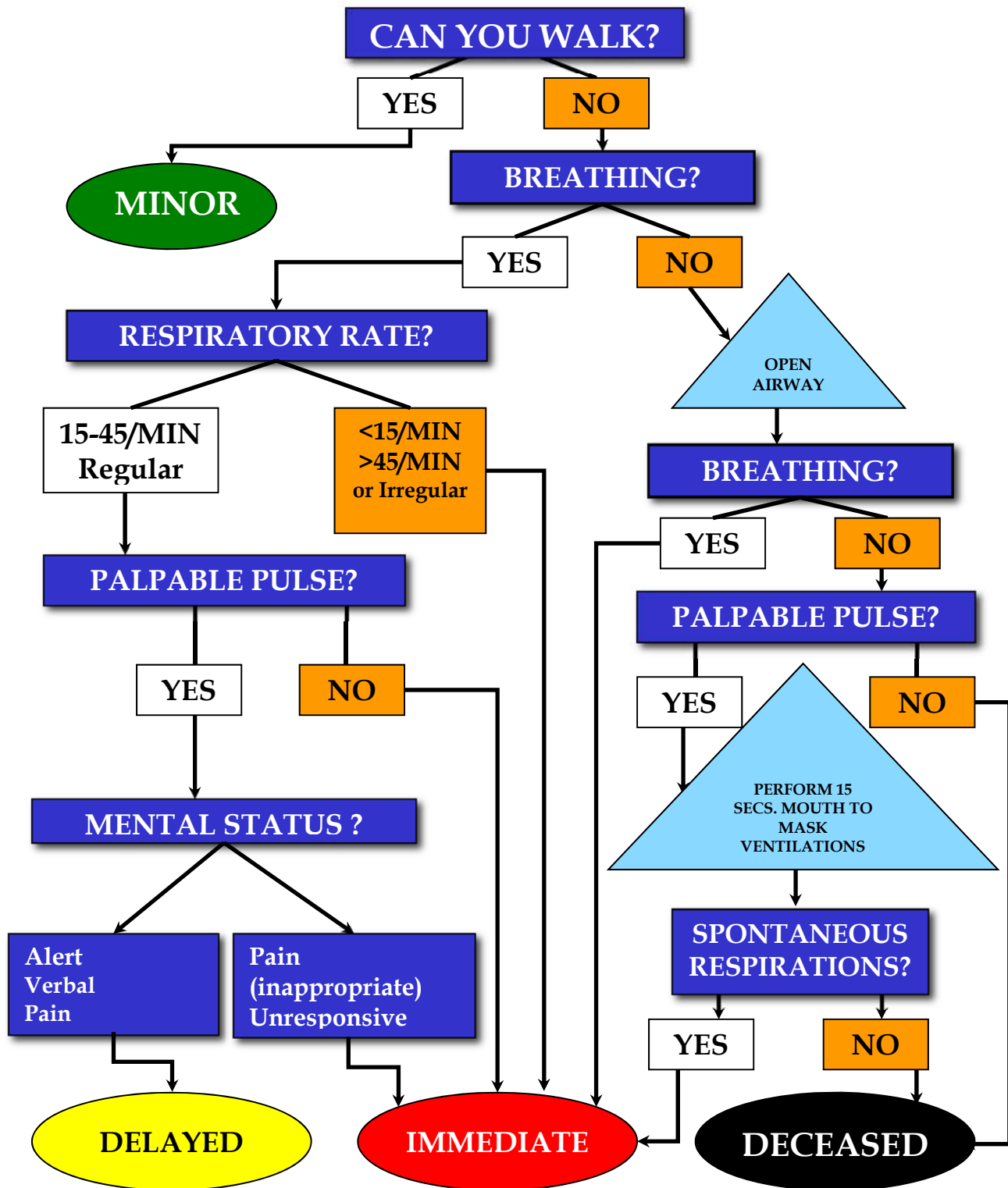
Appendix G

Simple Triage And Rapid Treatment



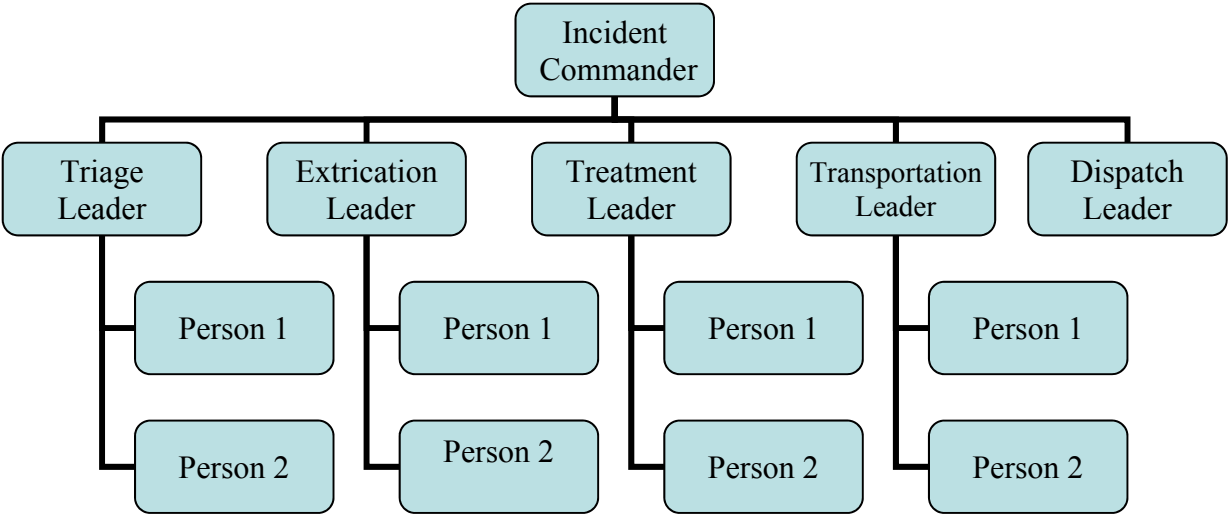
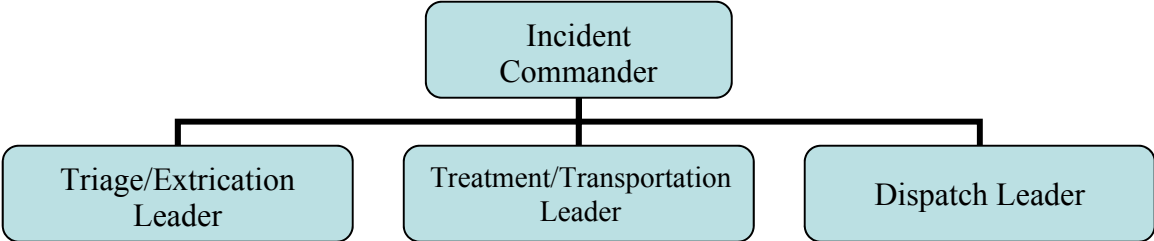
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Appendix H

Jump **START** (Pediatric)



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Appendix L



Above are the recommended schemes for a limited/delayed manpower MCI with four or more responders.