2002 MCI Plan

ALS & BLS Providers

MCI Update Training

Why the Update?

- QI Committee reviewed plan and found:
  - Plan was outdated, not really being used
  - Built with the premise of Base Hospital control
  - Utilized systems that no longer "fit" with EMS today

The Process

- Sub-committee of Fire & Private ALS providers, Hospital, Air providers, and EMS stakeholders
- Reviewed plan and made recommendations over the course of a year
- Approved by QI committee and EMCC in late 2002

Challenges of Process

- Very diverse county, both in terms of population and geography
- EMS and Fire resources differ drastically from one community to the next
- What to do with trauma?
- Hospital challenges outside of EMS

Ok, What's the Plan?

- Definition of "MCI" changed
- Responsibility for "declaring MCI" shifts to field
- Role of participants changed slightly
- Forms and tools revised and developed to help users stay organized

Definitions of an MCI

- *Level I :* "Garden variety" MCI. Any incident in which the number of injured fully engages medical resources of area for less than one hour.

Definitions of an MCI

- *Level II :* Bigger, uglier, but not necessarily more patients…. Any incident where the number of injured engages the available resources for greater than one hour.

Plan Assumptions

- Incident is limited in area, number of injured, and time required for control
- EMS resources not decommissioned as a result of incident
- Direction, control, coordination are maintained at the scene and affected hospitals
- No state of emergency has been declared and EOC has not been activated

The Players

- Fire Services
- EMS Providers
- Air Providers
- Dispatchers
- Coordinating Base Hospital
- Receiving Hospitals

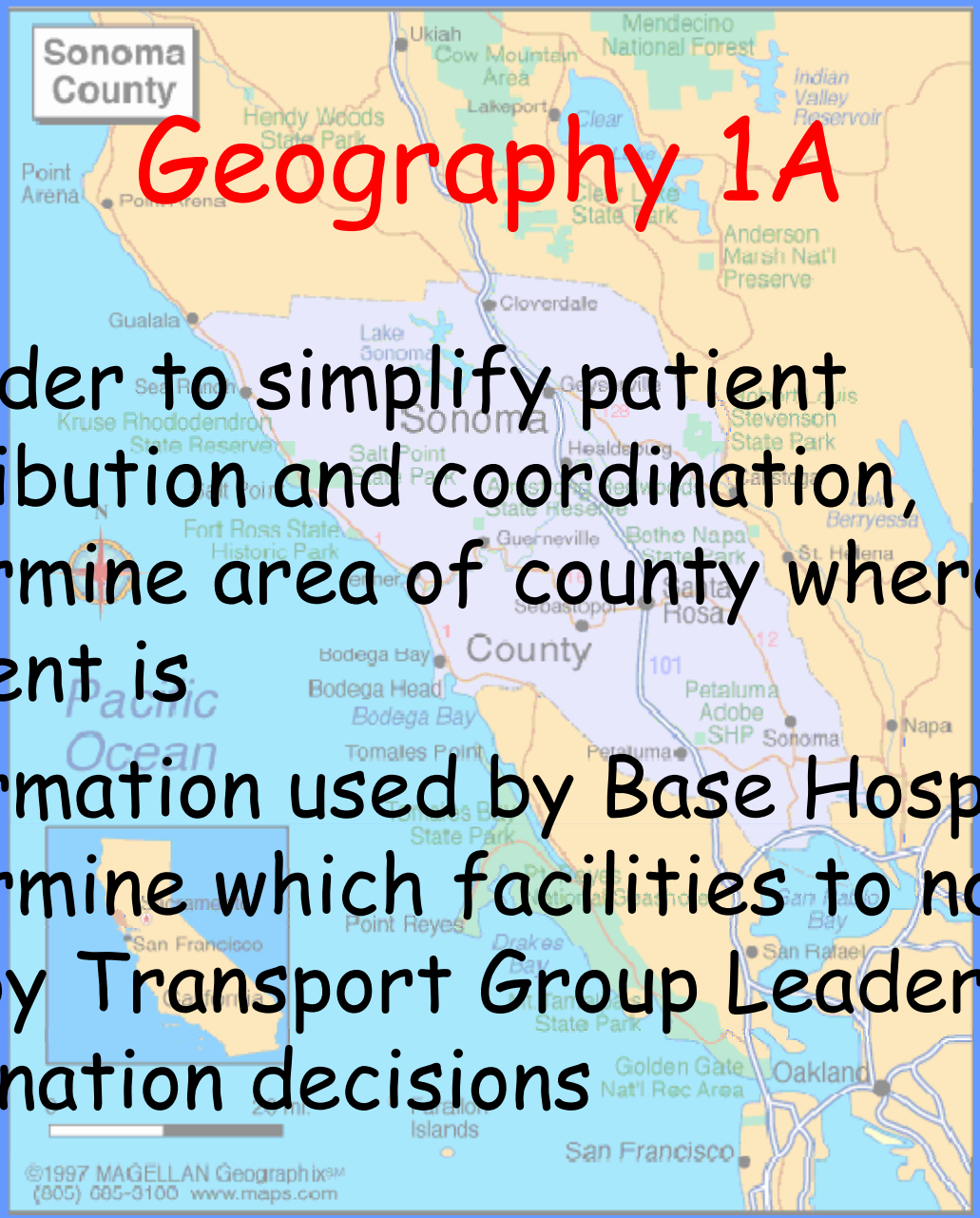
"Ground Rules"

- Incident Command System
  - IC is in charge of overall scene
  - Resource requests go through chain of command
  - A person assigned to an ICS position is responsible for not only that position, but all ICS positions/jobs under him or her until they are backfilled
- START principles
  - Greatest good for the greatest number

Declaration

- The first arriving resource (Fire/EMS/Law) has the authority to declare an MCI if based on scene size-up
  - Establish IC, notify dispatch, order additional resources as needed
  - Hand off jobs in accordance with ICS as resources arrive
- Determine geographic area

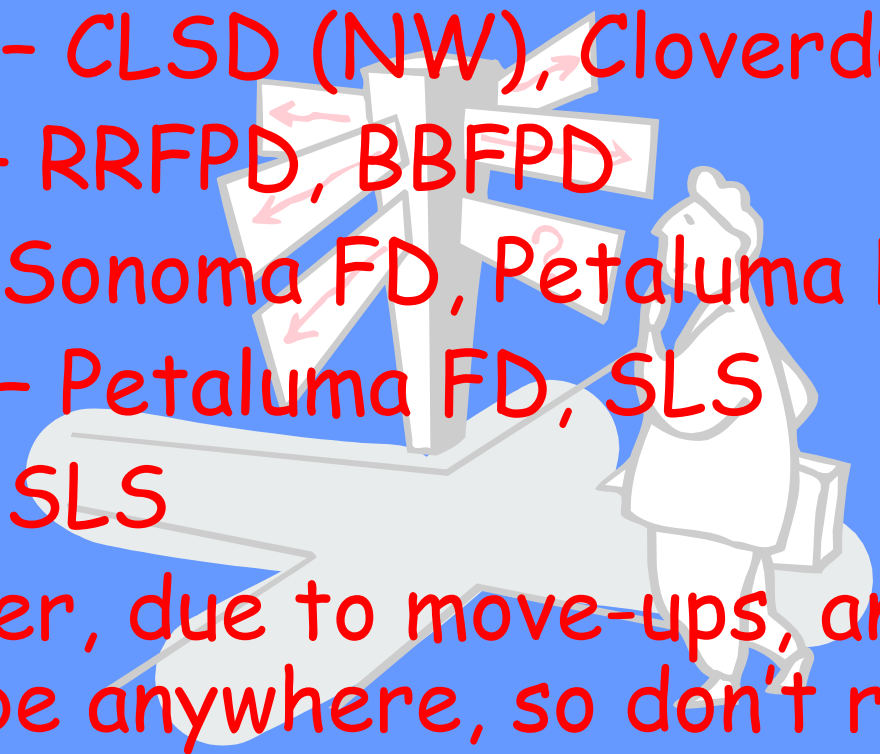
Geography 1A



- In order to simplify patient distribution and coordination, determine area of county where incident is
- Information used by Base Hospital to determine which facilities to notify and by Transport Group Leader for destination decisions

Where Are You?

- North – CLSD (NW), Cloverdale, Bell's
- West – RRFPD, BBFPD
- East – Sonoma FD, Petaluma FD (SE)
- South – Petaluma FD, SLS
- Core – SLS
- However, due to move-ups, any unit could be anywhere, so don't rely on responding unit number to determine area



Roles & Responsibilities
Fire Services

- Set up ICS
- Mitigation of hazards and fire suppression
- Rescue and Extrication
- Triage

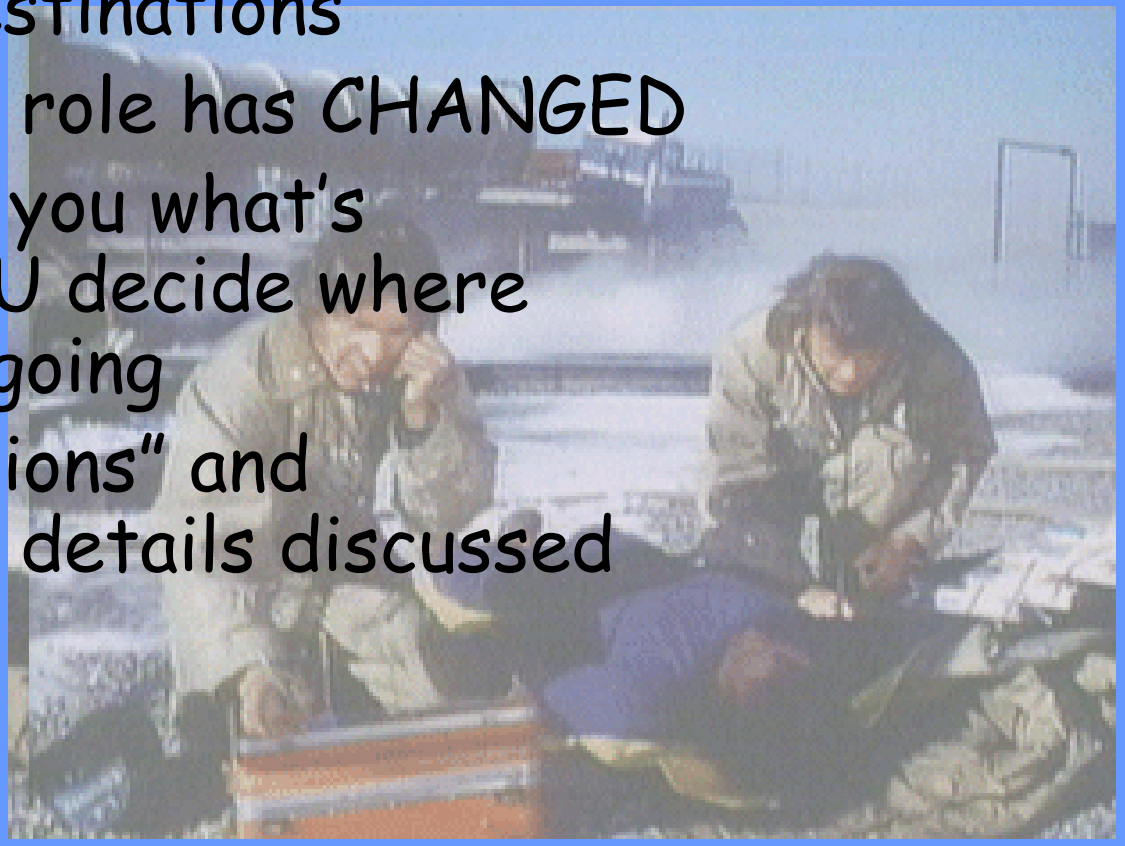
Command Vehicle - 1998 Cheverolet Suburban

Roles & Responsibilities EMS Providers

- First in medic(s) staff treatment area and medical communications
  - Medical Group Supervisor (acting as Treatment Unit Leader)
  - Transportation Group Supervisor (acting as Medical Communications Coordinator)
- Contact Coordinating Base & notify them of area involved

EMS Roles & Responsibilities

- Medical Communication and Transport Leaders will determine destinations
- Base hospital role has CHANGED
- They will tell you what's available, YOU decide where patients are going
- "Communications" and "Destination" details discussed shortly



Roles & Responsibilities
Air Providers

- Depending on the situation, air providers may be called on to transport patients out of the area
- May also be utilized for shuttling or rescue work if area is difficult to access with vehicles

Roles & Responsibilities Dispatchers

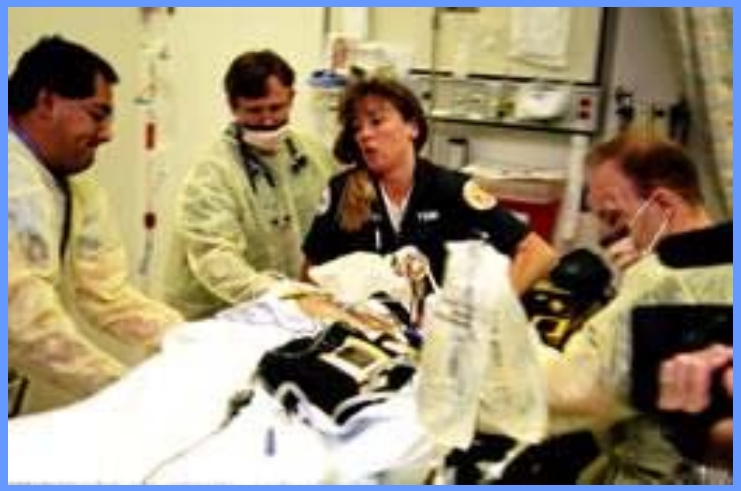
- Initial dispatch of resources
- Coordination of tactical channels and IC setup
- Sending additional resources and relaying information as requested by the IC
- Jurisdictional and Agency notifications outlined in plan

Roles & Responsibilities Coordinating Base Hospital

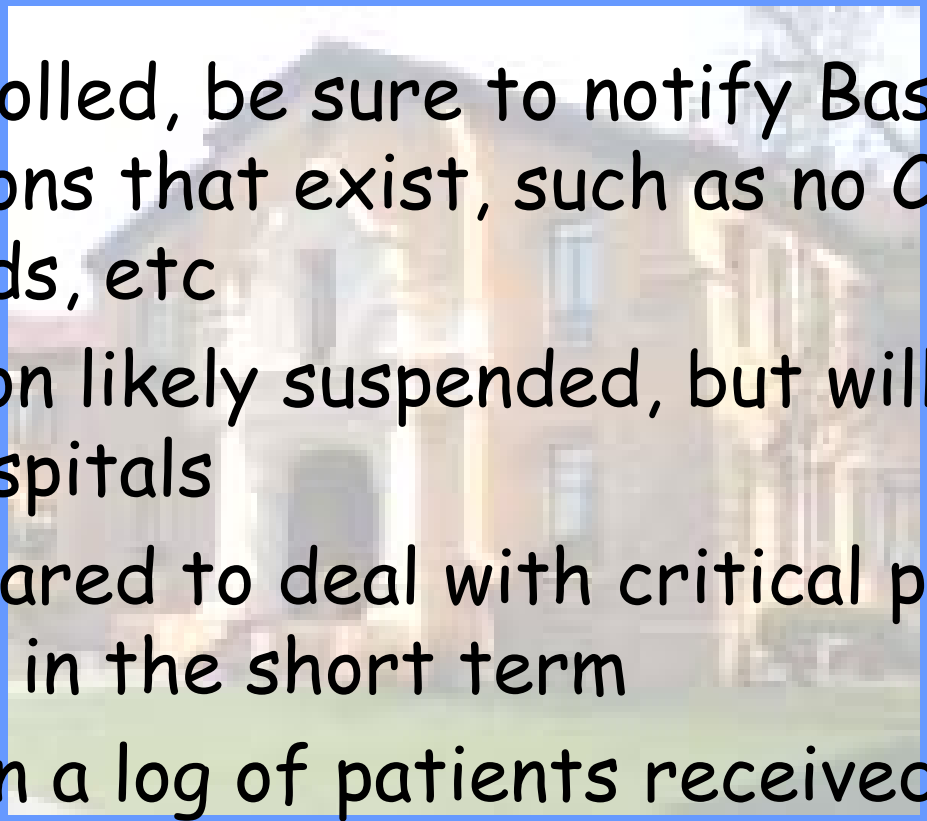
- Utilizing available tools, poll hospitals in area and determine bed availability
- Communicate availability to Paramedics on scene
- Notify receiving facilities of incoming patients and general severity
- Provide destination consultation *as requested by the on scene medics*

Base Roles & Responsibilities

- Notify hospitals who aren't getting patients (who were alerted) so they can "stand down"
- Maintain a log of patients and where they were sent



Roles & Responsibilities Receiving Facilities



- When polled, be sure to notify Base of any limitations that exist, such as no CT, no ICU beds, etc
- Diversion likely suspended, but will work with hospitals
- Be prepared to deal with critical patients, at least in the short term
- Maintain a log of patients received

Communications General

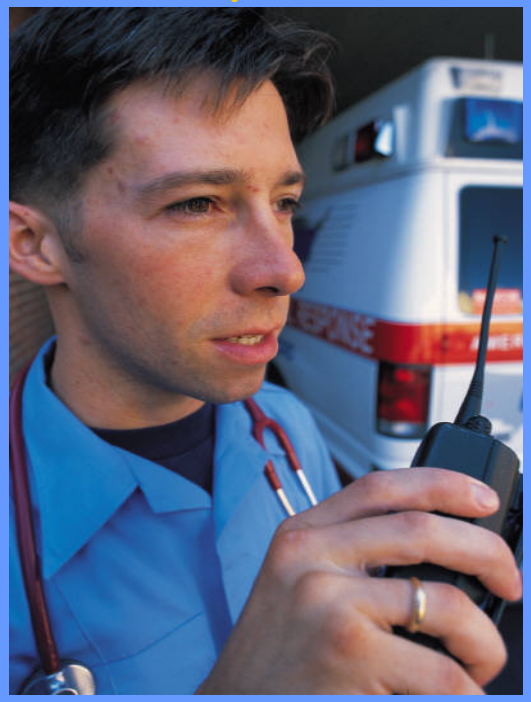
- Brief and Clear
- Not a discussion about patient condition
- Limit jargon and no "codes" - clear text only
- If possible, keep same people in communication roles

Communications Initial Report

- Key elements:
  - MCI (yes, they need to be told, they're not on scene)
  - Location of incident (I.e. N-E-W-S)
  - Type of incident (MVA/trauma/medical/etc)
  - Initial estimated number of patients
  - Initial estimated number of criticals
  - Estimated next call

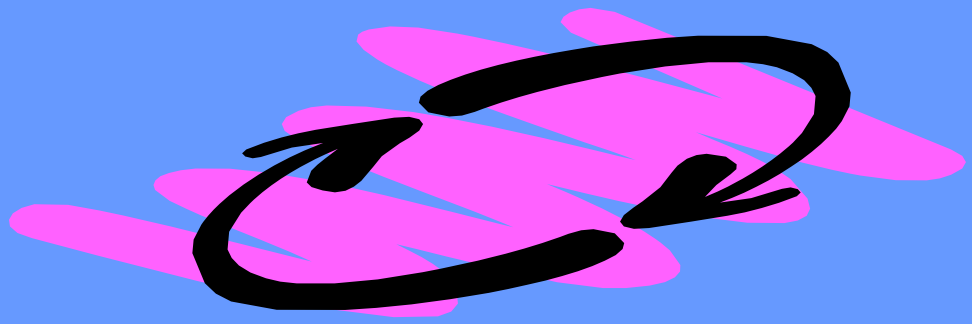
Communications
Continuing the Dialog

- When the field calls back, they should get: what area hospitals can accept
- What the Base should get for each patient:
  - Triage tag #
  - Triage category
  - Age/Gender
  - Chief Complaint
  - Destination (field decides)
  - Transporting unit



Communications
Closing the Loop

- Final Report:
  - Review and confirm all patient dispositions (ID by triage tag number)
  - Base may ask for clarifying information in order to track patients
  - Get MICN and Base Physician names



Communications
Notify the Receivings

- Each transport unit will contact their receiving facility using the FASTER or cell phone
- Early as possible
- Brief report to include:
  - Mechanism of injury
  - Critical deficiencies in VS
  - Treatment initiated

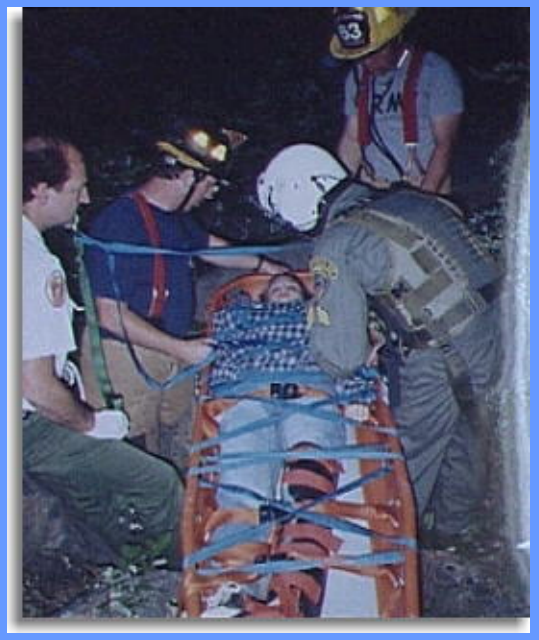
Tracking Tools

- What? Paperwork?
  - Simple forms to help keep it all straight
  - Writing on gloves, boxes, hands, heads etc all end up confusing mess by the end
- Forms are specific to field, base, and county – each is slightly different to address the needs of the user

Destination Decisions

- Paramedics are on scene, better able to see how critical patients are
- Hospitals may have to take patients they normally wouldn't (I.e. trauma)
- Don't bypass smaller hospitals, system load will depend on their participation

Destination: Trauma



- If a patient meets physiologic or anatomic criteria they should go to a trauma center *if possible.*
- Send most critical to local center, consider flying others out
- Ground ambulances shouldn't transport out of area unless directed to after base consult

Destination: Trauma

- "mechanism only" patients can go to local receiving hospitals
- Send trauma patients to receiving hospitals if:
  - Local trauma center full/compromised
  - You can't fly
  - Airway compromise or very unstable pt.

Bringing it all Together

A call comes in detailing a crash with multiple victims in Kenwood. How will this new MCI plan work? Who does what?

Initial Dispatch

- What's the dispatcher going to do? Does s/he declare an MCI?
- The dispatcher will send a normal assignment for the area – although after consultation with responding units and using available information, additional resources may be started.

First In

- A volunteer firefighter is first on scene. He finds a number of potential patients and extrication needed. What's he do?
- Advise incoming units of findings, begin mitigating hazards, START triage.

The Cavalry Arrives

- Assume that more people have arrived: what comes next?
- Fire: set up ICS, mitigate hazards, START triage, resources
- EMS: first medic contacts coordinating base hospital with initial report

The scene

- Once ICS is established and things are underway, what comes next?
- Base polls area hospitals for beds
- START triage and initial treatment
- Patients prioritized for transport
- Resources organized

Transporting Patients

- Where do they go and how do they get there?
- Medical Communications re-contacts Base for bed availability
- Notifies Base of destinations and patient details
- Transport units begin to leave scene

Transport

- Transport units have left, what factors decide destination? Who calls the receiving hospital?
- Anatomic and Physiologic trauma should go to trauma center if possible
- Transport units call receiving hospitals and give brief report

Trauma

- When should trauma patients be transported to non-trauma hospitals?
- When local trauma center full or compromised
- Airway compromise or very unstable
- Can't fly and ground transport >20 minutes to another trauma center

Deactivation

- What needs to happen at the end of the incident?
- MedCom contacts base and reviews the patients and their destinations
- CISM activation as needed
- Units returned to normal service

Questions? Comments?

- For questions that aren't covered by this presentation, please feel free to contact the EMS Agency.