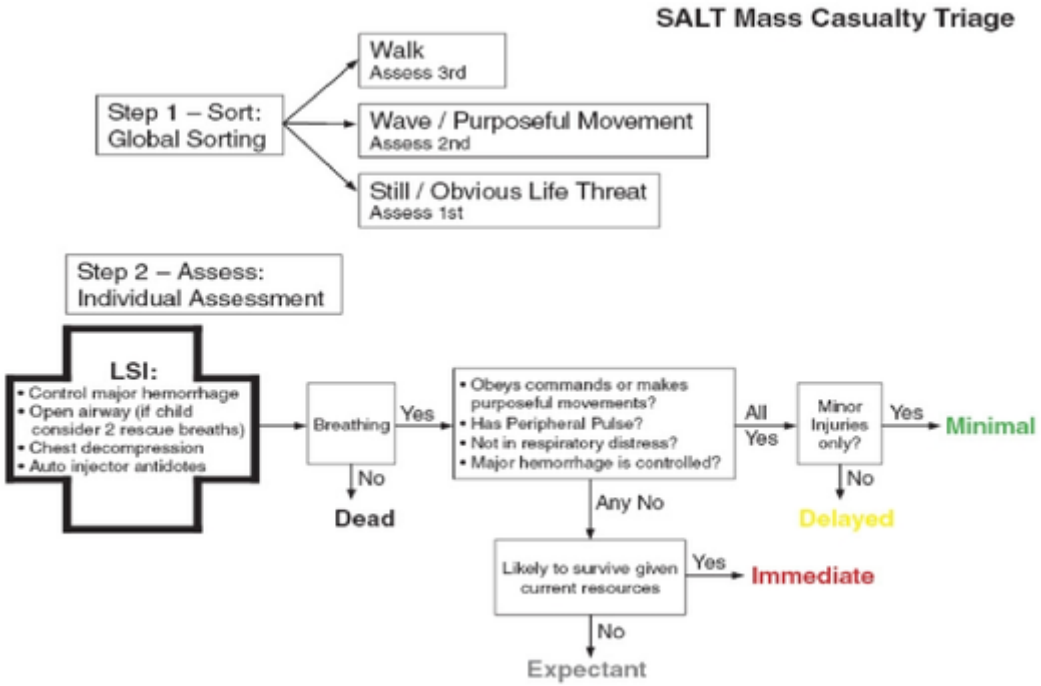
Mass Casualty Incident Response Protocol

Triage Clinical Considerations:

- It is important to use a Triage strategy any time there is a Mass Casualty Incident (MCI), or when limited resources need to be allocated to maximize the number of survivors
- SALT is an evidence-based, non-proprietary triage system developed in 2008. It is endorsed by the State of Wisconsin
- SALT stands for "Sort, Assess, Lifesaving Interventions, Treatment and/or Transport" and is based on the Model Uniform Core Criteria (MUCC) for Mass Casualty Incidents
- SALT Triage provides the framework for **initial** rapid triage of victims of an incident
- As the incident evolves additional clinical considerations need to be taking into account during subsequent triage and transportation decisions

SALT Triage Procedure:

- Step 1 – Global Sorting
    - Patients who can walk should be asked to move to a designated area and should be assigned LAST priority for **individual assessment**
    - Those who remain should be asked to wave or be observed for purposeful movement **those who do not move** and those with **obvious life-threatening** conditions should be **assessed FIRST** because they are the most likely to need lifesaving interventions
- Step 2 – Assess and Lifesaving Interventions (Lifesaving interventions should be performed only within the responder's scope of practice and only if the equipment is immediately available)
    - Control major hemorrhage through the use of tourniquets or direct pressure provided by other patients or other devices
    - Open the airway through positioning or basic airway adjuncts (no advanced airway devices should be used); if the patient is a child, consider giving 2 rescue breaths
    - Chest decompression procedure
    - Autoinjector antidote administration
- Step 3 – Treatment and/or Transport
    - Prioritize patients for treatment and/or transport based on 1 of 5 categories based on algorithm below;
        - Minimal (GREEN) – Mild injuries that are self-limited if not treated, and can tolerate a delay in care without increasing mortality
        - Delayed (YELLOW) – All patients who have more then minor injuries but do not meet criteria for triage to the Immediate (RED) category
        - Immediate (RED) – Do not obey commands, do not have a peripheral pulse, are in respiratory distress OR have uncontrolled major hemorrhage
        - Expectant (GRAY) – Provider determines injuries are incompatible with life given the current available resources
        - Dead (BLACK) – Not breathing even after lifesaving interventions are attempted



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Additional Considerations

- The prioritization process is dynamic and may be altered by changing patient conditions, resources and scene safety. Reassess patient condition as each stage of treatment/transportation process
- In general, treatment and/or transport should be provided for immediate patients first, then delayed, then minimal; EXPECTANT patients should be provided with treatment and/or transport when resources permit
- Efficient use of transport assets may include mixing categories of patients and using alternate forms of transport
- Within each priority category, additional sub-prioritization may need to occur. This additional prioritization should be done utilizing EMS clinical judgment
- In making destination determinations consider the following factors
    - Facility Capability and Specialization
        - Level 3 Trauma Hospitals have general surgeon and orthopedic surgeon availability but do not have neurosurgeon available so may be able to manage a severe abdominal or extremity injury more readily than an intracranial hemorrhage or spinal cord injury
        - Preferentially transport pregnant patients to hospitals with labor and delivery services
        - Preferentially transport pediatric patients not requiring highest level trauma center to hospitals with inpatient pediatric capability
    - Transportation Factor
        - Utilize helicopter EMS preferentially to transport patients to facilities further away,
        - Consider home site of transportation resources: ambulance transporting to hospitals in their primary service area may be able to re-stock more efficiently

Overall Mass Casualty Incident Response Process-Medical

This is a general overview of the MCI Response process. Most aspects will be the responsibility of the primary jurisdiction but MedEvac Personnel may be the highest level of medical responders on-scene and should provide support as appropriate**.**

- Step 1 – Ensure Incident Command is established early
    - Activate additional mutual aid resources (MABAS, etc) including air medical resources
    - Ensure that the closest hospitals have been notified and request an EMResource (previously WITRAC) notification be sent out to area hospitals to allow for activation of

internal MCI plans and determination of receiving capacity
    - **Notify MedEvac Administration on Call and MedEvac Medical Directors for any Mass Casualty Incident or similar event requiring emergent response by three or more MedEvac transport assets, activation or anticipated activation of hospital incident command, or expected to exceed regional resources**
- Step 2 – Ensure the establishment of the EMS Branch
    - The person in charge of EMS activities should assume the role of EMS Branch Director. This Director is tasked with assigning and supervising the roles of: *Triage Group Supervisor, Treatment Group Supervisor, Transportation Group Supervisor*
    - Consider assigning a record keeper to the Transportation Group Supervisor, to assist with patient tracking record keeping
- Step 3 – Ensure Communication (2-way) method with the coordinating hospital for ongoing information exchange during the incident
    - Communication can be accomplished via phone (exchange designated phone numbers) or via radio
        - MedEvac Communication Center may be able to assist with communication links
    - The contact person at the coordinating hospital will be providing objective data regarding resource availability using the information provided by hospitals via response to the EMResource alert
- Step 4 – Triage and Treatment
    - Patients should be triaged and managed in accordance with the **SALT Triage Procedure**
- Step 5 – Transportation
    - The Transportation Group Supervisor is responsible for assigning triaged patients to the most appropriate transportation mode based on acuity and resource availability
    - Like EMS, Hospital capabilities are NOT static; Walk-ins, security threats as well as increased staff presence can all impact the ability of our hospitals to receive and manage patients. Frequent and clear communication about the situation and the capabilities on both sides will be essential to successfully managing any event and optimizing patient outcomes
    - Hospital communication by transporting ambulances are conducted on the same channel/process as routine. Reports expected to be BRIEF and CONCISE so as to keep "radio traffic" to a minimum; it is likely there will be many trying to access these channels
- Step 6 – Event Resolution:
    - Once all patients have cleared the scene, a final notification needs to be made to the coordinating hospital needs and MedEvac Communication Center and Leadership
    - Ensure communication with receiving hospitals, emergency operations centers, etc in regards to which patients were transported to which hospital to help with reunification efforts