DISASTER MEDICAL MANAGEMENT

It is recognized that not all agencies may have the capabilities listed in this document; as such this protocol provides a general overview of how providers may manage patients with medical complaints following a disaster.

1. **Patient management**
   - **A. Assess scene**
     a. Survey scene: potential hazards, number of patients, need for specialized help.
        i. Protect rescuers first, mitigate gas spills, remove power lines, etc.
           1. Call for medical or technical backup as needed.
           2. Implement hazardous materials management procedures.
     b. Initiate the agency or area approved Incident Command System (ICS)
     c. Situational awareness: Continual situational awareness or assessment of hazards is the responsibility of every responder.

   - **B. Basic Triage:**
     a. Triage is the sorting of casualties, it is a continuous process and it is necessary to re-evaluate all patient priorities, as resources become available.
     b. If possible establish a triage and treatment area in a safe location
        i. Uphill and upwind of any potential hazards.
        ii. In sheltered location
        iii. Away from potential secondary devices or hazards (suspicious vehicles, etc)
     c. The SAEMS region recommends the following triage systems:
        i. START™ (adult patients) or JumpSTART©(pediatric patients)
           1. Ambulatory patients are triaged as Green (minimal/minor)
           2. RPM is then used to group non-ambulatory patients into yellow (delayed) and red (immediate) categories:
              a. **R**espiratory:
                 i. Rate > 30 (START) = Immediate
                 ii. Rate <15 or > 45 (JumpSTART) = immediate
              b. **P**erfusion:
                 i. Cap refill > 2s or absent radial pulse = Immediate
              c. **M**ental status:
                 i. Unable to follow simple commands = Immediate
        ii. Other agency specific triage systems as approved by Medical Direction Authority

     d. Casualties are sorted into four (4) categories. Please see Figure 2 and 3 for diagrams illustrating how to use these triage algorithms.

        i. **Immediate (RED):** Those with serious injuries or medical emergencies that can be treated, given available resources. Examples would include:
           1. Airway difficulties which can be alleviated with head tilt and OPA
           2. Controlled gross bleeding
        ii. **Delayed (YELLOW):** Those for whom treatment and transportation can be delayed while more seriously injured persons receive care.
        iii. **Minor (GREEN):** Those with minor injuries who can ambulate without assistance.

iv. **Expectant (BLACK):** Dead or dying patients who do not resume spontaneous breathing after positioning of the head and insertion of an OPA or have no spontaneous pulse. Return to these victims after all others have triaged and re-triage these patients.

C. Communication:

a. Scene Communications:
   i. Follow approved, agency specific, incident management procedures.
b. Direct Medical Communications:
   i. Online consultation may be obtained at any time from a specialty center:
      1. Burns - Burn Center
      2. Hazmat – Poison Center
      3. Pediatrics – Pediatric Receiving Center
      4. Trauma - Level I Trauma Center
c. Receiving Facility Communications – See Figure 1
   i. The Incident commander (IC) or their designee may initiate direct medical communications with a "Communications Center":
      1. MEDS
      2. Agency Dispatch
      3. Emergency Operations Center (EOC)
   ii. If resources from multiple medical facilities will be required the "Communications Center" may notify all affected receiving facilities.
   iii. Regional receiving facilities may provide the "Communications Center" with immediate bed availability via one of the following systems:
      1. EMResource
      2. "Ring Down" or "All Call"
      3. Channel 9
      4. Direct online communication
   iv. The "Communications Center" will provide regional bed availability to the IC or their designee.
   v. When possible the Incident Commander (IC) or their designee, "Communications Center," and regional receiving facilities should provide scene updates.
d. Individual Patient Care Communications:
   v. Once en-route, individual providers may provide direct, on-line communication with the receiving facility.
   vi. EMresource may be used to provide patient care information.
   vii. Hospitals may only receive courtesy notification of incoming patients if resources are not available.
   viii. The IC or their designee will notify the hospital of any patients sent by alternative means (ie bus, van, etc.)
e. Patient Care Information – see Figure 4
   i. Triage Tags may be utilized to identify and track patients .
      1. The main body of the card contains patient Information and is attached to the patient at all times.
      2. Bar code / Number - assists with patient tracking.
         a. Recorded by the triage or transport officer, the top tear off portion of the triage tag is kept on scene.
   ii. There are four (4) tabs at the bottom of the tag that are color coded for expedient identification of priority. Tear off the tabs such that a patients' triage level and all higher priority triage levels are still on the tag.
      1. IMMEDIATE (Red): Highest priority
      2. DELAYED (Yellow): Second priority
      3. MINOR (Green): Third priority
      4. EXPECTANT (Black): Lowest priority
f. Public Health Notification:

i. If additional resources are needed request may be made through the communications center, including:
   1. MMRS resources
   2. Office of Emergency Management resources.

D. Disposition

e. Disposition priority:
   i. First priority for transport to definitive care should be given to those with the highest priority triage level as outlined above.

f. Ambulance traffic flow:
   i. Ambulance crews should remain with their ambulances until given an assignment by the IC or their designee.
   ii. Keys are to remain in the vehicles at all times.

g. Destination determination:
   i. Ultimate patient destination will be determined by the IC or their designee based on regional hospital bed availability, available prehospital resources, and unique event circumstance.

II. DISASTER SCENE OPERATIONS

A. Follow approved area or agency specific Incident Management System procedures. Integrate activities of Law, Fire, and EMS agencies.
B. Volunteers can and should be used at a disaster scene to:
   a. Assist with scene control.
   b. Assist medical personnel in carrying patients or supply items.
   c. Assist the "walking wounded".
      i. Comfort victims and care for children

III. Administrative & Legal Responsibilities:

A. Once a disaster or multi-casualty incident is declared:
   a. Patients requiring ALS level care can be transported by BLS providers if necessary.
   b. Limited Resources may effect patient care and providers should provide the best care given available resources.

Figure 1: Medical Communications Flow

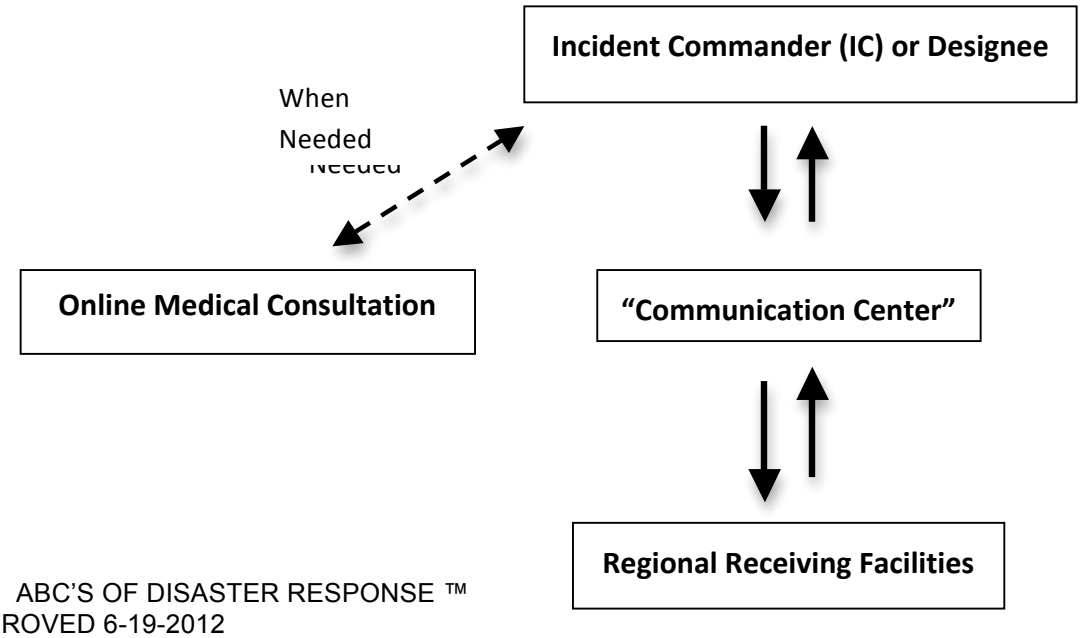

Figure 2: Start Triage

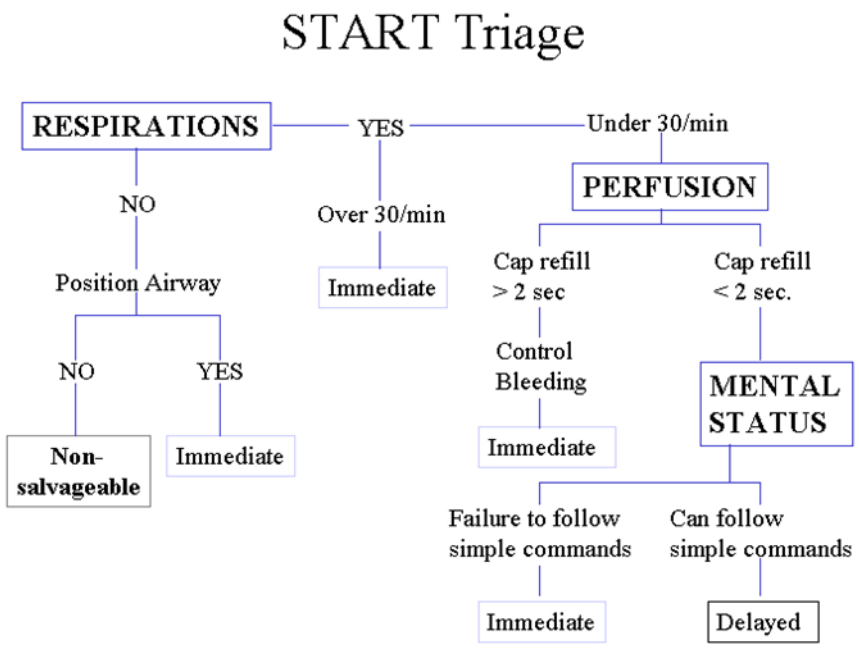

Figure 3: JumpSTART

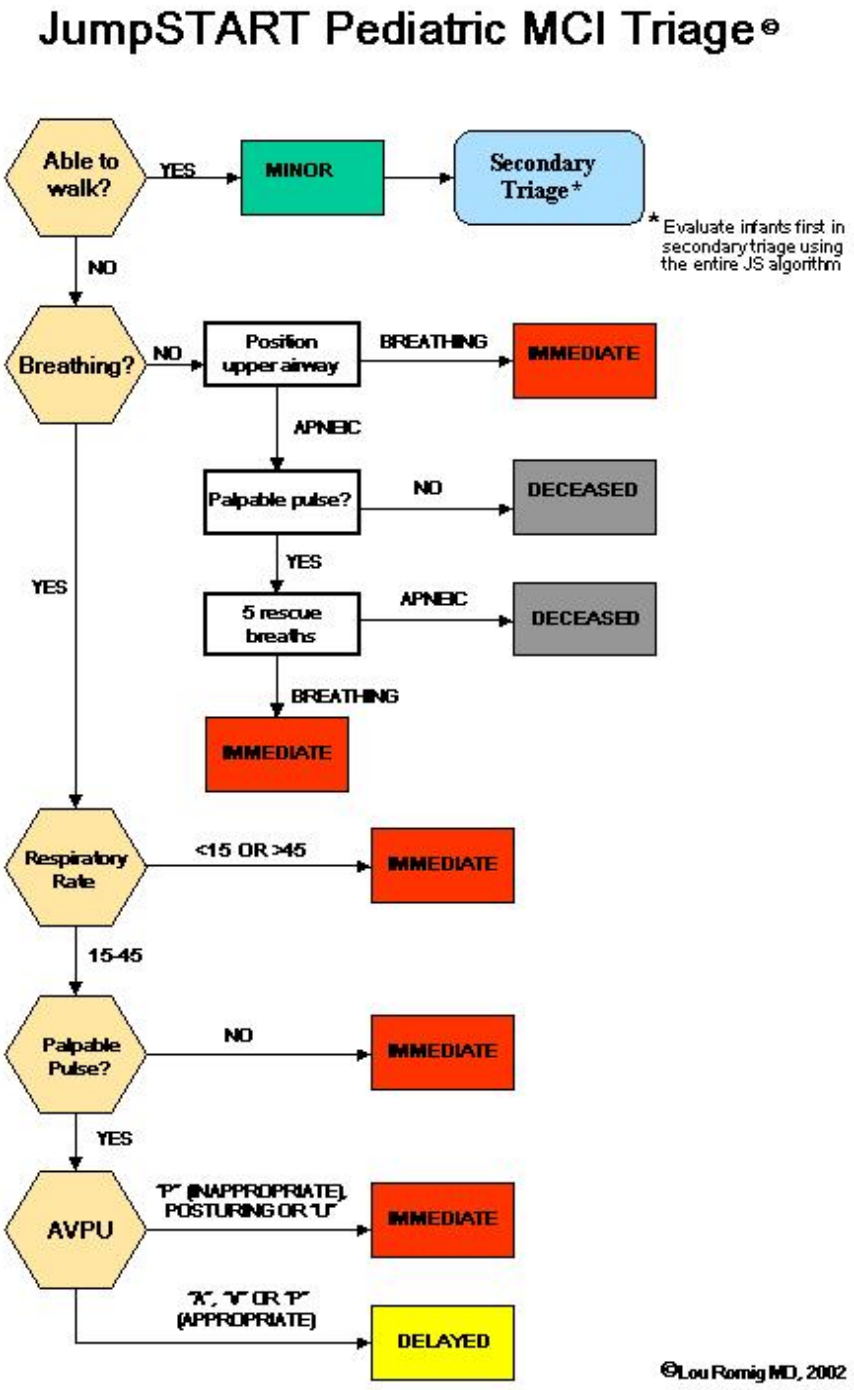

Figure 4: Triage Tag