COUNTY OF SACRAMENTO
EMERGENCY MEDICAL SERVICES AGENCY

Program Document: **Multi-Casualty Critique**
Policy Number: 7501.04

Initial Date: 07/29/14
Last Approved Date: 09/08/22

Effective Date: 05/01/23
Next Review Date: 09/01/24

Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish standards by which Pre-hospital providers, Receiving Facilities, and the Control Facility should complete and submit the designated form in the event of a multi-casualty incident (MCI) within the County of Sacramento.
B. To establish standards by which the Sacramento County Emergency Medical Services Agency (SCEMSA) will coordinate MCI debriefings for personnel involved with an MCI event.
C. To collect MCI data in order to assist in the Continuous Quality Improvement (CQI) of the EMS system within Sacramento County.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Definitions:

A. Small MCI: Four (4) or more patients transported to more than one (1) hospital and declared MCI.
B. Large MCI: Five (5) or more patients transported to more than one (1) hospital, declared MCI, and Control Facility (CF) determines the destination.
C. Major Incident: defined by Sacramento County Emergency Medical Services Agency (SCEMSA) after reviewing submitted reports.

Protocol:

A. Each provider shall submit the appropriate form completed by a staff member directly involved in the Incident. Completed forms shall be forwarded by the provider liaison to SCEMSA by the end of shift or within twenty-four (24) hours of the Incident.
B. Forms shall be submitted online or sent to SCEMSA via email or mail within ten (10) business days.
C. SCEMSA will review all submitted documents and collect data, meeting any criteria under the definitions section for use during CQI and to determine the need for a debriefing session.
D. Any organization may request a debrief of an incident through SCEMSA within forty-eight (48) hours of the Incident.
E. At any time, a field-level provider or hospital employee may submit an MCI critique form directly to SCEMSA.

OUT-OF-HOSPITAL PROVIDERS FORM

Please complete this form following MCIs meeting criteria.

Date: _____ Time: _____ Incident Name: _____

Incident Commander (IC): _____

Medical Group Supervisor (MGS) / Team Leader: _____

Patient Transport Group Supervisor (PTGS) _____

Destination Facility(s):_____

# of patients: _____ # of transport vehicles: _____ _____ Provider: _____
(Air) (Ground)

Immediate _____ Delayed _____ Minor _____ Refused _____ Deceased _____

Control Facility (CF) Notification:

Dispatch previously notified CF? Yes _____ No _____ Unknown _____
Control Facility Decisions? Yes _____ No _____ Unknown _____

	Yes	No	N/A	
Any barriers to patient care?				Explain on Reverse
Were Incident Commander and MGS readily identified?				If No; Explain on Reverse
Was an ambulance staging area established?				
Were triage tags used?				If No; Explain on Reverse
Patient destinations received without long wait?				If No; Explain on Reverse
Do you feel a debriefing is necessary?				If Yes; Explain on Reverse

Comments, suggestions, and observations in general: _____

_____

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_____

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Completed by: _____

PLEASE SUBMIT COMPLETED FORMS TO SCEMSA BY EMAIL or MAIL

SCEMSAInfo@saccounty.net

Sacramento County Emergency Medical Services
9616 Micron Avenue, Suite 960
Sacramento, CA. 95827

For questions please contact SCEMSA (916) 875-9753.

RECEIVING FACILITY FORM

Please complete this form following MCIs meeting criteria.

Date: _____ Time: _____

	YES	NO	N/A	
Was Alert Heard?				
Was it a Conference Call?				
Did you have sufficient time to prepare a Status Report?				
Were you given enough information concerning the MCI?				If no, explain below
Did the Control Facility keep you updated about the MCI?				
Receive Patients?				
Were you given the following information about your patients?				
Transport Unit?				
ETA?				
Injury?				
Was patient condition consistent with triage category?				
Were Triage Tags Used?				
Did you activate any portion of internal disaster plan?				

Any problems with this incident? _____

_____

_____

_____

Suggestions for the future: _____

_____

_____

_____

Follow-Up:

Triage / Reason		A / D*	Name	Injury

* A = admitted / D = discharged

Triage/Reason Key- See START Triage Program Document #7508.

_____
FACILITY

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CONTROL FACILITY FORM

Please complete this form following MCIs meeting criteria.

Date: _____ Time: _____ Location: _____

Control Facility Staff: _____

Patient Transportation Group Supervisor / Field Contact: _____
MCI Alert From: _____
Receiving Facility Alert: _____ (Time) By: EMSystem _____ Blast Phone _____ Other: _____

Issue(s) with MCI Alert: _____
_____

_____

Issue(s) with the Receiving Facility Alert: _____

_____
_____

Issue(s) communicating with Patient Transportation Group Supervisor / Field Contact: _____
_____
_____

_____

Was the scene cleared? Yes ___ No ___ Time: _____Time Receiving Facilities Notified: _____

Suggestions and/or General Comments: _____

_____

_____

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