

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	7501.04
	<u>PROGRAM DOCUMENT:</u> Multi-Casualty Critique	Initial Date:	07/29/14
		Last Approval Date:	09/10/20
		Effective Date:	07/01/21
		Next Review Date	09/01/24

Signature on File

EMS Medical Director

Signature on File

EMS Administrator

Purpose:

- A. To ~~serve as the~~ establish standards by which Pre-hospital providers, Receiving Facilities and the Control Facility should complete and submit designated form in the event of a multi-casualty incident (MCI) within the County of Sacramento.
- B. To ~~serve as the~~ 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 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 a MCI critique form directly to SCEMSA.

OUT-OF-HOSPITAL PROVIDERS FORM

Please complete this form following MCI's 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: _____ (Air) _____ (Ground) Provider: _____

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?

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Explain on Reverse

Were Incident Commander and MGS readily identified?

--	--	--

If No; Explain on Reverse

Was an ambulance staging area established?

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Were triage tags used?

--	--	--

If No; Explain on Reverse

Patient destinations received without long wait?

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If No; Explain on Reverse

Do you feel a debriefing is necessary?

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If Yes; Explain on Reverse

Comments, suggestions, and observations in general: _____

Follow-Up:

Triage / Reason		A / D*	Name	Injury

* A = admitted / D = discharged

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

FACILITY

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.

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: EMS System _____ 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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