

20 Questions – April, 2015

Multiple Casualty Incidents

1. You are called to a bleacher collapse at a high school gymnasium. Multiple students are injured. What is your first action upon recognizing the nature of the incident?
2. What changes occur in our radio protocols when a Tac-channel is designated for a special incident?
3. What is the first request you should make of the students?
4. Your partner and you will divide up responsibilities. What are the two cardinal divisions of labor for the first arriving crew?
5. The second crew arrives. What other two functional positions should be assigned as soon as practical?
6. What is the MOST difficult task you will face as the first arriving crew at an MCI?
7. What basic things should you look at to classify a patient's acuity during triage?
8. You have sorted out the ambulatory casualties and begin to triage the non-ambulatory students. The first victim you assess is alert, anxious, and complaining of chest pain. Her respiratory rate is 40. What color do you tag her?
9. The second person is bleeding heavily from a partially amputated leg. A tourniquet controls bleeding and his respirations are 20 non-labored, and he seems to be thinking clearly. What color do you tag him?
10. Following this call, you are called to the government center on a down. Upon arriving, you find multiple persons on the ground with no discernible cause. What should you do FIRST?
11. What should you do next?
12. What is the role of EMS at a contaminated scene?
13. What information might be helpful for MRCC and the hospitals?
14. In what situation might you use your PPE in a chemical exposure event?
15. A note found at the scene claims that this is a botulinum toxin attack by supporters of People United to Kombat Extremism. Could this be true?
16. After a short break, you are called to the airport for a possible crash. Where do we usually stage for aircraft accidents?
17. Because the airport is Allina's PSA, who do you report to?
18. What is the primary mode of death (and danger to the rescuers) in a plane crash?
19. You are put in charge of staging at the scene of an airline crash. BLS rigs from Allina and North are arriving. How do you stage them compared to the ALS rigs?
20. As the Transportation supervisor, you are matching patients with rigs. Should you clear all the red patients before sending green or yellow patients?

20 Questions – April 2015 – Mass Casualty Incident

1. The dispatch information and notes on the MDC help you anticipate the nature of incidents. While enroute to this call, prepare by discussion the immediate anticipated needs at this scene, the division of responsibility between crew members, and use the tri-fold IRP to help ensure actions aren't missed; especially the Scene Size-up that includes stating the approximate number of victims and types of injuries. Expect a radio Tac-channel for the incident, request additional crews, a supervisor, notify area hospitals via MnTRAC, and request an On-Call Medical Director.
2. Plain English should be used on the designated channel. Eg: crew roles/identification follow the IRP such as 'EMS Command', 400 becomes 'Hennepin EMS Dispatch', 10 codes should not be used. Rig/radio numbers must include role type, ie: 'Hennepin Ambulance 411', or 'Hennepin Supervisor 410', or 'Hennepin MD 409'. These changes are especially important in an event when multiple agencies are responding to the same scene, and not all resources are for patient transport.
3. 'Everybody that is able to get up and walk, get up and walk over HERE' (indicate where, of course!). This immediately creates your 'green' group (walking wounded).
4. The senior medic will function as EMS Command (per the IRP) and communicate with Hennepin EMS Dispatch to identify a staging area for additional EMS resources (per the Scene Size-up in the IRP). EMS Command must also locate the Fire IC and stick close to him/her. The importance of identifying the IC cannot be over-emphasized, as you will together determine the approach to the event (working together like this is termed Unified Command – this applies when more than one agency is working/responding to an event). The other medic becomes the EMS Operations Supervisor (per the IRP) which, includes responsibility for Triage and directing first responders in the initial treatment of non-ambulatory victims.
5. The EMS Operations person should immediately delegate responsibility for A Transportation Supervisor who will identify a patient loading area, materials/resources as needed, and most importantly, who will direct transport crews to patients based on Immediate, Delayed, Minor acuity status. This helps expedite patient transport by eliminating re-triaging of patients by inbound crews. If transport units are delayed, a casualty collection point may be needed to effectively begin treatment, transport should occur as soon as possible - keep the transports rolling!. If a treatment area (or casualty collection area) is not needed, the second position to be delegated is the Staging Supervisor who will coordinate the ambulance staging area (ingress/egress routes), and communicate with EMS Command to ensure/request enough transport units are immediately available.
6. Most responders will jump into clinical care of the victims, since that's what's familiar/comfortable, and that's what the injured will demand of you. However, coordination of an MCI usually succeeds or fails within the first several minutes of organization. Request ample resources (more than what you think you might need) after a quick scene size-up, delegate appropriate positions, THEN provide the care...
7. Three things define a RED patient – ABCD issues – if they have airway or breathing problems, signs of shock, or altered mental status then RED – you can also consider a Red somebody with penetrating torso injury – these are similar to what you do every day for the stab room so use your good judgement – otherwise, if non-ambulatory and no life-threats they are Yellow.
8. Red for difficulty breathing (START triage lists a respiratory rate >30 as an indicator – but respiratory distress is probably better and doesn't require counting. Refer to the IRP for shortened acuity descriptions.
9. Good question! Severe bleeding which **cannot** be controlled is Red, but once controlled this patient could wait if you have other priorities (shock, chest wounds, etc.)
10. GET OUT!! If you see multiple victims down and no explanation (or you have an explanation which is dynamic – eg: building collapse, sniper, etc.) you have NO business going in. Retreat to a safe area until you can gather further info and assure your safety.

11. Notify Dispatch so that other public safety personnel don't rush into the area. If a chemical event is suspected obtain wind and temperature info and request appropriate EMS resources. This information should also trigger a MnTRAC alert for area hospitals to be on guard for contaminated patient's who may self-transport.
12. Support public safety and provide patient care in the *cold zone* or as directed by EMS Command in conjunction with Unified Command. You do have chemically protective equipment on board the ambulance, but it is NOT appropriate for interior or warm/hot zone work. It could be used outside with permission from the IC if the situation requires it.
13. Number of victims, appropriate EMS staging point, ingress/egress routes for the rigs, patient collection point, decon point if needed, symptoms of the patients and physical exam findings if possible. Again, use the IRP as a job-aid to ensure important information and steps are not missed.
14. If ambulatory patients approach you that are contaminated, or if you are caught in a contaminated area put on your PPE to either guide the patients to decon (and begin basic care if required) OR escape from the warm zone to a safe location. ONLY if the IC and EMS Command have determined that the agent involved and levels of contamination allow Level C protection should you enter 'warm areas' to provide care wearing your PPE, and these usually should not be enclosed locations.
15. No. ALL biological agents have a lag time between exposure and symptoms which is at LEAST 6 hours or greater. If patients are exhibiting symptoms soon after exposure to an alleged biological agent three possibilities are: anxiety reaction, exacerbation of underlying disease (eg: asthma, cardiac disease), or use of a chemical agent.
16. Staging is at the 26th Ave. South airport gate. Report to the staging team leader and make sure to be careful where you drive! Driving on the tarmac generally requires a security escort (remember, if you have white lights on both sides of the road, that's an active runway, and a bad thing!)
17. Because all metro services use a standard Incident Response Plan the divisions are the same. If you are the first rig in, report to the IC, if you are the second, report to EMS Command, if staging is established report to the Staging Supervisor.
18. Fuel fires and the resulting toxic smoke cause most of the fatalities in ground-based crashes and pose a risk to responders.
19. BLS and ALS rigs should be treated the same in an MCI.
20. No. Make use of all the space in the departing rigs in order to clear the scene faster and reduce the patient's exposure to the elements. In general, try to place one red and two yellow or green patients on each rig. You may wish to assign green patients to red patients in the casualty collection zone to provide comfort and help you by watching the red patients and reporting changes in their condition. This will give the walking wounded a task and sense of purpose. Then, you can send the 'partner' patients in the same rig...

Be grateful that even though today may seem like a disaster, it's really not!...