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.

I. Patient Management:

A. Assess scene:

a. Survey scene: potential hazards, number of patients, need for specialized help.
b. Initiate the agency or area approved Incident Command System (ICS)
c. Practice situational awareness: continual assessment of hazards is the responsibility of every responder.

B. Basic Triage:

d. 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 (see Figures 1 and 2)
    ii. Other agency-specific triage systems as approved by Medical Direction Authority

e. Casualties are sorted into four (4) categories. Please see Figures 1 and 2 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. **Dead/Non-salvageable (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 been triaged and re-triage these patients.

C. Communication:

a. Scene Communications:
    i. Follow approved, agency-specific, incident management procedures.

b. Direct Medical Communications:
    i. Medical direction may be obtained at any time through a certified base hospital for specialty consultation (e.g. trauma, burns, peds, toxicology)
        Link: AZ Trauma Centers
c. Receiving Facility Communications
    i. The Incident Commander (IC) or their designee should communicate directly or via a Communications Center with the primary receiving facility. If resources from multiple medical facilities will be required, then all affected receiving facilities should be notified.
    ii. Regional receiving facilities should provide the Incident Commander via their designee or a Communications Center with bed availability for Immediate (Red) patients:
    iii. When possible the IC or their designee, the Communications Center, and regional receiving facilities should provide scene and receiving facility updates.
d. Individual Patient Care Communications:
    i. Once en-route, individual providers may provide direct, on-line communication with the receiving facility.
    ii. EMResource may be used to provide patient care information.
    iii. If field resources are not sufficiently available, hospitals may receive only communications limited to courtesy notification of incoming patients.
    iv. The IC, their designee, or the Communications Center will notify the hospital of any patients sent by alternative means (ie. bus, van, etc.) if known.
e. Patient Care Information – see Figure 3
    i. Triage Tags may be utilized to identify and track patients.
        1. The main body of the card contains patient information and should be 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.
f. Public Health Notification:
    i. If additional resources are needed, requests may be made through the communications center, including but not limited to:
        1. Office of Emergency Management resources
        2. MMRS resources

D. Disposition

a. Disposition priority:
    v. First priority for transport to definitive care should be given to those with the highest priority triage level as outlined above.
b. Ambulance traffic flow:

vi. Ambulance crews should remain with their ambulances until given an assignment by the IC or their designee.
vii. Keys are to remain in the vehicles at all times.

c. Destination determination:
viii. 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.

ll. 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 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".
    d. 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 affect patient care and providers should provide the best care given available resources.

Figure 1: Start Triage

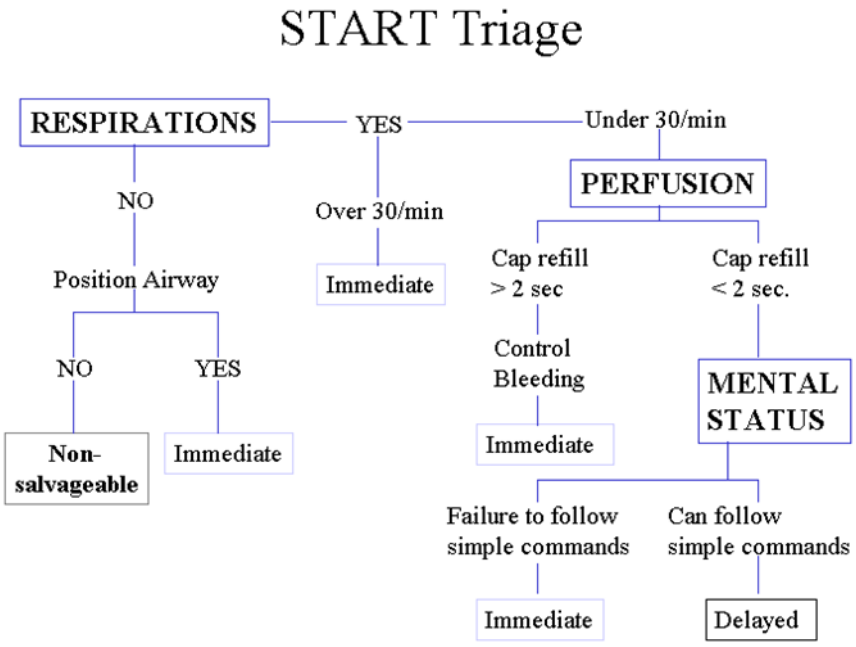

Figure 2: JumpSTART

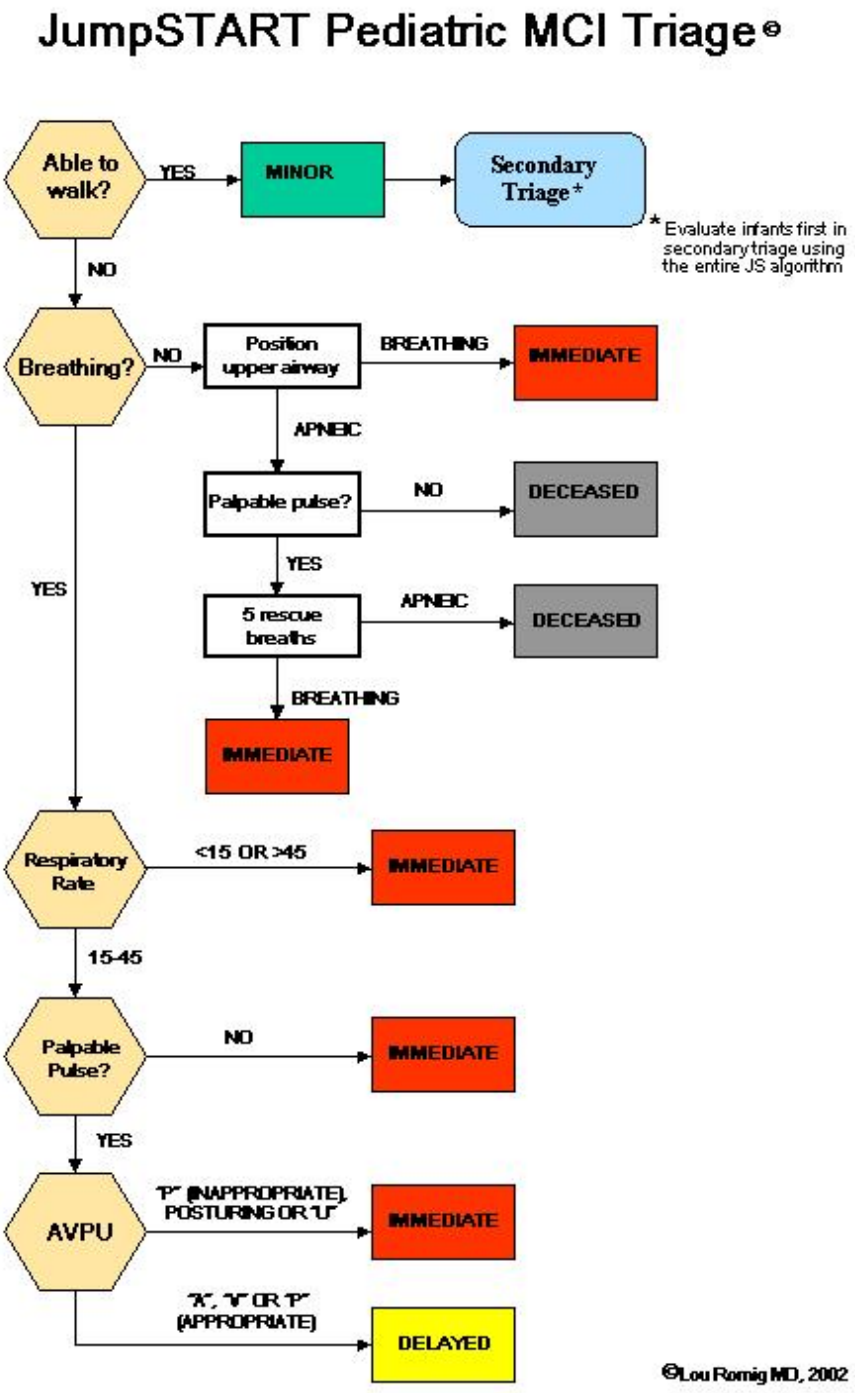

Figure 3: Triage Tag Example