

South Central Region Patient Care Procedures (PCPs)

Approved: June 25, 2025 (unless otherwise noted)

Table of Contents

- A. Contacts
 - B. Regulations
 - C. Revised Code of Washington (RCW)
 - D. Washington Administrative Code (WAC)
-
- 1. Level of Medical Care Personnel to Be Dispatched to An Emergency Scene
 - 2. Guidelines for Rendezvous With Agencies That Offer Higher Level Of Care
 - 3. Air Medical Services - Activation and Utilization
 - 4. On Scene Command
 - 5. Prehospital Triage and Destination Procedure
 - 5.1 Trauma Triage and Destination Procedure
 - 5.2 Cardiac Triage and Destination Procedure
 - 5.3 Stroke Triage and Destination Procedure
 - 5.4 Behavioral Health Destination Procedure
 - 6. EMS/Medical Control Communications
 - 7. Hospital Diversion
 - 8. Cross Border Transport
 - 9. Inter-Facility Transport Procedure
 - 10. Procedures to Handle Types and Volumes of Patients That Exceed Regional Resources
 - 10.1 MCI/All Hazards

A. Contacts

See website (www.screms) for current contacts.

B. Regulations

The following regulations provide guidance on the subject matter contained in this document. Please note that this is not an inclusive list. For more information, please contact a Department of Health Emergency Care System representative.

C. Revised Code of Washington (RCW)

1. [RCW 18.73](#) – Emergency medical care and transportation services
 - a. [RCW 18.73.030](#) - Definitions
2. [RCW 70.168](#) – Statewide Trauma Care System
 - a. [RCW 70.168.015](#) – Definitions
 - b. [RCW 70.168.100](#) – Regional Emergency Medical Services and Trauma Care Councils
 - c. [RCW 70.168.170](#) – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

D. Washington Administrative Code (WAC)

1. [WAC 246-976](#) – Emergency Medical Services and Trauma Care
 - a. [WAC 246-976-920](#) – Medical Program Director
 - b. [WAC 246-976-960](#) – Regional Emergency Medical Services and Trauma Care Councils
 - c. [WAC 246-976-970](#) – Local Emergency Medical Services and Trauma Care Councils
 - d. WAC 246-976-910 – Regional Quality Assurance and Improvement Program

1. Level of Medical Care Personnel to Be Dispatched to An Emergency Scene

A. PURPOSE:

The appropriate level of emergency, BLS, ILS, ALS personnel, aid or ambulance services will be dispatched to the emergency incident scene to provide timely patient care.

B. SCOPE:

Appropriate licensed and trauma verified aid and ambulance services are dispatched to all emergency medical and trauma incidents within an identified service area.

C. GENERAL PROCEDURES:

1) Dispatch

- a. Local EMS and Trauma Care Councils should identify primary and secondary Public Safety Answering Point (PSAP)/dispatch in each county and provide information to the Region Council of any changes.
- b. Dispatchers should be trained in and use an Emergency Medical Dispatch (EMD) Guidelines Program to include pre-arrival instructions.
- c. The appropriate level of service will be dispatched to the incident.
- d. EMS services are responsible to update PSAP/dispatch, DOH, Local and Region Councils of any response area changes as soon as possible.
- e. In the event a patient approaches a service seeking help or a unit happens upon an incident, PSAP/dispatch must be contacted to activate the EMS system.

2) Response Times

Response times are measured from the time the call is received by the responding agency until the time the agency arrives on scene.

3) Cancellation of Response Criteria

For all level EMS Agencies:

- a. The responsible party for patient care decisions is the highest-level EMS provider on scene with the patient.
- b. Communicate with PSAP/dispatch if no patient is found or non-injury or the following conditions are confirmed; (Proceed if requested by law enforcement.)
 - i. Decapitation
 - ii. Decomposition
 - iii. Incineration
 - iv. Lividity and Rigor Mortis

4) Slow Down

- a. The first on-scene unit should convey available patient information to responding transport units that may be used to slow response.

5) Diversion to Another Emergency Call

An EMS transport unit may be diverted to another call when:

- a. It is obvious the second call is a life-threatening emergency and first-in EMTs and/or paramedics report that the first call can await a second unit.
- b. A second ambulance is requested to the first call.
- c. The highest-level transport responding unit is closer to the second call and may be vital to the patient's outcome.
- d. If Priority Dispatch System used, follow local county operating procedures (COPs) for diversion to another call.

6) Staging/Standby

Dispatch should provide ALL pertinent information to the responding units so they can make a determination as to whether to stage. Units will advise Dispatch of intent to stage and request Law Enforcement response if appropriate.

D. APPENDICES:

None

2. Guidelines for Rendezvous With Agencies That Offer Higher Level Of Care

A. PURPOSE:

To guide EMS providers to initiate rendezvous with a higher level of care while en route to a receiving hospital based on patient needs and resource availability.

B. SCOPE:

BLS or ILS units may rendezvous with a higher level of care. Rendezvous is appropriate when:

- 1) Patient may benefit from a higher level of care.
- 2) Resources may be limited or not available.

C. GENERAL PROCEDURES:

- 1) The BLS/ILS ambulance should request ALS ambulance rendezvous by contacting dispatch.
- 2) Ground ambulance should rendezvous with a higher level of care based on patient illness or injury.
- 3) Benefit to patient should outweigh increase to out of hospital time.
- 4) Based on updated information, requesting units may cancel the rendezvous by contacting dispatch.
- 5) EMS providers should use effective communication with all incoming and on scene emergency responders, with responder safety and patient care as their highest priority.
- 6) Communication should include patient report when appropriate.

D. APPENDICES:

None

3. Air Medical Services - Activation and Utilization

A. PURPOSE:

Air Medical Service activation and utilization provides expeditious transport of critically ill or injured patients to the appropriate hospital including designated/categorized receiving facilities.

B. SCOPE:

Licensed and trauma verified aid and/or ambulance services utilize county protocols and county operating procedures (COPs) consistent with current "WA Statewide Recommendations for EMS Use of Air Medical" (within the WA State Air Medical Plan) to identify and direct activation and utilization of air medical services.

C. GENERAL PROCEDURES (Content based on State Air Medical Plan):

- 1) Air medical response should take significantly less time than it takes to travel by ground to the closest appropriate facility. Consideration should be given to activating the helicopter prior to arrival based on scene location, available system resources, or time savings by rendezvous enroute to a local hospital. This decision should be made as per local COPS in conjunction with local medical control.
- 2) Responders should involve dispatch to contact and activate air medical response to maintain system safety and integrity. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.
- 3) Responding EMS service may activate air medical service prior to arrival on scene based on dispatch information or upon arrival on scene based on initial assessment.
- 4) Air medical service will provide ETA of available, fully-staffed, closest air ambulance.
- 5) The final patient transport and destination decisions will be made on the scene by lead ground provider and air medical in conjunction with triage destination procedures.
- 6) Air medical service will notify PSAP/dispatch when activated by a mechanism outside the emergency dispatch system.
- 7) Air Medical transport is recommended for the following:
 - a. Trauma: Patient condition identified as a major trauma per the Trauma Triage Tool (see link to the WA Trauma Triage Destination Procedure in the appendix).
 - b. Non Trauma:
 - i. Any patient airway that cannot be maintained.

- ii. Patient with cardiac disease and is experiencing a progressively deteriorating course, is unstable, and/or requires measures not available en route (e.g. ALS level care, cardiac catheterization, thrombolytic therapy).
- iii. Patient is experiencing a severe neurological illness requiring neurosurgical or other intervention that is not available en route. (CVA, uncontrolled seizures, etc.).

8) Exceptions

Some patients that do not meet the above indications for air transport may still be candidates for air transport under the following circumstances:

- a. Long distance transport of critical patients (more than 2 hours by ground).
- b. Remote locations with isolated injury patients that could create a prolonged painful transport (i.e. logging injury).
- c. Situations where a ground CCT unit will not be available for an extended time period.
- d. Situations where resources at the sending facility and/or scene are severely limited.
- e. Mass casualty situations.
- f. Lack of availability of ground transport.
- g. Lack of availability of specialty care personnel (with a minimum of one registered nurse) to accompany patient.
- h. Road conditions which may extend ground transport times (e.g. icy roads, flooding, remote locations, bridge openings, heavy traffic, etc.).
- i. Land transport would deplete the local community of vital EMS services for an extended period of time.
- j. EMS regional or state-approved protocol identifies need for on-scene air transport.

9) Exclusions

Patients for whom air medical transport is contraindicated include:

- a. Patients who have been pronounced dead (the need for or potential for cardiopulmonary resuscitation is not a contraindication for air transport).
- b. Obstetrical patients in advanced active labor and in whom an imminent and /or precipitous delivery can be expected.
- c. Patients with actual or potential for violent or self-destructive behavior that cannot be adequately and safely restrained or controlled using chemical or physical restraints.

- d. A patient in traumatic full arrest if another critically injured patient requires air transport and is determined to have a greater chance of surviving with rapid transport by air.

D. APPENDICES:

- 1) Link to DOH website WA State Air Medical Plan
<https://www.doh.wa.gov/portals/1/Documents/Pubs/530129.pdf>
- 2) WA Trauma Triage Destination Procedure:
<https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf>

4. On Scene Command

A. PURPOSE:

Provide coordinated and systematic delivery of patient-centric emergency medical care and transport services at all incidents, to include single EMS agency, multi-agency, and multi-jurisdictional responses.

B. SCOPE:

The National Incident Management System (NIMS) Incident Command System (ICS) will be used when establishing on scene command.

C. GENERAL PROCEDURES:

- 1) Agencies are responsible for ensuring responders are trained in NIMS ICS per FEMA guidelines at the appropriate level.
- 2) ICS guidelines will be followed when establishing command and assigning other roles based on incident needs.
- 3) The Medical Group Supervisor should be an individual trained in the ICS, familiar with both the local EMS resources and the county Mass Casualty Incident and Disaster Plan, and capable of coordinating the medical component of a multiple patient incident.
- 4) Unified Command: An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the Unified Command, often the senior person from agencies and/or disciplines participating in the Unified Command, to establish a common set of objectives and strategies and a single Incident Action Plan.

D. APPENDICES:

None

5. Prehospital Triage and Destination Procedure

A. PURPOSE:

Provide guidance for transport destination decisions for Trauma, Cardiac, Stroke, Mental Health and Chemical Dependence patients from the emergency medical scene to the appropriate receiving facility.

B. SCOPE:

A coordinated system of care which identifies hospital levels of services available for specific categories of patient need. The triage destination procedures inform EMS providers of patient triage criteria algorithms to identify the transport destination to the appropriate designated/categorized hospital receiving facilities.

C. GENERAL PROCEDURES:

Prehospital providers will utilize the most current State of Washington Destination Procedure, local COPs, and Medical Program Director (MPD) protocols to transport critically ill or injured patients to an appropriate receiving facility.

D. APPENDICES:

None

5.1 Trauma Triage and Destination Procedure

Effective Date: 1/29/2026

PURPOSE

This Procedure provides guidance for County Operating Procedures (COPs) and Protocol development to meet state, regional and local EMS system needs and provides guidance to prehospital providers, decreasing the amount of decision making in the field, to ensure patients are delivered to the most appropriate trauma center equipped to reduce death and disability.

SCOPE

This PCP is intended for prehospital EMS providers to use when responding to victims of traumatic injury. It should be utilized in conjunction with COPs and Protocols to make decisions about patient destination based upon [WA State Trauma Triage and Destination Guidelines for Prehospital Providers](#)

GENERAL PROCEDURES

EMS dispatch and response to traumatic injury in the South Central Region should be consistent with PCP I—'Level of Medical Care to Be Dispatched to An Emergency Scene'. Dispatch and response COPs are specific to, and defined by, each Local EMS and Trauma Care Council. Memorandums of Understanding (MOUs) for mutual aid and rendezvous are developed by local stakeholders and incorporated into county dispatch criteria. Criteria should be reviewed annually to ensure an appropriate level of response.

Triage is performed using the [WA State Trauma Triage and Destination Guidelines for Prehospital Providers](#).

Activation of the trauma system is done through notification of Medical Control at the receiving trauma center. This can be done through dispatch, radio contact or phone/approved apps. COPs further define mode of activation based upon destination facility preference and internal procedures. Providers must provide activation at the earliest possible moment to ensure adequate resources are available at the receiving trauma center.

Transport of High Risk (Red Criteria) for Serious Injury: patients should be transported to the closest Level I or Level II trauma service within 30 minutes transport time (air or ground). Transport times greater than 30 minutes; take to the closest most appropriate trauma service unless otherwise specified in local County Operating Procedures (COPs). Transport of patients meeting Moderate Risk (Yellow) for Serious Injury should be transported to a designated trauma service; it need not be the highest level. Refer to table below for list of Designated Trauma Centers in the South Central Region or the [WA DOH Trauma Designated Services](#).

Interfacility transport of patients requiring additional definitive care not available at the primary trauma center after stabilization will be coordinated by the primary trauma center and be consistent with transfer procedures in RCW 70.170.

Specialty Care Services not available in the South Central Region such as burn patients will be triaged and transported in the same manner as all other trauma patients using the [WA State Trauma Triage and Destination Guidelines for Prehospital Providers](#).

Quality Measures are monitored by the Regional Quality Assurance Committee. Data should be regularly reviewed to determine the following system components.

- Adherence to the [WA State Trauma Triage and Destination Guidelines for Prehospital Providers](#)
- Adequacy of system resources
 - EMS Response
 - Level/adequacy of response
 - Request for ALS rendezvous
 - Use of air medical services
 - Initial stabilization by primary trauma centers
 - Transfers from primary trauma center for definitive care
 - System barriers to optimal care and outcome

APPENDICES

DESIGNATED TRAUMA FACILITIES IN THE REGION

Facility	Location (City/County)	Designation Level		
		Adult	Peds	Rehab
Kadlec Regional Medical Center	Richland/Benton	II	III P	
Providence St Mary Medical Center	Walla Walla/Walla Walla	III		II R
Trios Health	Kennewick/Benton	III		
Multicare Yakima Valley Memorial Hospital	Yakima/Yakima	III	III P	
Kittitas Valley Healthcare	Ellensburg/Kittitas	IV		
Sunnyside Community Hospital	Sunnyside/Yakima	IV		
Toppenish Community Hospital	Toppenish/Yakima	IV		
Lourdes Medical Center	Pasco/Franklin	IV		II R
Prosser Memorial Hospital	Prosser/Benton	IV		
Dayton General Hospital	Dayton/Columbia	V		

[WA DOH Designated Trauma Services](#)

[WA State Trauma Triage and Destination Guidelines for Prehospital Providers](#)

ASSOCIATED COPS AND PATIENT CARE PROTOCOLS

Each county in the South Central Region has County Operating Procedures (COPs) and MPD Protocols which offer additional guidance. These can be found on the region’s website at www.screms.org.

Submitted by:	Change/Action:	Date:	Type of Change	
Regional Council	Approved	1/29/2026	<input checked="" type="checkbox"/> Major	<input type="checkbox"/> Minor
			<input type="checkbox"/> Major	<input type="checkbox"/> Minor
			<input type="checkbox"/> Major	<input type="checkbox"/> Minor

			<input type="checkbox"/> Major	<input type="checkbox"/> Minor
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5.2 Cardiac Triage and Destination Procedure

A. PURPOSE:

Patients presenting with signs and symptoms of acute cardiac distress are identified and transported to an appropriate categorized Washington State Emergency Cardiac System participating hospital to reduce death and disability.

B. SCOPE:

Licensed and trauma verified aid and/or ambulance services utilize the most current State of Washington Prehospital Cardiac Triage Destination Procedure to identify patients with signs or symptoms of acute cardiac distress and transport to the appropriate categorized cardiac hospital.

C. GENERAL PROCEDURES:

Prehospital providers will utilize the most current State of Washington Prehospital Cardiac Triage Destination Procedure, local COPs, and MPD protocols to direct prehospital providers to transport patients to an appropriate categorized Washington State Emergency Cardiac System participating hospital.

D. APPENDICES:

- 1) Link to DOH website: Washington Prehospital Cardiac Triage Destination Procedure

<https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf>

- 2) Link to DOH website: List of WA State Emergency Cardiac and Stroke System Participating Hospitals

<https://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf>

5.3 Stroke Triage and Destination Procedure

A. PURPOSE:

Patients presenting with signs and symptoms of acute stroke are identified and transported to the appropriate categorized Washington State Emergency Stroke System participating hospital to reduce death and disability.

B. SCOPE:

Licensed and trauma verified aid and/or ambulance services utilize the most current State of Washington Prehospital Stroke Triage Destination Procedure to identify patients with signs or symptoms of acute stroke and transport to the appropriate categorized stroke hospital.

C. GENERAL PROCEDURES:

Prehospital providers will utilize the most current State of Washington Prehospital Stroke Triage Destination Procedure, local COPs, and MPD protocols to direct prehospital providers to transport patients to an appropriate categorized Washington State Emergency Stroke System participating hospital.

D. APPENDICES:

- 1) Link to DOH website: Washington Prehospital Stroke Triage Destination Procedure
<https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/530182.pdf>
- 2) Link to DOH website: List of WA State Emergency Cardiac and Stroke System Participating Hospitals
<https://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf>

5.4 Behavioral Health Destination Procedure

Approved: 4/22/2026

PURPOSE

To operationalize licensed and verified EMS services that may transport patients from the field to behavioral health facilities; to include mental health services, chemical dependency services, and 23-hour crisis centers.

SCOPE

Licensed and verified EMS services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, and to 23-hour crisis relief centers in accordance with RCW 71.24.916, with approval from the county Medical Program Director (MPD).

GENERAL PROCEDURES

1. Facility participation is voluntary.
2. Facilities and agencies must adhere to the Washington State Department of Health, EMS Guideline, Transport to Behavioral Health Facilities document.
3. Facilities that participate will work with the county Medical Program Director (MPD) and EMS services to establish criteria that all participating facilities and EMS entities will follow for accepting patients.
4. The MPD and Local EMS and Trauma Care Council must develop and establish a county operating procedure (COP) and a protocol inclusive of the standards recommended by the Washington State Department of Health, EMS Guideline, EMS Transport to Behavioral Health Facilities and regional PCP, to include dispatch criteria, response parameters and other local nuances to operationalize the program.
5. The MPD must develop and implement department-approved education for EMS personnel in accordance with the training requirements of the guideline; such educational programs must be approved by the DOH.

MONITORING

Biannually, system partners including Medical Program Directors, Local Council members, Regional QI Committee members, and behavioral health facility representatives, will review PCP 5.4 to evaluate relevance and intent. Continuous system monitoring is to be performed at the local level. Local EMS Councils must work with EMS Medical Program Directors to establish Quality Assurance Processes to monitor programs that are operating in their county.

APPENDICES

- Washington State Department of Health, EMS Guideline, Transport to Behavioral Health <https://doh.wa.gov/sites/default/files/2024-06/530262-EMSGuidelineTransportToBehavioralHealthFacilities.pdf>
- The Department of Health (DOH) licenses and regulates inpatient and outpatient Behavioral Health Facilities. An updated list of agencies that may be certified to

provide mental health, substance use disorder (SUD), problem gambling and gambling disorder services, or any combination of these types of services can be found on the DOH website at Behavioral Health Agencies, <https://doh.wa.gov/licenses-permits-and-certificates/facilities-z/behavioral-health-agencies-bha>

ASSOCIATED COUNTY OPERATING PROCEDURES (COPs) AND PATIENT CARE PROTOCOLS Accessible on the Southwest Region EMS and Trauma Care Council website by county at

- [Columbia County:](#)
- [Kittitas County:](#)
- [Mid Columbia County](#)
- [Walla Walla County:](#)
- [Yakima County:](#)

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved	04/22/2026	<input checked="" type="checkbox"/> Major <input type="checkbox"/> Minor
			<input type="checkbox"/> Major <input type="checkbox"/> Minor
			<input type="checkbox"/> Major <input type="checkbox"/> Minor
			<input type="checkbox"/> Major <input type="checkbox"/> Minor

6. EMS/Medical Control Communications

A. PURPOSE:

Communications between prehospital personnel, base station hospital (online medical control), and all receiving healthcare facilities are interoperable to meet system needs.

B. SCOPE:

Communication between prehospital personnel, base station hospital (online medical control), and all receiving health care facilities (to include designated trauma services and categorized cardiac and stroke services) utilize effective communication to expedite the exchange of patient care information.

C. GENERAL PROCEDURES:

- 1) Communication between EMS providers and healthcare facilities may be done directly or indirectly via local PSAP/dispatch.
- 2) Based on geographic area, communication via radio, cell phone and/or telephone may be used to expedite the exchange of information as needed.
- 3) EMS agencies and receiving healthcare facilities will maintain communication equipment and training to communicate effectively.

D. APPENDICES:

None

7. Hospital Diversion

A. PURPOSE:

Hospitals have diversion policies to divert trauma, cardiac, or stroke patients to other appropriate facilities based on that facility's inability to provide care and intervention.

B. SCOPE:

All designated trauma services and categorized cardiac and stroke hospitals within the Region have written policies to divert patients to other appropriate designated or categorized facilities.

C. GENERAL PROCEDURES:

- 1) Hospitals identify communication procedures for redirection/diversion of trauma, cardiac and stroke patients to another facility when resources are unavailable. The hospital must notify the EMS transport agencies and other designated services in their area.
- 2) Exceptions to redirection/diversion:
 - a. Airway compromise
 - b. Cardiac arrest
 - c. Active seizing
 - d. Persistent shock
 - e. Uncontrolled hemorrhage
 - f. Urgent need for IV access, chest tube, etc.
 - g. Disaster declaration
 - h. Paramedic discretion

D. APPENDICES:

WATrac Tracking and Alert System link: <https://doh.wa.gov/public-health-healthcare-providers/emergency-preparedness/watrac>

8. Cross Border Transport

This section is intentionally left blank.

9. Inter-Facility Transport Procedure

A. PURPOSE:

To provide guidance on transferring high-risk trauma and medical patients without adverse impact to clinical outcomes.

B. SCOPE:

All interfacility patient transfers via ground or air shall be provided by appropriate licensed or verified service with appropriate certified personnel and equipment to meet the patient's needs.

C. GENERAL PROCEDURES:

- 1) Medical responsibility during transport should be arranged at the time of the initial contact between referring and receiving physicians, and transfer orders should be written after consultation between them.
- 2) Immediately upon determination that a patient's needs exceed the scope of practice and/or protocols, prehospital personnel shall advise the facility that they do not have the resources to do the transfer.
- 3) When on line medical control is not available, prehospital protocols shall be followed during an EMS transport in the event that an emergency situation occurs while en route that is not anticipated prior to transport.
- 4) While en route, the transporting agency should communicate patient status and estimated time of arrival to the receiving health care service per MPD local protocols and COPs.

D. APPENDICES:

None

10. Procedures to Handle Types and Volumes of Patients That Exceed Regional Resources

A. PURPOSE:

To provide for the standardization and integration of Mass Casualty Incident (MCI) Plans between counties throughout the region.

B. SCOPE:

Major incidents/emergencies that create hazardous conditions that threaten public health, that exceed local resources, and may involve multiple counties and states.

C. GENERAL PROCEDURES:

- 1) All EMS agencies and Incident Commanders working during an MCI event shall operate within the National Incident Management System (NIMS).
- 2) Based on available local resources, prehospital EMS responders will use appropriate protocols and procedures consistent with the Washington State DOH "Mass Casualty-All Hazard Field Protocols" during an All-Hazards-MCI incident. Prehospital EMS responders will additionally follow any other All-Hazards-MCI protocols/county operating procedures (COPs) set forth by the County MPD and County EMS & Trauma Care Council.
- 3) The appropriate local Public Health Department will be notified when a public health threat exists. County Local Governing Officials with authority will proclaim a "state of emergency" for incidents/emergencies with health implications that threaten to overwhelm the emergency response resources and healthcare system.

D. APPENDICES:

None

10.1 MCI/ALL HAZARDS

A. PURPOSE:

To provide for the standardization and integration of Mass Casualty Incident (MCI) Plans between stakeholder agencies throughout the region.

B. SCOPE:

The following material represents a broad guideline for the common practice of our EMS providers when dealing with a mass casualty event.

C. GENERAL PROCEDURES:

1) Triage System:

- a. Initial triage should be rapid with an emphasis on identifying severe but survivable injuries.
- b. A single system should be used throughout the EMS system. For example, START and Jump/START are simple and effective tools for initial triage.
- c. A triage tag or identifier should be applied at the time of initial EMS contact.
- d. Secondary triage should be applied at the scene (treatment area) with a focus on identifying patients whose outcome will depend primarily on time critical hospital based interventions (surgery/critical care).

2) Transport:

- a. Critical patients should be the priority for earliest transport to receiving hospitals with an emphasis on those that need immediate surgical interventions.
- b. EMS staffed transport vehicles should be loaded to full capacity and provide ALS level EMS during transport, if possible.
- c. When ambulance capacity is exceeded, alternate transport vehicles (buses, etc.) should be considered to move the less severely injured. EMS personnel should be assigned to the vehicles.

D. APPENDICES:

None