

2005

**ASHTABULA COUNTY
MANAGEMENT OF THE
MASS CASUALTY
INCIDENT**

And Use of The

**MASS CASUALTY
INCIDENT
MANAGEMENT SYSTEM**

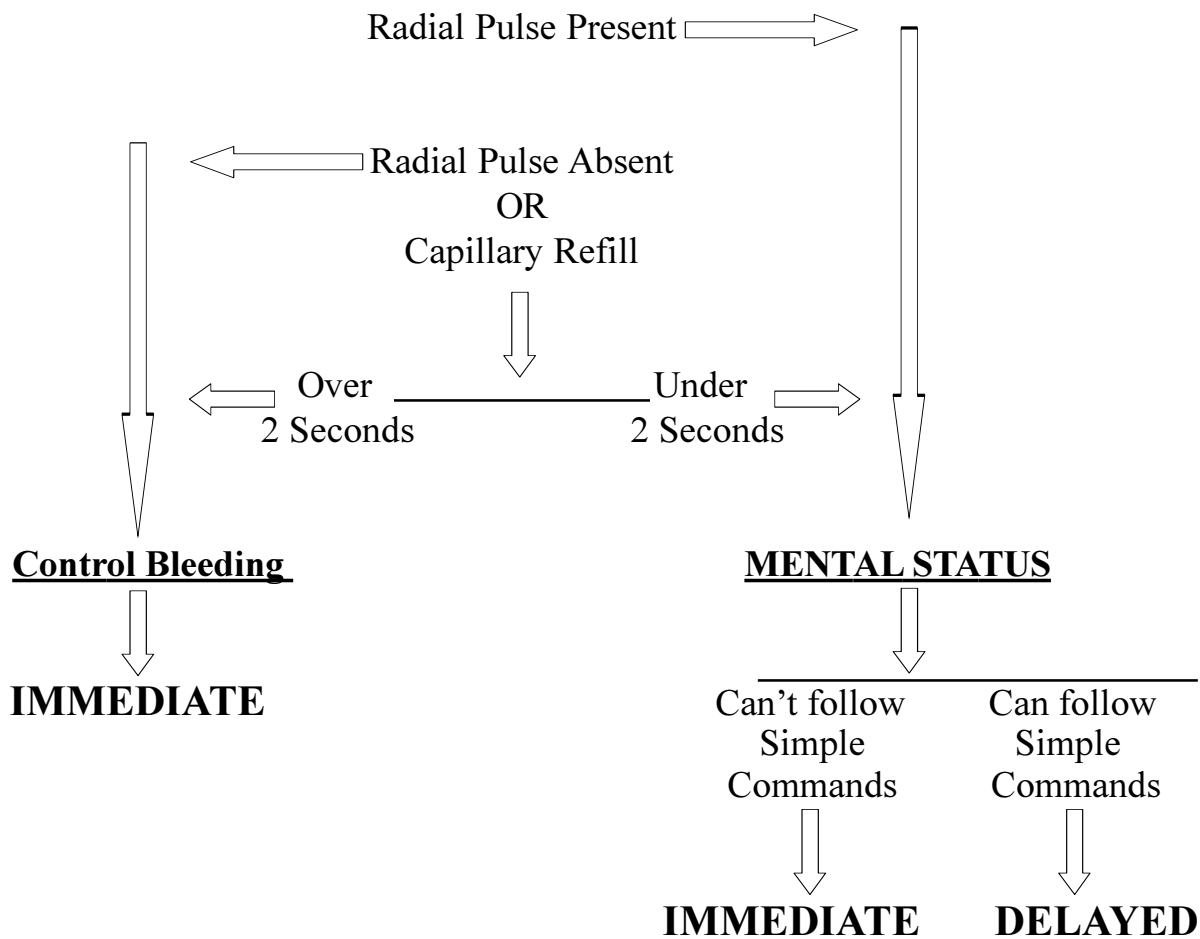
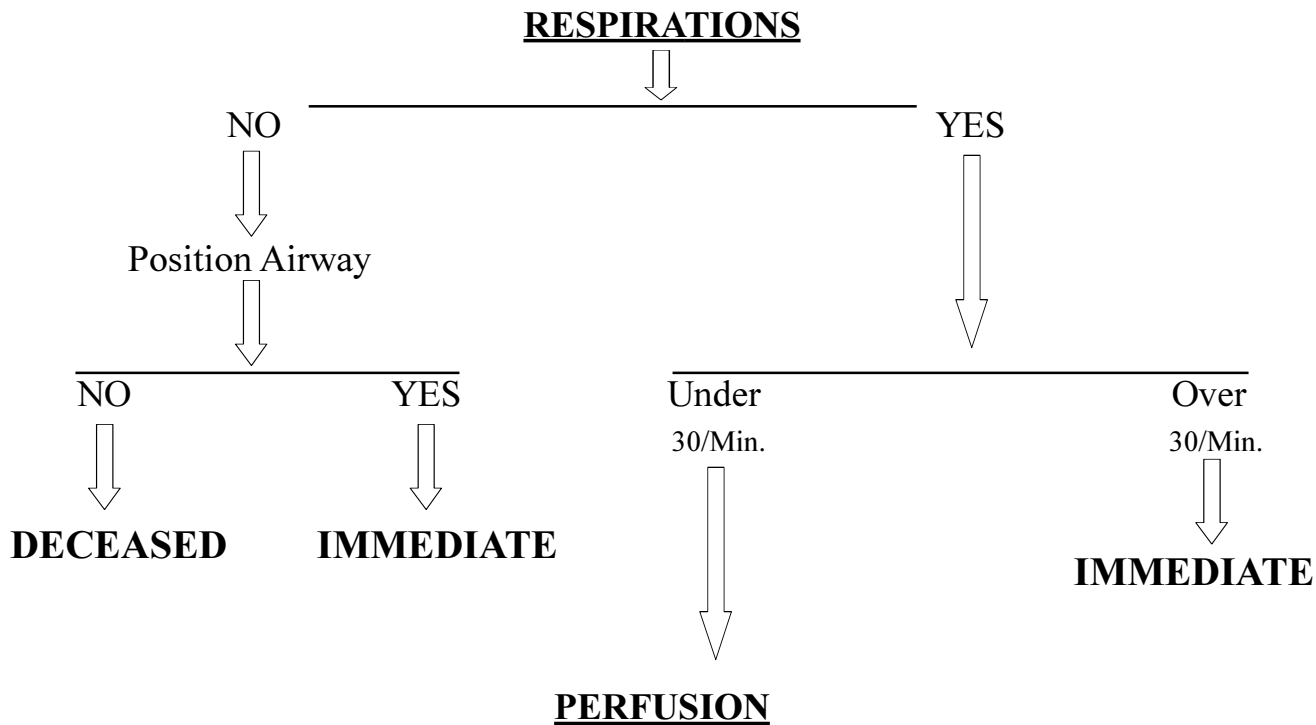
Approved by

**Ashtabula County Fire Chiefs Association
and Ashtabula County EMS Council**

MCS/LVI/MCI

1. MCS: (Multiple Casualty Situation) Any time there is more than one victim.
2. LVI: (Limited Victim Incident) Any time there is less than 25 victims.
3. MCI: (Mass Casualty Incident) Any event that places such a demand on available equipment and or personal resources that the system is stretched to its limits or beyond.
 - Squads will transport no less than two victims per ambulance during LVI or MCI.
 - Squads will add an additional EMS person to the back or an appropriate Non-EMS driver and move the EMS driver to the back.
 - During LVI/MCI no transport rules apply to the transportation of the walking wounded.
 - Keep in mind the victims needs, and the best possible use of equipment and personnel.
 - EMS personnel will use the START System for triage.
 - In MCI and some LVI situations no more than 60 seconds will be spent to triage each victim.
 - Three physical assessments will be used to meet the 60 seconds per victim triage goal. They are Ventilation, Perfusion, and Mental Status.
 - Follow the “START TRIAGE” algorithm on the next page.

START TRIAGE
ALL WALKING WOUNDED
MINOR



INTRODUCTION

The possibility of a Mass Casualty Incident (MCI) occurring in your area may seem remote. But MCIs do occur, and with the growth of technology, they will no doubt occur more often. Every EMS unit must be prepared to deal with an MCI.

This kit is designed to help you and your personnel to pre-plan, coordinate and manage a Mass Casualty Incident. Included in the kit are the guidelines, instructions, forms and much of the equipment needed to manage an MCI.

Early institution of a management system will determine the success, or failure, of a department's method of handling an MCI. The actual management phase may start upon arrival of the first one or two EMS personnel. These few people have much to do to begin managing the situation in an organized fashion.

The following pages provide an in-depth explanation of the principals of Mass Casualty Incident Management. Also explained are the specific uses of the forms and materials found in the kit, and helpful guidelines for developing a management plan. The time to review this material is not when an MCI occurs. This manual is NOT a field manual. It is also NOT a disaster plan. Disaster plans are usually in-depth, comprehensive plans which involve the total community response to a generally large-scale disaster. This book is a reference manual to be read immediately after receiving the kit, and to be constantly reviewed. As new techniques or ideas are implemented, periodic revisions may be needed. These revisions or additions should be made in this manual so that all department members can benefit from them.

We strongly suggest your department conduct a training session as soon as possible to familiarize all your personnel with the contents and use of this system. By doing this, even the least experienced personnel on the department may be able to assume the role of one of the EMS Sector Officers. Additionally, regular training and review is warranted. Only by continually fine tuning our skills can we truly claim to be qualified to handle an MCI.

INITIAL RESPONSE PHASE

Duties of First On-Scene Personnel

The first arriving EMS unit may consist of a minimal number of EMS personnel. Command officers or additional EMS units may not be immediately available to assist. It is imperative that the first arriving personnel switch from the role of “care-giver” to the role of “Mass Casualty Incident Managers”. If the MCIMS kit is available, the officer’s checklist in the portfolios of the kit will start providing step-by-step guidelines which may be followed. The following are some other general principles the first on-scene personnel should consider:

1. The first on-scene EMS personnel should NOT start treatment.
2. Quickly assess the situation.
 - A. Estimate the number of patients.
 - B. Estimate the number of EMS units required.
 - C. Assess the need for any special equipment or services.

EMS Command

It must be noted that the EMS Commander is NOT the same as the Incident Commander. The Incident Commander is in charge of the ENTIRE incident. In many areas, this position may be the responsibility of the Fire Chief or Safety Director. The EMS Commander is responsible for directing all EMS Operations. At an MCI, this may be the most critical command position.

The EMS Commander should address some immediate concerns early on:

1. Request additional EMS units as needed. The EMS EXTRA ALARM/MABAS ASSIGNMENTS sheets included in the kit should be utilized through the ICS system.
2. Start evacuation and/or triage when personnel become available and it is safe to do so.
3. Establish liaisons with fire and police commanders. Also establish communications with the Incident Commander and any other Safety Service Commanders.

If the assignment of the EMS Commander changes, the new EMS Commander should respond to the Command Post as the EMS representative and remain there. The previous Commander may then be reassigned for other duties. If it has not already been done, the EMS Commander should assign personnel to handle the duties of the other four (4) Sector Officers.

Establishment of the Command Post and Assignment of the EMS Commander

The Command Post should be established by first-in EMS personnel. Immediate EMS command is the responsibility of the most qualified member of the first on-scene EMS crew. This person is the EMS Commander. The EMS Commander should stay at the Command Post and not leave it. Command should be transferred only if a more qualified person arrives.

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COMMAND PHASE

Assigning EMS personnel to the additional positions of EMS sector officers should not depend on seniority, rank or popularity. Lives are at stake. This is a time to set aside personal feelings and antiquated ideas. Each of the five (5) key EMS Sector Officers' positions should be filled by the personnel MOST QUALIFIED to handle each job. This may mean an EMT or Paramedic well versed in the concept of triage or treatment will be a commander, while a Lieutenant or Captain may fill the position of a care-giver.

Assigning Other EMS Sector Officer Positions

Not all EMS Sector Officer positions may need to be filled. The needs will be dictated by the incident. The EMS Commander may need to assign:

- A Triage Officer, and designate primary and secondary Triage Areas (secondary in case the primary becomes unusable due to wind shift or other dangers).
- A Treatment Officer, and designate primary and secondary Treatment Areas.
- A Transportation Officer, who should work closely with the Treatment Officer. The two officers should designate a Loading Zone Area within the Treatment Area.
- An EMS Staging Officer, to report to the designated Staging Area established by the Command Post. Depending on the situation, this officer may be responsible for only handling EMS units.

Evaluation of Operation and Requests for Special Assistance

Early evaluation of the operation and request for special assistance or equipment may be guided by using the EMS TACTICAL COMMAND sheet, the EMS Commander may decide there is a need to request special support agencies or to perform certain duties. The EMS Commander may also find referring to the LOCAL RESOURCES list helpful, as there may be helpful resources that can easily be overlooked during this emotionally charged period.

The EMS Commander should continually re-evaluate the incident and the need for special units or other assistance. Additionally, the EMS Commander should request updates from the EMS Sector Officers and offer assistance where possible. Keep in mind that for the incident to flow smoothly, it is necessary for all command personnel, both EMS and Non-EMS, to work together and continually communicate. Don't forget about the needs and suggestions of the Incident Commander, Fire Commander, Police Commander and other sector commanders. No one knows it all.

Control Phase

The means of controlling a Mass Casualty Incident depends largely on the type of incident present. MCI's are often classified as either Open or Closed, Contained, or Continuing. The strategies for managing each type of incident may vary.

Open Versus Closed Incidents

In an Open Incident, patients are easily accessible or scattered over a wide area. An example of an Open Incident may be a natural disaster such as a tornado or hurricane, although some man-made disasters may also create Open Incidents.

Contained Versus Continuing Incidents

When a Contained Incident is encountered, the cause or causes of the incident have been stopped. For instance, after the bus has crashed, additional injuries will probably not occur.

When a Continuing Incident is encountered, the cause or causes of injury continue. A good example may be toxic fumes in an office building. Patients may continue to be affected, and additional patients may present themselves as the incident progresses.

Triage Operations and Duties of the Triage Officer

Whether the incident is Open or Closed, Contained or Continuing, one general rule should be followed: All patients should be seen by a Triage Officer and should be processed through the Treatment Area. Otherwise, maintaining patient accountability is impossible.

The actual mechanism of triage may vary based on local protocols. Additionally, a decision must be made as to whether triaging will be done where a patient is found or as patients enter the treatment area. This will depend on the type of incident.

The Triage Officer should be the person most knowledgeable in the principles of triage. Triage is an art, and to find tune one's skills requires constant training. Ashtabula County will use the "Mettag" system. In some areas, use of a specific triage tag is mandated by local protocols. Where not specified, preference as to the brand of triage tag used is up to the individual department. Mettags are included in the TRIAGE SUPPLIES portfolio.

If patients are to be triaged where found, they should be moved to the Treatment Area after they are triaged. The Triage Officer should request personnel from EMS Commander to assist in moving patients from the field to the treatment area. In large or complicated incidents, a Transfer Officer may be appointed to oversee this.

The order in which patients are moved should be based on patient location and severity of condition. Proper care should be exercised when moving patients so as not to aggravate injuries. The use of spinal immobilization devices (i.e. cervical collars and backboards) is highly recommended. Patients must be re-triaged after they enter the treatment area. A patient's condition may deteriorate while waiting to be moved or during the move.

Treatment Operations and Duties of the Treatment Officer

The Treatment Officer should not necessarily be the EMS person most qualified in patient care. The job of the Treatment Officer is more one of an administrator rather than a medical care provider. Personnel who are best qualified in the area of patient care and treatment should be utilized doing what they do best, treating patients.

Advanced Life Support personnel should be used to treat the more seriously injured patients. Remember, however, that the Treatment Area is not a hospital. Life threatening injuries should be stabilized, but time should not be wasted in treating every minor injury. Patients should be transported to definitive care facilities (i.e. hospitals) as quickly as stabilization allows.

When establishing the Treatment Area, think BIG. The Treatment Area must be capable of accommodating large numbers of patients and equipment. Consider the weather, safety of patients and personnel, and possible hazardous materials dangers. The area should be readily accessible and have clearly designated entrance area and exit area accessible and have clearly designated entrance and exit area (the ambulance Loading Zone). A secondary Treatment Area may be designated should the primary area become unusable for various reasons.

The Treatment Area should be divided into four distinct and well marked areas, corresponding to triage categories. The areas can be identified using color coded flags (included with the kit), barricade tape, and/or tarps. These areas are:

- A. Red (First Priority) - Seriously ill or injured patients. These patients most likely need rapid transport to a hospital.
- B. Yellow (Second Priority) - Patients with moderate injuries which need attention and/or may become life-threatening. These should be the second group of patients transported.
- C. Green (Third Priority) - Minor injuries (sometimes called the "Walking Wounded"). Treatment and transportation of these patients may be delayed.
- D. Black (Fourth Priority) - Patients who are dead or have injuries which will lead to certain death. This area serves as the morgue. For psychological reasons, this area should be separate from the other three treatment areas.

Actual medical control, or control of treatment, may become the responsibility of an on-scene physician or physicians. This does not mean that the physician becomes Treatment Officer. Additionally, this is not a time for Advanced Life Support personnel to be hindered by the need for verbal orders to perform life saving procedures.

Treatment Officer

The Treatment Officer will assign duties to EMS personnel as they are sent to the Treatment Area. Additional EMS personnel may be requested from the Staging Area if needed. Should a large number of personnel be needed in the Treatment Area, the request should be made through the EMS Commander. A special

call may be made for personnel only. This will prevent the depletion of personnel from the transport units, which could leave ambulances understaffed.

Patients should only leave the Treatment Area at the direction of the Treatment Officer. This requires an interaction between the Treatment Officer and the actual treatment personnel. All patient transfers should be coordinated with the Transportation Officer.

The Treatment Officer is also responsible for making sure an adequate stock of medical supplies is available. The Treatment Officer should continually consult the MEDICAL EQUIPMENT CHECKLIST to ascertain what supplies are needed. Supplies may be requested from a supply officer or the EMS Commander may need to acquire the necessary supplies.

Transportation Officer

The Transportation Officer has, perhaps, the most complicated and challenging assignment. It is of great importance that the person filling this position have a good working knowledge of the duties of the Transportation Officer. Familiarity with the forms and guidelines contained in the TRANSPORTATION OFFICER portfolio of the kit is also a must.

The Transportation Officer handles all routing of patients from the Treatment Area to the hospital. All hospital notifications are made by the Treatment Officer, utilizing standard departmental or local communication procedures. Due to increased radio traffic, the use of cellular telephone communications is highly recommended. Cellular fax machines may also be helpful if available. Individual ambulances should NOT communicate with the receiving hospitals. This can tie up the radio channels and may interfere with the communications of the Transportation Officer. It may also result in confusion of the Transportation Officer. It may also result in confusion due to conflicting reports or misunderstandings.

The capabilities of receiving hospitals and their bed counts are correlated by the Transportation Officer. Phone numbers for local hospitals can be recorded in advance on the HOSPITAL PHONE LIST sheet. When ascertaining hospital capabilities, it is most important to know what the hospital can handle in the Emergency Department and Surgical Department. The number of ER beds and OR suites is most important. Patients can be transferred to more distant hospitals for long term care after they are stabilized.

At smaller incidents, this information may be recorded in the appropriate area on the EMS TACTICAL COMMAND BOARD (the EMS Commander may double as Transportation Officer). In large incidents, this information should be recorded on the HOSPITAL CAPABILITY AND PATIENT TALLY SHEET. This sheet may have to be revised throughout the incident.

As transport units are needed, the Transportation Officer will contact the Staging Officer who will then send the proper number and types of units. The Staging Officer should be advised as to whether to send a unit capable of providing basic, intermediate, or advance life support while enroute to the hospital.

A part of the Treatment Area should be designated as the Ambulance Loading Zone. The location should be agreed upon by the Transportation Officer and Treatment Officer. The Transportation Officer should also consult with the EMS Commander and the Fire Commander before deciding on the best location for a landing area for aero medical helicopters.

A record should be kept of all patients leaving the treatment area using the HOSPITAL TRANSPORTATION LOG found in the TRANSPORTATION OFFICER portfolio. Additionally, each ambulance crew should be given a HOSPITAL DIRECTIONS CARD corresponding to the proper hospital destination. These cards should be filled out in advance.

As the ambulances leave the Loading Zone, the proper hospital should be notified of the pending arrival of patients. The hospital should be supplied with any pertinent information found on the HOSPITAL

TRANSPORTATION LOG. This may include:

- A. Name of the transporting unit.
- B. Number of patients being transported.
- C. A brief description of the patients by triage category and/or specific injuries
- D. The ETA of the transporting unit.

If a multiple part triage tag is used, the Transportation Officer should keep a copy of the triage tag before releasing the patient. If METTAGS are being used, keep a corner of the tag with the number on it.

To keep a running tally of the number of patients being sent to each hospital, place hash marks in the appropriate areas of the HOSPITAL CAPABILITY AND PATIENT TALLY SHEET. Hash marks should be placed within the designated area based on patient condition. Referring to this sheet should prevent overloading any one hospital with patients, especially critically injured patients. Directly compare the number of patients being sent in each category with the hospitals capability filled out earlier.

Because hospitals may be few and far between, it may be wise to designate closer hospitals as primary receiving facilities. EMS units from great distances may be requested to respond to these hospitals. After patients are delivered to the closer hospitals, they may be transferred to further facilities, thereby reducing the burden placed on the closer hospital. Additionally, the initial transport units are then free to return to the MCI scene.

Staging Operations and Staging Officer

To reduce congestion and confusion at the MCI scene, all responding EMS units should report to a designated Staging Area. The location of the Staging Area should be coordinated with the Incident Commander, EMS Commander and Fire Commander. The Staging Area should be readily accessible and easy to locate. It is good to consider the location of the Ambulance Loading Zone in the Treatment Area, as a simple route should be planned from Staging Area to Loading Zone. A Secondary Staging Area may be designated should the primary area become unusable for various reasons.

Ideally an EMS Staging Area separated in some way from the fire equipment staging area should be maintained. The area should be big enough to handle large numbers of ambulances. Additionally, this area should be divided into three distinct areas based on the medical capabilities of each unit: One for EMS units with Basic Life Support capabilities, One for Intermediate units, and One for Advanced Life Support (Paramedic) units. By keeping the units so divided, the EMS Staging Officer can quickly ascertain by sight when the supply of units in one area is getting low. This system also provides for quick dispatch of specific capability units to the Transportation Officer. As more units are needed, the EMS Commander should be notified. In turn, the EMS Commander will handle communications with the dispatcher to request additional units.

The Staging Officer should record all pertinent information on the EMS UNIT STAGING LOG. As ambulances arrive, the Staging Officer should distribute INCIDENT INFORMATION to each unit.

As ambulances arrive at the Staging Area, the Staging Officer should ascertain the name of the officer or person in charge of that unit. All crews with individual units should stay with their units at all times. Additionally, crew should be notified that radio traffic is to be handled only by designated EMS officers, and not by individual ambulance crews.

The Staging Officer should not send any units to the treatment area Loading Zone unless they are requested by the Transportation Officer.

Public Information Officer

The media must be viewed as an ally and not an enemy. If media members appear to be out of control, it may be due to inadequate supervision on the part of command personnel. The job of the Public Information Officer is to control the media and turn them into an asset, not a liability.

The media has a vital job to do, so use this to your advantage. For example, the media may be used to disseminate evacuation information. Or, hours of news footage shot by television crews may be invaluable in reviewing and critiquing an incident after its conclusion. Cooperation during the incident is the key to continued good relations after the incident. The Public Information Officer is one person, usually appointed by the Incident Commander after consulting with the Fire Commander, EMS Commander, and Police Commander. Ideally, the Public Information Officer should be someone who is diplomatic, tactful, concise, and preferably has good public speaking ability.

Only information approved by the Incident Commander should be released. The information may come from the EMS Commander, Fire Commander, or Police Commander.

This information may include, but is not limited to:

- A. The type of incident (What happened).
- B. Where the incident occurred.
- C. When the incident occurred.
- D. The number of persons killed or injured (DO NOT RELEASE NAMES)
- E. The current status of the incident.
- F. Additional information, as decided upon by the Incident Commander.

It is important to remember that ONLY FACTS should be released. Information about the cause on an incident, or any speculation concerning the incident, should be avoided. Saying too much may place a department or agency on shaky legal ground, opening the way for future legal action.

The media will want pictures. Work with them on this when possible. If groups of photographers are taken through the incident area, they should be accompanied by the Public Information Officer. Set ground rules ahead of time as to what photographers can and cannot photograph. If reporters accompany photographers, it must be made clear that they are not to interview any patients or emergency personnel without permission. Additionally, no one is to interfere with the work of any emergency services personnel.

The Incident Commander may wish to set up a Media Assembly Area, where all media members gather to be briefed by the Public Information Officer. This area may also be equipped with phones and other items for use by the media. News conferences and interviews may also be held in this area.

Concluding the Mass Casualty Incident

Toward the conclusion of the Mass Casualty Incident, the remaining ambulances at the Staging Area may be moved up to the incident scene. At least one unit should remain on the scene until all emergency activities are completed, since additional patients may be discovered or scene personnel may become incapacitated.

It is important to notify all participating hospitals and support agencies once the incident is concluded. If ambulance crews completed separate run reports on patients while enroute to the hospital, copies of the reports should be requested.

It may be good to have a meeting of the five EMS Sector Officers prior to a large critique session in which all agencies and personnel may be involved. The purpose of this meeting is to correlate paperwork, finish administrative work related to the incident, and discuss additional items which must be accomplished before the incident can really be considered concluded. The officers may also wish to use this time to analyze statistics and discuss any personnel concerns they have regarding the incident.

After the EMS Sector Officer's meeting, there is a need for an early critique of the incident. This meeting should include, at a minimum, command personnel from all areas such as EMS, Fire, Rescue, Police, Hospital, and other support agencies. The Incident Commander may wish to include other personnel as well. This is the time to BE CRITICAL AND BE HONEST! Identify areas needing improvement and specific problems which were encountered. More importantly, though, plan how to better handle the weak areas the next time.

It is very important to consider the needs of the care providers. Emotional and psychological injuries may not readily be noticed, but are there. If a Critical Incident Stress Debriefing program is available in the immediate area, it should be readily accessible to all personnel who were involved. This may include more than just the EMS, Fire, and Police personnel. If a program or team is not locally available, arrangements should be made ahead of time to access such a program, or other psychological support services, from a nearby area.

At the end of the incident, the Public Information Officer and Incident Commander should provide a final news release.

Summary of General Guidelines and Principles

- To manage the MCI in an organized manner, some additional points merit consideration or repeating.
- The first on-scene EMS unit should not start treatment. Personnel from this unit should start using the Mass Casualty Incident Management System. The first unit on the scene should not leave the scene until the conclusion of the incident.
- Any responding units arriving before the establishment of a Staging Area should report directly to the Command Post for their assignments.
- Definitive markings for Command Post, Triage Area, Treatment Area, and Staging Area should be utilized. It is suggested that a green warning light be used to make the Command Post easily identifiable. Color coded flags may also be used.
- Command personnel should be identified by marker vests.
- Any EMS personnel entering the primary perimeter must wear proper protective clothing.
- EMS Sector Officers should give constant updates to EMS Commander.
- Emergency service workers also need support. Should a rescuer be injured, they should be designated as a Red patient regardless of the severity of the injury and transported on the next available unit. Leaving them at the scene will have an additional psychological impact on the other rescuers.
- When at all possible, family units are to be kept together during treatment and transportation phases.
- An area for responding family members should be designated. It may be helpful to staff this area

with clergy and psychological support personnel.

- Emergency service workers also need support. The Ashtabula County Critical Incident Stress Debriefing (CISD) team should be utilized during the incident and after.
- Evacuation and relocation procedures, also communications guidelines, should be established by the Incident Commander or someone designated by the Incident Commander.
- Initial training in MCI management and continual review is a must. All EMS personnel should be thoroughly familiar with the principles of MCI management so as to be able to fill the roles of the various EMS Officers at any time. One and two day training courses are available from the manufacturers of this kit.

USE OF THE KIT

With any piece of emergency equipment, it is important for the people using it to be thoroughly familiar with its use and operation. We strongly suggest that all department members, not use officers, be familiar with the Mass Casualty Incident Management System and its operation. Regular training with the kit will be of benefit.

The system is comprised of four basic components, each of which will be described in detail. The components are: 1) Blue Command Vests, 2) Color coded Tarps, 3) The EMS TACTICAL COMMAND BOARD, and 4) EMS Sector Officer Portfolios. As each component, checklist, or form is explained, the proper item should be pulled from the kit for reference.

Command Vests

A blue coded vest is provided for each of the five (5) EMS Sector Officers. Since it may be difficult at times to read the lettering on the back of the vests, the blue color coding facilitates easier identification of the EMS Sector officers.

The color coding is as follows:

EMS COMMANDER	BLUE
TRIAGE OFFICER	BLUE
TREATMENT OFFICER	BLUE
TRANSPORTATION OFFICER	BLUE
STAGING OFFICER	BLUE

The identification vests should be distributed early in the incident to each of the EMS Sector Officers.

Color Code Tarps

Three (3) colored tarps are included with the MCI kit. Command post should be clearly identified. Alternate forms of identification, such as a green revolving light, may also be used. If a revolving light is used, it is important that the color be distinct from the colors of emergency lights on responding EMS, Fire, and Police vehicles.

Three (3) colored tarps (Red, Yellow, Green) are used to identify the sections of the Treatment Area. These tarps should be given to the Treatment Officer.

EMS Tactical Command Board (If available)

The EMS TACTICAL COMMAND BOARD provides the EMS Commander area to record information about the Mass Casualty Incident that can be quickly referenced. The information should be noted in the appropriate areas as needed. In some incidents, it may be helpful to have an additional board for the Transportation Officer. The board is also available as a less expensive laminated sheet and may be purchased from the same company you obtained your kit.

After unfolding the command board, it may be placed on an easel, the hood of a vehicle, or a desk in a command vehicle. The board may be written on with a dry erase marker, water-based marker, or grease pencil. As the incident progresses, the various sections of the board should be filled in. A map of the scene may be drawn. The map may include general geographical information, as well as note the relationship of the incident site with the locations of Treatment and Staging Areas.

Contents of EMS Sector Officer's Portfolios

Specially developed checklists, forms and reference cards for each EMS Sector Officer are packaged in individually labeled portfolios. Necessary pens, grease pencils, mechanical pencils (eliminating the need for sharpening), secretarial supplies, and miscellaneous specialty items are also in the portfolios. The officer should quickly review the contents of the portfolio, and the forms included.

Remember, depending on the size of the incident, not every officer's position may be assigned. Individual parts of the kit may be used independently if desired. A working knowledge of the contents of each EMS Sector Officer's portfolio will allow the EMS Commander to decide which parts of the kit may best be used.

Clipboards

Each portfolio contains a see-through clipboard. The EMS Sector Officer's checklist is placed within the clipboard, facing the back so that it can be read when the clipboard is turned over. This allows the officer to quickly reference the checklist without flipping pages, and protects the checklist from rain or snow. As each step is completed, a check may be placed on the corresponding line to the left of the instruction. Keep in mind that the checklist presents suggestions which may need to be adapted as dictated by incident. Additional steps may be included per department protocols.

The various forms for each officer should be placed under the clip on the front of the clipboard. Rather than placing a thick stack of forms under the clip (which may make accessing different forms difficult), the officer may wish to place only one or two of each form on the clipboard. As new forms are needed, they may be obtained from the portfolio to replace completed forms. An area is provided on each form for page numbering to ensure proper page order.

Since MCI's can occur in any type of weather, a plastic sheet protector is included, which may be placed over the forms on the front of the clipboard. This will keep the forms dry, and may also be marked on using a grease pencil. For night operation, a high intensity 30-minute Cyalume lightstick may be placed in the clip to illuminate the front of the clipboard.

IMPORTANT OPERATIONAL NOTE - **DO NOT** USE DRY ERASE MARKERS TO WRITE ON THE CLIPBOARDS AS THEY MAY PERMANENTLY MARK THE PLASTIC. USE ONLY GREASE PENCILS, SUCH AS THE ONE INCLUDED.

FORMS

EMS COMMANDER

- ___ Confirm Mass Casualty Incident Exists (determine PPE needs and hazards).
- ___ Make rapid assessment of Incident.
- ___ Activate department MCI Response Plan.
- ___ Establish and appropriately identify **Command Post** (May use flag or light).
- ___ EMS Commander **Must** remain at Command Post.
- ___ Request additional units and equipment per **ICS**.
- ___ **Do Not** begin treatment; First-In Unit must assume incident control.
- ___ Don Command Vest and review items in **EMS COMMANDER** Portfolio.
- ___ Advise Communication Center of First-In report information.
- ___ Have Communication Center make initial notification to appropriate area hospitals concerning existence of mass casualty incident; Transportation Officer will directly communicate specific information to hospitals as incident progresses.
- ___ Assign Sector Officers and distribute Corresponding Officer Portfolios:
 - ___ Triage Officer
 - ___ Treatment Officer
 - ___ Transportation Officer
 - ___ Staging Officer
- ___ Consult with Incident Commander to determine if it is safe to begin EMS Operations.
- ___ Utilize **EMS TACTICAL COMMAND BOARD**; complete appropriate sections. (If available)
- ___ Coordinate all EMS operations during incident; Consult with other Sector Officers as needed.
- ___ Consult with Incident Commander to appoint a **Public Information Officer**.
- ___ Act as liaison with other medical support agencies.
- ___ Assign and reassign personnel as necessary.
- ___ Reevaluate need for additional units and equipment.
- ___ Complete Post Incident forms.

EMS EXTRA ALARM ASSIGNMENTS

	DEPARTMENT NAME	UNIT ID	DISPATCH CENTER	FREQUENCY
A L A R M				
A L A R M				
A L A R M				
A L A R M				

POST-INCIDENT ANALYSIS REPORT

Incident Date: _____

Location: _____

Type of Incident: _____

Starting Time of Incident: _____

Ending Time of Incident: _____

Total Time of Incident: _____ Hours _____ Minutes

Total Patients - Red: _____

Total Patients - Yellow: _____

Total Patients - Green: _____

Total Patients - Black: _____

Grand Total Patients: _____

Average Time Patients Were Held In Treatment Area:

Red Patients: _____ Minutes

Yellow Patients: _____ Minutes

Green Patients: _____ Minutes

Overall Average: _____ Minutes

Total Ambulances - Basic: _____

Total Ambulances - Intermediate: _____

Total Ambulances - Paramedic: _____

Total Ambulances - Helicopter: _____

Grand Total Ambulances: _____

**Total Number of Hospitals to
Which Patients Were Transported:** _____

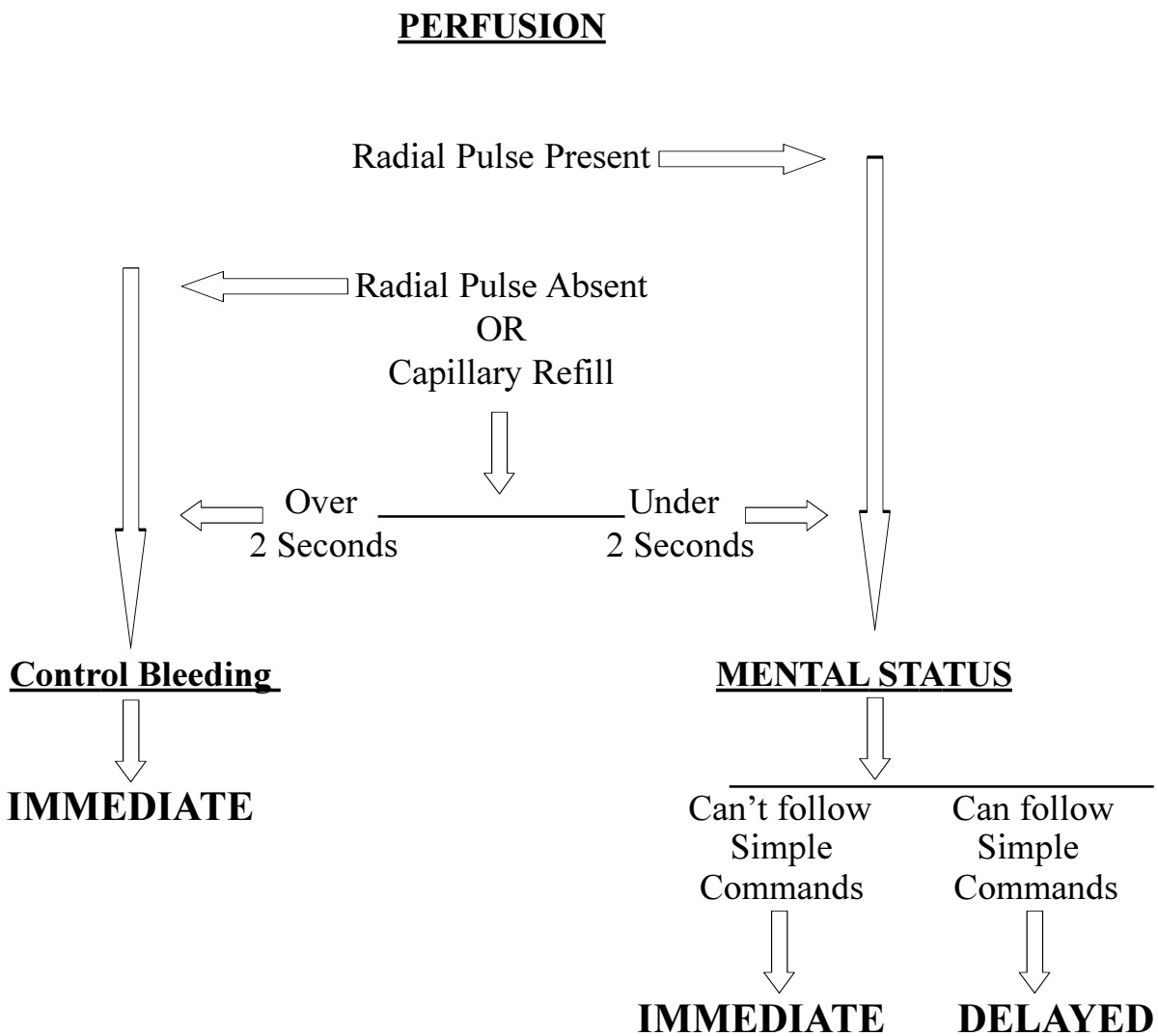
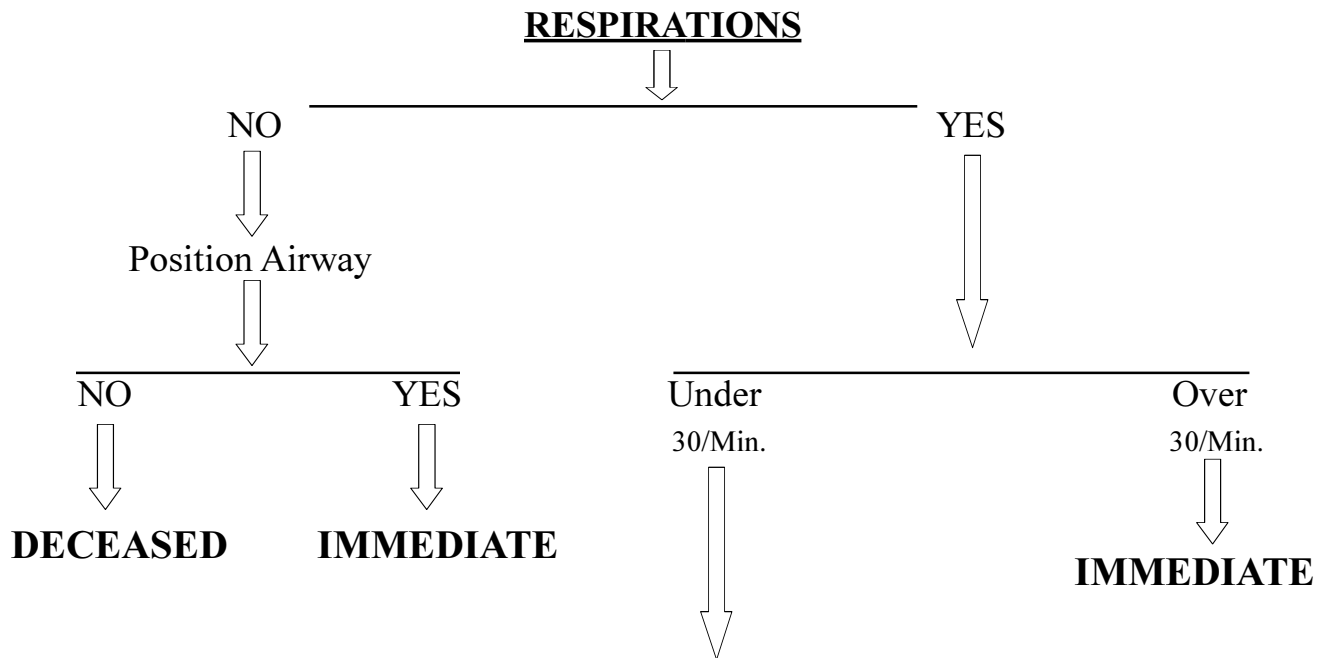
TRIAGE OFFICER

**** NO TREATMENT IS TO BE DONE IN THE TRIAGE AREA ****

*Possible Exceptions: Rapid Correction of Life Threatening Problems,
i.e. Opening Airway or Rapid Bleeding Control*

- ___ Obtain briefing from EMS commander (PPE needs and report of hazards).
- ___ Obtain **TRIAGE OFFICER** and **TRIAGE SUPPLIES** Portfolios.
- ___ Don command vest and review items in portfolio.
- ___ Determine Equipment and personnel needs of Triage Sector; request same from EMS Commander.
- ___ Coordinate Personnel assigned to Triage Sector.
- ___ Distribute Triage Tags or Ribbons to Support Personnel as appropriate.
- ___ Ascertain from the EMS Commander if it is **Safe** to begin Triage Operations.
- ___ Begin Triage Operations.
- ___ Advise Treatment Officer of approximate number of patients as soon as possible.
- ___ Coordinate transfer of patients by priority to appropriate Treatment Sector.
- ___ Request personnel and equipment as needed to transfer patients to Treatment Area.
- ___ **Check ALL areas around MCI Scene** for potential patients, walk aways, ejected patients, etc.
- ___ Advise EMS Commander when initial Triage and Tagging Operations are complete.
- ___ Begin relieving or reducing staff as necessary.
- ___ Report to EMS Commander for reassignment upon completion of tasks.

START TRIAGE
ALL WALKING WOUNDED
MINOR



TREATMENT OFFICER

- ___ Obtain briefing from EMS commander (PPE needs and report of hazards).
- ___ Obtain **TREATMENT OFFICER** Portfolio.
- ___ Don command vest and review items in portfolio.
- ___ Determine equipment and personnel needs in Treatment Area; request same from EMS Commander.
- ___ Coordinate Personnel assigned to Treatment Area.
- ___ Establish **Primary Treatment Area**:
 - Think Big - Treatment area must be capable of accommodating large number of patients and equipment.
 - Consider: Weather, Safety, Hazardous Materials.
 - Area must be readily accessible.
 - Designate Entrance and exit to area.
 - Divide Treatment Area into four (4) distinct and well marked areas: Use appropriate colored flags, barricade tape, and / or tarps.
- ___ Designate Secondary Treatment Area as alternative should Primary Area become unusable.
- ___ Inform EMS Commander of Primary and Secondary Treatment Area Locations.
- ___ Treatment Officer **Should Not** become involved in physical tasks.
- ___ Assign personnel to Treatment Areas based on medical capabilities.
- ___ Begin Treatment of patients.
- ___ Re-Triage patients upon arrival at Treatment Area: place patients in appropriate sections.
- ___ Complete **TREATMENT SECTOR LOG** as patients pass through Treatment Area.
- ___ Advise Transportation Officer when patients have been prepared for transport; notify Transportation Officer which hospital patient should be transported to; evacuate patients by priority.
- ___ Regularly inventory supplies using the **MEDICAL EQUIPMENT CHECKLIST** and obtain or order supplies when low.
- ___ Begin Relieving or reducing staff as necessary.
- ___ Report to EMS Commander for reassignment upon completion of tasks.

STAGING OFFICER

- ___ Obtain briefing from EMS commander (PPE needs and report of hazards).
- ___ Obtain **STAGING OFFICER** Portfolio; **Do Not** proceed to Staging Area at this time.
- ___ In cooperation with EMS and Fire Commanders, Establish Location of **Staging Area**:
 - EMS Staging Area should be distinct from Fire Staging Area, but may be in the same general location.
 - Think Big - Staging Area must be capable of accommodating large numbers of ambulances.
 - Consider: Safety and Hazardous materials.
 - Area must be readily accessible.
 - Designate entrance and exit to Staging Area.
 - Divide Staging Area into three (3) distinct and well marked areas for: Basic, Intermediate and Paramedic Units; Use appropriate markers.
 - Consider need for a Secondary Staging Area as an alternative should the Primary Staging Area become unusable.
- ___ Proceed to Staging Area.
- ___ Don command vest and review items in portfolio.
- ___ Determine Equipment and personnel needs in Staging Area; request same from EMS Commander.
- ___ Coordinate Personnel assigned to Staging Area.
- ___ Ascertain from Transportation Officer Location of Ambulance Loading Zone and best route to zone.
- ___ Ascertain from EMS Commander approximate number of EMS units to expect.
- ___ Maintain **EMS UNIT STAGING LOG**.
- ___ A driver must stay with each ambulance!
- ___ Send proper number and types of units to Ambulance Loading Zone when requested by the Transportation Officer.
- ___ As number of EMS Units in Staging Area decreases, advise EMS Commander of possible need to request additional units.
- ___ Report to EMS Commander for reassignment upon completion of tasks.

TRANSPORTATION OFFICER

* * ONLY PERSON TO COMMUNICATE WITH HOSPITALS * *

- ___ Obtain briefing from EMS commander (PPE needs and report of hazards).
- ___ Obtain **TRANSPORTATION OFFICER** Portfolio.
- ___ Don command vest and review items in portfolio.
- ___ Determine Equipment and personnel needs in Transportation Area; request same from EMS Commander.
- ___ Coordinate Personnel assigned to Transportation Area.
- ___ Provide and coordinate patient transport.
- ___ Communicate with area hospitals (Refer to **HOSPITAL PHONE LIST**); be specific, but brief:
 - Relay information concerning incident to hospitals as needed.
 - Ascertain each hospital's capabilities and number of specialty beds available.
 - Inform hospitals of number of patients to expect and their conditions.
- ___ Begin filling out **HOSPITAL CAPABILITY** and **PATIENT TALLY SHEET**.
- ___ Consult with Treatment Officer and establish ambulance **Loading Zone**; Zone should have separate entrance and exit routes.
- ___ Advise Staging Officer of location of Loading Zone and best routes for access.
- ___ Consult with IC and establish Landing Site for Air Support Units; notify EMS Commander of location.
- ___ Request ambulances from Staging Officer as needed; notify Staging Officer of level of care required (Basic, Intermediate, Paramedic)
- ___ Coordinate routing of patients to proper ambulances.
- ___ Maintain **HOSPITAL TRANSPORTATION LOG**; If Triage Tags are used, make sure tag is filled out appropriately; keep one corner or section of tag.
- ___ Fill out and distribute a **HOSPITAL DIRECTIONS CARD** to each ambulance's driver to ensure they know which hospital to go to and how to get there. (Return to Staging)
- ___ **Advise receiving hospital of:** Name of unit responding, number of patients in unit, brief description of patients by triage category and/or injuries, ETA of unit.
- ___ Do not become involved in physical tasks; appoint radio operator to assist if needed.
- ___ Update **HOSPITAL CAPABILITY** and **PATIENT TALLY SHEET** as patients are transported; Complete totals at conclusion of incident (Confirm that the numbers match).
- ___ Begin Relieving or reducing staff as necessary.
- ___ Advise Hospitals and EMS Commander when last patient is transported.
- ___ Report to EMS Commander for reassignment upon completion of tasks.

TRANSPORTATION OFFICER HOSPITAL CAPABILITY and PATIENT TALLY SHEET

Incident /

Date: _____ Location: _____

Continually keep track of the number of patients from each Triage Category sent to individual hospitals by placing hash marks in the appropriate columns. Compare this with the “Number of Patients Hospital Can Treat” column to avoid overloading hospital. Tally patient totals at the end of the incident.

Hospital Name	Hospital Specialties	Number of Patients Hospital Can Treat	Number of Patients Sent By Triage Category			Total
			Red	Yellow	Green	
		# of Red: # of Yellow: # of Green:				
		# of Red: # of Yellow: # of Green:				
		# of Red: # of Yellow: # of Green:				
		# of Red: # of Yellow: # of Green:				
		# of Red: # of Yellow: # of Green:				
Total Number Of Patients Transported In Each Triage Category						

