



# Emergency Medical Services MCI Protocol

## 2014



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# DISASTER/MCI PROTOCOL OUTLINE

**NOTE:** This document defines the structured response for the "EMS BRANCH", within the Incident Command Structure, to be utilized during Disaster/MCI responses. "Medical Branch Director" in this document defines the person responsible for the EMS Branch response.

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# Ottawa Medical Control Board Authority

## DISASTER/MCI PROTOCOL

### **PURPOSE:**

The purpose of this protocol is to provide a framework for EMS response to a significant event, which is defined as an event that requires or has the potential to require a large number of EMS and system resources over a long period of time. Examples include regional disasters such as tornadoes or floods and mass casualty incidents such as motor vehicle accidents, structure fires, building collapses, or plane crashes.

### **RATIONALE:**

The critical issue in significant event responses is the organizational structure and the need to ensure that critical functions are accomplished. This protocol details the role of EMS in the Incident Command Structure, advises how to access local resources, describes proper communications methods and provides specific information on select vulnerabilities.

This plan focuses on a systems approach to event management and is not limited to EMS. Successful mitigation of events requires both organization and a team approach with all other emergency responders, dispatch agencies, hospitals and event stakeholders.

### **EDUCATIONAL REQUIREMENTS**

All personnel functioning under this plan are required to possess additional training related to disaster preparedness. Educational requirements are outlined in Appendix "A". These criteria are specific only to disaster preparedness and do not outline all MCA required education for any particular provider level. These educational requirements are the minimum; additional education and training is strongly encouraged.

### **INCIDENT COMMAND STRUCTURE:**

Use of the Incident Command Structure is expected for all EMS scene responses. Formally establishing functional positions and using identifiers such as Command, Directors, Leaders, etc. is expected to take place when an EMS Plan 1 or higher is declared.

Events that are large in scale or in time commitment are also expected to have integration of EMS into Unified Command regardless of the number of EMS response vehicles/personnel.

- In smaller incidents, multiple functions may be filled by only one or two individuals.
- In larger incidents, functions may be assigned to personnel as subsequent personnel arrive on scene.
- Administrative functions become necessary as situations grow in time, in size, or in number of ill/injured.
- Functional personnel are coordinators/facilitators and should not routinely be involved in direct patient care

### **INDICATIONS FOR ACTIVATION OF THIS PROTOCOL:**

1. Incidents qualifying as an EMS Plan 1 or higher
2. Medical incidents in which routine transportation procedures are ineffective
3. Non-medical incidents of significance which involve a prolonged EMS presence
4. Incidents spread over a wide geographical area which require more/uncommon resources
5. Non-medical incidents with the need for an EMS Incident Action Plan in the event of a situation change

### **INCIDENT PLANNING TEAMS**

Participating MCA's, EMS agencies, Public Safety agencies, Emergency Management, Hospitals and Public Health are encouraged to form incident planning teams in order to generate event plans for either specific events or known vulnerabilities. These plans should be documented in advance of events utilizing accepted ICS forms.

## **PRIORITIES:**

Following nationally recognized standard procedures, units arriving on the scene of a potential significant event are to assess and manage the situation using the **DISASTER** Paradigm:

- **Detection:** Identify the event as having, or having the ability to generate, a significant number of patients.
- **Incident Command:** Meet with or establish Incident Command/Unified Command
- **Safety & Security:** Ensure that those on scene are not in harm's way and discuss/implement measures to keep the scene secure
- **Assess Hazards:** Look for things that can pose a danger and plan to avoid, notify about and/or mitigate the hazards.
- **Support:** Call dispatch to notify of the situation, the location of Incident Command, to request additional support and to advise of ingress/egress routes or safety issues for incoming resources. Contact MedCom to activate EMCC and to get a bed poll of the hospitals. Write down radio channels to be used.
- **Triage and Treatment:** Establish the areas to set up Triage and Treatment, Identify Triage and Treatment Supervisors
- **Evacuation:** Establish a location or locations for the Transportation Supervisor(s) to set up. Assign a Transportation Supervisor to set up patient tracking, to communicate with EMCC for patient destination and to create a check out point for all patients.
- **Recovery:** Coordinated with Incident Command

## **SITUATION REPORT**

The first arriving licensed life support agency (any level) at the scene of an event which appears to meet the activation criteria must provide a situation report to their dispatch center.

The situation report must include:

- The unit/vehicle number
- A synopsis of the event type, location, cause if known, chemical if known<sup>1</sup>
- Estimated or actual number of patients
- Location of command post, location of staging (if established)
- Routes of ingress and egress
- The initial declared EMS Plan level (defined later). The declared EMS Plan level may change as more information becomes available.

**Important note:** any event involving a possible hazardous materials (HAZMAT) situation is an event of significance. These events require specialized response and additional time for preparation to treat patients, for both EMS and hospitals. **The earliest possible notice of a possible HAZMAT event is critical for successful management of the situation.**

The first arriving transport ambulance shall provide a situation report to their dispatch center and confirm the EMS Plan level. Once notified, the receiving medical dispatch center will be known as DISCOM<sup>2</sup>. Their role will be to coordinate the EMS/ambulance response to the event. The receiving ambulance service will generate EMResource events, as needed.

In areas where the PSAP and the medical dispatch are separate, if a HAZMAT or MCI situation report is received by the PSAP from first responders or law enforcement, and the report indicates a medical component, the PSAP must notify the ambulance having jurisdiction of the situation specifics provided.

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<sup>1</sup> Early notification of HAZMAT events is critical to system integrity. More people report to hospitals on their own than arrive by ambulance in most HAZMAT/MCI events. Failing to report these events as soon as possible increases the odds of hospital contamination and the potential loss of a vital resource.

If an event has any component of a chemical exposure, the receiving hospital must be notified as early as possible to allow for decontamination consideration and preparation. Even innocuous exposures may pose a risk to others in the ED (diesel fuel, pepper spray, etc.).

<sup>2</sup> DISCOM responsibilities may be passed from the initial dispatch center to another if the capability of the initial center is insufficient to meet the situational demand. This will most likely be due to staffing level. Such a transfer of position must be agreed upon by both centers and be captured on a recorded line/channel.

## EMS PLAN LEVELS

The EMS Plan levels are established in order to provide the needed number and type of resources required when specific thresholds are met. The EMS Plan levels are not optional and must be used when the activation criteria are met.

### For all EMS Plan Levels, the following are required:

- ICS established
- EMResource notice with bed count request by DISCOM
- Radio channel assignment to the appropriate MCI channel
  - Med 3 NW, north of Fillmore St.
  - Med 3 SW, south of Fillmore St.
- Destinations, EXCEPT Hazmat events
  - Attempt to keep families together
  - Rotate transport destinations, as appropriate, and according to the destination and trauma criteria
- Destinations, Hazmat Events
  - Unless otherwise specified under an EMS Plan level, all patients needing decon should go to one hospital

### EMS Plan 1: (Approximately 4 to 8 patients)

The following resources will be automatically sent:

- Four (4) total ambulances.
- 1 supervisor – Supervisor will assume the Medical Command/Medical Branch Director Role (or may coach and coordinate with the person in this role).

### EMS Plan 2: (Approximately 9 to 16 patients)

- Hazmat event only: disperse to two hospitals (two hospital decon), attempt to keep a level I or level II Trauma Center free of Hazmat patients.
- DISCOM and Support Communications Centers begin moving out-of-area resources into area

The following resources will be automatically sent:

- Four additional ambulances (total of 8 assigned units)
- Two (2) supervisors, one (1) in Transport, one (1) and Medical Branch Director
- Consider requesting appropriate alternative means of transportation (bus, wheel-chair vans, etc.)

### EMS Plan 3: (Approximately 17 to 24 patients)

- Notify Emergency Management of event.
- Expanded EMResource notice/update with bed count – (Regional MCI template - not just Kent County)
- Radio use - hospitals to all switch to the same patient report channel on one of their radios and maintain the other radio on their daily channel
- Hazmat event only: disperse to two hospitals (two hospital decon), attempt to keep a level I or level II Trauma Center free of Hazmat patients.
- DISCOM and Support Communications Centers begin moving out-of-area resources into area

The following resources will be automatically sent:

- Four (4) additional ambulances (total of 12 assigned units)
- Manager sent to scene (2 supervisors, 1 manager), Manager to Unified Command
- Request and send an alternative means of transportation, if appropriate
- MMRS Trailer

**EMS Plan 4:** (Approximately 25 to 35 patients)

- Consider disaster declaration through Emergency Management. Consider assignment of resources to Emergency Operations Center (EOC) if applicable.
- Expanded EMResource notice/update with bed count (Regional MCI template – not just Kent County)
- Radio use - hospitals to all switch to the same patient report channel on one of their radios and maintain the other radio on their daily channel
- Hazmat event only: disperse to two or more hospitals, attempt to keep a level I or level II Trauma Center free of Hazmat patients.
- DISCOM and Support Communications Centers begin moving out-of-area resources into area, backfill with mutual aid units for transfers and maintain local units for event response

The following resources will be automatically sent:

- Four (4) additional ambulances (total of 16 assigned units)
- Additional manager and an additional supervisor (total 3 supervisors, 2 managers), positions delegated by Medical Command (including EOC as noted above).
- Consider requesting/sending an appropriate, alternative means of transportation
- Send MMRS trailer, as appropriate

**EMS Plan 5:** (Over 35 patients)

- Enact disaster declaration through Emergency Management
- Expanded EMResource notice/update with bed count (Regional MCI template – not just Kent County)
- Radio use - hospitals to all switch to the same patient report channel on one of their radios and maintain the other radio on their daily channel
- Hazmat event only: disperse to two or more hospitals, attempt to keep a level I or level II Trauma Center free of Hazmat patients.
- DISCOM and Support Communications Centers begin moving out-of-area resources into area, backfill for transfers and maintain local units for event response

The following resources will be automatically sent:

- Over 16 ambulances
- Two (2) Managers, three (3) Supervisors; Unified Incident Command/Medical Command to request additional as needed; additional resources will be assigned to functions by Command. Coordinate activities with EOC as applicable.



## **EMResource Alerts:**

Ottawa County Central Dispatch Authority (OCCDA), Transport Agency Dispatch Centers or OMCBA may initiate EMResource Alerts in order to provide system-wide notification of significant events. Below is a description of the alerts and their meaning.

**Any and all alerts which are DRILLS shall include the word DRILL before the Alert type.**

**HAZMAT EVENT** – These alerts use the Ottawa County Hazmat template and the words ADVISORY or CONFIRMED shall be used in the notification. The ADVISORY notification is sent to provide awareness of a potential local Hazmat event. This is a first notice and is intended for awareness only. It will include the event location. Very little information will accompany this level of alert due to the need to confirm information or identify chemicals or symptoms, if any. The purpose of this alert level is to generate awareness and may modify practices.

- Emergency Responders should avoid traveling through potential hot or warm zones
- If in the proximity of a hospital, assess for the need to activate HERT teams, consider implementing a change to the air handling system if there is an indication to do so

Each HAZMAT EVENT shall be followed by an update which shall include:

- If the event is CONFIRMED, ADVISORY or FALSE
- Location
- Number of patients, if any
- Chemicals, if known
- If chemical is unknown but the route of exposure is known, provide that information (unknown gas) along with symptoms
- NIOSH Guidebook number, if known
- If information is provided by Incident Command about any needed decon or precautions.

An Event Closing and Summary shall end the event

The summary shall include the event location, what was actually found, number of patient transported, number evaluated and released, and number deceased, if any.

Included Recipients:

- PSAPs
- Emergency Management
- Hospital Emergency Management designated personal
- Ambulance Service dispatch and designated personnel
- Medical Control Authority designated personnel

### **OTTAWA COUNTY MCI ALERT**

The Ottawa County MCI alert, titled as ADVISORY, is a broad alert intended primarily for notification of an event for initial awareness. If actual, and with patients who will be transported, the Ottawa County MCI alert will be followed by an MCI Confirmation and the declared EMS Plan level.

These alerts use the Ottawa County MCI template and the words ADVISORY or CONFIRMED shall be used in the notification. If the event is real but there are no known patients, updates will be provided using the MCI template. (Significant event but no patients)

Included Recipients:

- PSAPs
- Emergency Management
- Hospital Emergency Management designated personal
- Ambulance Service dispatch and designated personnel
- Medical Control Authority designated personnel
- AeroMed

## **OTTAWA COUNTY EMS ALS SYSTEM UPDATE**

This alert is intended for information sharing amongst Ottawa County ambulance services. The intent is that this would be used to communicate non-emergent information, of common interest to all of the ambulance services at one time and through the alerting process. (E.g., notification of protocols going into effect at a particular time, changes in processes, hospital entrance or access changes, etc.)

Intended Recipients:

- Medical Control Authority
- Ambulance services
- AeroMed

## **OTTAWA COUNTY SIGNIFICANT EVENT NOTIFICATION**

In the event of an incident which poses a threat to the community, a significant weather alert or any event of which emergency preparedness personnel should be aware, this alert may be used.

Examples:

- Flooding
- Significant vehicle chases
- Multiple deaths from a single cause
- Events reaching significant media coverage
- Highway closures
- Explosions, large fires

Included recipients: **(May select recipients when alert is created)**

- PSAPs
- Ambulance Services
- Hospitals
- Emergency Management
- Fire services
- Medical Control Authority
- AeroMed
- Long Term Care Facilities

## **RESPONDER ROLES for KEY EMS PERSONNEL:**

- Keep in mind that the Incident Management Structure BEGINS at the lowest possible level and expands from there. Incident Commander is the only MANDATORY position in the Incident Command Structure. As such, Incident Commander is the first established position when a Disaster/MCI is detected.
- IN MOST CASES, the Fire Department will establish and maintain Incident Command
- **POSITION NAMES MAY CHANGE AS AN EVENT SCALES UP**
- EMS responders tasked with key functional roles will be provided with labeled vests which indicate their position.

### Unified Command

- The first arriving EMS Unit will dedicate the most senior (or most educated in disaster preparedness) provider to become the Medical Representative in the Incident Command post.
- For brevity and consistency, this individual will assume the dual role of the **Medical Command/Medical Branch Director**, under the title **Medical Branch Director**. This person will be the lead Operations Director for the Medical Branch until such time as the position is passed to an arriving EMS agency supervisor.
- If the Command Post is established away from the scene the Medical Branch Director must ensure that they check-in with Incident Command and have a dedicated means of communication with the Incident Command Post. Once complete, the Medical Branch Director may leave the Command Post (CP); the EMS Command Vehicle should be placed with this individual at the scene to allow for communications, administrative and internet capabilities.
- The Medical Representative (Medical Command) to the Unified Command can be a back-filled position staffed with an administrative level EMS manager from the (in order of preference) EMS Agency handling DISCOM, an assisting Kent County based EMS service, or KCEMS.

### Medical Branch Director

- At the onset of a Disaster/MCI, following the establishment of an Incident Command (typically the Fire Department) and a Command Post, this is the MOST IMPORTANT and most critical function for the EMS responders to fill. This is a dual position of Medical Command and Medical Branch Director. Where command is broader, the Medical Branch Director role must focus on the establishment of the operations aspect. For initial scene management, and for most incidents, this is the most appropriate position.
- The size of the incident directs the roles that this individual must assume and the objectives which must be accomplished.
- The functions associated with this position are detailed in the Medical Branch Director Taskbook
- This is the role that is responsible for setting up the structure and coordinating the medical response to the incident.

### Medical Group Supervisor (Triage/Treatment/Transportation)

- The Medical Group Supervisors will be titled according to their actual functional role, whether that is triage, treatment, transportation or another ancillary role.
- The role of this level is to coordinate a very specific action or area.
- This individual(s) may function as “doers” within their groups in smaller incidents but will be coordinators in larger events.
- These individuals may supervise/coordinate Units under them.
  - I.E. The Treatment Group Supervisor may oversee and coordinate
    - The IMMEDIATE Treatment Unit (RED)
    - The DELAYED Treatment Unit (YELLOW)
    - The MINIMAL Treatment Unit (GREEN)
  - This individual would oversee/coordinate individual groups rather than individual people

### Agency Supervisors/Managers

- Local EMS Agency Supervisors/Managers are required to have training above and beyond that of a street-level ALS provider. As such, they are tasked with roles in a Disaster/MCI that necessitate additional education and experience for the continued planning and coordination of the medical response.
- Agency supervisors will assume the position of the Medical Branch Director when they arrive on scene. When more than one agency supervisor arrives on scene, the agency that is operating DISCOM will assume the Medical Branch Director position. This individual may, at his/her discretion, pass the duty role to another supervisor/manager from their agency or to an agency supervisor from another Ottawa County agency provided the transfer of duty occurs face-to-face and the receiving agency supervisor has agreed to accept the position. Notification of the transfer must be made to the Incident Commander as well as to DISCOM. The individual passing the position must remain with the new Medical Branch Director until a detailed Situation Report (SITREP) has been given and the individual has been released from the scene and check-out through the accountability process, or has been reassigned to other duties at the discretion of the current Medical Branch Director.
- Agency supervisors/managers may also be tasked to backfill into Medical positions within a Unified Command Structure.
- An EMS Command Vehicle should remain with the agency supervisor that is tasked with the Medical Branch Director duty.
- Additional EMS Command vehicles may be deployed to the Transportation Supervisor or to the Incident Command Post if it is remote from the actual scene.

## **RESPONDER ROLES – OPTIONAL ROLES for MEDICAL PERSONNEL:**

### **EMS Staging – Not a common EMS position in ICS**

- Incident Command should identify a staging area for additional EMS personnel and vehicles to report. This should be an area near the scene, but situated so that additional traffic created by reporting vehicles does not interfere with scene operations or transportation from the scene. When a staging area has been established, vehicles are not to report directly to the scene, until so ordered. All vehicles, resources and personnel must report initially to Staging for Check-In. The driver of a responding unit must remain with the vehicle AT ALL TIMES. The passenger should report, in person, to the Staging Group Supervisor and await instructions.
- Staging is typically staffed with non-medically trained personnel.
- Communications must be facilitated between the Transportation Supervisor and Staging in order to procure transporting units. This may be accomplished through use of a U-Tac channel, or obtaining a Fire portable that has the channel available that has been assigned to Staging.

### **Assistant**

This individual will assist others in lead functional positions. Most commonly, under the Medical Branch, these individuals would be placed with the Medical Branch Director and/or the Transportation Supervisor. The titles would be the Medical Branch Assistant and the Transportation Assistant, respectively.

### **Scribe**

This individual will aid another member of Incident Command with note taking during a Disaster/MCI incident. EMS training is not necessary.

### **Public Information Officer**

The Medical Branch **should not have a PIO separate from the Incident Command designated PIO**. EMS personnel at all levels should refrain from providing any comments to those not either being treated or others working the incident, other than to direct curious individuals to the PIO. The Incident Command designated PIO may need a medical liaison to help detail how a situation is progressing from a medical standpoint, this will be left to the discretion of the Incident Commander and the PIO to seek out or designate a Medical Branch Individual to function in such a capacity.

### **EMS Assistant Safety Officer/Supervisor – (Assistant to the Safety Officer)**

- It is the role of Incident Command to establish an Incident Safety Officer. All responders to a scene have a primary duty to guard their own safety but also to advise others of potential safety issues of which they become aware.
- It is possible that the Incident Safety Officer may designate an EMS Safety Officer to monitor EMS activities specifically.
- It is possible that the Medical Branch Director may appoint an EMS Safety Supervisor in situations where there is a need to monitor and evaluate EMS activities relating to safety. (A reasonable need would be if volunteers were being used to move patients and the Incident Safety Officer were busy with other duties. The EMS Safety Supervisor would then be tasked with ensuring that all aspects of the EMS process were safe and for correcting those found to be risky or unsafe.)
  - Environmental safety
  - Physical safety
  - Structural Safety
  - Process safety

## **RESPONDER ROLES for SUPPORTING or NON-MEDICAL PERSONNEL:**

### Roles of Police and Fire (Informational purposes)

- Police: Primary responsibility is for crowd control, traffic control, and scene security and investigation.
- Fire: Primary responsibility is for incident command, fire suppression, hazard control, search and rescue, field triage and extrication.

### Ambulance Dispatch

- Upon Disaster/MCI activation, OCCDA or the lead EMS communication center will assume the role of DISCOM. The DISCOM center will oversee and coordinate all communications related to the Disaster/MCI.
- If an event is of a scope or size which is beyond the operational capability of the dispatch center in which the event is occurring, the function of DISCOM may be passed from one center to another, so long as both centers agree to the transfer. This transfer must take place on a recorded line/channel.
- The DISCOM center will also maintain its own non-disaster related units at all times, as will the unaffected dispatch centers.
- For smaller events, DISCOM may choose to leave ambulance management to the responding unit's dispatch center.
  - The assisting agency tracks their own units and the unit communicates with their dispatch directly except while they are on the scene and on the assigned MCI channel.
- For larger events, prolonged events, etc. DISCOM may choose to have ambulance management transfer to DISCOM for the duration of the event, or until the resource is no longer needed.
  - Units assigned to the event check out with their dispatch, check in with DISCOM and remain under the control of DISCOM for the event or until they are released by DISCOM.
- All EMS communications centers will work in unison to send the closest appropriate units to the Disaster/MCI and non-related Disaster/MCI calls regardless of their geographical service area. The method of ambulance management will be agreed upon between the Kent County dispatch centers and crews will be advised of the communication and control structure.
- DISCOM will also be the point of contact for all arriving mutual aid units.
- DISCOM will communicate on the designated medical disaster channel (MED 6 or 8).
- Other local EMS Communications Centers will monitor the medical disaster channel and will assist DISCOM as needed.

### Dispatched Ambulances Reporting to the Scene

- The first arriving ambulance activates the Disaster/MCI protocol, if not already activated by non-transport EMS, and the ambulance crew members assume the roles of Medical Branch Director and Triage Supervisor unless the Triage Supervisor position is already filled by fire personnel. If the Triage Position is filled, the second crew member becomes the Treatment Supervisor. Integration with Incident Command must be a primary goal.
- A Situation Report must be called through to DISCOM.
- All vital information regarding the scene, potential hazards and safety should be given to all units by their own dispatch centers while responding. This includes the channel assignment for disaster communications, the location of Staging, and preferred routes for ingress to either the scene or into Staging.
- Ambulances assigned to the MCI event may be directed to switch to the MCI channel and check in with DISCOM prior to arrival at staging. Once such a transition is made, the unit is tracked and accounted for by DISCOM and shall remain an asset of DISCOM until formally released by DISCOM.
  - Once assigned under DISCOM, even if a unit transports, they notify DISCOM of their arrival at the hospital and their availability after. DISCOM will be their dispatch center until they are released.
  - Once released by DISCOM, a unit should notify their agency dispatch that they are released and returning to their service area for regular duty assignments.
- If not assigned to DISCOM prior to arrival at the event, units should initially call out on scene on their normal frequency, then switch to the designated disaster channel and check in with DISCOM for accountability purposes.
- SEE THE TASK BOOKS FOR SCENE FUNCTIONS
- Arriving vehicles report directly to the Medical Branch Director to receive assignments **until Staging is established.**
- Once Staging is established, **all responding units and assets must physically check-in through Staging.**
- The vehicle driver must remain with the vehicle; the second member of the crew must report in person to the Staging Group Supervisor, or to the Medical Branch Director if a Staging Group Supervisor hasn't yet been established.

### Individuals NOT Dispatched to the scene

- **All off duty personnel should report to their own agency for assignment and NOT to the scene.**
- If the event is so large as to have individuals from outside the system responding to assist at the scene, these people should be directed to the volunteer check-in area. Establishment of this area will be at the direction of Incident Command and/or the EOC.
- If individuals start to show up prior to the creation of a volunteer area, they should be directed to remain outside of the event perimeter and Incident Command should be advised that volunteers are present and where they will be waiting. It will be up to the discretion of Incident Command where these people should be sent, and if they will be utilized. Volunteers that have been requested by the UICS should be directed to report to Staging.
- In rare instances, at the very onset of an event, bystanders may volunteer to help. The decision to utilize these people will be left to the discretion of the Medical Branch Director and/or Incident Commander.

### OMCBA Staff:

- The Medical Director, Assistant Medical Director, and/or EMS Systems Administrator may respond to assist in Disaster/MCI situations
  - On-scene with the Medical Branch Director
  - On scene with Medical Command
  - On scene as a scribe/assistant
  - At the EOC
  - At the Medical Coordination Center (MCC local or regional), if activated
- The role of the OMCBA representative(s) will be to assist with and to evaluate the EMS system aspects of the event response. OMCBA staff will typically not staff ICS positions.
- The Medical Director or his/her designee may assume the Medical Branch Director role, or any other assigned roles, in the Incident Command System.
- OMCBA administrative staff must meet the educational requirements for administrative and supervisory level system providers.
- The Medical Director and Assistant Medical Director may assume roles in patient care/physical movement. Administrative staff holding current medical licensure may function to their licensure level, if necessary.

### RACES – Radio Operators

- Coordination of communications
  - Joining different radio frequencies to permit communications interoperability
  - IT support for radio issues
- Radio operators
  - 800 MHz communications with EOC
  - Communications assistant to Incident Command
- May assign individuals to key areas to facilitate interoperable communications (i.e. Transport to DISCOM if radio problems exist.)
  - These individuals are very adept at solving communications/radio problems, their resources should be considered very early if any communications problems are present.
- RACES may be activated by contacting the Kent County Emergency Manager or the EOC. Scene requests should be directed to the Incident Commander.

### Medical Reserve Corps (MRC)

- The Medical Reserve Corps of Ottawa County is an active group of volunteers that have undergone background checks and credentialing in order to work as part of this volunteer organization.
- There is a very wide range of skills amongst this group.
- The volunteers are an available resource that can be activated in advance for preplanned events to help staff first-aid areas or treatment areas. When coordinated in advance, individuals suited to the skill-set needed to staff the functions can be selected.
- The volunteers are also available to be activated to assist in triage and treatment areas for very large events, or events that last over a long period of time. Again, individuals can be assigned to areas that correspond with their licensed skill-set.
- MRC volunteers may also be used to help augment staffing at Acute Care Centers, Neighborhood Emergency Centers or volunteer reception centers
- In order to activate this resource, the Emergency Manager or the EOC must be contacted.

### Regional Incident Management Team

- The Regional Incident Management Team (IMT) is a regional resource comprised of experts trained in the operationalization of all aspects of the Incident Command System. They are adept at implementation, evaluation and optimization of ICS. They may be utilized for pre-planned events, prolonged events or large events expected to approach, or exceed a single 8 hour operational period.
- The Regional IMT may be requested by contacting Lake County Central Dispatch at (231) 745-6249.

### Third Riders

Participating as a “third rider” on an EMS vehicle is an important part of the educational program of many health care providers. However, most of these persons are not appropriately educated in Disaster/MCI response activities. Should an EMS crew have a third rider with them when dispatched on a Disaster/MCI response, the crew should accommodate the third rider in the following manner (in order of preference):

- If the response vehicle will be used for the treatment and transport of patients from the scene ONLY, the third rider may stay with the crew to assist with patient care.
- If the response vehicle is one of the first two on scene and will be involved in setting up the EMS command structure, the third rider MUST stay with the vehicle at all times until he/she can be returned to the Staging Area.
- **There may be special situations in which third riders may be requested by the Medical Branch Director to remain at the scene to serve as scribe support personnel for an EMS Group Supervisor. This will be done ONLY at the direction of the Medical Branch Director.**
- Deliver the third rider to agency headquarters for drop-off if that can be done in an expeditious manner while responding to the scene
- If the response vehicle reports initially to the Staging Area, the third rider should remain at the Staging Area.
- At a time convenient to the response activities, all third riders will be collected from the Staging Area and returned to the transporting agency headquarters.

### Air Medical

Air medical resources (e.g. Aero Med and other regional and state air ambulance programs) will be requested to assist with the disaster response as needed for personnel, treatment or transport resources. The request may be initiated by Medical Branch Director, in consultation with the Incident Command, or by Incident Command. The request will be communicated to the Aero Med Communication Center for all Air Medical requests @ 1-800-862-0921 or 616-391-5330.

- Incident Command will identify a properly trained Landing Zone Coordinator (LZC) who will be responsible for establishing the landing zone. A radio frequency will be designated by the Aero Med Communications Center which will allow the aircraft and the Landing Zone Coordinator to communicate. (Most often it would be AIR LZ 1, AIR LZ2 or 155.400 PL 35.)
- If more than one aircraft will be landing at the scene, the first arriving aircraft will assume responsibility of the LZ on arrival.
- Staging and response to the scene for all responding aircraft will be handled by the Aero Med Communications Center.
- LZC will establish a LZ capable of handling rotor aircraft of all sizes.
- The Medical Branch Director will inform the LZC of the purpose of the air medical crew's activities and the location to which they should be sent after landing. The LZC will communicate this information to the air medical crew.
- In the event the air medical crew is the first EMS resource on the scene, the air medical crew will initiate triage and EMS resource organization until additional EMS crews arrive. Once additional EMS resources become available to establish the Medical Branch Director and assume triage functions, the air medical crew may be released for other functions including patient transport.

### Other Individuals:

- Many other disciplines may be represented within the Incident Command Structure depending on the type and location of the incident.
  - School or hospital administration
  - Facility management and/or maintenance
  - Public Health
  - Security Company representatives
  - Department of Public Works



## RESOURCES:

### Acute Care Sites (ACS) or Acute Care Centers (ACC)

The two acronyms are used interchangeably and mean the same thing. These sites are pre-established medical overflow/surge locations which are activated by each hospital at the discretion of the hospital emergency management personnel, in cooperation with the local Emergency Manager and with approval from the State EOC (SEOC). If an event is of significant scope to open such facilities, direction and communications with EMS agencies will be provided. EMS personnel may be tasked to function within these facilities through the EOC.

### EOC – Emergency Operations Center

For the purpose of this plan, the “EOC” refers to a county or local governmental EOC, under the control of the municipal Emergency Manager

**If the event is very large in size, scope or severity, consideration should be given to early activation of the EOC.** It takes roughly an hour to get the EOC activated, staffed and operational. Many of the initial functions common to the EOC are handled by the dispatch centers of the respective disciplines initially.

The EOC should be activated very early in an event if:

- Resources from multiple departments within and outside the county are needed
- The event will last for a long time (typically longer than one duty shift)
- Specialized equipment or resources are needed
  - HAZMAT
  - Heavy Equipment
  - Neighborhood Emergency Help Centers (NEHC's) or Acute Care Centers (ACC's) if community immunizations or large numbers of patients are present
- The event is an act of terrorism
- The event covers a large geographical area

The decision to activate the EOC should be made within the Incident Command/Unified Command. Consideration for activation should be done early in the event and, if not activated, should be reconsidered periodically as the event unfolds or develops. See EOC Task Book for roles and responsibilities.

### Evacuation Centers/Temporary Sheltering for Uninjured Victims

Evacuation Centers are typically established after the EOC is activated and a request is received for activation from the Incident/Unified/Area Commands for large or very large events. Local events such as an apartment fire, local tornado touch-down, or a multi-car accident on a highway may require an immediate point of evacuation for uninjured victims of the event. The Medical Branch Director must consider the need to address the sheltering of these victims quickly; especially if adverse weather conditions exist, so as to avoid further injury. In cooperation with the Incident Command(er), resources should be requested or locations identified as primary evacuation points for the uninjured.

- Busses
- School gyms
- Churches
- Nearby buildings or structures that are structurally sound
- Any area where individuals may shelter temporarily where they are protected from further harm and from the elements

In very large events where Evacuation Centers are opened by the EOC or the local Emergency Manager, EMS resources may be tasked with roles in staffing and providing medical treatment at, or evacuation from, these sites. This will be coordinated through the EOC/LMCC/RMCC. (Acute Care Centers and Neighborhood Emergency Help Centers)

### MI-TESA

The Michigan Transportable Emergency Surge Assistance Medical Unit (Mi-TESA Medical Unit) is a State resource which is a scalable, mobile, tent-hospital system with supporting supplies. These interconnecting tents effectively form mobile hospitals. In the event that a Disaster/MCI event has a patient surge that exceeds the ability of the local hospitals to house and treat patients, Mi-TESA may be requested. This resource is requested by the Medical Representative to the EOC via the MCC/RMCC in contact with the State EOC. This resource should be operational following a request in under 24 hours.

### Disaster Trailers/MMRS Trailer

Disaster trailers are available within Ottawa County and Region 6 that can be quickly deployed to a scene to provide administrative supplies, generators, MCI supplies, O<sub>2</sub> supplies, blankets, trauma supplies, lighting, etc.

- See the Trailer Supply list in the Appendices (Appendix D) for a complete and detailed list of the supplies available when this resource is requested.
- To utilize this resource, contact DISCOM and request that the Disaster Trailer be sent from the housing agency to the scene. Advise the where the trailer should be sent and the preferred ingress route. (Reporting to Staging is the most appropriate.)
- The Kent County (MMRS Trailer) trailer may be requested through Mutual Aid. The trailer must be requested through KCSD.
- The Disaster Trailer can be deployed within minutes and can be at your scene within approximately 60 minutes of being requested (depending on hook-up and travel time).
- Additional trailers are available if needed. Requesting these resources is also done by contacting DISCOM and requesting Regional Trailers. Time to delivery will increase slightly with each request as the trailers will come from points further away.

### MEDDRUN

MEDDRUN – Michigan Emergency Drug Delivery and Resource Utilization Network

This program provides caches of medications specific to the treatment of nerve agents/organophosphates, cyanide compounds, and general treatment and PPE for some respiratory agents and biologicals. A complete list of contents and the MEDDRUN Protocol is contained in the supplemental documents section. This resource is housed locally and can be accessed by contacting Survival Flight (877) 633-7786. Pickup is expected to be in less than 15 minutes and arrival to scene is expected within 45 minutes. Prolonged times may occur if there is a need to transport these supplies by ground. See Appendix B for MEDDRUN contents.

### ChemPack

ChemPack is a CDC program that has placed large caches of nerve agent/organophosphate antidote kits and ancillary supplies throughout Michigan. A complete list of contents and the ChemPack Protocol is contained in the supplemental documents section. This resource is housed locally and can be accessed very quickly. To utilize this resource to a scene or emergency treatment site(s), contact (877) 633-7786. Arrival to scene is estimated at approximately 1 hour. Prolonged times may occur if there is a need to transport these supplies by ground. See Appendix C for a contents list/

### Strategic National Stockpile

The Strategic National Stockpile (SNS) is a national repository of antibiotics, chemical antidotes, antitoxins, life-support medications, IV administration supplies, airway maintenance supplies and medical/surgical items. The SNS is designed to supplement and re-supply state and local public health agencies in the event of a national emergency anywhere and at any time within the U.S. or its territories.

The SNS is designed to be flexible and rapidly mobilized with Push Packs available within 12 hours (of a federal decision to deploy SNS assets) and additional medications and supplies available afterward. Accessing this resource is done through contact with the local Emergency Managers. This can be accomplished by contacting the on-site Incident Commander. See the CDC/Strategic National Stockpile document in the supplemental documents section.

### Medical Coordination Center (MCC) [Local and Regional: LMCC or RMCC]

The MCC is specifically geared toward community medical resources. Activation of an MCC may come at the request of Incident Command on scene, but more likely will result as a request of the medical and/or hospital representative to the involved EOC. The MCC includes representatives from local hospitals, EMS, and Public Health with the goal of coordinating bed availability, providing medical guidance when needed, Public Information, the development/implementation of a Casualty Transport System and activation of local ACCs and/or NEHCs. This group works as a Medical Panel of Experts to support the EOC and/or Medical Branch Director. Activation of this resource from a scene should go through the Incident Commander and should be directed to the local Emergency Manager. Incidents that go beyond Kent County may prompt the activation of the Regional MCC. This is a further expansion of the local with coordination and leadership provided by the Region 6 BT Coordinator or the Regional Medical Director and including representative of Regional Hospital, EMS and Public Health Partners. See the Modular Emergency Medical System guide in the supplemental documents section. MCC Participants see the MCC Taskbook.

### Region 6 Supply Caches

Region 6 has medical equipment and supplies distributed throughout Region 6 that may be accessed/utilized for ACC and NEHC activations. These resources may also be available to augment supplies at Emergency Treatment/Evacuation areas not formally recognized as either an ACC or an NEHC. Requests for equipment should be made through the Incident Commander/Medical Branch Director and should be directed toward the EOC/Medical Representative. Please call 1-855-734-6622 to request these supplies. These supplies include 12-lead monitor defibrillators, AEDs with 3 lead monitoring capability, portable ventilators and Regional Supply Trailers. Delivery time will vary based on the needed equipment; typically this will be around 6 – 12 hours.

### Region 6 Medication Supply Caches

Region 6 Partner hospitals/Public Health have medication caches that may be used to augment MEDDRUN and ChemPack supplies. These are Regional assets and may be activated by calling 1-855-734-6622. Requests for these caches should be made via Incident Command to the EOC/Medical Representative.

### Stair Chairs

All local EMS agencies were supplied with Stair Chairs through grant dollars to facilitate evacuation of multistory buildings. Local hospitals also received a small number of these chairs as well. In the event of a multistory building evacuation, a request may be made by the Incident Command/Medical Branch Director to request that the Stair Chairs be delivered to a scene for evacuation. Following the event, these resources are of course returned to the agencies.

### EMResource

EMResource (formerly called EMSsystem) is a web-based application used by all of the local EMS dispatch agencies, local hospitals and PSAPs to track bed availability, Opening and Closing status of hospitals and also functions as an event management system/communications portal that can be monitored by other stakeholders. This resource is active 24/7 and is used daily for hospital Opening and Closing updates.

### Specialty Fire/Hazmat/Rescue Vehicles and Resources

Specialty HAZMAT and Fire Resources are available through various Ottawa County Agencies including, but not limited to, HAZMAT Response vehicles, ladder trucks, DECON tents, Urban Search and Rescue Teams, K-9 Units, Confined Space Rescue, High Angle Rescue, Swift Water Rescue, Tactical Teams, etc. These resources should be requested through Incident Command.

### Patient Tracking

Patient Tracking within Ottawa County is used on a weekly basis for tracking of patients through the system. In Disaster/MCI response, this application is used to track patients from the scene to various hospitals, ACCs, NEHCs and/or individuals that have been evaluated and released. This resource is available on all transport ambulances. The use of this resource for patient flow is detailed under the Treatment Officer's checklist. Basically, triage tags are applied in the Triage area as patients are sorted into IDME categories. From there, they are moved to the appropriate treatment area where a sticker from the tag is removed and added to the Treatment Area Log; stickers may also be applied to the patient's personal property. The patient is then turned over to a transport vehicle that scans/enters the patient into the system and adds a sticker to the Daily Log. Prior to leaving the scene, all vehicles must check-out with a Transportation Supervisor (there may be more than one in large events) where the tag will be scanned, a sticker will be added to the Transportation Log and the transporting unit will receive their destination assignment. **NO TRANSPORTING VEHICLE MAY LEAVE THE SCENE WITHOUT CHECKING OUT WITH THE TRANSPORTION SUPERVISOR.**

### USDOT – PHMSA Emergency Response Guide (ERG)

The ERG is carried on all ambulances and on the EMS Command Vehicles, as well as many fire apparatus and in EMS dispatch centers. This Guidebook is a valuable resource in identifying placarded vehicles and containers and identifying the contained substances as well as providing general treatment guidelines.

### WebWiser

This is a HAZMAT identification program which is available for local download or web access. A google search for webwiser will show results for NIH - National Library of Medicine. Select this site. Once on the site, either a chemical can be researched or symptoms entered to allow for chemical identification. Phone downloads are available for Android and iPhones.

### Emergency Care for Hazardous Materials Exposure Text

This text is carried on all EMS Command Vehicles and is also located in all of the EMS Dispatch Centers. This guide provides specific treatment regimens for Chemical and Biological exposures.

### MI-MORT

MI-Mort is a Michigan based mortuary team that can be activated to manage bodies of deceased victims' at large Disaster/MCI events. Activation of this resource is through local Emergency Management via the Incident Commander. See the supplemental documents section for additional information.

### DMORT

DMORT is a federal Disaster Mortuary asset that may be requested through the EOC.

### DMAT

A Disaster Medical Assistance Team (DMAT) is a federal resource through the National Disaster Medical System, under FEMA, and provides a group of medical and support personnel designed to provide emergency medical care during a disaster or other unusual events.

DMATs deploy to disaster sites with adequate supplies and equipment to support themselves for a period of 72 hours while providing medical care at a fixed or temporary medical site. They may provide primary health care and/or augment overloaded local health care staff. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation resolved. Each DMAT deployable unit consists of approximately 35 individuals; however, teams may consist of more than three times this number to provide some redundancy for each job role. This insures that an adequate number of personnel are available at the time of deployment. The team is composed of medical professionals and support staff organized, trained, and prepared to activate as a unit. This resource may be requested through the EOC.

### Canteen Service

Canteen Service may be requested for prolonged incidents through Incident Command.

### CISM

Critical Incident Stress Management personnel may be requested to the scene by the UIC. Debriefing after an incident may be requested by contacting the local Emergency Manager or KCEMS. Any EMS agency or department, or KCEMS, may arrange critical incident stress debriefing (CISD) sessions following any Disaster/MCI at the discretion of the EMS Medical Director or at the request of any EMS agency. The debriefing will generally be held within 48 hours of the incident.

It is strongly recommended that all individuals involved in the Disaster/MCI response participate in the debriefing sessions. The EMS Medical Director and/or your agency may make these mandatory. An agency or individual EMS practitioner may also make contact directly for assistance from the team at any time following the incident. Individuals will be given the initial assessment and crisis intervention, and then will be referred to an agency or counselor if ongoing therapy is needed.

### Michigan State Police Radio Cache

Local MSP has a cache of approximately 50 (fifty) 800 MHz radios. These may be requested through the Incident Command or through the EOC, if needed.

### 800 MHz Event Channels

800 MHz event channels may be requested through North Ottawa Dispatch. They may be contacted through 800 MHz, CHREG6 or through a phone call to their dispatch center at 616-847-5333.

### REHAB

A medical unit tasked with assessment, recurring evaluation and medical treatment of response personnel may be activated under the Logistics Section. EMS responders, the MRC or mutual aid responders may be assigned to this role. These personnel report to the Logistics Section Chief and are not to be pulled for non-responder treatment or transport of patients without following the proper chain of command.

## ACCOUNTABILITY:

- Access to the scene will be restricted to those individuals possessing appropriate identification. **All EMS personnel** should have in their possession approved Identification Cards (2) and should be displayed in a visible area for easy identification.
- Individuals that are on scene in functional roles must leave their approved ID Card with the Medical Branch Director or the designated Accountability Supervisor. ID's must be presented when checking in, and must be picked up when checking out of the scene.
- Individuals arriving on scene with an ambulance for the purposes of transporting patients, but which will not be staying on scene, must remain at or near their vehicle. ID's must be shown in the Staging area but must remain with the individual. An ambulance with two or more dedicated staff is considered one "resource" and will be tracked "IN and OUT" of Staging and "OFF SCENE" by the Transportation Supervisor. It is very important that crew members do not leave the immediate vicinity of their ambulances if they are transport units.
- Any individual who responds as part of a resource (transport ambulance) and reports in to Staging that is tasked through a directive of the Medical Branch Director into a functional role must first check IN with Accountability (leave the second ID) before reporting for their assigned task.
- Any individual who arrives as part of a non-transport resource, but was requested to report to the scene must check in at Staging and should remain in the immediate vicinity of their vehicle. These individuals must check out of the scene through the Staging Supervisor (not through Transport). This may include wheel-chair vans bringing supplies, etc.
- Any individual or resource that arrives at the request of the Medical Branch Director which will be utilized in a functional level or as an assistant should check in first at Staging and may then be directed to either to Accountability (if established) or to the Medical Branch Director for assignment.
- Any volunteer individual that arrives that was not requested to be there should be directed to report to their own agency (if appropriate), or to report to a volunteer check-in area if one has been established. If a check-in spot has not been established, the individual should be directed to an area outside of the perimeter until a volunteer check-in is established by Incident Command. Command should be notified that volunteers are available.

## TRIAGE PROCESS OVERVIEW:

(See the SALT Diagram in the appendix)

- It is the responsibility of the first arriving EMS unit to ensure that the Triage Supervisor position is staffed with either the second EMS crew member or a fire department individual. The Triage Supervisor must initiate/coordinate triage procedures including selecting areas for Formal Triage and Treatment with advice from Incident Command.
- Unless the incident is quite small, the Triage Supervisor should not be actively triaging patients where they lay.
- There are two distinct phases of triage: **Field Triage**, where the individual patient is triaged in the field where they lay, and **Formal Triage**, where the individual is brought to a designated Triage Area
- The Triage Group Supervisor will form a team(s) of Triage personnel to go into the Field and triage patients using the **SALT** Triage process. Patients are to have color coded tape applied to their body (not to clothing); one piece is attached to the patient and a small piece is torn off and stored in a pocket to help with counting of patients by category. Triage tags may be used in the Field if colored tape is not available.
- The Triage Supervisor must ensure that a means of communication with Triage Group(s) is in place before the Triage personnel go into the Field, or ensure that the Triage personnel report directly back, in person, to the Triage Supervisor with the numbers and color categories of the victims.
- Patient Removal Teams should follow behind the Triage personnel to remove patients to the Triage Area or to the appropriate Treatment Area (as directed by the Triage Supervisor).
- The Triage Supervisor should set up an easily identifiable area(s) where patients are to be brought for Formal Triage. If tape was applied, the priority should be quickly verified, a triage tag applied, and the patient then sent to the appropriate Treatment Area. If a tag was already applied, verify that the tag has a barcode. If not, add a tag with a barcode; leave the old tag in place as well. If a bar-coded tag is in place, send the patient to the appropriate Treatment area.
- **Depending on the magnitude of the event, more than one formal Triage Area may be necessary.**
- The purpose of triage is to provide for the best available medical care for the largest number of patients based upon available resources. Salvage of life takes precedence over salvage of limb. Viable patients should be treated before those mortally wounded.
- Patients triaged as **EXPECTANT** in the field should be tagged as **IMMEDIATE** and be brought to formal triage. In formal triage, as long as the person has signs of life, they should be sent to the **IMMEDIATE** treatment area and an "E" should be written visibly on the triage tag are held in the Treatment Area. If the person still exhibits signs of life after all other Immediate patients have been transported from the scene, the expectant patient may be considered for transport to a hospital.

### 1. Triage Priorities

**IMMEDIATE** (Red, Priority One) patient's must be transported and treated quickly. It involves patients where shock and/or hypoxia are present or imminent, the patient can be stabilized without labor intensive care, and there is a high probability of survival with treatment and transport:

- 1) Airway and breathing difficulties
- 2) Uncontrolled or suspected severe bleeding
- 3) Shock
- 4) Major abdominal or chest wounds
- 5) Severe medical problems: poisoning, diabetes with complications, cardiac disease
- 6) Spinal injuries with neurologic deficit
- 7) Multiple fractures
- 8) Severe burns

**DELAYED** (Yellow, Priority Two) patient's treatment and transport may be temporarily deferred (45-60 minutes). It involves patients whose injuries have systemic implications and effects without immediate life threatening problems:

- 1) Vascular wounds
- 2) Serious burns under 25% BSA
- 3) Spinal injuries without neurological deficit
- 4) Minor open fractures
- 5) Lacerations with tendon or nerve damage
- 6) Maxillofacial injuries without asphyxia

**MINIMAL** (Green, Priority Three) patient's treatment and transport are required but can be deferred several hours, and transport need not be by ambulance. Consideration should be made to having these patients removed to medical facilities in school buses, Red Cross vans, etc., accompanied by at least one ambulance with communications in the event of patient deterioration. Removal should be made to more distant medical facilities if the closest hospital(s) are receiving numerous red and yellow patients.

- 1) Lacerations
- 2) Minor puncture-wounds
- 3) First and second degree burns
- 4) Abrasions
- 5) Minor fractures

**EXPECTANT** (Blue or Black tag, reevaluate after IMMEDIATES are treated)

- 1) Victims with injuries not consistent with life but not yet deceased
- 2) Resources are not utilized initially to care for them
- 3) Resources may be assigned as they become available

**DEAD** (Black, dead) should be tagged but left where they lie until the Medical Examiner arrives. (In RARE circumstances where the bodies are at risk of deterioration or disintegration, bodies may need to be moved. Locations of bodies should be well documented! Confirm decision to move with Medical Examiner or police prior to movement if at all possible.)

2. Patients are subsequently taken to the Treatment Area corresponding with their IDME-Dead category.
3. The triage tag should be attached to the body\* and the appropriate section removed to indicate priority by the last remaining section. List any medications given at the scene on the tag. If the receiving hospital decides to re-triage upon arrival, the original tag should be retained, but all priority colors should be removed from the tags.

\*Ambulatory Patients: triage tag on LUE or RUE (order of preference)

\*Non-ambulatory patients: triage tag on LLE or RLE (order of preference)

4. A separate category of triage should be noted in a hazardous materials situation and/or a WMD event, as it supersedes all others. Victims who have undergone hazardous materials or radiation contamination and are suspected of being contaminated must be identified with an orange ribbon or triage tag and decontaminated as an initial step. **Hazmat and radiation victims that die, and their personal effects, must also be decontaminated. Orange ribbon or an orange line across the triage tag will NOT indicate that the patient has been completely decontaminated.**



## **Other Considerations:**

### Practitioner fatigue

All practitioners should acknowledge the potential for practitioner fatigue. Appropriate rest breaks will be assigned. Back up help should be available to allow the teams to follow the guideline. CISM interaction may be available on the scene and may be mandated by Incident Command or Medical Branch Director for practitioners.

### Withdrawal from scene

When all patients have been removed from the scene, the Medical Branch Director will report "All clear" to the EMCC and order the Triage, Treatment and Transportation areas to gather equipment and check out. The Command Structure, including DISCOM, may continue based on the needs of the incident. In those cases, the communications system may continue to function, including routine updates to MEDCOM/EMCC and the hospitals. All personnel that were assigned on-scene duties must check out through the defined accountability process.

### Post Event Documentation

Following any activation of the Disaster/MCI plan, all individuals tasked with functional roles according to this policy, as well as EMCC, DISCOM, LMCC and the EMS Representative to the EOC, must complete an After Action Report that outlines the flow of the incident from their perspective, along with areas where they feel improvement to the plan should be made and copies of all Taskbooks with accompanying notes/logs. EMS agencies transporting patients from a Disaster/MCI incident must submit paper copies of all patient care reports from the incident.

The agency that has been tasked with the Transportation Supervisor role must also submit an electronic or paper copy of the Transport Log and the patient tracking application log for the incident. These documents must be sent to KCEMS within 24 hours of the incident. For prolonged incidents, reports are due daily.

EMCC/MedCom must also provide recordings of all Disaster/MCI traffic to KCEMS within 2 business days.

### Bioterrorism Events/Pandemic Events

Such an event will activate additional preparedness plans within the Region/State. These plans call for atypical uses of EMS personnel, atypical methods of public notification, and checklists for allocation of resources and equipment and mutual aid agreements specific to the event. The activation of these plans/protocols will be accompanied with direction to key individuals in leadership roles for dissemination and application. Examples include smallpox, influenza, anthrax, etc. Given that these vary so widely in presentation, incubation period and modality of mitigation, specific instructions will be provided at the time of the event.

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## Table 1: ICS Organization

| Organizational Element | Leadership Position     |
|------------------------|-------------------------|
| Incident Command       | Incident Commander (IC) |
| Command Staff          | Officer                 |
| Section                | Section Chief           |
| Branch                 | Branch Director         |
| Divisions and Groups*  | Supervisors             |
| Unit**                 | Unit Leader             |

\* The hierarchical term *supervisor* is only used in the Operations Section.

\*\* Unit Leader designations apply to the subunits of the Planning, Logistics, and Finance/Administration Sections.

## Table 2: DISASTER Paradigm

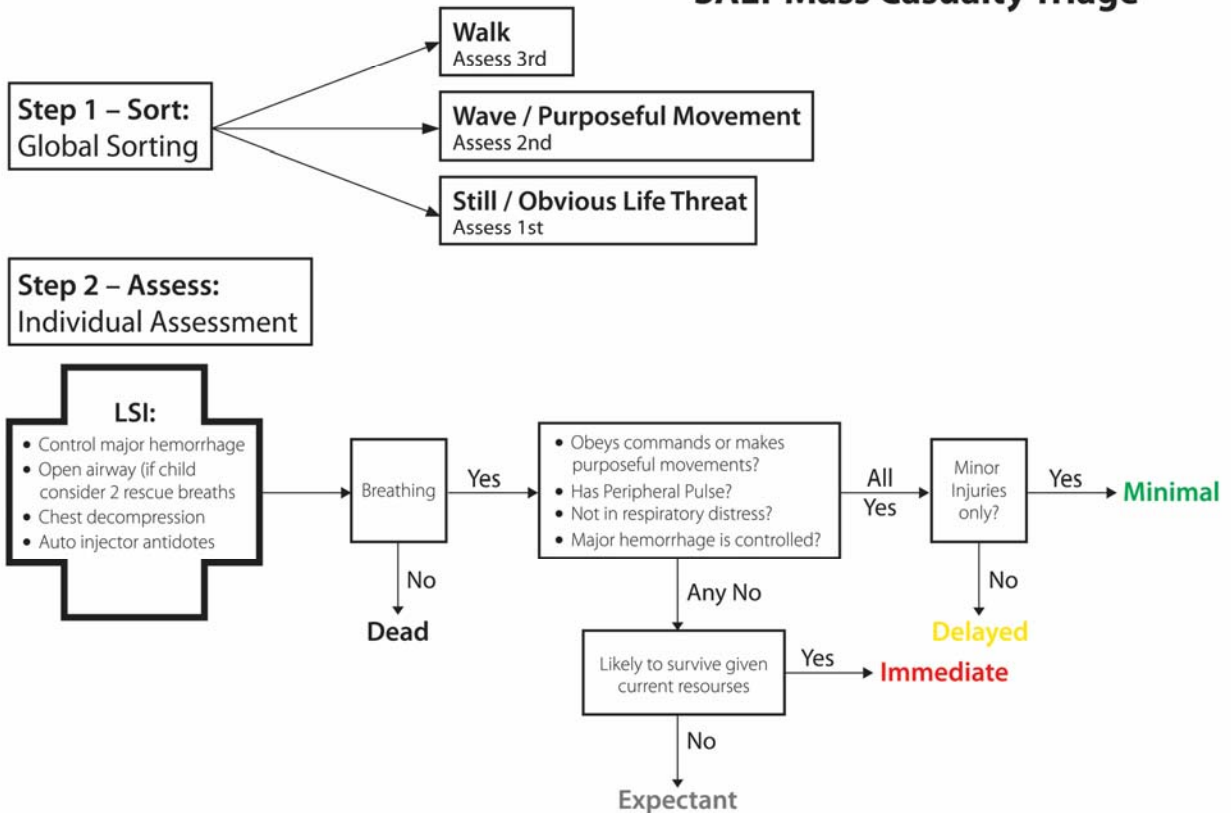
|          |                     |  |
|----------|---------------------|--|
| <b>D</b> | Detect              | What caused this?                            |
| <b>I</b> | Incident Command    | Do we need Incident Command?                 |
| <b>S</b> | Safety and Security | Is a Safety or Security issue present?       |
| <b>A</b> | Assess Hazards      | Are there any hazards?                       |
| <b>S</b> | Support             | What support, people or supplies are needed? |
| <b>T</b> | Triage & Treatment  | Do we need triage, how much treatment?       |
| <b>E</b> | Evacuation          | Can we evacuate/transport the victims?       |
| <b>R</b> | Recovery            | What Recovery issues are present?            |

## Table 3: IDME Categories

|          |                  |   |
|----------|------------------|---|
| <b>I</b> | <b>Immediate</b> | Life or limb threatening. Often with ABC problems.                                      |
| <b>D</b> | <b>Delayed</b>   | Need Definitive medical care, but should not worsen rapidly if initial care is delayed. |
| <b>M</b> | <b>Minimal</b>   | Walking wounded. Treated and released. Source of volunteer help.                        |
| <b>E</b> | <b>Expectant</b> | Severely injured with little or no chance of survival.                                  |
|          | <b>Dead</b>      | Already deceased.   |

## Table 4: Triage Criteria

## SALT Mass Casualty Triage



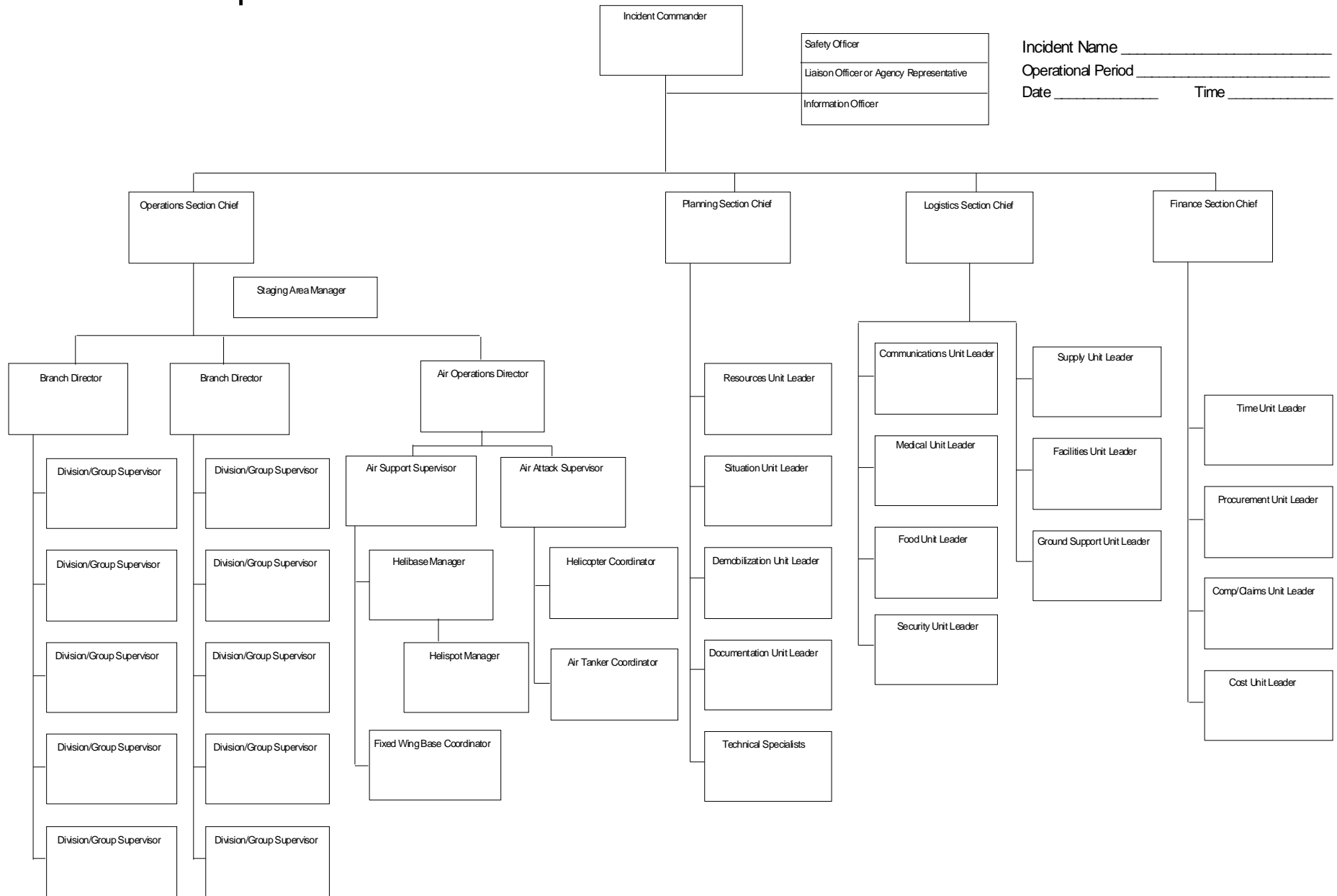
These Triage Criteria are used to evaluate an individual patient and determine in which of the IDME-D categories they belong.

These Triage Criteria may be used in a rapid field triage (assessing where they lay) and also for patients brought to the triage area for assessment.

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# Table 5: Sample ICS Structure



## APPENDIX A – Educational Requirements for MCI Plan

This document is cited in the MCI protocol as a reference document; it exists as a separate document in order to allow for rapid changes, when needed, so as not to be hampered by the time requirements of the protocol review and adoption process. In this way, when classes change or become outdated, this document may change and the integrity of the protocol remains intact. This is very similar to protocol references to AHA protocols, the NIOSH guidebook, etc.

- All MCA approved agencies functioning under this plan are required to adhere to these guidelines regardless of their participation or non-participation in grant programs
- All providers must be trained on, and competent in, the application of the MCI protocol.
- All providers must be trained on, and competent in application of all protocols relating to chemical, biological, radiological, nuclear, and explosive events, relative to their level of function.

| Class                     | MFR | EMT | Specialist | Paramedic | Dispatcher | Supervisor | Manager |
|---------------------------|-----|-----|------------|-----------|------------|------------|---------|
| IS 100                    | X   | X   | X          | X         | X          | X          | X       |
| IS 200                    | X   | X   | X          | X         | X          | X          | X       |
| IS 300                    |     |     |            |           |            | X          | X       |
| IS 400                    |     |     |            |           |            |            | X       |
| IS 700                    |     |     |            | X         | X          | X          | X       |
| IS 800                    |     |     |            | X         |            | X          | X       |
| BDLS <sup>3</sup>         |     |     | X          | X         |            | X          | X       |
| ADLS <sup>4</sup>         |     |     |            |           |            | X          | X       |
| 800 MHz <sup>5</sup>      |     |     |            |           | X          | X          | X       |
| DuoDotes <sup>6</sup>     | X   | X   | X          | X         |            | X          | X       |
| Cyanokit                  |     |     |            | X         |            | X          | X       |
| MEDDRUN/CHEMPAK           |     |     |            |           |            | X          | X       |
| Disaster Trailers         |     |     |            | X         |            | X          | X       |
| SALT Tri <sup>7</sup> age | X   | X   | X          | X         |            | X          | X       |
| EOC Operations            |     |     |            |           |            |            | X       |
| EMResource                |     |     |            |           | X          |            | X       |
| EMTrack                   |     |     |            | X         |            | X          | X       |
| Web - EOC                 |     |     |            |           |            |            | X       |
| Web-wiser                 | X   | X   | X          | X         | X          | X          | X       |

<sup>3</sup> Basic Disaster Life Support, or another equivalent MCA approved course, is required of all personnel

<sup>4</sup> Advanced Disaster Life Support is required of all supervisory level personnel who may assume the Medical Branch Director/Medical Command roles – this applies to transport services only

<sup>5</sup> 800 MHz is used as a primary mode of communication in some EMS Systems, mutual aid agencies operating on UHF or VHF should receive training on 800 MHz radio use. 800MHz is also used as a state-wide administrative platform, those who will be operating in dispatch, the EOC or who may request the radio cache should be trained in their use.

<sup>6</sup> All personnel should have training in the use of Duo-Dotes for self-administration.

<sup>7</sup> Training in use of EMTrack is required of all personnel that work for transporting services.