California Governor's Office of Emergency Services
REGION III

MCI PLAN (Manual 1)

MULTI-CASUALTY INCIDENT FIELD OPERATIONS

Revised: June 15, 2017

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PURPOSE OF THE FIELD OPERATIONS MANUAL

The Field Operations Manual describes the response organization, personnel, equipment, resources, and procedures for field operations that are designed to be utilized by the thirteen counties which make up the Governor's Office of Emergency Services (OES) Region III. This plan is intended to establish a regional "minimum" standard. This does not prevent local agencies from developing additional protocols or procedures that do not conflict with this regional standard.

The State approved Incident Command System (ICS) is used to provide the basic organizational structure for the following multi-casualty field operations manual. ICS was developed through a cooperative inter-agency (local, State and Federal) effort. The basic organizational structure of the ICS has been developed over time and is designed to coordinate the efforts of all involved agencies at the scene of a large, complex, emergency situation, as well as the small day-to-day situation. The organizational structure of ICS is designed to be developed and expanded in a modular fashion based upon the changing conditions and size/scope of the incident.

Providers within this region shall be trained to the ICS 100 level, and are strongly encouraged to be trained to the ICS 200 level.

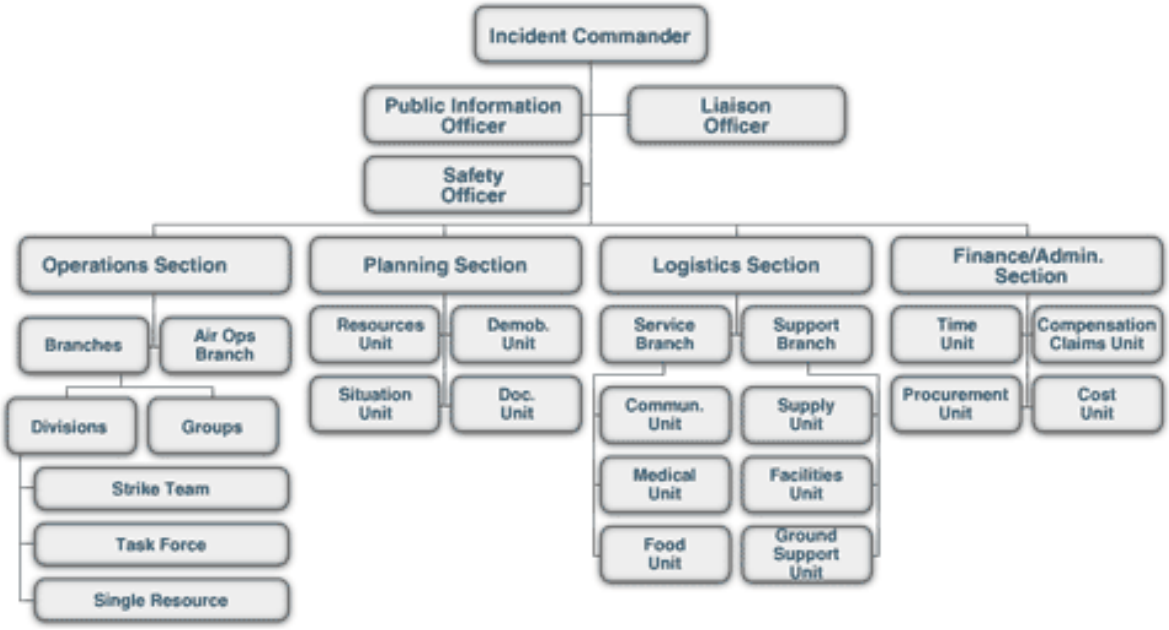
This Field Operations Manual contains standardized position titles, procedures, checklists, forms, and tags in an effort to more efficiently and effectively utilize regional resources during a multi-casualty incident.

SEMS/NIMS Compliant

Manual 1 concentrates on the field level and positions within the Standardized Emergency Management System (SEMS). In addition, this plan complies with the National Incident Management System (NIMS).

INCIDENT COMMAND SYSTEM

The ICS organization develops around five major functions that are required on any incident whether it is large or small. For some incidents, and in some applications, only a few of the organization's functional elements may be required. However, if there is a need to expand the organization, additional positions exist within the ICS framework to meet virtually any need.



ICS establishes lines of supervisory authority and formal reporting relationships. There is complete unity of command as each position and person within the system has a designated supervisor. Direction and supervision follows established organizational lines at all times.

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SECTION 1: COMMAND & CONTROL

Within the ICS, the Incident Commander is that individual which holds overall responsibility for incident response and management, and shall be that individual present on scene representing the public service agency having primary investigatory authority or responsibility. Some examples are as follows:

* HIGHWAY PATROL
  All freeways; all roadways in unincorporated areas to include right-of-way. (CVC 2454)

* SHERIFF'S OFFICE
  Off-highway unincorporated areas, i.e., railroad right-of-ways, parks, private property, etc. (Local policy)

* LOCAL FIRE/POLICE
  Specific areas of authority within their jurisdiction except freeways.

* AIRPORT FIRE/POLICE
  Airports

* U.S. MILITARY
  National Defense Area; a military reservation or an area with "military reservation status" that is temporarily under military control, e.g., military aircraft crash site.

The Incident Commander has responsibility for coordination of all public and private agencies engaged at the incident site, and controls all responding agencies, such as medical, coroner staff, etc. The Incident Commander has the specific responsibility for establishing and identifying the Command Post (CP) for notifying county dispatch centers, requesting resources, and providing the initial field assessment to enable appropriate decisions regarding the level of response necessary.

Jurisdictions where the City Council or other authority has assigned the function of Incident Commander to other than traffic law enforcement, i.e., fire service, that agency shall perform the incident command functions.

A. SELECTION OF THE "TYPE" OF COMMAND

The choice of type of command will usually be made based upon the number of jurisdictions involved, complexity, and size of the incident.

Single Command: This is a system wherein a person determined by the impacted jurisdiction is given the lead role as Incident Commander. This person, initially, would be the most qualified official of the jurisdictional agency(ies) at the scene. In the ICS, as the incident progresses in size or scope, the incident command may be turned over to a higher ranking or more qualified official.

Some incidents may require an advisory (liaison) staff to assist the Incident Commander. This will generally be comprised of officials of the major agencies involved such as fire, law enforcement, public works, and EMS. For large, complex incidents an EMS representative will be assigned by the Health Officer/EMS Medical Director or his/her designee and will normally be a member of the Health Department/Local EMS Agency or an ambulance service manager.

Unified Command: This is a system where a group of officials from the major agencies involved share the lead responsibility. These officials may include fire, law enforcement, public works, and EMS. The EMS representative will again be determined by the Health Officer/EMS Medical Director or designee.

B. FUNCTIONS OF THE INCIDENT COMMANDER

The Incident Commander shall be responsible for the following general functions:

- **Command**: Overall management of the incident and setting of objectives.
- **Planning**: The development of a procedure to deal with operational problems.
- **Logistics**: The acquisition and distribution of resources.
- **Finance**: Recording, for purposes of reimbursement, who and what was involved in the incident.
- **Operations**: The direct control of tactical operations and the implementation of objectives.

Depending on the size and duration of the incident, the Incident Commander may directly supervise operations or delegate this responsibility to an Operations Chief.

The EMS Multi-Casualty Field Operations will fall within the responsibility of Operations.

- The Incident Commander will determine when EMS personnel are no longer required and may be released from the incident, and will approve any information releases to the media. **Personnel shall not release information to the media without approval.**

SECTION 2: COMMUNICATIONS

Communications at the incident are managed through the use of a common communications plan and an incident based communications center established solely for the use of tactical and support resources assigned to the incident. All communications between organizational elements at an incident should be in plain English or clear text. No codes should be used, and all communications should be confined only to essential messages. The Communications Unit is responsible for all communications planning at the incident. This will include incident-established radio networks, on-site telephone, public address, and off-incident telephone/microwave/radio systems.

A. RADIO NETWORKS

Radio networks for large incidents should be pre-designated, when possible, through a cooperative effort of all involved local agencies and will normally be organized as follows:

Command Net - This net should link together: Incident Command, key staff members, Section Chiefs, Division and Group Supervisors.

Tactical Nets - There may be several tactical nets. They may be established around agencies, departments, geographical areas, or even specific functions. The determination of how nets are set up should be a joint Planning/Operations function, and should be pre-designated whenever possible. The Communications Unit Leader will develop the plan in the event a pre-designated system is not in place.

Support Nets - A support net will be established primarily to handle status-changing for resources as well as for support requests and certain other non-tactical or command functions.

- The scene-to-Control Facility frequencies (Med-Net) fall under the categories of Support Net and, again, should be pre-designated.

Ground to Air - A ground to air tactical frequency may be designated, or regular tactical nets may be used to coordinate ground to air traffic.

Air to Air - Air to air nets will normally be pre-designated and assigned for use at the incident.

SECTION 3: EQUIPMENT & SUPPLIES

It is imperative that all tools necessary for initial scene organization and patient triage are available to the first-in emergency response units. A Triage Kit (see Appendix D) and a minimum of two position (e.g. Triage Unit Leader & Medical Group Supervisor) vests should be carried on all initial response units.

All remaining vests, Position Checklists, and the Medical Group Implementation Supplies should be carried in a supervisor/battalion vehicle which would be in the second wave dispatch to an MCI.

SECTION 4: ACTIVATION/NOTIFICATION

Activation of the Multi-Casualty Incident System consists of the mobilization of the necessary resources, notification of the Control Facility, and initiation of the ICS.

The mobilization of resources and the notification of the Control Facility should be initiated as soon as possible to assure adequate time for the system to respond. It is not necessary to wait until emergency personnel have arrived on scene. As soon as it is determined that an emergency call may prove to be a multi-casualty incident, an additional response dispatch and Control Facility notification should occur.

A. MOBILIZATION OF RESOURCES

Three main categories of resources that should be considered are (E,M,T):

- **Equipment and Supplies:**
  - Medical Group Implementation Supplies
  - Medical Supply Caches/Disaster Trailers/Disaster Medical Supply Units
  - Rescue Equipment
  - Specialized Equipment

- **Manpower:**
  - ALS Personnel
  - BLS Personnel
  - Litter Bearers
  - Task Forces

- **Transportation:**
  - Ground Ambulances
  - Air Ambulances
  - Buses /Alternate Transport Vehicles (should be established prior to an incident, as part of an OA plan)
  - Ambulance Strike Teams (ALS or BLS)

B. NOTIFICATION OF THE CONTROL FACILITY

Enroute

The notification of the Control Facility (CF) should occur as soon as there is information that an MCI may exist. If this occurs at the time of dispatch or while responding to the incident, the CF should be contacted and advised of an "MCI Alert". Information concerning the location, approximate number of victims (if known), and a description of the incident should be given. The CF can be contacted by the dispatch center or pre-hospital responders.

On Scene

Immediately Upon Arrival (or upon confirmation of on-scene EMS first responders):

- Confirm or cancel MCI alert with CF.
- Identify location of MCI.

Following Scene Size-up, Update CF on:

- Classification of Incident
  - MCI Trauma — Surgeon may be required for Immediate victims.
    - Mass Violence – Used to assist the CF and Receiving facilities in establishing internal security notifications. Do not use terms Active Shooter/bombing etc over the radio. Landline if possible with the CF regarding details of these events.
  - MCI Medical — e.g., chlorine gas inhalation or burns in which a surgeon would not be required at the receiving facility.
  - MCI HazMat — An incident requiring decontamination.
- Approximate number of victims.
- Name of incident
- Estimated time when triage will be completed.

Following Triage, Update the CF on:

- Total number of patients by triage category and major injury, e.g., "A total of ten patients: 2 Immediate Heads, 4 Delayed, and 4 Minors."
- Number and description of transport units, e.g., "2 ALS ground ambulances, 1 BLS ground ambulance, and 1 ALS air ambulance.

SECTION 5: INCIDENT OPERATIONS

A. SCENE INITIATION OF ICS

Report to the IC and get permission to establish the medical group (or temporarily assume IC and **establish the ICS)**, including:

- **R** esources: Ensure adequate resources have been ordered (**E**quipment, **M**anpower, **T**ransportation), and clarify with IC the ordering process (i.e. can MGS order additional medical resources). Update ambulance dispatch and the Control Facility as soon as possible upon arrival.
- **A** ssignments: Assign Triage Unit Leader to begin triage.
- **C** ommunications: Determine medical tactical channel, command net, air ops (if any), etc. in cooperation with the IC.
- **I** ngress / Egress: Determine the best routes in and out of the incident with IC, and notify dispatch.
- **N** ame: Clarify incident name with IC, and notify dispatch.
- **G** eography: Quickly determine with the IC where incoming resources will stage, establish triage, treatment, transport areas.

Note: The first in ambulance should generally be the last ambulance to leave the scene. Additionally, medical supplies from the first in ambulance should be used by triage/treatment units.

B. EMS FIELD MANAGEMENT PERSONNEL

At the time any of the following positions are assumed or assigned, it is imperative that the personnel being assigned be given:

- The appropriate vest for the position.
- The appropriate position checklist.
- Mode of communications to be utilized.

1. Medical Group Supervisor (MGS)

This person is in charge of EMS Field Operations in an initial and reinforced level of response. While formal identification is not necessary on routine calls, on multi-casualty incidents, an identification vest will be used.

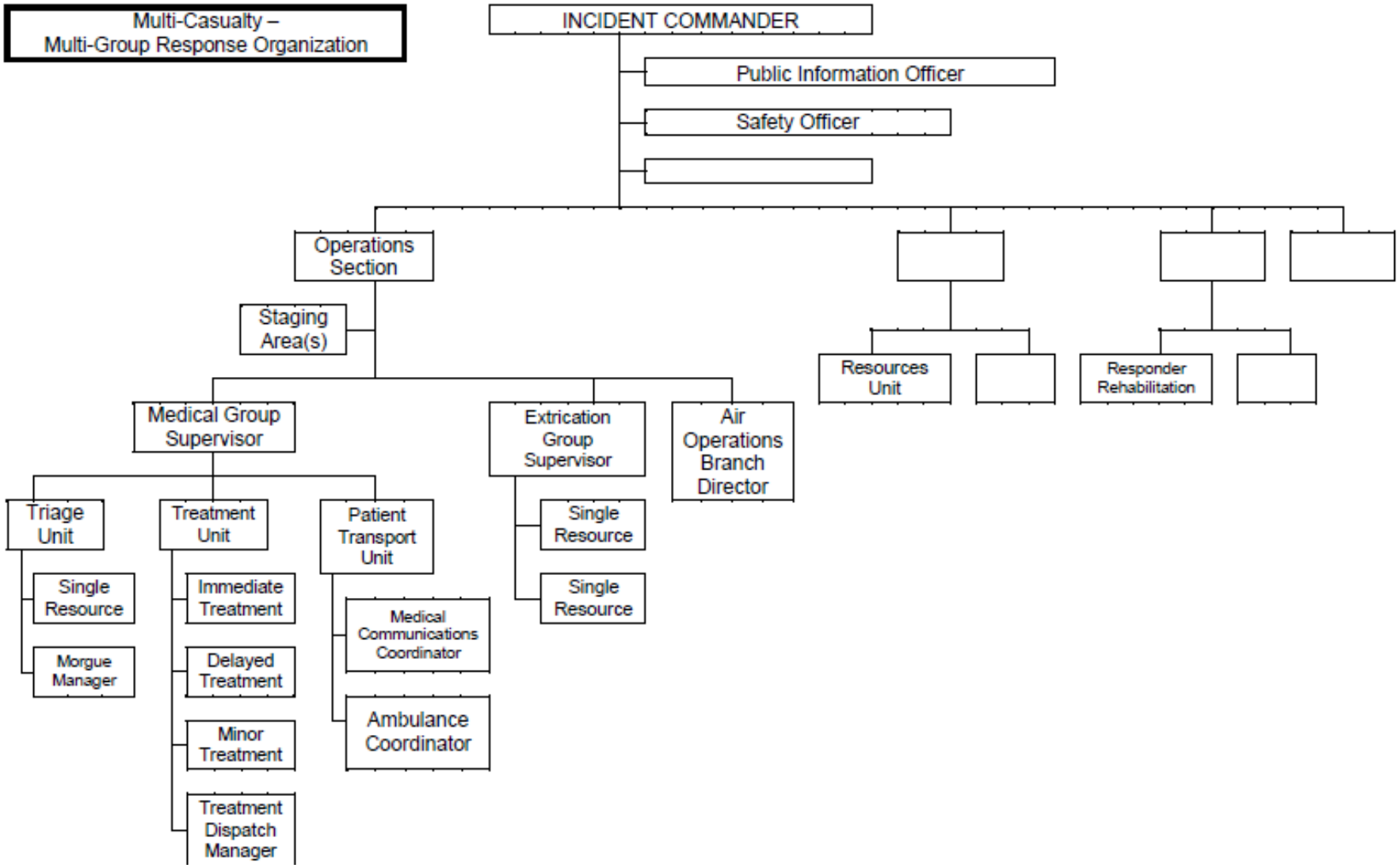
The Medical Group Supervisor will report to the Incident Commander or designee. If an Incident Commander has not been established early in a multi-casualty incident, the Medical Group Supervisor will coordinate operations with fire and law enforcement until an Incident Commander is assigned.

Overall command of EMS field operations in a Full Branch Response would be delegated to the Medical Branch Director.

Selection: The Medical Group Supervisor shall be the first qualified responder for the position on the scene and, in accordance with local policy, may be a law enforcement, fire department, or private provider personnel.

The initial Medical Group Supervisor may be relieved or assisted by personnel more qualified for the position as they arrive.

FIRESCOPE- Multi-Casualty Organization Chart



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Function: The Medical Group Supervisor or Medical Branch Director if assigned, will be responsible for triage, treatment, and transportation in the multi-casualty incident, and should not be directly involved in patient care unless he/she is the only rescuer at the scene for extended lengths of time.

The EMS field organization builds from the top down with responsibility and performance placed initially with the Medical Group Supervisor. The specific organizational structure established for any given incident will be based upon the management needs of the incident. If one individual can simultaneously manage all major functional areas, no further organization is required. If one or more of the areas require independent management, an individual should be named to be responsible for that area.

In a small MCI, or in the early phases of a large MCI, the Medical Group Supervisor may also need to serve as the Triage, Treatment, and Transportation Unit Leader/Group Supervisor and coordinate communications with the Control Facility for patient dispersal.

The Medical Branch Worksheet (ICS-MC-305), and the Position Checklists found in Appendix A, should be used any time it is appropriate. However, the Worksheet and Position Checklists must be used whenever more than two components of field operations have been assigned to other individuals.

Personnel: The Medical Group Supervisor will appoint personnel depending upon the needs of the incident. Personnel can be placed in charge of several areas if this is the best utilization of available resources. Additional personnel may include, but are not limited to:

- Triage Unit Leader
- Treatment Unit Leader
- Transportation Unit Leader/Group Supervisor
- Medical Supply Coordinator
- Medical Communications Coordinator

2. Triage Unit Leader

The Triage Unit Leader (BLS level preferred) will coordinate the triage of all patients. After all patients have been triaged and tagged, this person will supervise the movement of patients to a treatment area. This person will remain at the triage area and will report to the Medical Group Supervisor. The Triage Unit Leader may assign as needed:

- Triage Personnel
- Morgue Manager

3. Treatment Unit Leader

The Treatment Unit Leader, who reports to the Medical Group Supervisor, is responsible for on scene emergency medical care of victims in the treatment area. This person will be located at the treatment area and may assign Treatment Managers to the Immediate, Delayed, and Minor Treatment Areas as needed. The Treatment Unit Leader may also assign a Treatment Dispatch Manager to coordinate patient readiness with the Patient Transportation Unit Leader. Positions that may also be assigned are:

- Treatment Dispatch Manager

- Immediate Treatment Manager
- Delayed Treatment Manager
- Minor Treatment Manager

4. **Patient Transportation Unit Leader/Group Supervisor** (PTUL/PTGS)

This position may be filled concurrently by the Medical Group Supervisor in the event there are not enough qualified personnel available. The Patient Transportation Unit Leader/Group Supervisor may assign the following personnel as necessary:

- Medical Communications Coordinator
- Ambulance Coordinator

C. DESIGNATED AREAS

Locations of designated areas, as detailed below shall be approved by the Incident Commander or designee. Once the location has been assigned to EMS, the Medical Group Supervisor or designee will oversee the organizing of specific areas within the agreed upon location.

1. Treatment Areas

Treatment areas should be safely distanced from hazards, upwind from toxic fumes, including EMS vehicle exhaust, and allowance made for vehicle access to an adjacent loading area. There should be adequate space to lay the patients side-by-side/end-to-end and grouped by triage priority.

In a small incident, if a treatment area needs to be established, a single treatment area is recommended for the Immediate and Delayed patients. The Minor patients should be grouped and treated away from all areas of active operations.

In the case of large incidents or if problems with having only one treatment area develop, a treatment area may be designated for each triage category. The Immediate and Delayed treatment areas should be grouped close together and the Minor treatment area located a distance away.

Remember, Immediate patients must be transported as soon as possible. Movement of these patients to a treatment area may be inappropriate if it unnecessarily delays transport.

2. EMS Staging Area

This area will be the collection point for EMS personnel and equipment. A Staging Area Manager should be assigned by the IC or designee. Transport vehicles will be maintained in a one-way traffic pattern towards the loading area, if possible. Request law enforcement assistance through the Incident Commander, if a change of normal traffic pattern is necessary. If necessary, a supply cache will be established at the staging area. In a large incident, the staging area will include many other non-medical components. In this case, the Ambulance Coordinator will handle EMS resources and report to the person in charge of staging for the entire incident. EMS staging may be incorporated in a joint Staging Area if one has been established by the Operations Chief.

3. Loading Area

This area is for loading patients into transporting vehicles. The loading area should be adjacent to the treatment area(s) and in line with the one way traffic from the Staging Area.

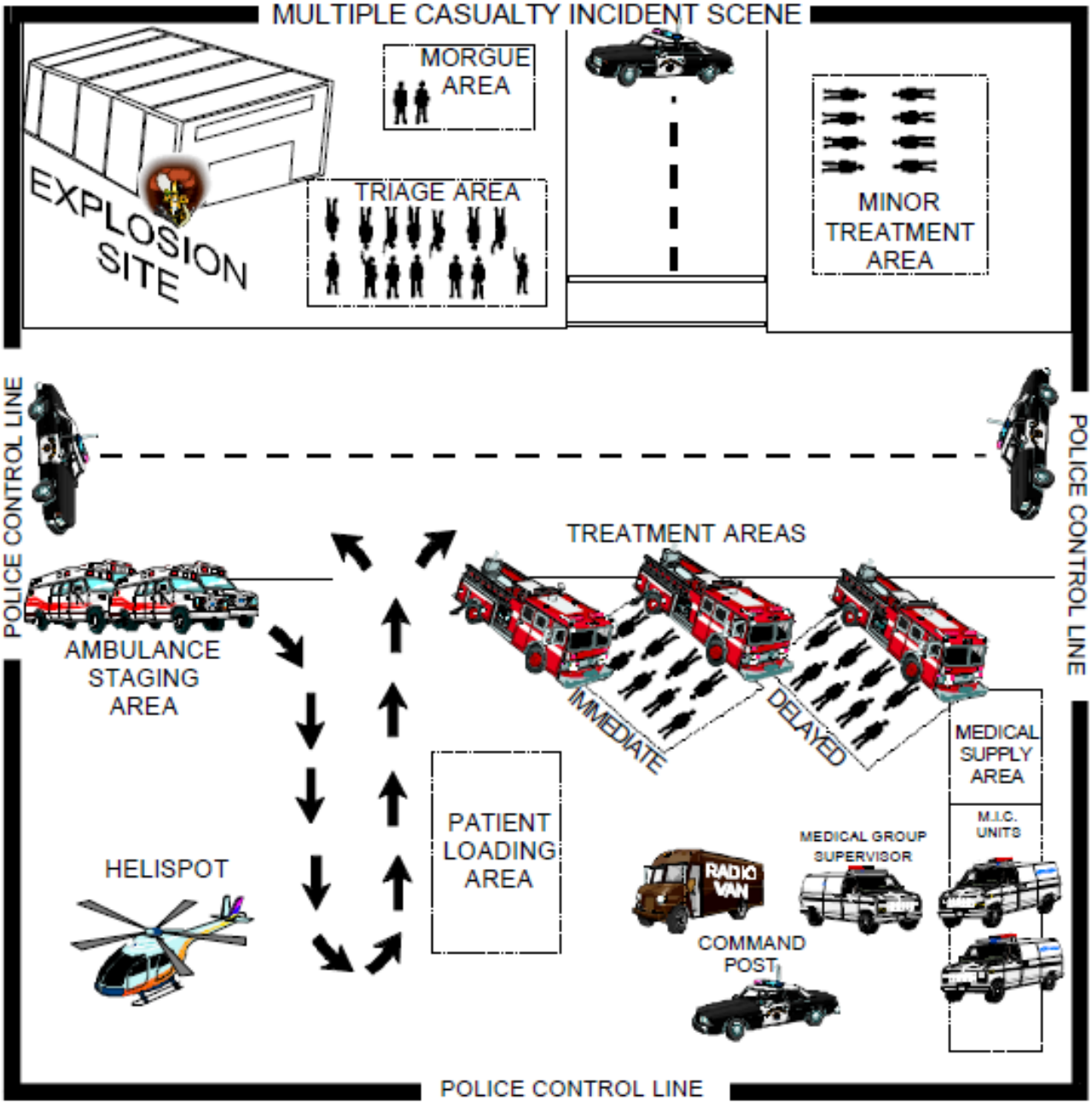
4. Morgue Area

Most MCI events may be considered crime scenes and the deceased should not be moved. A Morgue Area should be established only if it becomes necessary to remove deceased patients from the impact site, i.e., to gain access to salvageable patients. This area should be located away from the treatment area(s) and is the responsibility of the Coroner's Office/Law Enforcement. EMS personnel assistance may be required in the establishment of the field morgue.

There may be instances in which it may be necessary to establish a second morgue area for victims that expire within the treatment areas if it is impractical to remove those casualties to the morgue area established at the impact site.

5. Triage Area

Victims should usually be triaged where they lie. If this is not feasible due to physical or hazardous restraints, the victims may be removed to a safe area where the Triage Unit Leader or triage teams will triage, tag, or utilize optional flags. See Section 5.3 and direct litter bearers to the appropriate treatment area.



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D. TRIAGE

Once it has been established that the scene is safe from hazards, an initial walk through may be necessary to provide a baseline estimate of casualty figures. Initially Triage will be conducted by the first-in medical personnel. The Triage Unit leader will assign the personnel to conduct triage as needed by the size and complexity of the incident.

Treatment prior to triage of all patients shall be restricted to airway establishment and hemorrhage control, to include the use of tourniquets and/or hemostatic dressings.

CPR generally should not be initiated unless an overabundance of ALS personnel, equipment, transport units, and immediate receiving facilities exist.

The Medical Group Supervisor or Triage Unit Leader is responsible for stopping CPR when not appropriate in multi-casualty situations.

Initial triage should take 30 seconds or less per patient. Initial triage should be performed utilizing the S.T.A.R.T. method (see Appendix C). All providers in OES Region III should be utilizing the DMS All Risk Triage Tags. Adjustments may be necessary during re-triage and when triage is being done by higher trained personnel. Triage of patients should occur where they lie only if the area is safe. If a hazard exists, patients should be moved to a safe triage area. Patients should be triaged and tagged prior to leaving the triage area. Do not wait to triage patients until they are placed in a treatment area. This will cause confusion as the patients will have to be rearranged into triage categories.

Providers may utilize "triage ribbon" as part of their initial triage. The appropriate ribbon color must be clearly displayed on the patient. It is recommended that providers use strips of ribbon that are approximately 2 (two) feet long, comfortably tied on an uninjured extremity. Triage Tags must be placed on all patients either when placed in the appropriate treatment area or prior to transport to ensure proper patient tracking.

Triage personnel will return unused tags to the Medical Group Supervisor or Triage Unit Leader and will, at that time, be reassigned as appropriate.

1. Triage Categories

Note: These can be very dynamic. A patient's condition may rapidly worsen and change categories. START is designed to be a rapid, but not thorough evaluation technique.

- **IMMEDIATE**: (Critical, life-threatening)
  These patients require immediate intervention and definitive medical care. Any patient that had a tourniquet applied or had a hemostatic dressing applied to control hemorrhage shall be deemed an Immediate patient regardless of the START triage algorithm. *(Target field to facility transport time: within thirty (30) minutes)*

- **DELAYED**: (Serious, may be life threatening)
  These patients have serious injuries, and should be observed closely for decompensation. *(Target field to facility transport time: within 2 hours)*

- **MINOR**: (Walking wounded, non-life or limb threatening injuries)
  These patients do not demonstrate serious injuries, but should be observed for changes in their condition. *(Target field to facility transport time: within 6 hours or as soon as practical)*

- **DECEASED**: (Mortally injured)
  These patients are deceased or not expected to survive. They may receive expectant/palliative care.

E. TREATMENT

Once all patients have been triaged, the Immediate patients must be transported as soon as possible. If there is going to be a delay in transport due to a lack of transportation units or a high number of victims, patients should be moved to a treatment area. The Treatment Area will be supervised by the Treatment Unit Leader (if assigned). The Treatment Unit Leader may in turn assign supervision of the various treatment areas to Treatment Manager(s).

- Assign EMS personnel to specific patients or groups of patients, ensuring adequate BLS/ALS coverage to the extent possible (priority to immediate and delayed patients). Volunteer medical personnel must report to the staging area. The Transportation/Ambulance Provider will advise the Air/Ground Ambulance Coordinator, as to assignment of personnel. EMTs and EMRs should be assigned to the minor treatment area.

- CPR should not be initiated unless staffing allows for immediate treatment of all immediate and delayed patients.

- Re-triage every fifteen (15) minutes, if possible. If staffing allows, re-triage should be more precise than the initial S.T.A.R.T. method.

1. Immediate

Once in the treatment area, a set of vital signs should be taken, vital signs recorded on the triage tag, and patients prepared for transportation. Treatment should not delay transporting immediate patients. As with all critical trauma patients, the emphasis is on the ABCs and early transport.

2. Delayed

These patients should be re-triaged (assessment and vital signs) as often as manpower allows. Delayed patients may require ALS and/or BLS treatment while waiting for transportation.

3. Minor

Minor patients should be kept away from all areas of active operations, including other treatment areas, morgue, and impact area (inner perimeter). These patients should receive an assessment and have vital signs taken and have triage tags applied. BLS treatment should be performed as necessary.

4. Deceased

Deceased patients should be left in the position they are found, if possible. Do not separate patient from

identification. If it is necessary to move deceased patients, a field morgue will be established away from the other areas and under the direction of the Coroner or Law Enforcement. Movement of deceased patients shall be done only after consultation with the Coroner's Office or Law Enforcement, if possible.

F. EMS RESOURCE MANAGEMENT

EMS resources shall be requested through the Incident Commander/Designee or Logistic Section if developed. In a small incident, the Medical Group Supervisor and Patient Transportation Unit Leader may be allowed to directly request EMS resources, but this should not be assumed. A procedure for requesting resources should be arranged with the Incident Commander. In an incident with expanded ICS activation, resources are the responsibility of Logistics.

EMS resources will be supervised by the Medical Group Supervisor. Supervision of a medical staging area may be assigned by the Incident Commander to the Patient Transportation Unit Leader/ Patient Transportation Group Supervisor, who may assign an Air/Ground Ambulance Coordinator.

- All EMS personnel, equipment, and supplies shall be directed to the staging area.

- Resources (personnel, equipment, etc.) will be assigned or distributed to specific tasks. They will be dispatched by the Ambulance Coordinator or the Patient Transportation Unit Leader/Group Supervisor at the request of the Medical Group Supervisor.

- Transport vehicles will be maintained in a one way traffic pattern adjacent to the loading area. The Patient Transportation Unit Leader or Ground Ambulance Coordinator if assigned, may request law enforcement assistance through the Incident Commander or his/her designee if necessary to assist with traffic flow.

- If possible, keep a driver with each vehicle. If drivers are needed for triage or treatment, KEYS MUST BE LEFT IN VEHICLE.

- Remove equipment not necessary for transport. Create a field inventory at the staging area which can be rapidly moved to treatment area(s) as needed, e.g., backboards, stretchers, splints, oxygen, solutions, etc.

G. TRANSPORTATION/PATIENT DISPERSAL

Once transporting vehicles are available, patients will be moved from the treatment area to the loading area.

The Patient Transportation Unit Leader/Group Supervisor will request transport vehicles from the Ambulance Coordinator as patients are ready for transport.

- Vehicle loading should be maximized without jeopardizing patient care. Unless it is the only option, two immediate patients should not be transported in the same ambulance. Instead, an immediate may be transported with a delayed patient to better assure that pre-hospital staff can adequately care for patients during transport. Each patient transported must be registered in the

Patient Transportation Summary Worksheet (MCM-403). See sample below.

- In a large MCI, the method of transportation for minor priority patients may be of a type that cannot be used for the transportation of Immediate and Delayed patients, i.e., buses with fixed seats. Loading of minor patients should not interfere with the loading of immediate or delayed patients and a separate loading area may be required. Minor patients can be transported in the front seat of ambulances transporting Immediate or Delayed patients if necessary.

- Once prepared for transportation, the Treatment Unit Leader should notify the Patient Transportation Unit Leader/Group Supervisor of the number of patients, their triage categories, and a one word classification of their injuries, i.e., "one Immediate head and one Immediate chest." After receiving direction from the Control Facility, the Patient Transportation Unit Leader/Group Supervisor will advise the transporting units of the appropriate hospital destination.

- The Patient Transportation Unit Leader/Group Supervisor should assign either the Ambulance Coordinator or a recorder to log patient names and/or triage tag numbers, unit numbers of transporting units, triage category, destination, time of transport, and ETA on a Patient Transportation Summary Worksheet as the patients are loaded for transport.

H. CONTAMINATION

Pre-hospital personnel must remain alert to the potential for toxic and hazardous materials at the scene of all incidents. Familiarization with the State document "Hazardous Materials Medical Management Protocols" and the Incident Command System document "Hazardous Materials Operational System Description (ICS-HM-120-1)" is essential to avoid further and unnecessary contamination of personnel/equipment. General guidelines include:

- Contaminated patients and the entire area of contamination must be isolated from equipment and other personnel and the area labeled a "hot zone." An additional "warm zone" must be established around the periphery. Only personnel who have been trained in the proper use of self-contained breathing apparatus and are equipped with appropriate suits should enter the hot zone. All designated areas must be established upwind from the hot zone and no one should be allowed to enter the area downwind of the hot zone unless they are equipped with self-contained breathing apparatus and properly attired. Patients are usually received from the Contamination Reduction Corridor.

- Accurate information on the identification and health effects of the substance and the appropriate pre-hospital evaluation and care of the victim must be obtained.

- Initial decontamination must occur on scene by qualified personnel. Decontaminated patients must be properly packaged to prevent contamination of the transporting units and personnel and be transported by medical triage categories and not by level of contamination.

  NOTE:Transportation units other than ambulances may be needed to transport some victims with significant exposure to prevent secondary contamination and the subsequent removal from service of those ambulances.

- The Control Facility should be advised of patient contamination as early as possible to assure that a properly equipped facility can accept them.

- Clearly indicate on the triage tag and field assessment form "CONTAMINATED", in addition to the specific identity of the contaminate, if known.

I. STANDING ORDERS

During an MCI, it is imperative that radio transmissions be kept to a minimum. Therefore, advanced life support and limited advanced life support personnel will function under standing orders.

If Base Hospital contact is necessary due to extenuating circumstances, the following guidelines should be adhered to:

- On-Scene:
  Contact should only be made following approval of the Medical Group Supervisor or Patient Transportation Unit Leader/Group Supervisor.

- Enroute:
- Updates with the receiving facilities should only be made if there is a clear frequency not being utilized for the incident.

SECTION 6: RESOURCES & ANCILLARY OPERATIONS

A. DAY-TO-DAY MUTUAL AID

During small incidents or in the initial phases of a large incident, resources should be requested utilizing the usual day-to-day mutual aid process.

B. MASTER MUTUAL AID

If the usual day-to-day mutual aid system will not provide adequate resources, the Master Medical Mutual Aid system should be accessed as soon as possible. Instructions for the activation of this system are outlined in CAL-EMA REGION III Medical/Health Mutual Aid Plan.

C. ANCILLARY OPERATIONS

Besides fire, EMS, and law enforcement agencies, the following is a list of ancillary services involved in EMS Field operations and should be involved in any local multi-casualty incident planning and training.

- Dispatch Centers
- Control Facilities
- Receiving Facility
- Local Emergency Medical Services Agencies
- Local Office of Emergency Services
- Local Military Establishments
- Local Red Cross
- Local H.A.M. Operators

SECTION 7: DOCUMENTATION

Original ICS-MC & MCM FORMS for use with this manual are found in Appendix E. An Index is provided listing the most recent form number and date for each form. Position Checklist forms are found in Appendix A.

A. TRIAGE TAGS

Note: .OA's should utilize the DMS (Disaster Medical Services) All Risk Triage Tags to ensure uniformity across the region and improve mutual aid MCI operations

Fire and EMS personnel upon arrival at the scene, will distribute tags to qualified triage personnel. The number of tags distributed should be noted to better assess the actual number of patients.

1. Triage Personnel should:

- initially tag patients with the S.T.A.R.T. triage method;
- attach triage tags directly to the patient, and not clothing; in a readily visible location for other responders, and avoid injured areas;
- report to the Medical Group Supervisor or designee;
- return unused tags and ask for further assignment.

2. Treatment Personnel should:

- when the victims arrive in the treatment areas, indicate the time, date of triage, and briefly the chief complaint/major injuries;
- document vital signs and times obtained on Part I of the tag;
- list treatment and time administered on Part II of the tag;
- assign non-medical personnel to complete patient identification section of the triage tag (name, address, phone, sex, age, weight) if possible.

Re-evaluate triage as necessary. If the initial triage was categorically incorrect or is full of information, DO NOT REMOVE. Obtain a second tag, detach and discard all numbered tabs, and mark through all tag numbers on second tag. Leave all remaining tabs on the original tag. The original tag number shall remain as the patient number until the victim is hospitalized. Note on the second tag the time and reason it was attached.

Once the destination facility has been determined, it will be written on the tag. The Patient Transportation Unit Leader/Group Supervisor will note the tag number on a Patient Transportation Summary Worksheet (MCM-403).

Transporting personnel will note the triage tag number on the patient care record/field assessment form. This will enable information to be obtained at a later time and permit a rapid return to the incident scene.

Hospital admitting personnel will use the triage tag number in the admitting process in such a means that patient information and medical records may be retrieved rapidly by the use of the triage tag number.

B. FORMS

1. Field Pre-Hospital Care Records

Pre-hospital Care Records should be completed according to local policy.

2. Medical Branch Worksheet

The Medical Branch Worksheet (MCM-402) is used by the Medical Group Supervisor as an organizational aid. This worksheet is an abbreviated flow chart that provides space for names of persons filling positions and a checklist for other resources to be considered. The Medical Group Supervisor must use this form whenever more than one component has been delegated to other individuals.

3. Patient Transportation Summary Worksheet

This worksheet (see instructions, Appendix E) may be used by the Patient Transportation Unit Leader/Group Supervisor, Medical Communications Coordinator, Treatment Unit Leader, and Air/Ground Ambulance Coordinators to maintain an accurate status list of patients as they are moved through the system.

It is used by the Medical Communications Coordinator (if assigned) to record information from the Treatment Unit regarding the status of patients ready for transport as well as to record patient destination information as directed by the Control Facility (CF). The Worksheet is also utilized by the Patient Transportation Unit Leader/Group Supervisor (PTUS/PTGS) and Ambulance Coordinator to record the transport of patients from the scene.

In the event that Medical Communications Coordinator or Air/Ground Ambulance Coordinator has not been assigned, a single worksheet can be utilized by the Patient Transportation Unit Leader/Group Supervisor to record all of the above information.

4. Ambulance Staging Resource Status

This status worksheet (MCM-404) should be maintained by the Ground Ambulance Coordinator to track ambulance availability and activities. Space is provided for the agency name and unit identification number, as well as their time in and out of staging.

5. Supply Receipt & Inventory Form

This status form (ICS-MC-312) is used by the Medical Supply Coordinator to document supplies and equipment obtained from response agency vehicles for allocation to medical group units.

C. MULTI-CASUALTY INCIDENT REVIEW/QUALITY IMPROVEMENT

Copies of all multi-casualty incident forms will be forwarded to the local EMS agency by the Medical Group Supervisor within forty-eight (48) hours after the incident. The local EMS Agency may conduct an "all agency critique" of a multi-casualty incident for the purpose of improving future coordination and/or performance. An "all agency critique" will be conducted with incidents involving ten (10) or more immediate patients or a combination of fifteen (15) or more immediate and delayed patients. At least one all-agency critique of a multi-casualty incident will be conducted every six (6) months.

SECTION 8: TRAINING

All providers in OES Region III should conduct regular MCI training. This training should include:

- Scene size up and CF notification procedures (CF notification should include incident location, incident name, type of MCI and approximate number of victims
- Triage Training, review of START triage procedures, RPM. This training may include regularly scheduled "Triage Training Days" where providers utilize Triage Tags for a certain period of time, triaging regular patient contacts
- Patient Tracking, ensuring all response vehicles have the appropriate Patient Tracking forms. Triage Training should incorporate patient tracking.
- Disaster Drills or Planned Events. These events allow MCI planning objectives to be practiced with local providers and the Control Facility. Please refer to your LEMSA MCI Plan for reporting and documentation requirements.

SECTION 9: Active Shooter/Mass Violence/Hostile Event

LEMSA's should have a policy/protocol to guide EMS responders in the response and handling of a Mass Violence event regardless of the activity that leads to the event. These events may include active shooter, mass violence (riots, attacks on large crowds with vehicles, improvised explosive devices etc).

A successful response to the above incidents is predicated on a sound level of communication will ALL responders to these events. This communication must begin prior to these events in meetings and trainings. Topics would include Law, Fire and EMS responsibilities and expectations. Each systems or provider area must determine the best response for their area. Agencies must way the impact of such events on their systems and resources.

Systems should evaluate the need for additional personal protective equipment for their personnel. Training on any personal protective equipment (PPE) should be completed on a regular basis with those assigned or expected to wear such PPE.

Suggested additional training topic would include.

- Rescue Task Force
- Casualty Care (Hemorrhage control, casualty evacuation)
- Transition from casualty care to MCI management.

• APPENDIX A: POSITION CHECKLISTS

MEDICAL GROUP SUPERVISOR (MGS)

- Resources: assess need for additional resources:
  - **E**quipment: medical supplies (e.g. medical caches, backboards, litters, cots).
  - **M**anpower: FRs, EMTs, paramedics
  - **T**ransportation: air/ground, vans, buses
- Assignments:
  - Establish Medical Group, assign personnel.
  - Direct and/or supervise on-scene personnel from agencies such as Coroner's Office, Red Cross, ambulance, etc.
- Communications:
  - Participate in Medical Branch/Operations Section planning activities.
  - Ensure notification of the Control Facility.
- Ingress/Egress: Report staging area and transport routes to dispatch.
- Name: Confer with IC/Ops Chief to determine incident name, report to dispatch / Control Facility.
- Geography: Designate Treatment Area locations.
  - Isolate Morgue and Minor Treatment Area from Immediate/ Delayed Treatment Areas.
  - Request proper security, traffic control, and access for the Medical Group work areas.
- Maintain Unit/Activity Log (ICS Form 214).

TRIAGE UNIT LEADER

- Develop organization sufficient to handle assignment.
- Inform Medical Group Supervisor of resource needs.
- Implement triage process.
  - Ensure triage tags are properly applied to each victim.
- Coordinate movement of patients from the Triage Area to the appropriate Treatment Area.
- Give periodic status reports to Medical Group Supervisor, including total victim counts by triage category.
- Maintain security and control of the Triage Area.
- Establish Morgue.
- Maintain Unit/Activity Log (ICS Form 214).

TREATMENT UNIT LEADER

- Develop organization sufficient to handle assignment.
- Direct and supervise Treatment Dispatch, Immediate, Delayed, & Minor Treatment Areas.
- Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
- Request sufficient medical caches and supplies as necessary.
- Establish communications and coordination with Patient Transportation Unit Leader.
- Ensure continual triage of patients throughout Treatment Areas.
- Direct movement of patients to ambulance loading area(s).
- Give periodic status reports to Medical Group Supervisor.
- Maintain Unit/Activity Log (ICS Form 214)

PATIENT TRANSPORTATION UNIT LEADER

- Ensure the establishment of communications with the Control Facility.
- Designate Ambulance Staging Area(s).
- Direct patient destinations as reported by the Medical Communications Coordinator and Control Facility.
- Ensure patient information and destination are recorded on the Patient Transport Worksheet.
- Establish communications with the Ambulance Coordinator.
- Request additional ambulances as required.
- Notify Ambulance Coordinator of ambulance requests.
- Coordinate requests for air ambulance transportation through the Air Operations Branch Director.
- Coordinate the establishment of the Air Ambulance Helispots with the Medical Branch Director and Air Operations Branch Director (if assigned).
- Maintain Unit/Activity Log (ICS Form 214).

MEDICAL BRANCH DIRECTOR

The Medical Branch Director is responsible for the implementation of the Incident Action Plan within the Medical Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group(s) and the Patient Transportation function (Unit or Group). Patient Transportation may be upgraded from a Unit to a Group based on the size and complexity of the incident.

- Review Group Assignments for effectiveness of current operations and modify as needed.
- Provide input to Operations Section Chief for the Incident Action Plan.
- Supervise Branch activities.
- Report to Operations Section Chief on Branch activities.
- Maintain Unit/Activity Log (ICS Form 214).

TREATMENT AREA MANAGER

- Request or establish Medical Teams as necessary.
- Assign treatment personnel to patients received in the Treatment Area.
- Ensure treatment of patients triaged to the Treatment Area.
- Assure that patients are prioritized for transportation.
- Coordinate transportation of patients with Treatment Dispatch Manager.
- Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
- Ensure that appropriate patient information is recorded.
- Maintain Unit/Activity Log (ICS Form 214)

MEDICAL COMMUNICATIONS COORDINATOR

- Establish communications with the Control Facility.
- Determine and maintain current status of hospital/medical facility availability and capability.
- Receive basic patient information and condition from Treatment Dispatch Manager.
- Coordinate patient destination with the hospital alert system.
- Communicate patient transportation needs to Ambulance Coordinator based upon requests from Treatment Dispatch Manager.
- Communicate patient air ambulance transportation needs to the Air Operations Branch Director based on requests from the Treatment Area Manager(s) or Treatment Dispatch Manager.
- Maintain Patient Transport Worksheet.
- Maintain Unit/Activity Log (ICS Form 214)

AMBULANCE COORDINATOR

- Establish appropriate staging area for ambulances.
- Establish routes of travel for ambulances for incident operations.
- Establish and maintain communications with the Air Operations Branch Director regarding Air Ambulance Transportation assignments.
- Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager.
- Provide ambulances upon request from the Medical Communications Coordinator.
- Assure that necessary equipment is available in the ambulance for patient needs during transportation.
- Establish contact with ambulance providers at the scene.
- Request additional transportation resources as appropriate.
- Provide an inventory of medical supplies available at ambulance staging area for use at the scene.
- Maintain records as required and Unit/Activity Log (ICS Form 214)

MEDICAL SUPPLY COORDINATOR

- Acquire, distribute and maintain status inventory of medical equipment and supplies within the Medical Group*.
- Request additional medical supplies*
- Distribute medical supplies to Treatment and Triage Units.
- Maintain Unit/Activity Log (ICS Form 214).

*If the Logistics Section is established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader.

TREATMENT DISPATCH MANAGER

- Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
- Establish communications with the Patient Transportation Unit Leader.
- Verify that patients are prioritized for transportation.
- Advise Medical Communications Coordinator of patient readiness and priority for transport.
- Coordinate transportation of patients with Medical Communications Coordinator.
- Assure that appropriate patient tracking information is recorded.
- Coordinate ambulance loading with the Treatment Managers and ambulance personnel.
- Maintain Unit/Activity Log (ICS Form 214)

MORGUE MANAGER

- Assess resource/supply needs and order as needed.
- Coordinate all Morgue Area activities.
- Keep area off limits to all but authorized personnel.
- Coordinate with law enforcement and assist the Coroner or Medical Examiner representative.
- Keep identity of deceased persons confidential.
- Maintain appropriate records.

APPENDIX B: MEDICAL BRANCH MODULAR DEVELOPMENT

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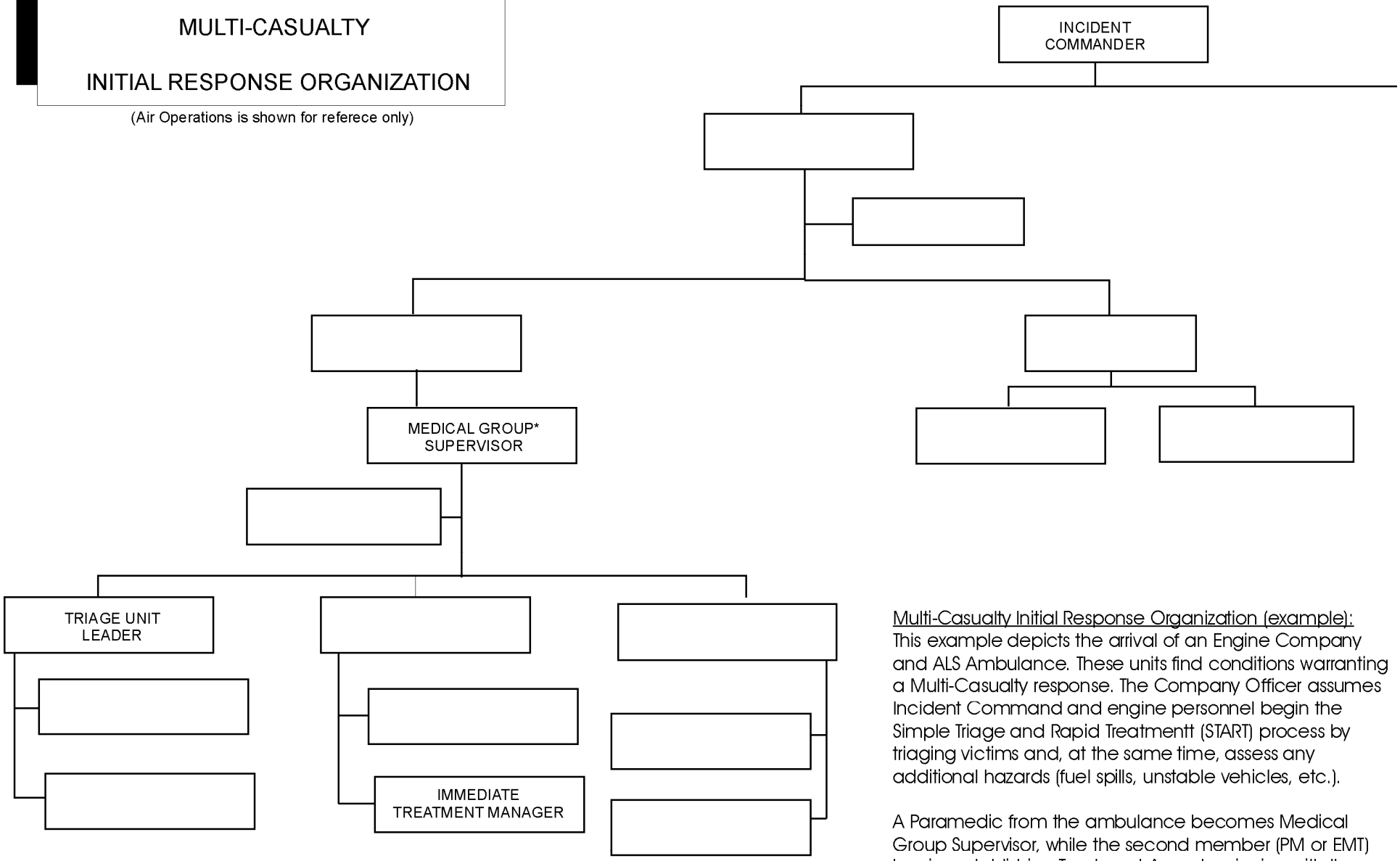
MULTI-CASUALTY

INITIAL RESPONSE ORGANIZATION

(Air Operations is shown for referece only)



*The June 2004 FIRESCOPE Field Operations Guide suggests filling the Medical Communications Coordinator (Med Comm) position during MCI Initial Response.

Multi-Casualty Initial Response Organization (example):
This example depicts the arrival of an Engine Company and ALS Ambulance. These units find conditions warranting a Multi-Casualty response. The Company Officer assumes Incident Command and engine personnel begin the Simple Triage and Rapid Treatmentt (START) process by triaging victims and, at the same time, assess any additional hazards (fuel spills, unstable vehicles, etc.).

A Paramedic from the ambulance becomes Medical Group Supervisor, while the second member (PM or EMT) begins establishing Treatment Areas beginning with the Immediate Treatment Area.

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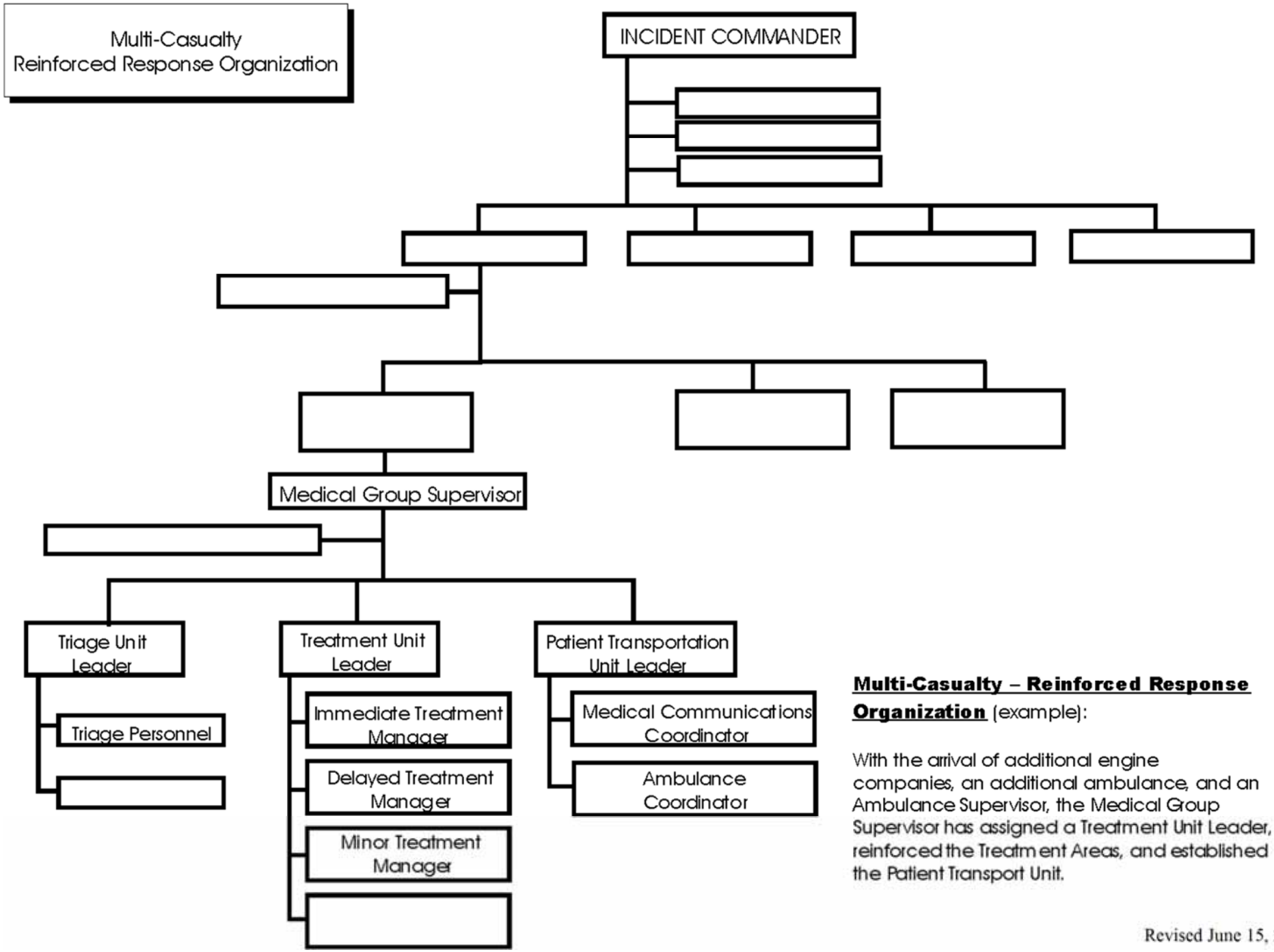


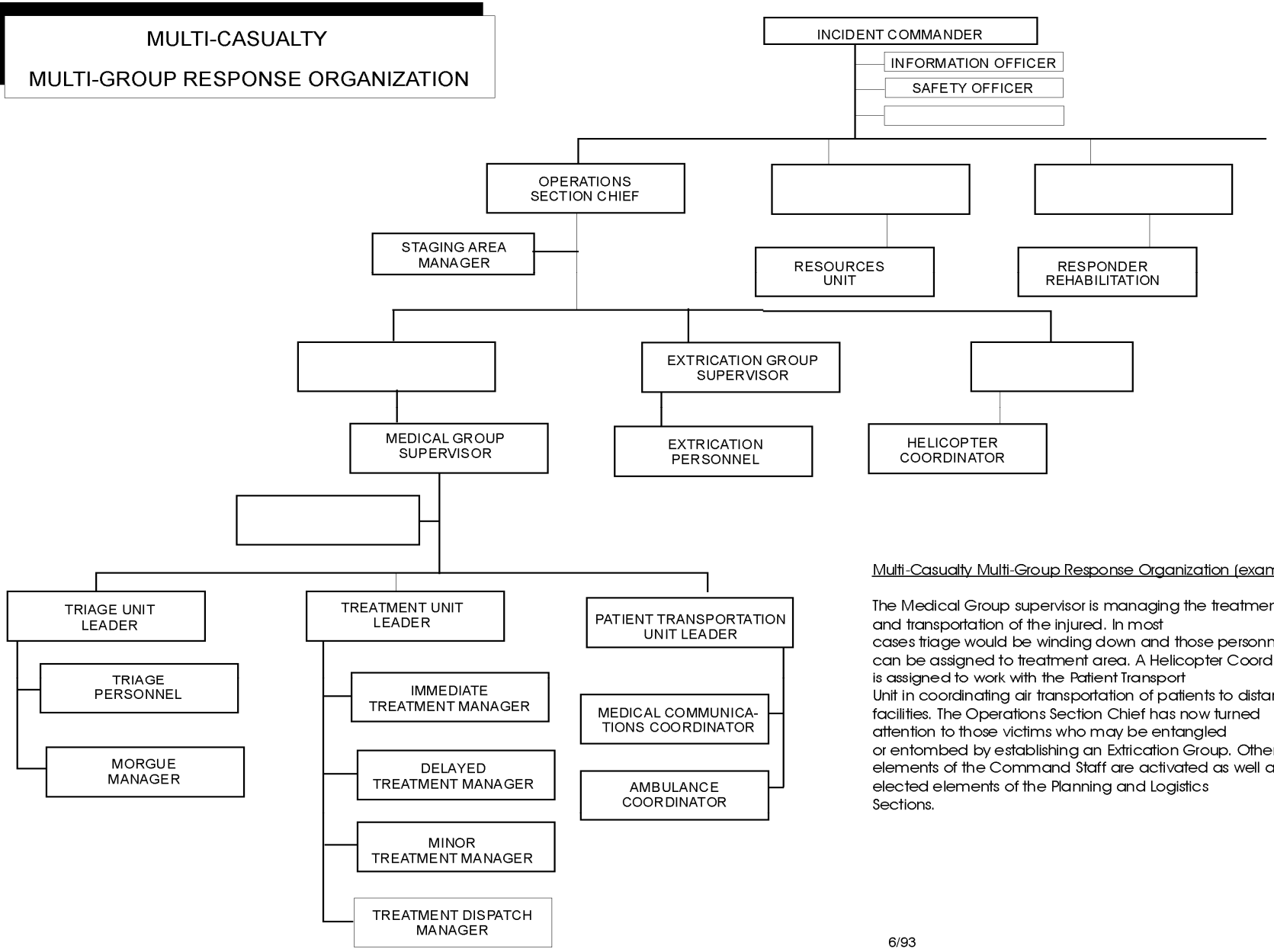
Multi-Casualty – Reinforced Response Organization (example):

With the arrival of additional engine companies, an additional ambulance, and an Ambulance Supervisor, the Medical Group Supervisor has assigned a Treatment Unit Leader, reinforced the Treatment Areas, and established the Patient Transport Unit.

Revised June 15, 2017

MULTI-CASUALTY

MULTI-GROUP RESPONSE ORGANIZATION



Multi-Casualty Multi-Group Response Organization (example):

The Medical Group supervisor is managing the treatment and transportation of the injured. In most cases triage would be winding down and those personnel can be assigned to treatment area. A Helicopter Coordinator is assigned to work with the Patient Transport Unit in coordinating air transportation of patients to distant facilities. The Operations Section Chief has now turned attention to those victims who may be entangled or entombed by establishing an Extrication Group. Other elements of the Command Staff are activated as well as elected elements of the Planning and Logistics Sections.

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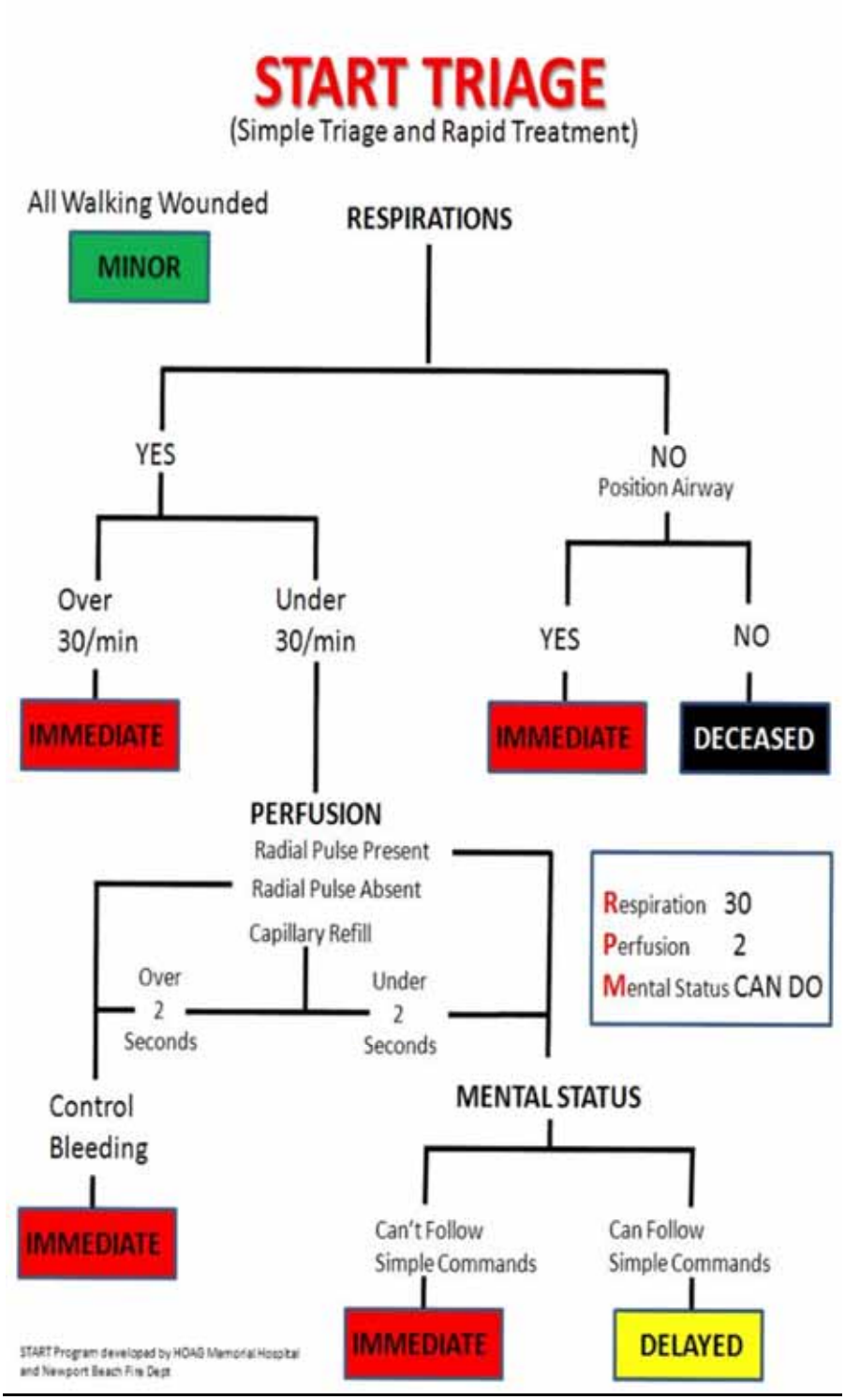
APPENDIX C: S.T.A.R.T



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APPENDIX D: SAMPLE TRIAGE KIT

The following list is a recommended inventory of MCI supplies to be carried on each first response vehicle, including fire fighting vehicles, ambulances and where appropriate, law enforcement vehicles. Equipment should be kept in a readily accessible location within the vehicle, preferably accessible from the cab.

2 ea MCI position vests for Triage and Medical Group Supervisor positions

1ea Position Checklist for the following positions

- Medical Group Supervisor
- Medical Communications Coordinator
- Triage Unit Leader
- Treatment Area Leader
- Patient Transportation Unit Leader
- Medical Supply Coordinator

30ea DMS All Risk START Triage Tags (must meet OA/LEMSA requirement for content and quantity)

2ea Grease pencils, ball point pins

1ea Trauma Shears

1ea Clipboard (consider small dry erase clipboard with markers)

1ea START Triage reference sheet

1roll Barrier Tape

2ea Glow Sticks

1ea Folio or gear bag for contents

1ea CF Communications Plan

2 ea Forms:

- Medical Branch Worksheet
- Patient Transportation Summary Worksheet
- Ambulance Staging Resources
- Medical Supply Receipt/Inventory

APPENDIX E: FORMS

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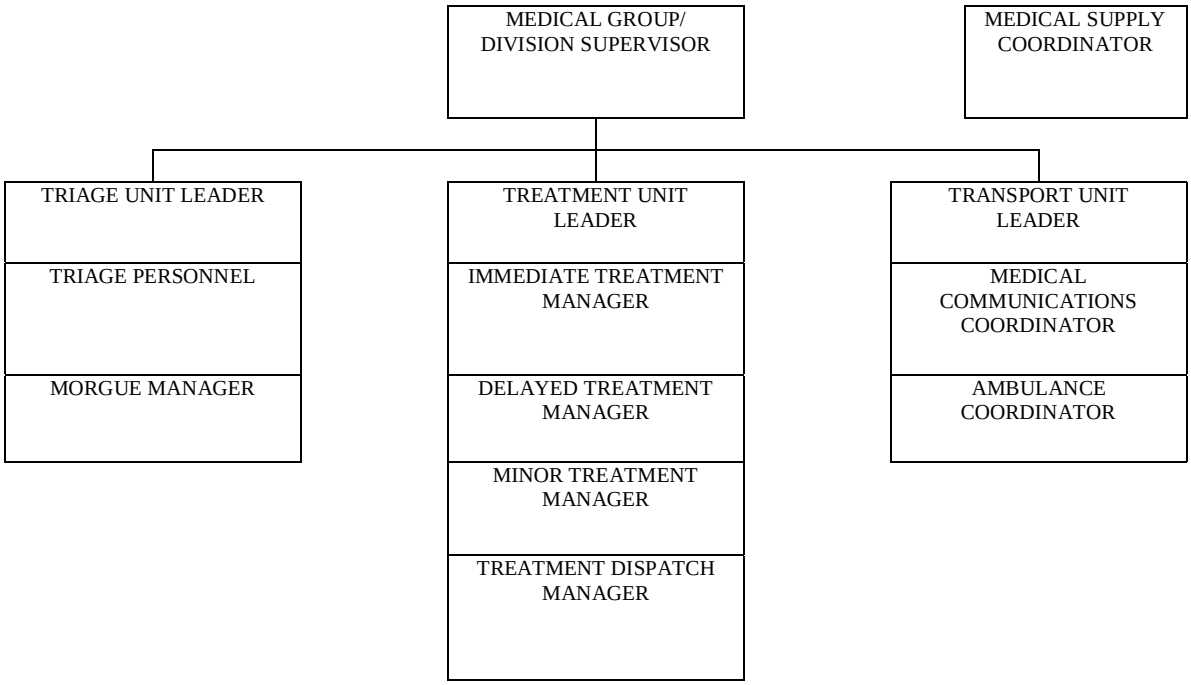
MEDICAL BRANCH WORKSHEET

INCIDENT NAME	DATE	TIME
INCIDENT COMMANDER	MEDICAL BRANCH DIRECTOR	



OTHER

MEDICAL CACHES
AIR AMBULANCES
LAW ENFORCEMENT
RADIO FREQUENCIES
CORONER
RED CROSS
CHAPLAIN
BUSES
MENTAL HEALTH

ICS-MC-305

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AMBULANCE STAGING RESOURCES STATUS	1. INCIDENT NAME			2. DATE PREPARED	3. TIME PREPARED
AGENCY	UNIT NUMBER			TIME IN STAGING AREA	TIME OUT STAGING AREA
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
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			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______
			ALS BLS	_______ : _______	_______ : _______

Revised June 15, 2017

MEDICAL SUPPLY
RECEIPT AND INVENTORY FORM

INCIDENT NAME	INCIDENT NUMBER
INCIDENT COMMANDER	MEDICAL BRANCH DIRECTOR

A. Supplies / Equipment received from: _____ DATE: / /

Agency: _____ Unit I.D. _____ Name: _____
(whenever possible, use masking tape and markers to identify all equipment)

B. Supplies / Equipment received by:

NAME: _____ INCIDENT POSITION: _____

No.	Item Description (PRINT all entries)	Unit*	Amount

*****Unit - list a measurable description of the item (gauge, gm, ml, bag, doz., etc.)

Form distribution: **Original** - Medical Supply Coordinator, **Copy** - Source of Supply

INCIDENT RE-IMBURSEMENT OF ANY SUPPLIES/EQUIPMENT WILL BE BASED ONLY UPON ORIGINAL FORM LISTINGS.

I-MC-312

Revised June 15, 2017

Multi-Casualty Incident Patient Tracking Worksheet

Incident Name/Location	Incident Date	Form Completed By	Contact Telephone #

Triage Status	Triage Tag # (Last 4) Patient Name (First & Last)	Age Gender	Primary Injury Type	Ready For Trans.	Hospital Destination	Trans. Unit ID	Trans. Time	ETA	CF Advised
I D M		M F							
I D M		M F							
I D M		M F							
I D M		M F							
I D M		M F							
I D M		M F							
I D M		M F							
I D M		M F							

Instructions: Completed worksheets shall be sent to the appropriate EMS Agency or RDMHS as soon as possible - 1) Take a picture of the completed worksheet with a smartphone and email the photograph to rdmhs.region3@ssvems.com

Revised June 15, 2017

APPENDIX F: GLOSSARY

MULTI-CASUALTY OPERATIONS GLOSSARY

ALS (Advanced Life Support) - Allowable procedures and techniques utilized by PARAMEDIC and Advanced EMT- personnel to stabilize critically sick and injured patient(s) which exceed Basic Life Support procedures.

BLS (Basic Life Support) - Basic non-invasive first-aid procedures and techniques utilized by PARAMEDIC, Advanced EMT, EMT, and EMR personnel to stabilize critically sick and injured patient(s).

Delayed Treatment - Second priority in patient treatment. These people require rapid aid, but injuries are less severe than immediate victims.

EMR- Emergency Medical Responder - An individual trained in Basic Life Support and who has a current and valid EMR certificate in the State of California.

EMT (Emergency Medical Technician) - An individual trained in Basic Life Support according to the standards prescribed by the Health and Safety Code and who has a current and valid EMT certificate in the State of California issued pursuant to the Health and Safety Code.

AEMT (Advanced Emergency Medical Technician) - An individual with additional training in limited Advanced Life Support according to the standards prescribed by the Health and Safety Code and who has a current and valid certificate issued pursuant to the Health and Safety Code.

Paramedic - An individual who has received additional training in Advanced Life Support according to the Health and Safety Code and who has a current and valid State Paramedic License issued pursuant to the Health and Safety Code.

Hospital Alert System - A communications system between medical facilities and on-incident medical personnel, which provides available hospital patient receiving capability and/or medical control.

Hospital Emergency Response Teams (HERT) - Prearranged hospital teams that respond to the incident upon request.

Immediate Treatment - A patient who requires rapid assessment and medical intervention for survival.

Qualified - A person meeting the certification and/or requirements established by the agency that has jurisdiction over the incident.

Team - Combinations of medical trained personnel who are responsible for on scene patient treatment.

Supply Cache - A cache consists of standardized medical supplies and equipment stored in a predetermined location for dispatch to incidents.

MICU - Mobile Intensive Care Unit refers to a paramedic equipped vehicle. It would include drugs, medications, cardiac monitors and telemetry, and other specialized emergency medical equipment.

Minor Treatment - These patients injuries require simple rudimentary first-aid, and are ambulatory.

Morgue (Temporary on Incident) - Area designated for temporary placement of the dead. The Morgue is the responsibility of the Coroner's Office when a Coroner's representative is on scene.

Multi-Casualty Incident - The combination of numbers of injured personnel and type of injuries going beyond capability of an entity's normal first response.

Patient Transportation Recorder - Supervised by the Patient Transportation Unit Leader/Group Supervisor. Responsible for recording pertinent information regarding off-incident transportation of patients.

START - S.T.A.R.T. - Acronym for Simple Triage And Rapid Treatment. This is the initial triage system that has been adopted for use by the California Fire Chiefs' Association.

Standing Orders - Policies and Procedures approved by the local EMS Agency for use by an EMT, Advanced EMT, or PARAMEDIC in situations where direct voice contact with a Base Hospital cannot be established or maintained.

Triage - The screening and classification of sick, wounded, or injured persons to determine priority needs in order to ensure the efficient use of medical manpower, equipment, and facilities.

Triage Personnel - Personnel responsible for performing triage on patients at the scene of an incident, and assigning them to an appropriate Treatment Area.

Triage Tag - A tag used by triage personnel to identify and document the patient's medical condition.