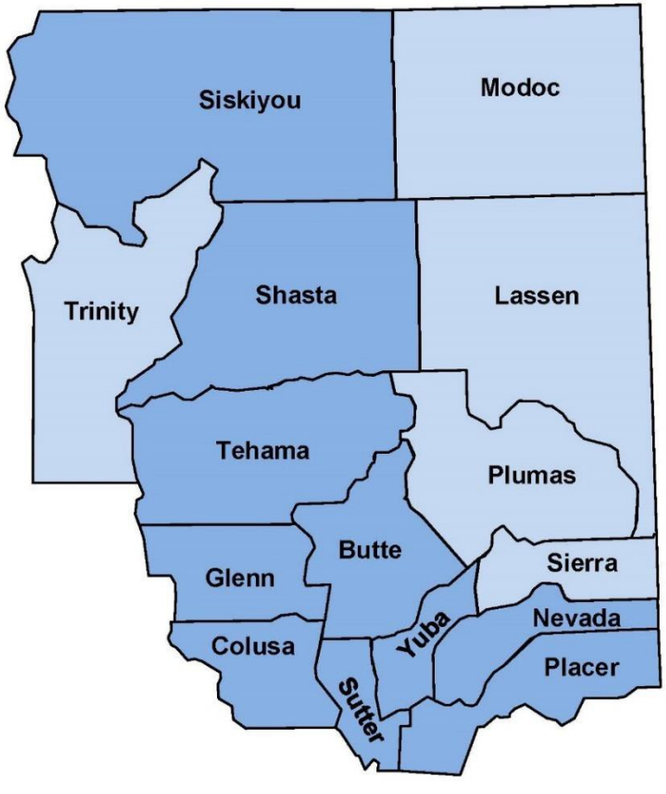
NOR-CAL EMS/S-SV EMS

Regional MCI Plan – Manual 1

Field Operations



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Learning Objectives

- Understand ICS
- Understand Communications in an MCI
- Know the equipment and supplies necessary in an MCI
- Understand Activation/Notification
- Understand Incident Operations
- Know the proper documentation
- Understand MCI Review, Training, and QI
- Know where to access relevant forms

SECTION 1: Introduction

Manual 1 MCI plan describes the field response, organization, personnel, equipment, resources, and procedures for MCIs within the Nor-Cal and S-SV LEMSA jurisdictional regions.

The State of California approved Incident Command System (ICS) is used to provide the basic organizational structure for the manual. The 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 routine day-to-day situations and is designed to be adjusted based on the size/scope of the incident and changing incident conditions. The manual contains standardized position titles, procedures, checklists, and forms in an effort to more efficiently and effectively utilize regional resources during an MCI.

The MCI manual 1 focuses on the field operations level, and positions within the Standardized Emergency Management System (SEMS). In addition, the manual complies with the National Incident Management System (NIMS).

SECTION 2: Incident Command

The ICS organization develops around five (5) major functions that are required on any incident, large or small. For some incidents, and in some instances, 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. There is complete unity of command as each position/person within the system has a designated supervisor, and direction/supervision follow established organizational lines at all times.

ICS Functions

Command

- Defines incident goals & operational period objectives
- Includes an Incident Commander, Safety Officer, Public Information Officer, Senior Liaison & Senior Advisors

Operations

- Establishes strategy & tactics to accomplish the goals/objectives set by Command
- Coordinates & executes strategy & tactics to achieve response objectives

Planning

- Coordinates support activities for incident planning
- Supports Command & Operations in processing incident information
- Coordinates information activities across the response system

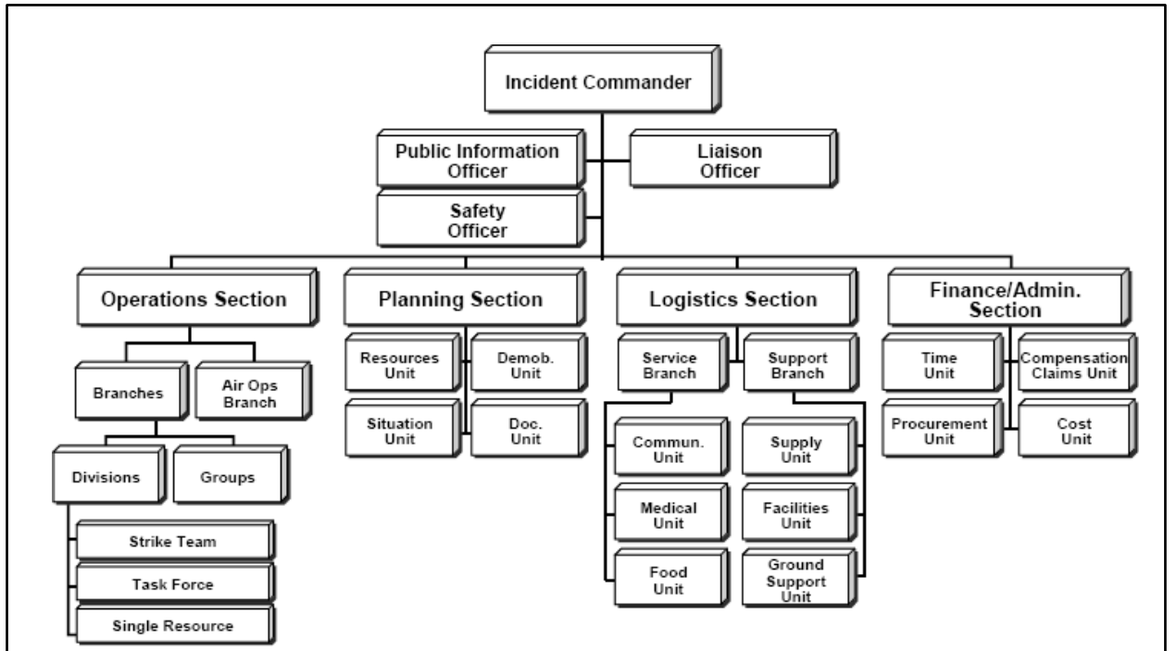
Logistics

- Supports Command & Operations in their use of personnel, supplies & equipment
- Performs technical activities required to maintain the function of operational facilities & processes

Finance/Admin

- Supports Command & Operations with admin issues as well as tracking & processing incident expenses
- Includes such issues as licensure requirements, regulatory compliance & financial accounting

Basic ICS Organizational Chart



Within the ICS, the Incident Commander (IC) is the individual who holds overall responsibility for incident response/management, and shall be the individual on scene representing the public service agency having primary investigatory authority. Some examples are as follows:

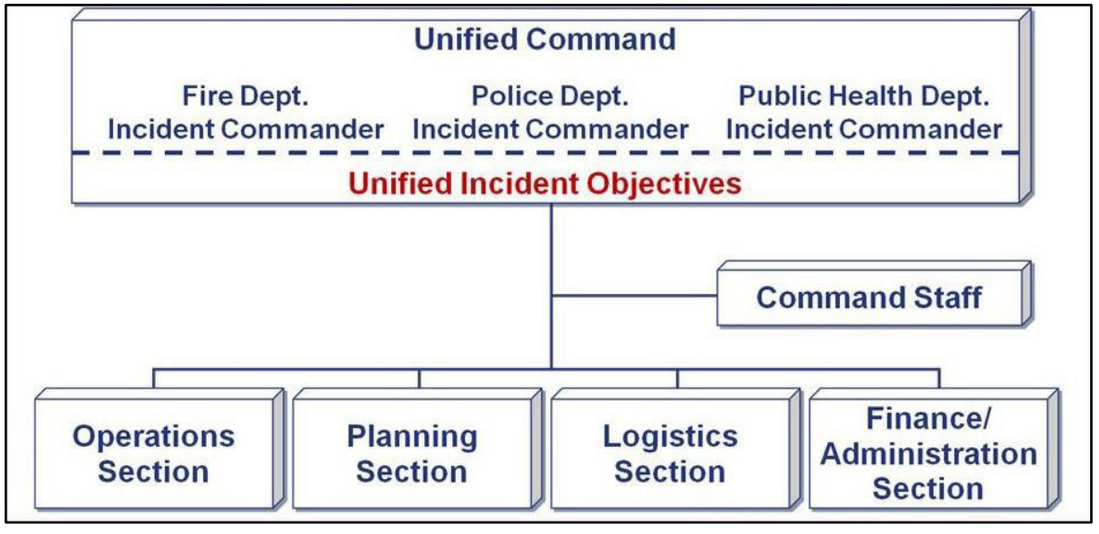
- **California Highway Patrol (CHP)**
  - All freeways; all roadways in unincorporated areas to include right-of-way.
- **Sheriff's Office**
  - Off-highway unincorporated areas (parks, private property, etc.).
- **Local Fire/Police**
  - Specific areas of authority within their jurisdiction except freeways.
- **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 IC has responsibility for coordination of all public and private agencies engaged at the incident site, and controls all responding agencies. The IC is responsible for establishing the Command Post (CP), notifying applicable dispatch centers, requesting resources, and providing the initial field assessment to enable appropriate decisions regarding the level of response necessary. In jurisdictions where an appropriate authority has assigned the function of IC to an entity other than law enforcement (i.e. fire service), that entity shall perform the incident command functions.

The choice of command type 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 single individual, determined by the impacted jurisdiction, is given the lead role as IC. This individual would initially be the most qualified official of the jurisdictional agency at the scene. As the incident progresses in size/ scope, the IC may be turned over to a higher ranking or more qualified individual.
  - Some incidents may require advisory (liaison) staff to assist the IC. This will generally be comprised of officials of the major agencies involved with the incident such as fire, law enforcement, EMS, public works, etc.
- **Unified Command**
  - This is a system where a group of officials from the major agencies involved with the incident share the lead incident command responsibilities. These officials may include fire, law enforcement, EMS, public works, etc.

Sample Unified Command Organizational Chart



The IC is responsible for the following general functions:

- **Command**
  - Overall management of the incident and setting of objectives.
- **Operations**
  - The direct control of tactical operations and the implementation of objectives.
- **Planning**
  - The development of a procedure to deal with operational problems.
- **Logistics**
  - The acquisition and distribution of resources.
- **Finance**

- Recording, for reimbursement purposes, who and what was involved in the incident.

Depending on the size and duration of the incident, the IC may directly supervise operations, or delegate this responsibility to an Operations Section Chief. EMS MCI field operations fall within the responsibility of the Operations Section. The IC will determine when EMS personnel are no longer required and may be released from the incident. The IC will also approve any information releases to the media. EMS personnel shall not release incident information to the media without approval.

SECTION 3: Communications

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

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 the IC, 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 tactical 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 (CF) 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 4: Equipment & Supplies

It is imperative that all equipment/supplies necessary for initial scene organization and patient triage are available to the first-in emergency response units. An MCI Kit (Appendix B), including a minimum of two position vests (Triage Unit Leader & Medical Group Supervisor), should be carried on all initial response units. Additional vests, position checklists, and the Medical Group implementation supplies should be carried in a Supervisor/Battalion Chief vehicle.

SECTION 5: Activation/Notification

Activation of the MCI system consists of the mobilization of resources, notification of the CF, and initiation of the ICS. Mobilization of resources and CF notification should be initiated as soon as possible. It is not necessary to wait until emergency personnel have arrived on scene. As soon as it is determined that a call may be an MCI, additional resources should be dispatched and CF notification should occur.

Resource Mobilization

Three main resource categories that should be considered are known by the acronym 'EMT':

- **E: Equipment & Supplies**
  - Medical Group implementation supplies.
  - Medical supply caches/disaster trailers/Disaster Medical Support Units (DMSUs).
  - Rescue/specialized equipment.
- **M: Manpower**
  - ALS personnel, BLS personnel, litter bearers, etc.
- **T: Transportation**
  - Single resource ground & air ambulances.
  - Buses/alternate transport vehicles – should be established prior to an incident, as part of an Operational Area (OA) plan.
  - Ambulance strike teams (ALS or BLS).

Control Facility (CF) Notification

- CF notification 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, and a description of the incident should be provided to the CF. The CF can be contacted by a dispatch center or prehospital responders.

- Immediately upon arrival (or upon confirmation by on-scene personnel):
  - Confirm or cancel the MCI alert with the CF.
  - Identify/update/confirm the MCI location (if necessary).

- Following scene size-up, update the CF of the following information:
  - MCI Type
    - **Trauma MCI**
      - Incidents involving traumatic injuries (motor vehicles accidents, explosions, active shooter/mass violence incidents, etc.).
      - Advise the CF as soon as possible of any active shooter/mass violence incidents to assist in establishing internal hospital security notifications. Avoid using terms such as active shooter/bombing/etc. over the radio. If possible, utilize a mobile/landline telephone to communicate the details of these types of incidents with the CF.
    - **HazMat MCI**
      - Incidents involving hazardous materials exposure requiring decontamination.
    - **Medical MCI**
      - Mass overdose or other incidents that do not involve traumatic injuries or hazardous materials exposures.
  - Approximate number of victims.
  - Name of incident.
  - Estimated time when triage will be completed.
- Following triage, update the CF of the following information:
  - Total number of patients by triage category & major injury (i.e., "A total of 10 patients: 2 IMMEDIATE Heads, 4 DELAYED, and 4 MINORs").
  - Number & description of available patient transport resources (i.e., "2 ALS ground ambulances, 1 BLS ground ambulance, and 1 ALS air ambulance are available for patient transportation").

SECTION 6: Incident Operations

Scene Initiation of ICS

Once on scene, EMS personnel shall check in with the IC and establish medical command (or temporarily assume IC and establish the ICS if necessary). The Medical Branch is initially responsible for 'R-A-C-I-N-G.':

- **R: Resources**
  - Ensure adequate resources have been ordered (**E**quipment, **M**anpower, **T**ransportation), and clarify with the IC the ordering process (i.e. can the Medical Group Supervisor order additional medical resources?). Update ambulance dispatch and the CF as soon as possible upon arrival.
- **A: Assignments**
  - Assign personnel, including a Triage Unit Leader to begin triage.
- **C: Communications**
  - Determine a medical tactical channel, command net, air ops (if any), etc. in coordination with the IC.
  - Ensure early notification of the Control Facility (CF).
- **I: Ingress/Egress**
  - Determine a staging location and best routes in and out of the incident in coordination with the IC, notify dispatch and responding units of this information.
- **N: Name**
  - Clarify incident name with the IC, notify dispatch and the CF of this information.
- **G: Geography**
  - Establish triage, treatment, transport areas.

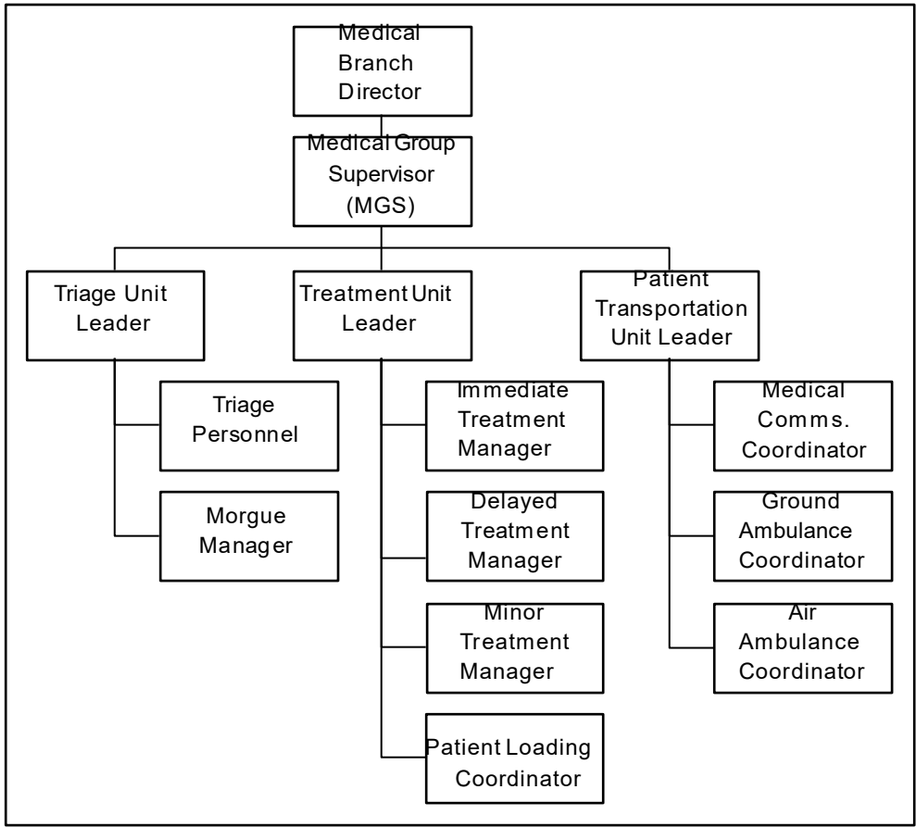
Note: The first in ambulance should generally be the last ambulance to leave the scene. Medical supplies from the first in ambulance should be used by the triage/treatment units.

MCI Medical Branch

When MCI Medical Branch positions are assigned, it is imperative that the individual being assigned has an adequate understanding of their responsibilities and be given the following:

- The applicable identification vest for the position.
- The applicable position responsibilities reference (Appendix C).
- The mode of communications to be utilized.

MCI Medical Branch Organizational Chart



MCI Medical Branch Supervisor/Leader Positions

- **Medical Group Supervisor (MGS)**
  - This position is in charge of EMS field operations. While formal identification is not necessary on routine calls, on MCIs an identification vest will be used.
  - The MGS will report to the IC (or designee). If an IC has not been established early in an MCI, the MGS will coordinate operations with fire and law enforcement until an IC is assigned.
  - Overall command of EMS field operations in a Full Branch Response (if necessary) would be delegated to the Medical Branch Director.

- **MGS Selection**:
  - The MGS shall be the first qualified person for the position on the scene and, in accordance with local policy, may be a law enforcement, fire department, or private EMS provider personnel.
  - The initial MGS may be relieved or assisted by personnel better qualified for the position as they arrive.

- **MGS Function**:
  - The MGS, or Medical Branch Director if assigned, will be responsible for MCI triage, treatment, and transportation, and should not be directly involved in patient care unless they are the only rescuer on scene for extended periods of time.
  - The EMS field organization builds from the top down, with responsibility placed initially with the MGS. The specific organizational structure established for any given incident will be based upon the management needs of the incident. If one person can simultaneously manage all major functional areas, no further organization is required. If one or more of the areas require independent management, additional personnel may be assigned responsibility for that area.
  - In a small MCI, or in the early stages of a large MCI, the MGS may also need to serve as the Triage, Treatment, and Transportation Unit Leader/Group Supervisor, and coordinate communications with the CF for patient dispersal.
  - The Medical Branch Position Responsibilities Reference (Appendix C) and Medical Branch Worksheet (Appendix D) should be used any time it is appropriate, including when more than two (2) Medical Branch components have been delegated to other personnel.

- **MGS Personnel Appointments**:
  - The MGS 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:
    - Triage Unit Leader.
    - Treatment Unit Leader.
    - Patient Transportation Unit Leader.
    - Medical Communications Coordinator.
    - Medical Supply Coordinator.

- **Triage Unit Leader**
  - The Triage Unit Leader will coordinate the triage of all patients. After all patients have been triaged and tagged, this individual will supervise the movement of patients to a treatment area. This person will remain at the triage area and will report to the MGS. The Triage Unit Leader may assign the following additional personnel as needed:
    - Triage Personnel.
    - Morgue Manager.

- **Treatment Unit Leader**
  - The Treatment Unit Leader is responsible for on scene medical care of victims in the treatment area. This person will be located at the treatment area and may assign the following additional personnel as needed:
    - Immediate, Delayed and Minor Treatment Managers.
    - Patient Loading Coordinator.
- **Patient Transportation Unit Leader**
  - This position may be filled concurrently by the MGS in the event there are not enough qualified personnel available at the scene. The Patient Transportation Unit Leader may assign the following additional personnel as needed:
    - Medical Communications Coordinator.
    - Ground and/or Air Ambulance Coordinator.

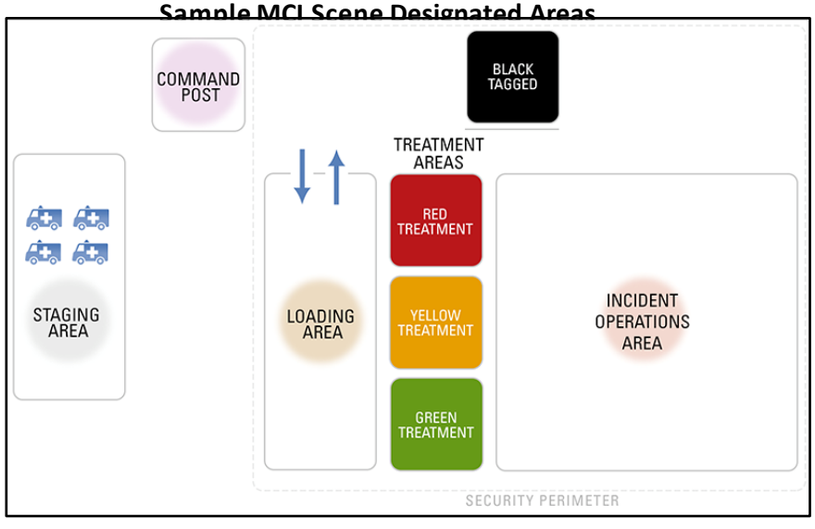
Designated Areas

Locations of designated areas, as detailed below, shall be approved by the IC (or designee). Once the location has been identified, the MGS (or designee) will oversee the organizing of specific areas within the agreed upon location.

- **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 patients side-by- side/end-to- end and grouped by triage priority.
  - In a small incident a single treatment area (if needed) is recommended for both IMMEDIATE and DELAYED patients. The MINOR patients should be grouped and treated away from areas of active operations. In 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.
  - IMMEDIATE patients must be transported as soon as possible. Movement of these patients to a treatment area may be inappropriate if it delays transport.

- **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 IC, 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 may include other non-medical assets. In this case, the Ground Ambulance Coordinator will handle EMS resources and report to the person in charge of staging for the incident. EMS staging may be incorporated in a joint staging area if one has been established by the Operations Section Chief.
- **Loading Area**
  - This area is for loading patients into transport vehicles. The loading area should be adjacent to the treatment area, and in line with the one-way traffic from the staging area.

- **Morgue Area**
  - Most MCIs may be considered crime scenes, and decedents should not be moved. A Morgue Area should be established only if it becomes necessary to move decedents from the impact site (i.e., to gain access to salvageable patients). This area should be located away from the treatment area, and is the responsibility of Law Enforcement/Coroner. 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.
- **Triage Area**
  - Victims should usually be triaged where they lie. If this is not feasible due to physical or hazardous constraints, victims may be moved to a safe area where triage functions will occur.

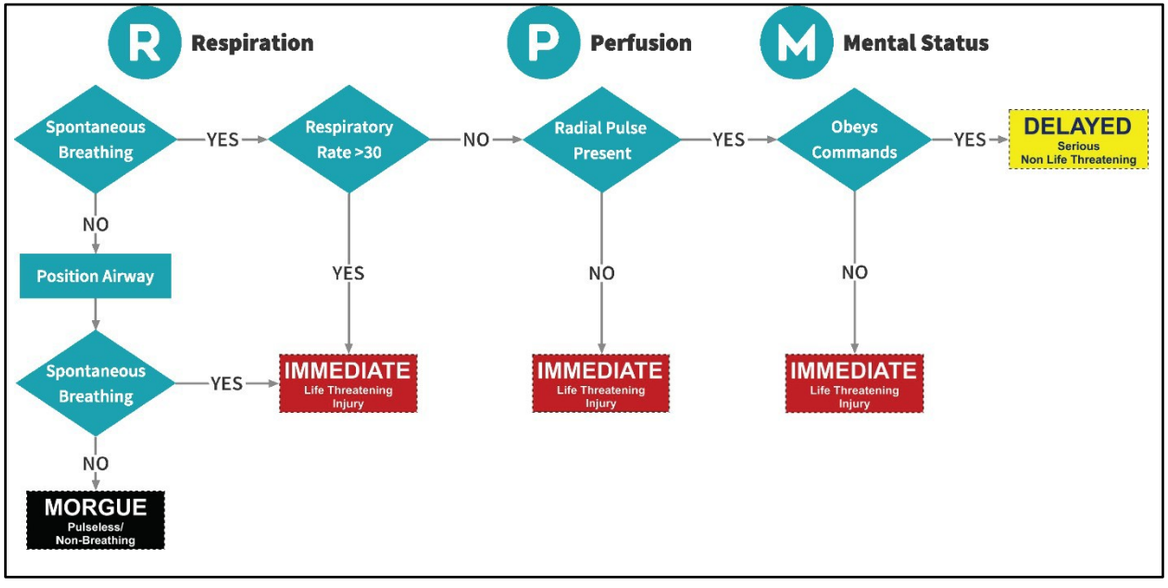


Triage

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. Triage will initially be conducted by first-in EMS personnel. The Triage Unit Leader will assign 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 BLS airway establishment and hemorrhage control (including the use of tourniquets and/or hemostatic dressings).
- CPR generally should not be initiated unless an adequate number of EMS personnel, equipment, transport units, and receiving facilities exist. The MGS or Triage Unit Leader is responsible for stopping CPR when it is not appropriate.
- Initial triage, utilizing the 'START' method and standardized DMS All Risk Triage Tags, should take 30 – 60 seconds per patient. Adjustments may be necessary during re- triage, and when triage is being completed by higher trained EMS personnel.

START 'RPM' Method for Triage of Non-Walking Wounded Patients



  - Direct in a loud voice for anyone who is injured and needs medical assistance to move to a designated area. These patients are initially triaged as MINOR (Walking Wounded). As soon as enough medical resources arrive, these patients will need to be re-assessed/re- triaged to evaluate for more serious conditions.
  - Triage of other patients should occur where they lie (only if the area is safe). If a hazard exists, patients should be moved to a safe 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 as this will likely cause confusion and additional patient movement.
- A colored ribbon system may be utilized for initial triage. The appropriate ribbon color must be clearly visible on the patient. It is recommended to use strips of ribbon that are approximately two (2) 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.
- Once all patients have been triaged, triage personnel will return unused triage tags to the MGS or Triage Unit Leader and may be reassigned to other positions as appropriate.

- **Triage Categories** (Note: These can be very dynamic. A patient's condition may rapidly worsen. START is designed to be a rapid, but not thorough evaluation technique):
  - **MORGUE**: Pulseless/Non-Breathing/Mortally Injured
    - These patients are deceased or not expected to survive.
    - These patients may receive expectant/palliative care as appropriate.
  - **IMMEDIATE**: Life Threatening Injury/Critical
    - These patients require immediate intervention and definitive medical care.
    - Any patient who has a tourniquet or hemostatic dressing applied to control hemorrhage shall be deemed an IMMEDIATE patient, regardless of the START RPM algorithm.
    - Target field to facility transport time: within thirty 30 minutes.
  - **DELAYED**: Serious, Non-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
    - 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.

Treatment

Once all patients have been triaged, 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 a 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). Ambulance providers will advise the Air/Ground Ambulance Coordinator as to availability/assignment of personnel. EMT, EMR and/or PSFA personnel 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 patients every 15 minutes (if possible) until transported or released at scene. If staffing allows, re-triage should be more precise than the initial START method.
- IMMEDIATE Patents:
  - Once in the treatment area, a set of vital signs should be taken/recorded on the triage tag and the patient should be prepared for transportation. On-scene treatment should not delay transporting IMMEDIATE patients. As with all critical patients, the emphasis is on ABCs and early transport.

- DELAYED Patents:
  - 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.
- MINOR Patients:
  - MINOR patients should be kept away from areas of active operations, including other treatment areas, morgue, and impact area (inner perimeter). These patients should receive an assessment, including initial vital signs, and have triage tags applied. BLS treatment should be performed as necessary.
- MORGUE Patients:
  - Decedents should be left in the position they are found (if possible). Do not separate decedents from their identification. If it is necessary to move decedents, a field morgue will be established away from the other areas and under the direction of Law Enforcement/Coroner. Movement of decedents shall be done only after consultation with Law Enforcement/Coroner (if possible).

EMS Resource Management

EMS resources shall be ordered through the IC (or designee), or Logistic Section if activated. In a small incident, the MGS and Patient Transportation Unit Leader may be allowed to directly order EMS resources, but this should not be assumed. A procedure for ordering resources should be arranged with the IC. In an incident with expanded ICS activation, resource ordering is the responsibility of Logistics.

EMS resources will be supervised by the MGS. Supervision of a medical staging area may be assigned by the IC to the Patient Transportation Unit Leader, who may in turn assign a Ground and/or Air Ambulance Coordinator.

- All EMS personnel, equipment, and supplies shall be directed to the staging area (if established).
- Resources will be assigned to specific tasks. They will be dispatched by the Patient Transportation Unit Leader or Ambulance Coordinator at the request of the MGS.
- 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 IC (or designee) if necessary to assist with traffic flow.
- If possible, keep a driver with each vehicle. If drivers are needed for triage or treatment, the keys should be left in the vehicle.
- Remove equipment not necessary for transport. Create a field inventory at the staging area which can be rapidly moved to treatment areas as needed (e.g., backboards, stretchers, splints, oxygen, IV supplies, etc.).

Patient Transportation/Dispersal

Once transporting vehicles are available, patients will be moved from the treatment area to the loading area. The Patient Transportation Unit Leader will request transport vehicles from the Ground and/or Air Ambulance Coordinator as patients are ready for transport.

- Vehicle loading should be maximized without jeopardizing patient care. Unless it is the only option, two (2) IMMEDIATE patients should not be transported in the same ambulance. Instead, an IMMEDIATE patient may be transported with a DELAYED or MINOR patient to better assure that prehospital personnel can adequately care for patients during transport.

- If necessary, patients may be transported by BLS ambulances and/or non-traditional transport resources (e.g. buses, vans) as determined appropriate by the Patient Transportation Unit Leader/Medical Communications Coordinator in consultation with the CF. EMS personnel should always accompany patients transported by non-traditional transport services.

- Once prepared for transportation, the Treatment Unit Leader should notify the Patient Transportation Unit Leader of the number of patients, their triage categories, and a one- word classification of their injuries, i.e., "1 IMMEDIATE head and 1 IMMEDIATE chest." After receiving direction from the CF, the Patient Transportation Unit Leader will advise the transporting units of the appropriate hospital destination.

- The Patient Transportation Unit Leader should assign either the Ground/Air Ambulance Coordinator or a recorder to log patient names, triage tag numbers, transporting unit numbers, triage category, destination, time of transport, and ETA on the Patient Tracking Worksheet (Appendix E).

Hospital Communications

During an MCI, it is imperative that EMS hospital communications are appropriate, effective and kept to a minimum in order to avoid negatively impacting patient transportation/dispersal activities.

- EMS patient destination traffic shall be routed through the CF, even for non-MCI patients, as non-MCI patients will potentially affect receiving facility capacities.
- Patient reports should not be given directly to the receiving facilities by individual transporting units, unless this can be accomplished using alternate communication systems that will not interfere with MCI operational communications.
- EMS personnel will function under standing orders when possible. If base hospital consultation is necessary, the following guidelines should be followed:
  - On-scene base hospital consultation should only be made following approval of the MGS or Patient Transportation Unit Leader.
  - During patient transport, base hospital consultation should only be made due to extenuating circumstances or if there is a clear radio frequency or other appropriate method of communication not being utilized for the incident.

Hazardous Materials Incidents

Prehospital personnel must remain alert to the potential for toxic and hazardous materials at the scene of all incidents. Familiarization with applicable State and local Hazardous Materials Medical Management documents/protocols 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 designated a Hot Zone. An additional Warm Zone must be established around the periphery. Only personnel who have been trained and equipped with the appropriate PPE 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 trained and equipped with the appropriate PPE. Patients are usually received from the Contamination Reduction Corridor.

- Accurate information on the identification and health effects of the substance and the appropriate prehospital evaluation and treatment 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.
  - o 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 CF 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.

Active Shooter/Mass Violence Incidents

LEMSA's should have a policy/protocol to guide EMS personnelin the response/management of mass violence incidents (active shooter, riots, attacks on large crowds with vehicles, improvised explosive devices, etc.). A successful response is predicated on a sound level of communication will all responders to these types of incidents. This communication should begin in meetings and trainings, prior to the actual occurrence of such incidents. At a minimum, meeting/training topics should include law enforcement, fire/rescue and EMS responsibilities/expectations.

Additional suggested training topics include:

- Rescue Task Force concepts.
- Tactical Casualty Care (hemorrhage control, casualty evacuation, etc.).
- Transition from Tactical Casualty Care to MCI management.

Each system must determine the best response for their area. Systems should also evaluate the need for additional PPE for their personnel, and training on any specialized PPE should be completed on a regular basis.

SECTION 7: Documentation

- Triage Tags
  - Triage personnel will initially identify/categorize patients utilizing the START method described in this document. Triage tags should be attached directly to all patients, avoiding injured areas, and be readily visible to other prehospital and hospital personnel. The Triage Unit Leader will report to the MGS (or designee) once all patients have been triaged, and await further assignment/instructions.
  - When victims arrive in the treatment area, treatment personnel will indicate the time of triage and chief complaint/major injuries. Treatment personnel should also document additional assessment/treatment information (vital signs, procedures/ medications and time administered). Non-medical personnel, if available, may be assigned to complete the patient identification section of the triage tag.

- Patients should be re-assessed/re-triaged as necessary, at least every 15 minutes (if possible) until transported or released at scene. If the patient's triage category changes or the tag is full of information, do not remove the initial applied triage tag. Attach a second triage tag indicating the current/correct triage category, mark through all patient tracking numbers on the second triage tag, and detach/discard all colored triage category tabs from the initial triage tag. The initial triage tag number shall continue to be utilized for patient tracking purposes until they are hospitalized or released at scene. Note on the second tag the time and reason it was attached.
- The triage tag number will be documented on the EMS patient care report (PCR) and hospital admitting record, so that patient information and medical records may be retrieved rapidly utilizing the triage tag number.

- EMS Patient Care Report (PCR)
  - PCRs shall be completed according to applicable LEMSA policies/procedures.
- Medical Branch Worksheet (Appendix D)
  - The Medical Branch Worksheet is used by the MGS as an organizational aid. This worksheet is an abbreviated flow chart that provides space for names of persons filling positions and other pertinent information. The MGS must use this form when more than two (2) Medical Branch components have been delegated to other personnel.
- Patient Tracking Worksheet (Appendix E)
  - This worksheet shall be utilized to track all patients during an MCI.
  - The Patient Transportation Unit Leader should assign either the Ground/Air Ambulance Coordinator or a recorder to log patient names, triage tag numbers, transporting unit numbers, triage category, destination, time of transport, and ETA.
  - Copies of completed patient tracking worksheets shall be submitted to the applicable LEMSA as soon as possible (either during or immediately following the conclusion of the event as appropriate).

- Ground Ambulance Resource Staging Log (Appendix F)
  - This log shall be utilized by the Ground Ambulance Coordinator to track ambulance availability and activities anytime an ambulance staging area is established.
- ICS 214 Activity Log (Appendix G)
  - This log is used to record details of notable activities at any ICS level, including single resources, equipment, Strike Teams, Task Forces, etc. These logs provide basic incident activity documentation, and a reference for any after action report. An ICS 214 can be initiated and maintained by personnel in various ICS positions as it is needed or appropriate. Personnel should document how relevant incident activities are occurring and progressing, or any notable events or communications.

SECTION 8: MCI Incident Review/Quality Improvement

EMS provider agencies should conduct a hotwash as soon as possible after the conclusion of the incident. An MCI Details/Feedback Form (Appendix H) shall be submitted to the applicable LEMSA within seven (7) working days by the following providers:

- Prehospital ground and air transport providers.
- Control Facility (CF) and receiving facilities.
- Prehospital non-transport/first responder providers

(recommended/optional). LEMSA staff will evaluate the incident details/documentation and determine if additional formal after-action review/follow-up is necessary.

SECTION 9: Training

All EMS personnel shall be minimally trained to the ICS 100 level, and are strongly encouraged to be trained to the ICS 200 level. All EMS provider agencies should conduct regular MCI training, to include:

- Scene size up and CF notification procedures.
- Triage Training. This training may include regularly scheduled "Triage Days" where providers utilize Triage Tags for regular patient contacts.
- Patient Tracking.
- MCI/disaster drills or planned events.

MCI References & Standardized Forms

The following can be found in Reg III Manual 1:

- **Appendix A:** Regional Control Facility Locations Map
- **Appendix B:** MCI Kit Recommended Inventory
- **Appendix C:** MCI Medical Branch Position Responsibilities
- **Appendix D:** Medical Branch Worksheet
- **Appendix E:** Patient Tracking Worksheet
- **Appendix F:** Ground Ambulance Resource Staging Log
- **Appendix G:** ICS 214 Activity Log
- **Appendix H:** MCI Details/Feedback Form

Thank You