Survival Factors Attachment 4- Thurston County

Multiple Casualty Incident Plan

DuPont, Washington

RRD18MR001

(70 pages)

Thurston County Multiple Casualty Incident Plan

Adopted October 5, 2017
Thurston County Medic One Operations Committee

Acknowledgements

Thurston County Multiple Casualty Incident Plan

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Thurston County Fire, EMS, and Law Enforcement agencies define a Multiple Casualty Incident (MCI) as any time the presence of multiple patients at an incident affects the treatment decisions of individual patients. Thurston County strives to always provide the best care possible to any patient. However, when there are more patients than the resources on scene can adequately take care of, the goal must be to provide the best treatment possible for as many patients as possible. This means that operations must be adjusted to maximize the efficient use of available resources.

The "Golden Hour" of emergency medicine is a well-accepted concept which states that victims of trauma need to have surgery within one hour of the insult or injury to maximize survivability. Therefore, rapid transport to definitive care centers is the best way to increase survivability in an MCI.

The plan seeks to reduce unnecessary actions, and streamline efforts to reduce the time it takes to remove all patients from the scene. This includes:

➢ Using the Sick/Not Sick triage patient care protocol standard which encompasses the SALT (referenced in the Thurston County Response to Large-Scale Violent Incidents, such as an active shooter response, Appendix I), START/RPM, triage system utilizing color coded surveyors tape;

➢ Having the first arriving company establish a transportation corridor to ensure a smooth flow of transportation resources;

➢ Establishing geographic divisions in larger incidents to speed triage and extraction;

➢ Scaling patient tracking and documentation with the size and complexity of an incident.

MCI's can be as small as a few patients or as large as hundreds. Flexibility is integrated into this plan to accommodate all sizes of incidents. Issues related to a fractured or geographically challenging incident are also addressed. The federal disaster levels were used to help determine MCI incident sizes and the appropriate protocols for each level.

This plan is designed to be shared and integrated with local, state, and federal governmental agencies to ensure coordination and cooperation. During an incident, interagency cooperation will be in accordance with the National Incident Management System (NIMS). This document has been written to be compliant with NIMS, as well as to follow the Incident Command System (ICS). It is understood that based on the size and complexity of any incident, ICS positions may or may not be filled. Throughout this document MCI positions will be named, however ICS designators will not be assigned.

With the emphasis on rapid transport and efficient use of resources, Thurston County Fire, EMS, and Law Enforcement agencies will be ready to handle a Multiple Casualty Incident.

II. PLANNING ASSUMPTIONS

The traditional definition of an MCI is: any incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at that incident. A more specific working definition is any time the presence of multiple patients at an incident affects the treatment of individual patients.

The priority of an MCI response is to streamline efforts to speed patient transition to definitive care centers.

This plan is scalable to all sizes and complexity levels of MCI responses. Any action that delays the treatment or transport of patients should be modified or eliminated as long as it does not increase the risk to responders.

A transportation corridor needs to be established and secured early in the incident to facilitate rapid patient transport.

Thurston County emergency responders will use the Sick/Not Sick model for MCI triage. "Sick" patients will be classified as red. "Not Sick" patients will be classified as yellow or green. Other triage types may be used if approved by the Thurston County Medical Program Director (MPD).

All triage systems produce similar results, resulting in red, yellow, green and black (deceased) patients. Therefore, when working with other agencies, it does not matter if different triage systems are used.

On scene treatment is dynamic, allowing alteration of treatment protocols to match available resources.

It is generally recognized that similar mechanisms of injury will have corresponding patterns of sick and not sick patients. This allows responders to quickly estimate the patient distribution based on total patient count. Using this assumption allows the first arriving officer to simply state the estimated total number of patients during the initial scene size up, rather than trying to determine the number of red, yellow, and green patients upon arrival. Assuming that 50% of the patients on scene will be red or yellow, this will give a quick guide to the number of resources that should be immediately requested and establish the scope of the incident.

Extrication priorities will be dynamic based on severity, access, and resources. It may be necessary or prudent to remove some yellow patients before red patients. Situations such as extended extrication times, yellow patients blocking the access of red patients, physical barriers, or a shortage of staffing may necessitate altering extrication priorities.

A choke point to the treatment area will be used to upgrade or down grade triaged patients coming in from the hot zone. Deceased patients will not be moved, unless it is necessary to extract a live patient.

The mental stress to these responders during an MCI can cause dramatic adverse effects. All agencies are encouraged to develop a program to help care for emotional and mental health of their staff including the use of defusing techniques and Critical Incident Stress Management.

Alternative Care Facility (ACF): Location, preexisting or created, that serves to expand the capacity of a hospital in order to accommodate or care for patients when an incident overwhelms local hospital capacity. In an MCI, patients will be triaged and transported to the hospital not the ACF for definitive care.

ALS/BLS Transport Staging: Designated parking area for patient transport vehicles. Operators and attendants will not leave their vehicles.

Apparatus Level I Staging: Staging at incident address, a block away or otherwise in the immediate area.

Apparatus Level II Staging: Staging away from incident, usually at a set location with other apparatus.

Ballistic Vest: Worn on the torso and is often called a bulletproof vest. This item of personal armor helps absorb the impact and reduce or stop penetration to the body from firearm-fired projectiles- and shrapnel from explosions. The vest would also carry triage tags, colored surveyors tape, scissors and other lifesaving equipment such as tourniquets while entering a "warm zone" during violent incidents such as an active shooter scenario.

Casualty Collection Point (CCP): An overall area found at the scene of an MCI where patients are gathered then moved to triage/treatment areas in preparation for transport.

Color Identifiers (Surveyors Tape/Triage Tags/Tarps): A color coded identification system used to designate medical priority of patients during a Multiple Casualty Incident.

> Red (immediate)

> Yellow (delayed)

> Green (minor)

> Black (deceased)

Decon: To decontaminate a person or persons in accordance with the Thurston County Hazardous Materials/Weapons of Mass Destruction Operating Guidelines. Joint Base Lewis McCord Fire and Emergency Services has a 300 person Decon Trailer. Regionally Decon resources are available on site at Capital Medical Center, Providence St. Peters and Centralia Hospitals.

Disaster Medical Control Center (DMCC): The DMCC (also known as Hospital Control) is the Hospital responsible for providing Transport with a coordinated distribution of patients to area hospitals based on patient needs and the hospitals capabilities. For the purpose of the plan, Providence St. Peter Hospital will be the primary DMCC for Thurston County with Good Samaritan Hospital as backup.

Extraction: The process of moving patients out of the hot zone to the treatment and transport areas.

Extrication: The process of removing a patient from an entrapment.

Field Treatment Site: Area designated or created by emergency officials for the congregation, triage, medical treatment, holding, and/or evacuation of casualties following a multiple casualty incident.

Field Triage: The process of rapidly categorizing a large number of patients according to their severity of injury in order to prioritize their extrication and/or extraction to the treatment area.

Various forms of triage used to determine the severity of a patients injuries and condition. Examples are:

> **Sick / Not Sick:** The Sick/Not Sick approach to triage utilizes the EMT's knowledge and experience to rapidly evaluate a patient's physiological status. The sick patient is categorized as Red. The not sick patient is considered Green if they are able to get up and walk on their own, and Yellow if they have injuries preventing moving themselves. It is understood that the Sick/Not Sick model encompasses the START/RPM, and other triage systems used to determine the patient's severity and transport priority.

> **START / RPM Triage:** An acronym for **S**imple **T**riage and **R**apid **T**reatment, and is defined as being a method that first responders evaluate a patient's status based on **R**espirations, **P**ulse , and **M**entation during a multiple casualty incident.

Green Patient Area: An area dedicated for congregation, treatment, and care of patients with minor injuries. Designated as a separate area from Treatment due to the large number of potential patients and the special considerations they may need such as shelter, food and restroom facilities. Depending on the type of incident they may also be considered witness/suspects and require police presence.

Green Patient Manager: A functional IMS position designed to manage the green patients at an MCI.

Medical Direction: Physician direction over pre-hospital activities. Also includes written policies, procedures, and protocols for pre-hospital emergency medical care and transportation.

Medical Program Director (MPD): This position is certified by and appointed by the Washington State Department of Health, and operates under the direction and protection of the state. In this role, the MPD is responsible for the education, certification, and quality assurance for the care provided by all emergency medical services in Thurston County. Thus, all emergency medical services personnel in Thurston County work under his/her state license.

Medical Group/Branch: Ensures that Triage, Extraction, Treatment, Transportation, Green Patient Area, Medical Staging, and Morgue Team functions are performed; establish positions as necessary.

Medical Staging: An area established to maintain medical supplies, personnel and equipment. The Medical staging Area will not be necessary at all incidents, when it is indicated, Medical will assign a Medical staging Manager.

Multiple Casualty Incident (MCI): An incident resulting from man-made or natural causes with associated illness or injury to a large number of people. The effect is that patient care cannot be provided immediately to all and resources must be managed.

MCI Response: Varied level of resources dispatched to an incident dependent upon the nature of the incident, the number of patients, and their severity of injury.

MCI Unit: A mobile unit, which contains large quantities of medical supplies that can be dispatched to a scene of an MCI.

Personal Protective Equipment (PPE): Refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment include physical, electrical, heat, chemicals, biohazards, and airborne particulate matter.

Recon: The act of gathering information to support the operation or function being performed.

Rescue Group/Branch: In larger or more complex incidents Rescue Branch will oversee Groups/Teams for the extraction and extrication of patients.

Special Operations Rescue Team (SORT): SORT is a Multi-Disciplinary Technical Rescue Team made up of Rescue Tech Level Career Firefighters from multiple fire agencies within Thurston Co., WA.

Staging: Location where incident personnel and equipment are assigned on an immediately available status.

Treatment Area: The designated area for the collection and treatment of patients.

➢ **Red:** an area where patients require immediate assistance

➢ **Yellow:** an area where patient injuries are serious (delayed) but not life-threatening

➢ **Green:** an area where patients with minor injuries are kept

Unique Identifier: Number preprinted on a band, tag (METTAG®) or bracelet to assist in tracking patient throughout the incident from initial entry to final disposition.

Zones (Hot, Warm, Cold, Exclusion): Operating zones that define areas of an incident and provide for a safe working area for responders. These Zones are also used in response to Thurston County Fire/EMS Response to Large – Scale Violent Incidents involving threats or acts of violence in cooperation and coordination with responding Law Enforcement Agencies as found in Appendix "I" Definitions.

The Hot Zone: will be considered a higher risk area, and should be restricted to personnel who have donned appropriate PPE, have the appropriate training, e.g. Haz-Mat, SORT teams and have an assigned task at their training level within this area.

The Warm Zone: is the transition area between the Hot and Cold Zones and will contain any decontamination procedures. This area should be restricted to personnel who have donned appropriate PPE, have the appropriate training, e.g. Haz-Mat, SORT teams and have an assigned task at their training level within this area.

The Cold Zone: will contain all Emergency services activities not involved in Hot or Warm Zones. This includes the Treatment area, Transportation Corridor, Command Post and Staging areas.

The Exclusion Zone: will be the outside limit of the Cold Zone. The public and media will be located outside the Exclusion Zone. Small incidents will allow scene tape to be used to physically designate the Exclusion Zone. Law Enforcement should be used in larger incidents to secure the Exclusion Zone.

A. Dispatch

TCOMM 911 (Thurston 911 Communications) is the answering point and dispatch center for all law enforcement, fire services, and Medic One in Thurston County. TCOMM dispatch center has put in place a matrix and/or a run card to activate an MCI and dispatch the proper resources to the scene of the incident. All requests for MCI upgrades and Mutual Aid are coordinated through dispatch. A dispatcher or the Incident Commander (IC) can call an MCI incident. If the dispatcher calls for one, they will notify the IC to let them know why. For both the dispatcher and the IC, the following are the guidelines for calling an MCI:

Patients	Fire Units	Medic Units	Aid Units	Transport	Command Officer
MCI – 1 (1st Alarm) 1-6 Pts.	3 Engines	2	3	All Private Ambulance Companies	1
MCI – 2 (2nd Alarm) 7-12 Pts.	6 Engines 1 MCI Trailer (TFD)	4 Out of County ALS Units	6	All Private Ambulance Companies	2
MCI – 3 (3rd Alarm) >12 Pts.	9 Engines 1 MCI Trailer (FD6)	6 Out of County ALS Units	All Available	All Private Ambulance Companies	3

B. Initial Report and Size Up

As with any fire or rescue response, the initial company is responsible to give an initial CAN (Conditions, Actions and Needs) report. These reports give dispatch and all incoming units a "picture" of what the initial company is seeing.

Upon arrival the initial company officer will broadcast the initial report over the radio, including the following in the report:

➢ Unit identifier

➢ The location, or corrected location

➢ Initial basic impression

As soon as possible, the officer will give a size-up report including:

➢ Briefly describe an impression of the scene, including known hazards

- Cause of the incident if known

- Estimate total number of patients

- Establish the Command Designator and Command Post Location

- Designate the Transportation Corridor (see Transportation Corridor)

- Initial actions and assignments

- Staging locations

- Additional resource requests

1. Progress Reports

Progress reports are required any time there is a change of the Incident Commander and every 10 minutes.

The progress reports should include the flowing:

- Current estimated total patient count

- Update transportation corridor location as needed

- Numbers of red, yellow, green, and black (deceased) patients when known

- Number of patients remaining to be extracted

- Number of patients transported

- Progress of hazard mitigation

- Additional resources needed

2. Tactical Benchmarks

- All patients extracted

- All red patients transported

- All patients transported/clear of incident

- Any tactical benchmarks appropriate for hazard mitigation

C. Initial Actions

The initial actions of the first arriving company officer are critical to ensuring a successful outcome. Depending on the size and complexity of the incident, the initial company may be able to fill many roles, or handle only a few assignments.

Critical Initial Company Actions:

➢ Initial and size-up reports

➢ Establish and secure the transportation corridor

➢ Give assignments to incoming units (to include staging)

Assignments to be handled by initial companies:

➢ Begin Recon and Triage, as soon as possible

➢ Perform a risk assessment and begin hazard mitigation for the purpose of reducing the immediate danger to patients, rescuers, or the public

➢ Designate a green patient area and have all green patients move to that location

➢ Begin extraction and treatment of patients as able

D. Recon

A rapid reconnaissance of the entire MCI site is essential to establish the scope and scale of the incident. Depending on the size and complexity of the incident, this may require a Recon Group consisting of multiple teams. The overriding factor should be speed as opposed to specificity to ensure that the information reaches the IC in a timely manner.

Recon should identify the following:

➢ Equipment needs

➢ Levels of PPE that will be required. (Note: Differing levels may be required in different areas.)

➢ Estimate the number and condition of patients involved so that the appropriate MCI response can be initiated through the IC

➢ Hazards

➢ Cause of the incident

➢ Any physical barriers preventing easy access between areas in the hazard zone. If so, identify areas for multiple treatment and transportation areas

Recon teams should consider using an elevated platform to help form an overall picture of the incident. This can include nearby buildings, aerial ladders, or geographical highpoints. Helicopters may also be considered for Recon. If MEDIVAC is being considered, Recon should evaluate any restrictions to landing zone locations. Additionally, consider the possibility of implementing temporary flight restrictions to news helicopters and other aircraft that may be operating over the emergency scene.

Recon reports directly to Operations (example below).

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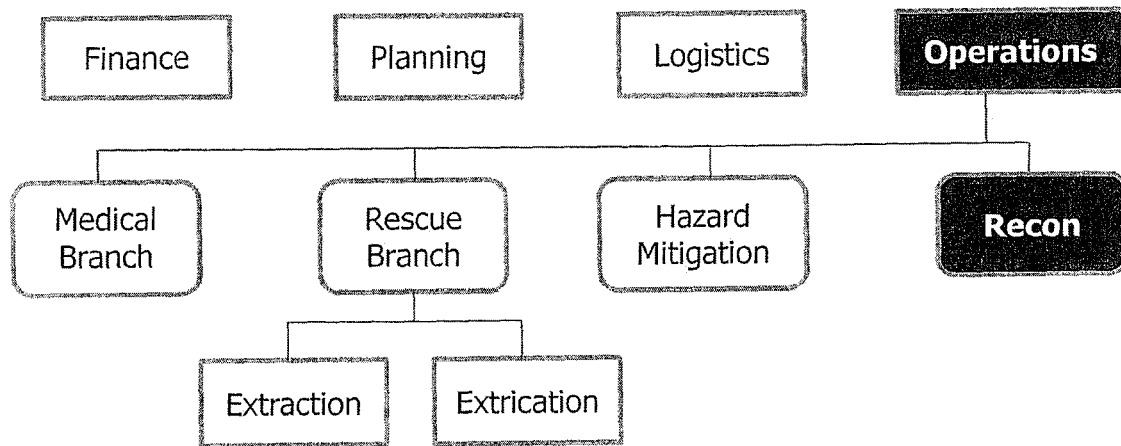
E. Scene Security

Scene security will be the responsibility of law enforcement, but Fire and EMS personnel must stay alert to potential security issues including but not limited to:

➢ Secondary Devices

➢ Crowd control

➢ Traffic control

The situation may cause the delay of certain operations while law enforcement clears the hazard area. Clear and consistent communication between Fire, EMS, and Law Enforcement is critical to maintain security.

1. Operational Zones

Initial companies need to clearly establish appropriate operational zones for the incident. The zones must be clearly communicated to all on-scene responders, including law enforcement. The operational zone locations should be broadcast over the main tactical channel to inform all incoming units even if coordination with law enforcement is handled face to face. Fire scene tape should be used to clearly mark the exclusion zone (outer perimeter) of an incident when possible. Larger sites may need to be secured by law enforcement.

The following list outlines the zones that should be established:

The Hot Zone: will be considered a higher risk area, and should be restricted to personnel who have donned appropriate PPE, have the appropriate training, e.g. Haz-Mat, SORT teams and have an assigned task at their training level within this area.

The Warm Zone: is the transition area between the Hot and Cold Zones and will contain any decontamination procedures.

The Cold Zone: will contain all emergency services activities not involved in Hot or Warm Zones. This includes the Treatment area, Transportation Corridor, Command Post and Staging areas. Other stakeholder entities such as Thurston County Public Health, emergency management will be allowed in this area depending on the incident and need.

The Exclusion Zone: will be the outside limit of the Cold Zone. The public and media will be located outside the Exclusion Zone. Small incidents will allow scene tape to be used to physically designate the Exclusion Zone. Law Enforcement should be used in larger incidents to secure the Exclusion Zone.

2. Crowd Control

Care must be given to crowd control, but total exclusion of bystanders and volunteers may not be possible or practical as victims of the incident may have been separated from friends, or family members, and will experience even greater anxiety when dealing with unknown.

If at all possible, reunification may help in this effort as needed or appropriate. If exclusion is impossible or impractical, attempts should be made to moderate the risk to both bystanders and rescue personnel with the help of law enforcement.

3. Volunteers

MCI incidents may draw civilian and professional volunteers with varying levels of skill and expertise. These volunteers can be helpful if utilized in a safe and organized way, but if they are ignored, they can hinder efforts and increase the risk to both themselves and personnel.

Volunteers may be assigned appropriate tasks according to their self-claimed knowledge, skills, and abilities as long as the risks associated with these tasks are minimized. It may be difficult or impossible to verify the claims of expertise by volunteers and care should be taken to place them in supervised roles. It is important to remove or replace volunteers as resources become available.

F. Staging

Three separate staging areas should be considered based on the size and complexity of the MCI. The first staging area should be for personnel or equipment immediately available for use.

There should be a separate Transportation Staging area that is established for apparatus that will be used to transport patients from the scene to a facility. The transportation Staging area may be managed by a private ambulance supervisor with capabilities of communicating to both Transport as well as the staged units. In the Transportation Staging area, personnel are not to leave their vehicles.

G. Transportation Corridor

The transportation corridor must be established early and clearly communicated by the first arriving company officer during the initial size-up. The exact street, entry point, exit point, and direction of flow must all be determined and communicated. Law enforcement will clear and protect the designated corridor; all other apparatus should keep this location clear. Large incidents may require law enforcement to extend the protected corridor all the way to the hospitals.

The first arriving company is responsible for defining and determining a transportation corridor. The corridor must be maintained until law enforcement takes over the security of the corridor. If the initial company cannot commit a member, they will assign that task to another unit from the initial response.

The member controlling the corridor should anticipate requirements for treatment and decontamination areas, and a patient loading area adjacent to the designated corridor.

All apparatus operators must keep the transportation corridor clear.

H. Treatment Area

The patient treatment area will be established in conjunction with the transportation corridor. It should be adjacent to the transportation corridor to facilitate Communication, tracking, and patient transfer. If the treatment area and transportation corridor are unable to be co-located, they should be located as close as possible with a clear path between the two and their locations broadcast over the primary tactical radio channel.

The treatment area will be the responsibility of TREATMENT, typically, a senior ALS member appointed by MEDICAL.

Extracted patients will be delivered directly to the treatment area through a choke point unless diverted to the transport corridor by Treatment.

Large incidents may necessitate large treatment areas with separate areas and staff for red and yellow patients. Multiple treatment areas with corresponding transportation corridors may be needed. TREATMENT needs to request enough staff to handle care for the expected number of patients that may be present.

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by TREATMENT in accordance with Thurston County EMS Standing Orders, Policies, Procedures, Guidelines and/or direction from DMCC / Hospital Control.

1. Field Treatment Site

When circumstances dictate that EMS resources must continue to treat patients, Medical should consider establishing a Field Treatment Site (FTS). An FTS may be as simple as extended use of the treatment areas created at the incident or as complex as translocating patients to an Alternate Care Facility that has been opened to EMS. In some cases local agencies and jurisdictions will predetermine where EMS might naturally establish an FTS. Ad-hoc FTSs may be established wherever the IC can rally enough resources to effectively care for patients.

EMS may need to establish an FTS for any of the flowing reasons:

➢ Transport resources are inadequate

➢ Transport cannot keep pace with Extraction

➢ Number of patients at the incident cannot be handled at hospitals

I. Triage

Triage will be dynamic, but will be a collective and ongoing effort to constantly evaluate patients at every step in the MCI process. The Sick/Not Sick triage standard will be used to evaluate patients.

It is understood that all patients should be triaged. However, depending on the variables of the scene, triage may be accomplished by: a Triage team, extraction teams, or after safely leaving the area.

Geographic triage allows a member to triage patients in their assigned area and prioritize those patients for extraction utilizing color coded surveyors tape.

J. Green Patient Area

The Triage Team(s) at an MCI will direct those that can walk to a designated area of refuge, or Green Patient Area. These patients will be initially classified as green patients. As soon as possible, a Green Patient Area Manager should be designated.

The Green Patient Area Manager is responsible for the following:

➢ Find or create a proper Green Patient Screening Area if one does not already exist and tag each of the Green Patients as green. Green patients will be included in the overall patient count

➢ Liaison with law enforcement

➢ Medically evaluate all patients, upgrading patients to red or yellow as needed, and moving those patients to the treatment area(s)

➢ Provide basic medical care

➢ Contain patients as needed (share responsibility with law enforcement)

➢ Consider comfort needs such as restroom facilities, water, blanket, etc.

➢ Provide information as it becomes available to the green patients

➢ Consider the need for emotional support including the chaplains, family members, or outside counseling support. Many of the green patients may have been separated from friends, or family members, and will experience even greater anxiety when dealing with unknown

➢ Documentation

➢ Patient Tracking

➢ Victim Assistance and Family Reunification

➢ Coordinate transportation of the green patients to the appropriate facility for treatment or family reunification (Emergency responder should accompany green patients during transport)

Law enforcement is critical in establishing and maintaining the green patient area. Law enforcement will likely want to interview and document green patients for investigation purposes. Security in the green patient area may be necessary.
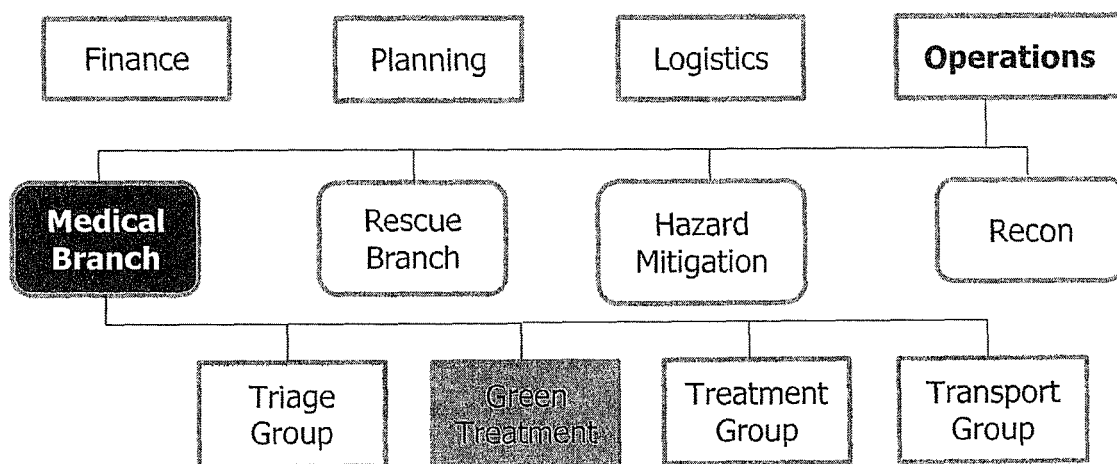
K. Communications

A single tactical radio channel may be adequate for a small MCI. Large or complex MCIs may quickly overwhelm a single radio channel, hampering critical communication. Therefore, maintain radio discipline as required. The Incident Commander should forecast incidents and with the assistance of the dispatch center, may designate multiple radio channels for the incident. Possible radio channel assignments are:

Operations channel to include:

➢ Operations

➢ Recon

➢ Rescue (May need a separate channel)

➢ Hazard mitigation groups

Medical channel to include:

➢ Medical

➢ Triage

➢ Treatment

➢ Transportation

Disaster Medical Control Center (Hospital Control) to include:

➢ Establishing communications from scene to DMCC/Hospital Control via cell phone

➢ Transportation

Radio communication may be further affected by many factors including:

➢ Areas of reduced radio signals

➢ Damage to radio/cell tower infrastructure

➢ System overload/outages

Note: All Thurston County Medic Units are equipped with the Washington State Hospital Emergency Medical Services Emergency Radio System (WHEERS) VHF radio. It is used in Region 3 of Washington State (Thurston, Kitsap, Mason, Pacific, Lewis, Good Samaritan in Pierce and Grays Harbor Counties) for inter-hospital communications during disasters. This form of communication should be considered if the aforementioned factors are present.

A. Rescue

Patient extraction from the hazard zone will be prioritized based on the patient's condition and difficulty of extraction. In larger incidents, Rescue will supervise Extraction as well as Extrication if needed.

Large or complex incidents may require the hazard zone to be divided into geographical divisions. Supervisors should be alert to recon their assigned area.

Geographical recon includes:

➢ Number of patients in their area

➢ How many of those patients are Red, Yellow, and Black (deceased)

➢ Extraction needs, including number of patients and complexity

➢ Hazards inside their area

1. Extraction

Extraction teams (litter carriers) will be composed of one or more pairs of personnel and will report to Medical or Rescue, depending on incident size, for the purpose of patient removal (harvesting) and delivery to the patient treatment area.
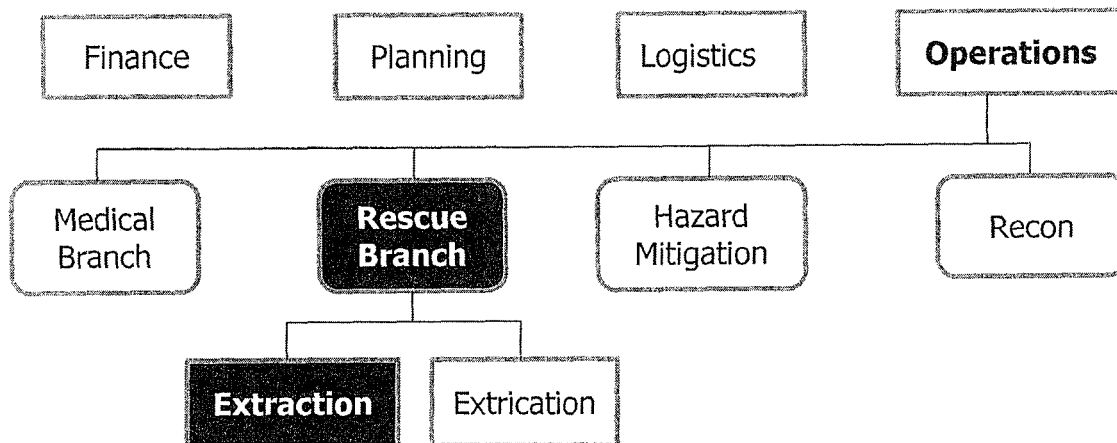
2. Extrication

Disentanglement and technical rescue may be handled by extrication teams under direction of Rescue. When trapped patients are located, the extrication teams will be sent to assist with the technical removal of those patients. Extrication teams must prioritize their operations to remove as many viable patients as possible in the shortest amount of time.

In smaller incidents it is appropriate for litter-bearers to be assigned to Medical versus their own group under Operations.

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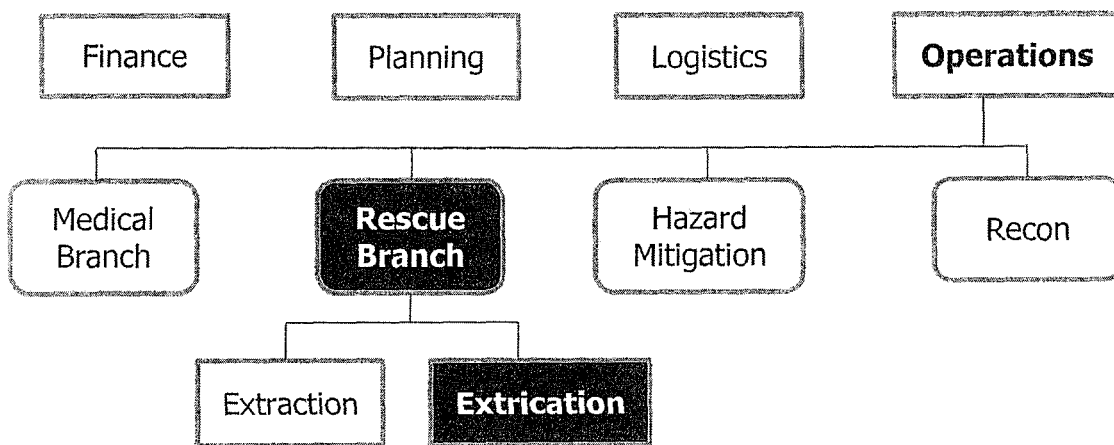
B. Decontamination

Any MCI, natural or intentional, may include the release of hazardous materials (haz-mat). Rescuers will need to evaluate the potential need for a haz-mat response and decontamination procedures. If a haz-mat release is known or suspected, a haz-mat response should be requested if not already dispatched. Primary tasks of the initial companies include: wear the appropriate level of PPE, consider a larger evacuation zone, and start emergency decontamination procedures.

Treatment and/or transport of any patient cannot occur until the patient has gone through emergency decontamination.

It may be difficult to determine in the field if a patient is completely decontaminated, therefore patient contact should be limited to essential procedures in the field and during transport.

Tyvek suits should be used for patients after gross decon when their clothing has been discarded.

Decontamination procedures will occur in the warm zone.

If decontamination procedures are required, the IC must ensure that a large enough footprint has been established for both gross and technical decon.

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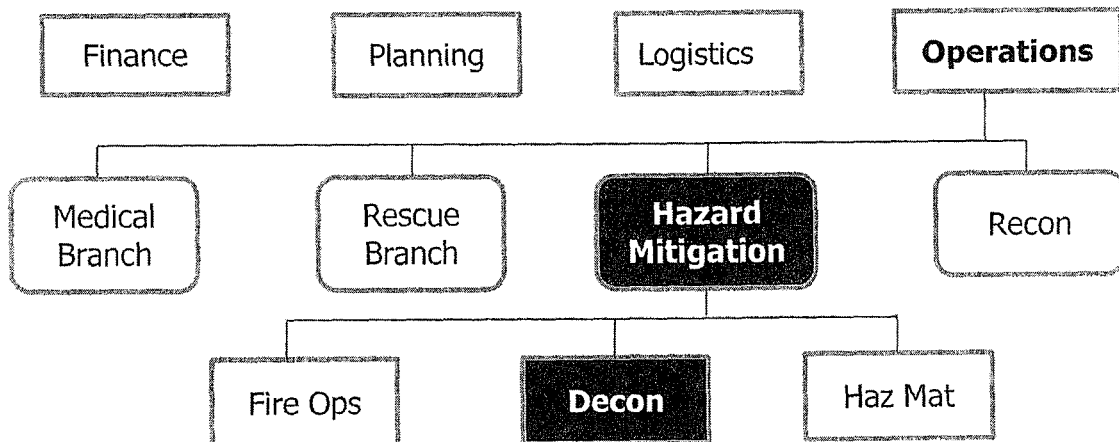
C. Patient Sheltering

Every attempt should be made to provide shelter for the patients in the patient treatment and green patient areas. The shelter should provide protection from the hazards, weather, media, and the public.

Shelters of opportunity, or existing buildings, should be considered first. Priority will be given to structures with bathroom facilities, running water, and buildings with access that can be easily controlled. If no existing buildings are easily accessible or adjacent to the transportation corridor, then temporary shelters may be used.

Possible temporary shelters include:

➢ Tents from Decon Units

➢ Public / School transportation

➢ MCI Bus (if available)

When choosing a shelter, the possibility for an expanding incident needs to be considered, ensuring patients are not placed into an existing or future hazard zone.

D. Field Treatment

In general, personnel will treat "Red" patients first, "Yellow" patients only as time allows, and "Black" (deceased) patients only after assuring that all patients from the red and yellow categories are stabilized. Note: Deceased patients will not be moved, unless it is necessary to extract a live patient. Depending on acuity and number of patients, it may be necessary to transport ALS patients in BLS units without the oversight of ALS personnel.

Providence St. Peter Hospital shall serve as the primary DMCC (Hospital Control). Good Samaritan Hospital shall serve as back up DMCC. Once contact has been made with Hospital Control the connection shall not be disconnected.

If neither primary nor back up DMCC is able to coordinate patient destination, Harborview Medical Center shall serve as the third option. Transport shall notify the receiving hospital of patient numbers and triage status prior to patient transport if possible. Individual transporting units will not routinely communicate to hospitals unless directed to do so.

E. Patient Count and Tracking

Patient count and tracking are important aspects of an MCI, especially when the incident is large and complex. Every effort will be made to count and track every patient that is cared for at an incident. The level of tracking may have to be scaled to an individual incident. Factors such as environment, severity of injuries, hazards, and number of patients will dictate the level of tracking. At no time will these activities be priorities above patient care and transport.

Patient count and tracking will be the responsibility of Transportation in coordination with Treatment. An attempt will be made to attach a unique identifier to each individual patient. Transportation will attempt to keep track of the number of red, yellow, and green patients as they are transported.

Any first responder may be assigned to Transportation as an aide to assist in patient count and tracking.

F. Documentation

1. Medical Incident Report Forms (MIRFS)/Electronic Patient Care Reporting (ePCR)

Patient documentation is important; however documentation should never delay patient care or transport. Individual MIRFs/ePCRs should be attempted at every incident, however, as an incident grows in size and complexity MIRFs/ePCRs may not be reasonable to complete. Incidents may have segments when MIRFs/ePCRs may be completed and other segments that circumstances prevent usage of MIRFs/ePcRs. At a minimum, a photograph of all command and control boards, MCI position sheets (Reference Guides, Job Aides) shall be taken and filed with the incident report or official record. Consider taking a picture of the patient with their tag by their face.

2. Unique number with transporting agency

When a patient is received by a transporting unit, personnel will document the unique identifier that is attached to the patient onto their agency's MIRF/ePCR. If a unique identifier has not been assigned to the patient, then the transporting unit's personnel will do so. Every effort will be made to give a copy of the unique identifier to Transport.

G. Transportation

TRANSPORTATION will assign patients to transporting units as those resources arrive. Constant communication between TRANSPORTATION and TREATMENT is important to ensure that patients are ready to be transported.

Larger incidents may require non-traditional assets. If non-traditional assets without emergency signal devices are used, consideration should be given to using law enforcement escorts to aid during travel. Containing bio-hazardous material in non-traditional assets may be difficult, but tarps, plastic, or other resources should be used to limit the spread of this material.

If a Green patient is not transported e.g. the patient has been reunified with friends or family, their name should be documented on the Transport Unit Patient Log.

A. Medical

One of the first arriving ALS members should assume the role of Medical. The role of Medical, while initially filled by one of the first arriving ALS members, should be assumed by a senior ALS member, likely a Medical Services Officer (MSO), when possible. Intimate knowledge of the plan is necessary for MEDICAL.

MEDICAL is responsible for the following tasks:

➢ Transportation

➢ Treatment

➢ Triage

➢ Consider activation of the DMCC (Hospital Control)

➢ Green Patient management

MEDICAL may handle most or all of the responsibilities in smaller incidents. Larger or complex incidents will require Medical to be proactive in forecasting the incident and begin assigning roles as soon as possible. The use of Aides or Assistants will be needed particularly in complex incidents. Circumstances may dictate a large number of ALS and BLS personnel where:

➢ ALS personnel need to be prioritized to treatment due to a high patient count;

➢ Patient removal from the hazard zone will require a large amount of BLS personnel and/or complex coordination.
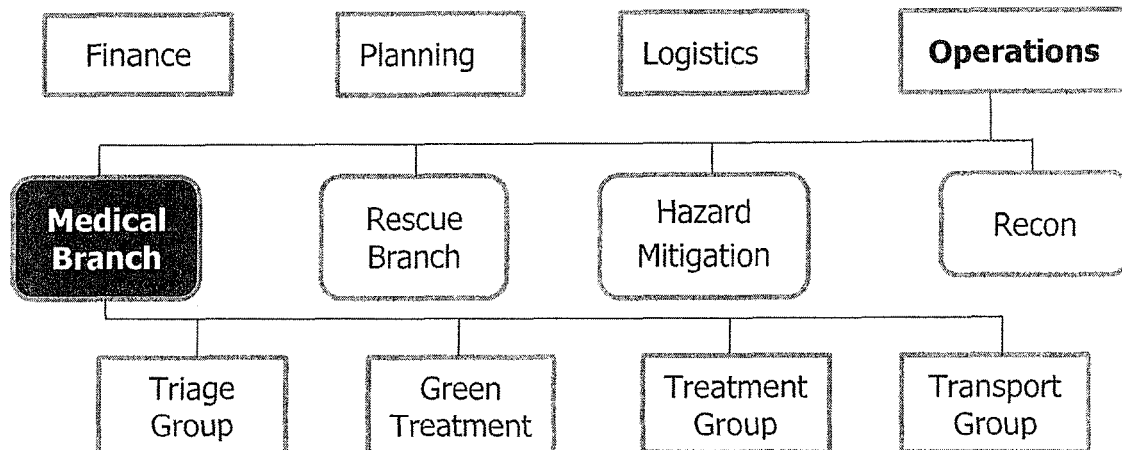
1. Treatment

Medical may designate an ALS member to be TREATMENT. (Note: Smaller incidents may allow Medical to retain this role). Treatment is responsible for the following:

➤ Receiving patients from Extraction

➤ Supervising treatment of patients

➤ Managing Treatment Personnel

➤ Coordinating with Transportation

➤ Prioritizing patients for transport

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by the Treatment Team Leader.

TREATMENT, with input from TRANSPORTATION, may elect to have patients delivered directly to the transportation corridor for transport.

TREATMENT should request adequate personnel and resources to care for the expected number of patients.

The use of Aides or Assistants will be needed particularly in complex incidents.
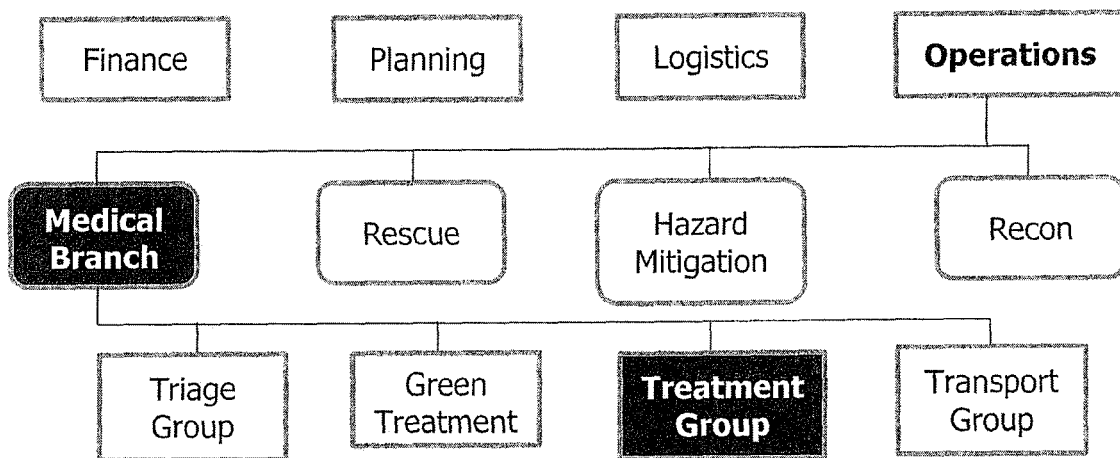
2. Transportation

TRANSPORTATION should be designated early by MEDICAL. Smaller incidents may allow MEDICAL to retain this role. TRANSPORTATION should be a senior ALS member capable of performing a wide range of duties including:

➢ Communication with DMCC (Hospital Control)

➢ Keeping a total patient count of all transported patients (may be delegated to one or more Aides)

➢ Coordination with Treatment

➢ Coordination with law enforcement to clear the transportation corridor

➢ Liaison with transportation resources

➢ Maintain adequate transportation resources

➢ Initiate tracking if unique identifier not already assigned

Incidents that require multiple transportation corridors must have multiple personnel assigned to Transport. They may act independently of each other. Transportation may contact the DMCC (Hospital Control) independently for patient destinations and be responsible for patient count and tracking.

The use of a Transportation Group Aide will be needed particularly in complex incidents.
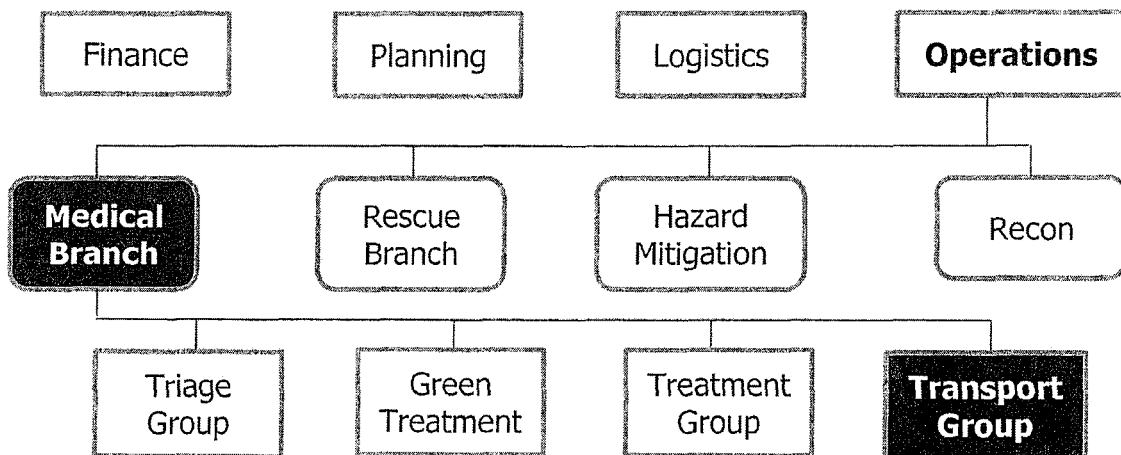
B. Rescue

Rescue should be considered when:

➢ ALS staffing needs to be prioritized to patient treatment and transport

➢ Any part of patient removal from the hazard zone will require a large amount of BLS resources

Rescue may be in charge of triage and extraction of all patients from the hot zone into the patient treatment areas.

Technical Rescue Teams will report to Rescue to serve as technical advisors, and participate in extrication as needed.
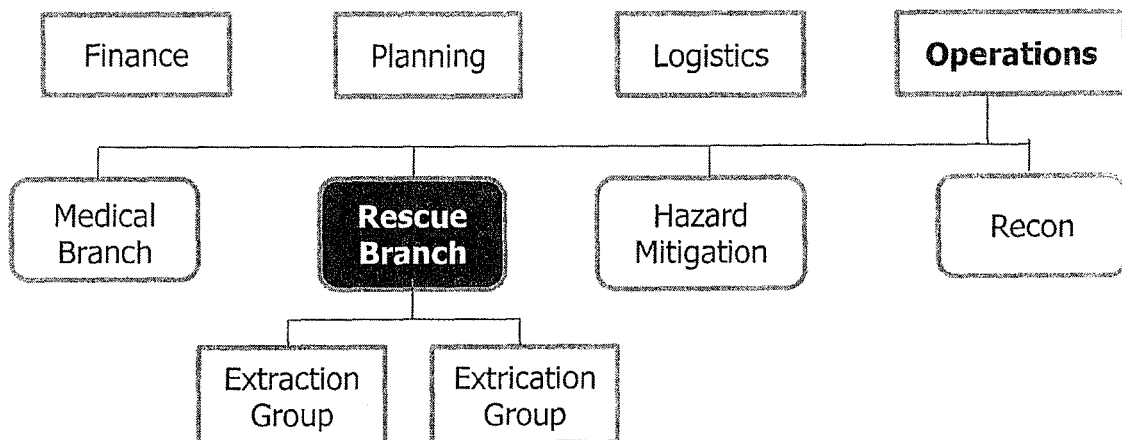
Appendix A: MCI RUN CARDS

Thurston County Run Cards for MCI

Patients	Fire Units	Medic Units	Aid Units	Transport	Command Officer
MCI – 1 (1st Alarm) 1-6 Pts.	3 Engines	2	3	All Private Ambulance Companies	1
MCI – 2 (2nd Alarm) 7-12 Pts.	6 Engines 1 MCI Trailer (TFD)	4 Out of County ALS Units	6	All Private Ambulance Companies	2
MCI – 3 (3rd Alarm) >12 Pts.	9 Engines 1 MCI Trailer (FD6)	6 Out of County ALS Units	All Available	All Private Ambulance Companies	3

Note: Consider the following if MCI is larger than MCI – 3. The request for the resources below would be attained through TCOMM.

> Out of County Structural Task Forces

> Out of County Engine Strike Teams

> Out of County EMS Task Forces

> Out of County ALS Strike Teams

> SORT Team

> Haz-Mat Team & Decon for up to 300 (JBLM F&ES)

> Mass Casualty Unit (JBLM)

Appendix B: MCI Notifications

- ➤ Medic Units (TCOMM)

- ➤ Disaster Medical Control Center (Hospital Control) Providence St. Peter Hospital. Good Samaritan is the backup (From the Scene)

- ➤ Private Ambulance & BLS Transport Providers (TCOMM)

- ➤ PIO (Host Agency / Delegated)

- ➤ All MSO's (TCOMM)

- ➤ Chief Officer Notification (TCOMM)

- ➤ Predetermined Out of Area ALS Strike Team, EMS Task Force, Engine Strike Team, Structural Task Force (TCOMM)

- ➤ Intercity Transport and School District Buses (TCOMM)

- ➤ MCI Units, Trailers etc. (TCOMM)

- ➤ SORT (TCOMM)

- ➤ Haz-Mat (TCOMM)

- ➤ Thurston County Coroner's Office (TCOMM)

- ➤ Thurston County Emergency Management (TCOMM)

- ➤ Thurston County Public Health (TCOMM)

MEDICAL BRANCH – Quick Start Card
Take 1 minute to read this card, it may save hours in the long run
Responsibilities
1. Oversee the Medical aspect of an MCI
2. Assign – Triage, Treatment, Transportation Groups
3. Declare an MCI to Disaster Medical Control Center
4. Maintain Safety, Staffing & Equipment of the Medical Area
5. Request additional resources through Incident Command
6. Ensure smooth and efficient Flow of patients through Triage, Treatment & Transport areas

Instructions
1. Medical Branch Reports to Command
2. Don Medical Branch Vest and Radio
3. Request separate Radio Frequency for Medical Branch Early if Scene Size indicates
4. Obtain Thurston County MCI Reference Guide from MCI Kit
5. Contact Hospital Control to Declare MCI
6. Maintain Passport Accountability for all crews assigned to "Medical"
7. Assign Triage Group Supervisor (Usually First EMT On Scene)
8. Assign Treatment Group Supervisor (Usually 2nd Medic on Scene)
9. Assign Transport Group Supervisor (Usually 3rd Medic On Scene)
10. Keep Track of patient count and triage color
11. Obtain all Staffing and Equipment Needs requested by Triage and Treatment
12. Ensure Transport Group Supervisor defined BLS/Transport staging area and proper number of Transport Units

Triage
Patient Flow (Movement to Choke Point)
Treatment
Transport
BLS Staging
Medical
Incident Flow Diagram

MEDICAL BRANCH – Important Reminders

1. (Recommended) – Draw Diagram of MCI Scene on Medical Group board to assist incoming crews with seeing the Triage, Treatment, Transport Flow
2. Ensure supervisors have proper Vests
3. Create the shortest yet safest distance between Triage, Treatment and Transport areas to decrease time wasted with patient movement
4. Request all on scene units assigned to MEDICAL to bring EMS equipment to Treatment area
5. Maintain Efficient Flow between Triage, Treatment and Transport
6. Initial goal should focus on patient movement from triage to treatment
7. Secondary goal should focus on patient treatment while awaiting transport units
8. Add resources where bottle necks occur
9. Toward the end of the event you may reassign on scene units to transport if needed
10. Ensure Transport Supervisor or their designee has contacted Medical Control and is working to provide for patient Transport Destination
11. Request additional resources if needed
12. Consider the need for MCI units, trailers etc.
13. Request a Bus for Green Patients and a Bus for Rehab of personnel
14. Request Airlift for Delayed Extrication of Patients
15. Request Law Enforcement and ME for Morgue area
16. Request Chaplain
17. Additional BLS Transports
18. Minimum of 2 patients per transport unit
19. Try to limit each BLS Unit to one Red if possible
20. Requests that BLS Transport Units Return to Scene in Large event

First On Scene
☐ First Officer – IC
☐ First FF/EMT or (2nd Medic) – Triage
☐ First Medic – Medical Group

Additional Units Assigned to MEDICAL
2nd Medic – Treatment Group Supervisor
3rd Medic – Transport Group Supervisor
2nd Officer Guides Litter Carriers to Treatment area

Additional Staffing
BLS Providers – Litter Carriers for Triage
Medics – Assigned to Treatment

Example of First Alarm Assignment

Appendix D: Thurston County Multiple Casualty Incident Reference Guides

MEDICAL BRANCH DIRECTOR
SUPERVISOR: *OPS SECTION CHIEF or INCIDENT COMMANDER*

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	*Phone*
TRIAGE GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**

INCIDENT COMMAND STRUCTURE
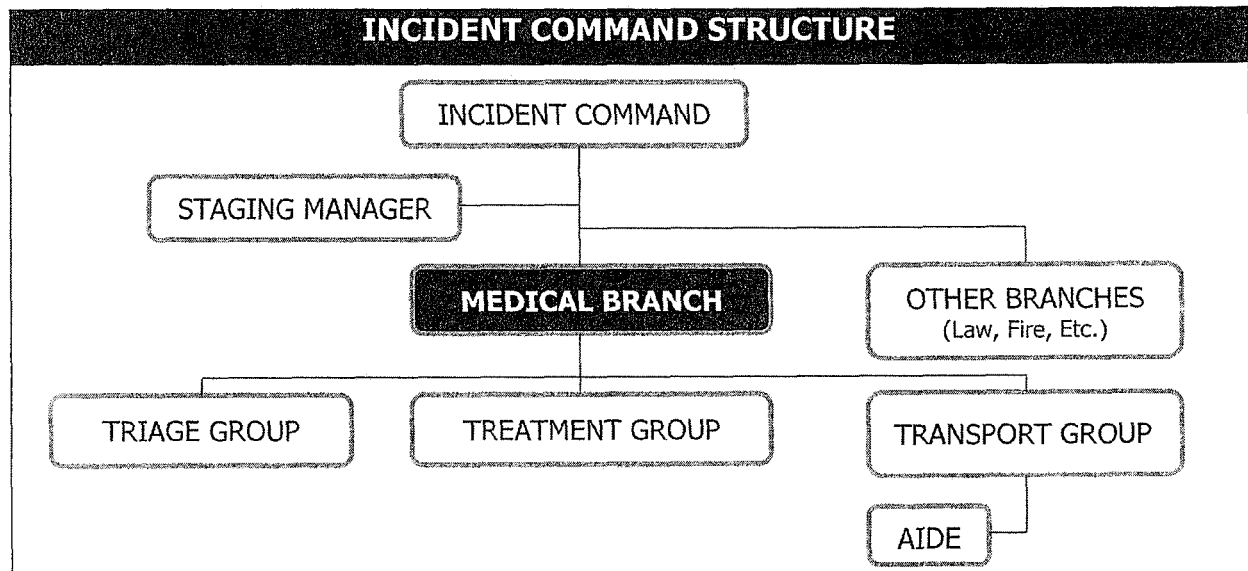
STRATEGY
1) Life Safety – Responders and Civilians
2) Incident Stabilization
3) Property Conservation
4)
5)

MEDICAL BRANCH ASSIGNED RESOURCES

Resource Name	Resource Type			ETA	Assignment
	E	A	M		
	E	A	M		
	E	A	M		
	E	A	M		

MEDICAL BRANCH DIRECTOR TACTICS

- ☐ Don GREEN ICS vest
- ☐ Receive briefing
- ☐ Contact Base Station (PSPH) 360.491.8888 or 360.438.6666
- ☐ Good Samaritan Puyallup Back-up 253-697-4000
  - ☐ Type of incident
  - ☐ Estimated patient census
  - ☐ Special situations (WMD, decontamination, etc.)
- ☐ Consider span-of-control
  - ☐ Triage Group Supervisor   *Name:*
  - ☐ Treatment Group Supervisor   *Name:*
  - ☐ Transportation Group Supervisor *Name:*
- ☐ Direct Casualty Collection Point
  - ☐ Direct Loading Area
  - ☐ Direct RED and YELLOW Treatment Areas
  - ☐ Direct Triage Choke Point
  - ☐ Direct GREEN Treatment Area
- ☐ Direct location of Medical Supplies
- ☐ Receive actual patient census from Triage Group Supervisor
- ☐ Monitor Critical Success Factors

CASUALTY COLLECTION POINT SCHEMATIC

	1st ALARM
1-6 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT Amb.
	2nd ALARM
7-12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
	3rd ALARM
>12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer
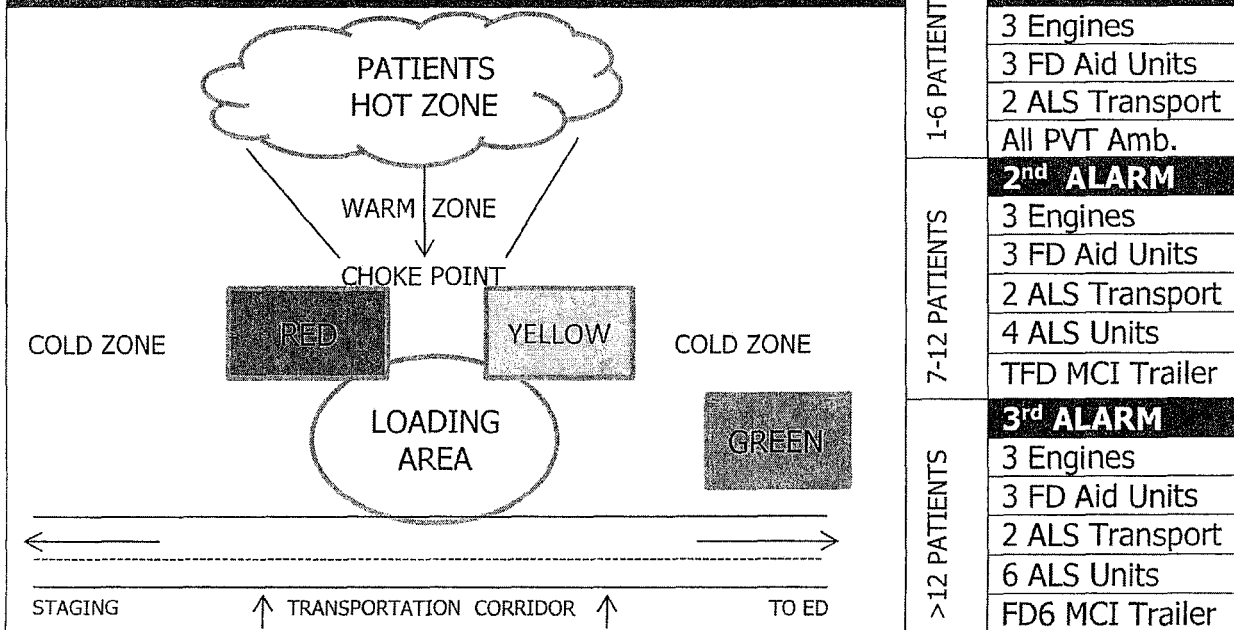
MEDICAL BRANCH DIRECTOR CRITICAL SUCCESS FACTORS

- [ ] Receive briefing from Incident Command
- [ ] Evaluate and mitigate for all hazards
- [ ] Maintain communications with Incident Command
- [ ] Maintain communications with all subordinates
- [ ] Maintain span-of-control
- [ ] Maintain awareness of resource status
    - [ ] Triage Group Supervisor
    - [ ] Treatment Group Supervisor
    - [ ] Transportation Group Supervisor
- [ ] Maintain awareness of subordinate progress toward objectives
    - [ ] Triage
        - [ ] START Triage completed – all patients tagged
        - [ ] Establish Triage Choke Point; provide 2 triage
        - [ ] Supervise Harvesters
    - [ ] Treatment
        - [ ] Establish RED, YELLOW, GREEN Treatment Areas
        - [ ] Ensure adequate treatment resources
        - [ ] Coordinate transport unit loads with Transport Group
    - [ ] Transport
        - [ ] Establish Loading Areas
        - [ ] Appoint Transport Group Aide
        - [ ] Ensure communications: Aide and Base Station
        - [ ] Coordinate transport unit loads with Treatment Group
        - [ ] Document patient disposition

NOTES

UNIT LOG – ICS 214	
Time	**Major Events**
Prepared By *(Name & Position)*	

TRIAGE GROUP SUPERVISOR
SUPERVISOR: *MEDICAL BRANCH DIRECTOR*

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRIAGE GROUP SUPERVISOR	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**

INCIDENT COMMAND STRUCTURE

```
                    INCIDENT COMMAND
                          |
    STAGING MANAGER ------|
                          |
          MEDICAL BRANCH        OTHER BRANCHES
                          |     (Law, Fire, Etc.)
                          |
 TRIAGE GROUP   TREATMENT GROUP    TRANSPORT GROUP
                                          |
                                        AIDE
```

STRATEGY

1) Life Safety – Responders and Civilians
2) Incident Stabilization
3) Property Conservation
4)
5)

TRIAGE GROUP ASSIGNED RESOURCES

Resource Name	Resource Type			ETA	Assignment
	E	A	M		
	E	A	M		
	E	A	M		
	E	A	M		
	E	A	M		

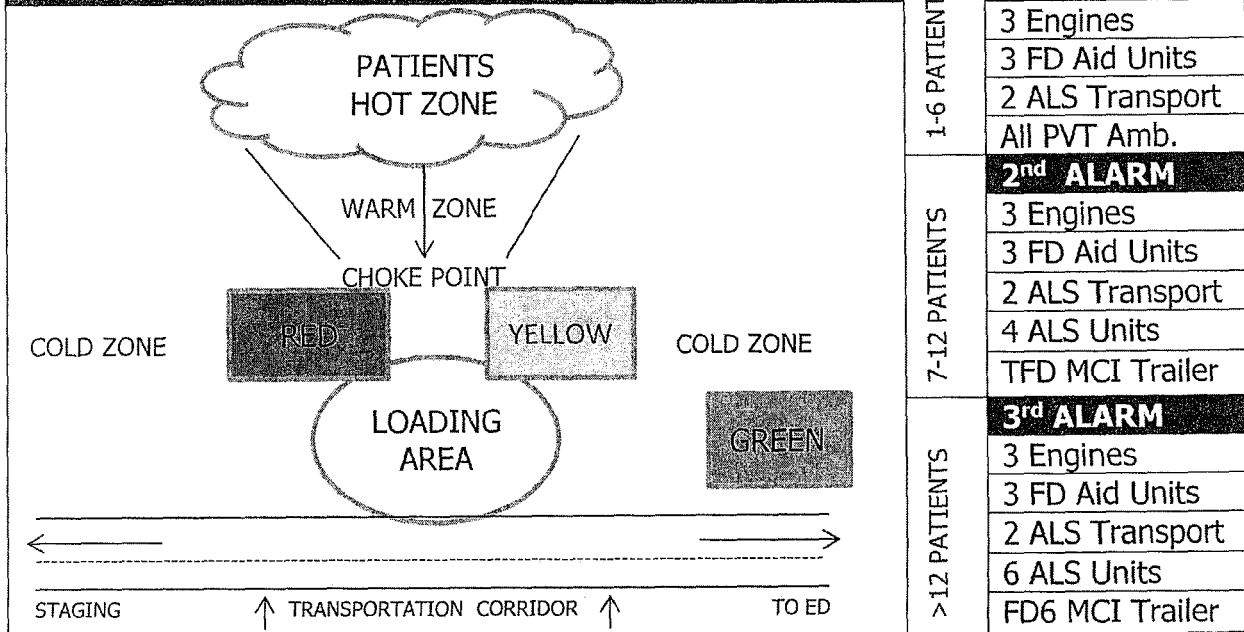## TRIAGE GROUP SUPERVISOR TACTICS

- ☐ Don RED ICS vest
- ☐ Receive briefing
- ☐ Assure safety of work area; mitigate hazards
- ☐ Brief subordinates
- ☐ Ensure START Triage
    - ☐ Ensure all patients receive Triage Tag
    - ☐ Retrieve Triage Tag stubs from Triage Teams
    - ☐ Provide Triage Tag stubs & patient census to Medical Branch
- ☐ Establish Choke Point
    - ☐ Conduct focused exam for each patient
    - ☐ Determine RED or YELLOW treatment for each patient
    - ☐ Remain at Choke Point until harvesting complete
    - ☐ Direct RED and YELLOW Treatment Areas
    - ☐ Direct Triage Choke Point
- ☐ Ensure availability of sufficient harvesters, boards, litters
- ☐ Monitor Critical Success Factors

CASUALTY COLLECTION POINT SCHEMATIC

1-6 PATIENTS	1st ALARM
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT Amb.
7-12 PATIENTS	2nd ALARM
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
>12 PATIENTS	3rd ALARM
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

TRIAGE GROUP SUPERVISOR CRITICAL SUCCESS FACTORS

- ☐ Receive briefing from Medical Branch Director
- ☐ Evaluate and mitigate for all hazards
- ☐ Maintain communications with Medical Branch Director
- ☐ Maintain span-or-control
  - ☐ Triage/Harvester Team #1   *Ldr Name:*
  - ☐ Triage/Harvester Team #2   *Ldr Name:*
  - ☐ Triage/Harvester Team #3   *Ldr Name:*
- ☐ Maintain awareness of subordinate progress toward objectives
  - ☐ Triage Team(s)
    - ☐ START Triage completed – all patients tagged
    - ☐ Accurate patient census determined
  - ☐ Harvester Team(s)
    - ☐ RED patients harvested first, if possible
    - ☐ Four rescuers per patient
  - ☐ Treatment
    - ☐ Establish RED, YELLOW, GREEN Treatment Areas
    - ☐ Ensure adequate treatment resources
    - ☐ Coordinate transport unit loads with Transport Group
- ☐ Provide Secondary Triage
  - ☐ Establish Choke Point
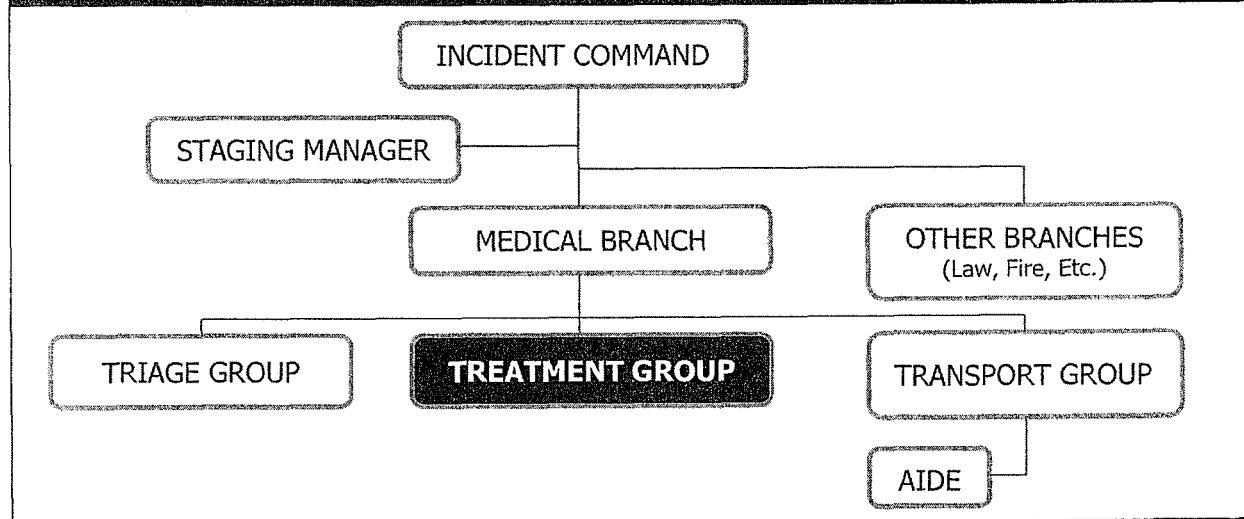 - ☐ Conduct brief exam of each patient

NOTES

Time	Major Events

Prepared By *(Name & Position)*

TREAMENT GROUP SUPERVISOR

SUPERVISOR: MEDICAL BRANCH DIRECTOR

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRIAGE GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**

INCIDENT COMMAND STRUCTURE

STRATEGY

1) Life Safety – Responders and Civilians
2) Incident Stabilization
3) Property Conservation
4)
5)

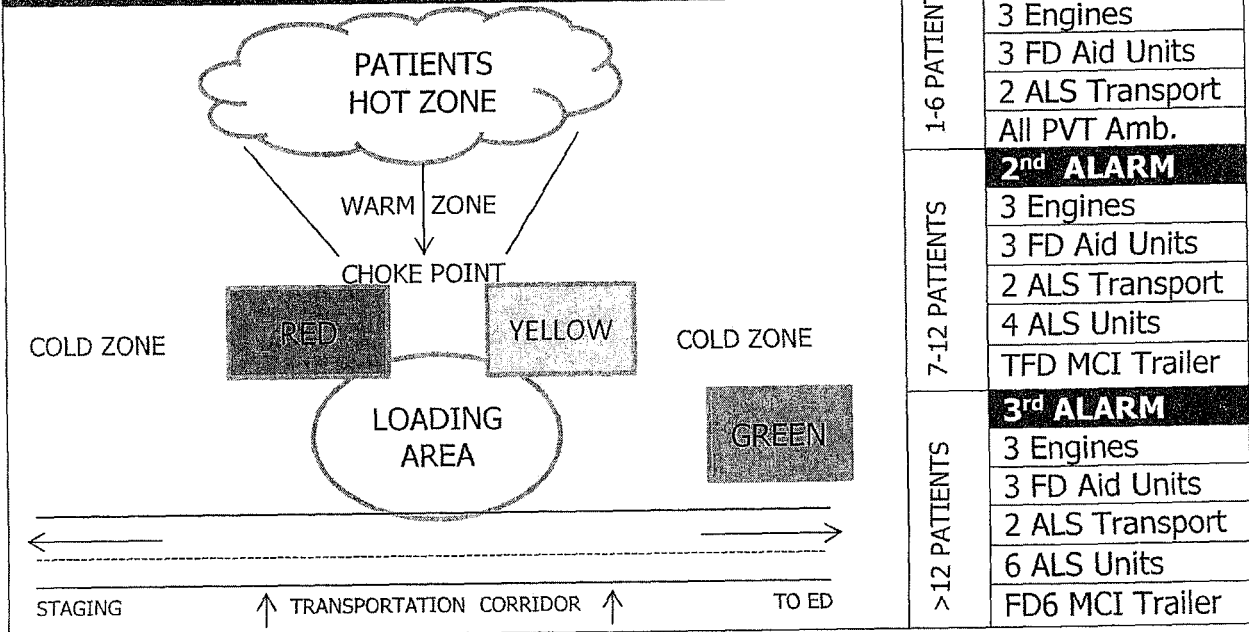## TREAMENT GROUP ASSIGNED RESOURCES

Resource Name	Resource Type			ETA	Assignment
	E	A	M		
	E	A	M		
	E	A	M		
	E	A	M		
	E	A	M		

TREATMENT GROUP SUPERVISOR TACTICS

- ☐ Don BLUE ICS vest
- ☐ Receive briefing
- ☐ Assure safety of work area; mitigate hazards
- ☐ Set up and staff Treatment Areas
    - ☐ RED   *Ldr Name:*
    - ☐ YELLOW   *Ldr Name:*
    - ☐ GREEN   *Ldr Name:*
- ☐ Ensure adequate medical supplies
- ☐ Ensure adequate treatment personnel
- ☐ Coordinate with Transport Group Supervisor for development of patient loads
- ☐ Monitor Critical Success Factors

CASUALTY COLLECTION POINT SCHEMATIC

	1st ALARM
1-6 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT Amb.
	2nd ALARM
7-12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
	3rd ALARM
>12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

Schematic labels: PATIENTS HOT ZONE, WARM ZONE, CHOKE POINT, RED, YELLOW, COLD ZONE, COLD ZONE, LOADING AREA, GREEN, STAGING, TRANSPORTATION CORRIDOR, TO ED

TREATMENT GROUP SUPERVISOR CRITICAL SUCCESS FACTORS

- [ ] Receive briefing from Medical Branch Director
- [ ] Evaluate and mitigate for all hazards
- [ ] Maintain communications with Medical Branch Director
- [ ] Maintain communications with all subordinates
- [ ] Maintain span-of-control
- [ ] Maintain awareness of resource status
  - [ ] RED Treatment Team
  - [ ] YELLOW Treatment Team
  - [ ] GREEN Treatment Team
- [ ] Maintain awareness of subordinate progress toward objectives
  - [ ] Treatment Team(s)
- [ ] Ensure adequate medical supplies
- [ ] Ensure adequate numbers of providers
- [ ] Arrange transport for RED patients first, if possible

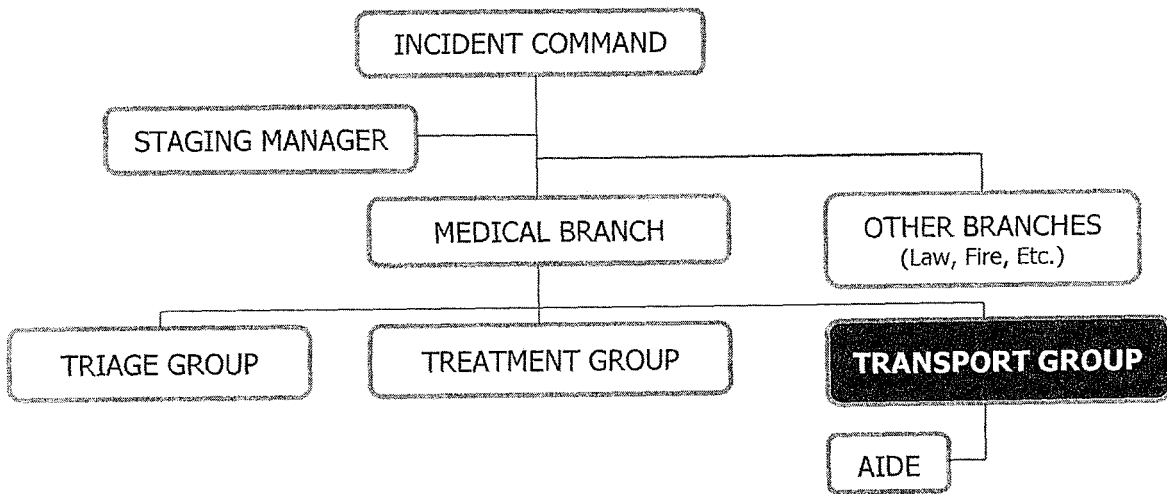## NOTES

Time	Major Events

UNIT LOG – ICS 214

Prepared By *(Name & Position)*

TRANSPORT GROUP SUPERVISOR
SUPERVISOR: MEDICAL BRANCH DIRECTOR

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRIAGE GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**

INCIDENT COMMAND STRUCTURE

```
                    INCIDENT COMMAND

   STAGING MANAGER

                    MEDICAL BRANCH          OTHER BRANCHES
                                            (Law, Fire, Etc.)

   TRIAGE GROUP     TREATMENT GROUP         TRANSPORT GROUP

                                                AIDE
```

STRATEGY

1) Life Safety – Responders and Civilians
2) Incident Stabilization
3) Property Conservation
4)
5)

TRANSPORT GROUP ASSIGNED RESOURCES

Resource Name	Resource Type			ETA	Assignment
	E	A	M		
	E	A	M		
	E	A	M		
	E	A	M		
	E	A	M		

TRANSPORT GROUP SUPERVISOR TACTICS

- ☐ Don YELLOW ICS vest
- ☐ Receive briefing
- ☐ Establish Loading Area
    - ☐ Flat, level, paved
    - ☐ Well – lit (consider auxiliary lighting)
    - ☐ Allows loading and departure without turn around
- ☐ Appoint Transportation Group Aide
    - ☐ Direct Aide to contact and maintain an open communications line with PSPH ED, 360.491.8888 or 360.438.6666
    - ☐ Good Samaritan Puyallup Back-up 253-697-4000
- ☐ Ensure adequate Loading Teams
- ☐ Ensure adequate numbers of transport vehicles
    - ☐ Order 1 transport vehicle per 2 patients, RED or YELLOW
- ☐ Plan for transport of GREEN patients (e.g., bus)
- ☐ Coordinate with Treatment Group Supervisor for development of patent loads
- ☐ Maintain transport unit logs, deliver to Medical Branch Director
- ☐ Monitor Critical Success Factors
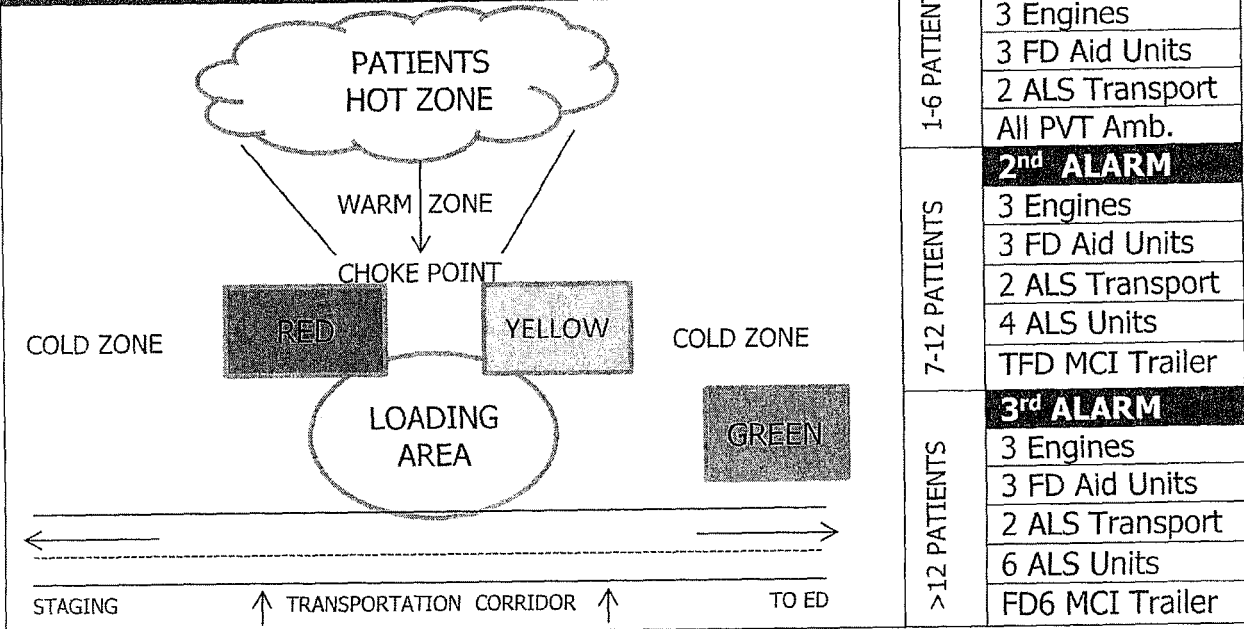
CASUALTY COLLECTION POINT SCHEMATIC

	1st ALARM
1-6 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT Amb.
	2nd ALARM
7-12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
	3rd ALARM
>12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

TRANSPORTATION GROUP SUPERVISOR CRITICAL SUCCESS FACTORS

- ☐ Receive briefing from Medical Branch Director
- ☐ Evaluate and mitigate for all hazards
- ☐ Maintain communications with Medical Branch Director
- ☐ Maintain communications with all subordinates
- ☐ Maintain span-of-control
- ☐ Identify Loading area
- ☐ Maintain awareness of resource status
  - ☐ Transport GS Aide   *Name:*
  - ☐ Loading Team   *Name:*
- ☐ Maintain awareness of subordinate progress toward objectives
  - ☐ Aide
    - ☐ Consult with PSPH for destination of each load
    - ☐ Process all patients one load at a time
  - ☐ Loading Team
    - ☐ Attempt to mix (1) RED, (1) YELLOW per load
  - ☐ Transport Vehicles
    - ☐ Ensure sufficient numbers on scene or enroute
    - ☐ Coordinate with Treatment for makeup of each load
- ☐ Maintain records of patent disposition

NOTES

UNIT LOG – ICS 214	
Time	**Major Events**
Prepared By *(Name & Position)*	

TRANSPORT GROUP SUPERVISOR AIDE
SUPERVISOR: *TRANSPORT GROUP SUPERVISOR*

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRIAGE GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP AIDE	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
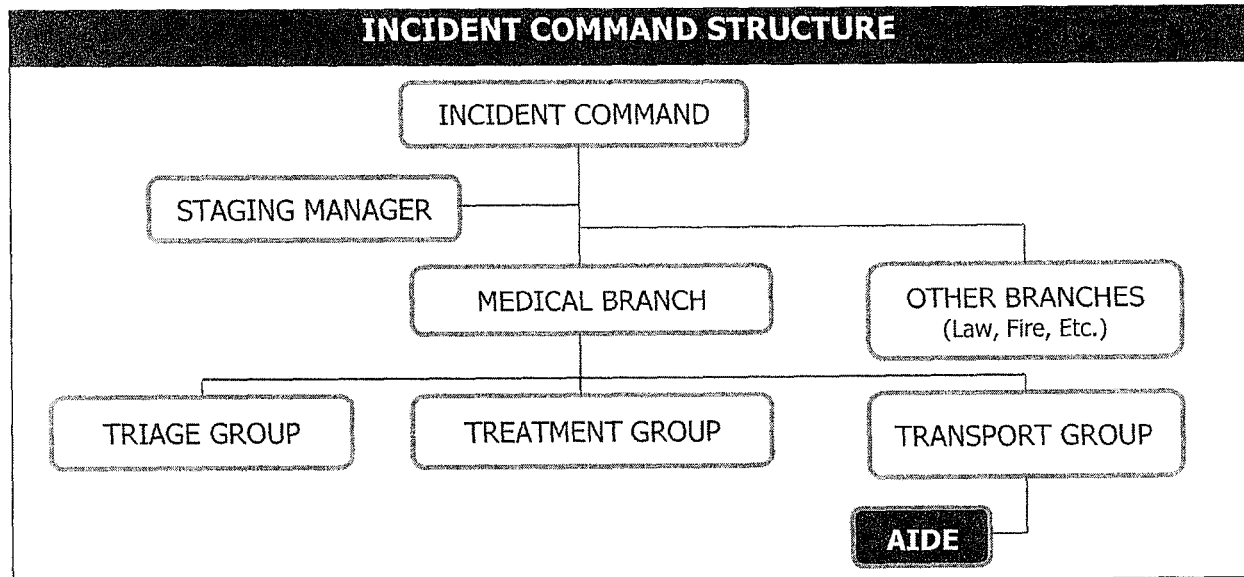
INCIDENT COMMAND STRUCTURE

STRATEGY

1) Life Safety – Responders and Civilians
2) Incident Stabilization
3) Property Conservation
4)
5)

TRANSPORT GROUP ASSIGNED RESOURCES

Resource Name	Resource Type			ETA	Assignment
	E	A	M		
	E	A	M		
	E	A	M		
	E	A	M		

TRANSPORT GROUP SUPERVISOR AIDE TACTICS

☐ Receive assignments from and assist Transport Group Supervisor
☐ Possible tasks include:
  ☐ Contact and maintain an open communications line with PSPH 360.491.8888 or 360.438.6666
  ☐ Good Samaritan Puyallup Back-up 253-697-4000
  ☐ Complete transport unit Patient Logs
  ☐ Communicate transport destinations to transport units
  ☐ Communicate with Staging Area Manager to request transport resources to move into transport area
  ☐ Other tasks as assigned by Transport Group Supervisor
  ☐
  ☐
  ☐

CASUALTY COLLECTION POINT SCHEMATIC

	1st ALARM
1-6 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT Amb.
	2nd ALARM
7-12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
	3rd ALARM
>12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer
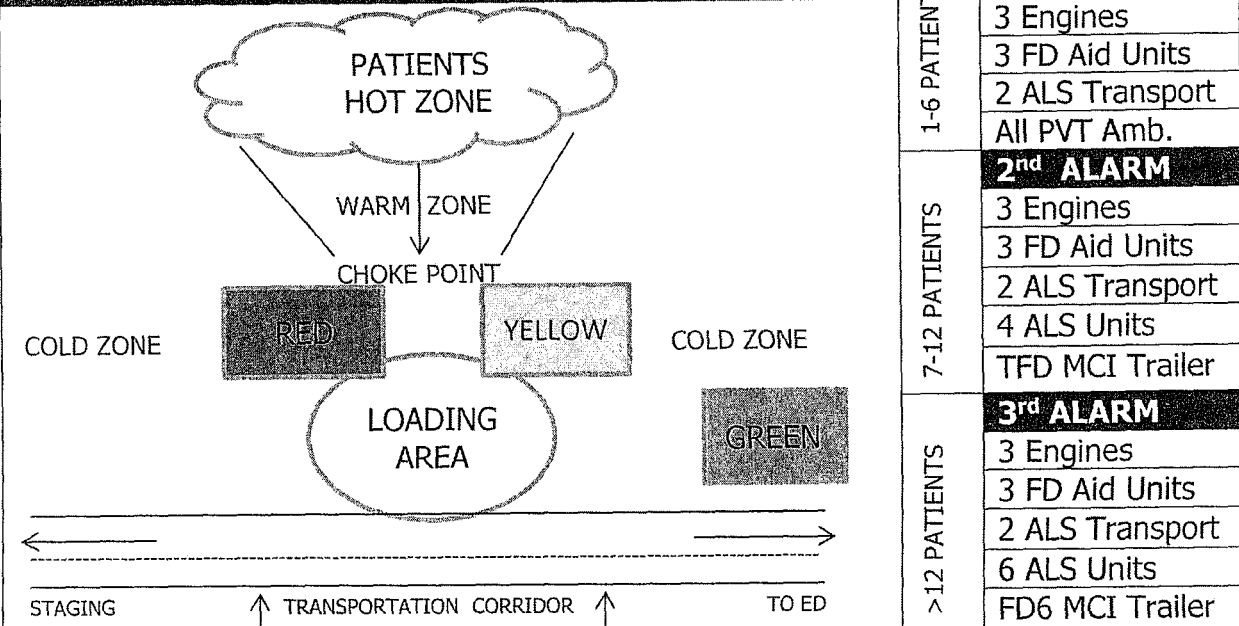
TRANSPORT GROUP AIDE CRITICAL SUCCESS FACTORS

- ☐ Receive briefing from Transport Group Supervisor
- ☐ Evaluate and mitigate for all hazards
- ☐ Maintain communications with Transport Group Supervisor
- ☐ Maintain communications with PSPH for destination of each load
- ☐ Maintain span-of-control
- ☐ Maintain awareness of resource status
- ☐ Process all patients one load at a time
- ☐ Maintain communications with Loading Team(s)
- ☐ Maintain records of patient disposition for transport

NOTES

UNIT LOG – ICS 214	
Time	**Major Events**

Prepared By *(Name & Position)*

Appendix E: Transport Unit Patient Log

TRANSPORT UNIT PATIENT LOG

Unit ID #   ☐ ALS ☐ BLS (Check One)

Loading: :   Transporting   :   Destination: Name of Facility

TAG #	AGE/SEX	SEVERITY	INJURIES
1	M F	☐ RED ☐ YELLOW ☐ GREEN	Always List RED Patients First
2	M F	☐ RED ☐ YELLOW ☐ GREEN	
3	M F	☐ RED ☐ YELLOW ☐ GREEN	
4	M F	☐ RED ☐ YELLOW ☐ GREEN	
5	M F	☐ RED ☐ YELLOW ☐ GREEN	

THIS FRONT PAGE TO BE RETAINED BY TRANSPORT UNIT

TRANSPORT UNIT PATIENT LOG

Unit ID #   ☐ ALS ☐ BLS (Check One)

Loading: :   Transporting   :   Destination: Name of Facility

TAG #	AGE/SEX	SEVERITY	INJURIES
1	M F	☐ RED ☐ YELLOW ☐ GREEN	Always List RED Patients First
2	M F	☐ RED ☐ YELLOW ☐ GREEN	
3	M F	☐ RED ☐ YELLOW ☐ GREEN	
4	M F	☐ RED ☐ YELLOW ☐ GREEN	
5	M F	☐ RED ☐ YELLOW ☐ GREEN	

RETURN THIS DUPLICATE FORM TO TRANSPORT GROUP SUPERVISOR

Appendix F: Triage Tags

Maximize Survivors
MET°TAG

Unique Identifiers

FRONT
A. Enter time and date of triage
B. Enter name of patient (if conscious and coherent
C. Enter Street address (if conscious and coherent)
D. Enter city, state, and zip (if conscious and coherent)
E. Enter pertinent medical information & observations on blank lines
F. Enter name of triage personnel on signature (X)

BACK
G. Indicate location of bodily injuries on front & back diagrams
H. Enter B/P, pulse, and respirations in vital signs chart with time taken. Indicate if pulse is full or weak, and if regular or irregular. Multiple vital signs may be taken.
I. Enter intravenous (IV) and time
J. Enter intramuscular (IM) & time

TRANSPORT PATIENT BY PRIORITY LEVELS

O BLACK (TERMINAL – Dead or Expected)
I RED (CRITICAL – Primary Care)
II YELLOW (SERIOUS – Secondary Care)
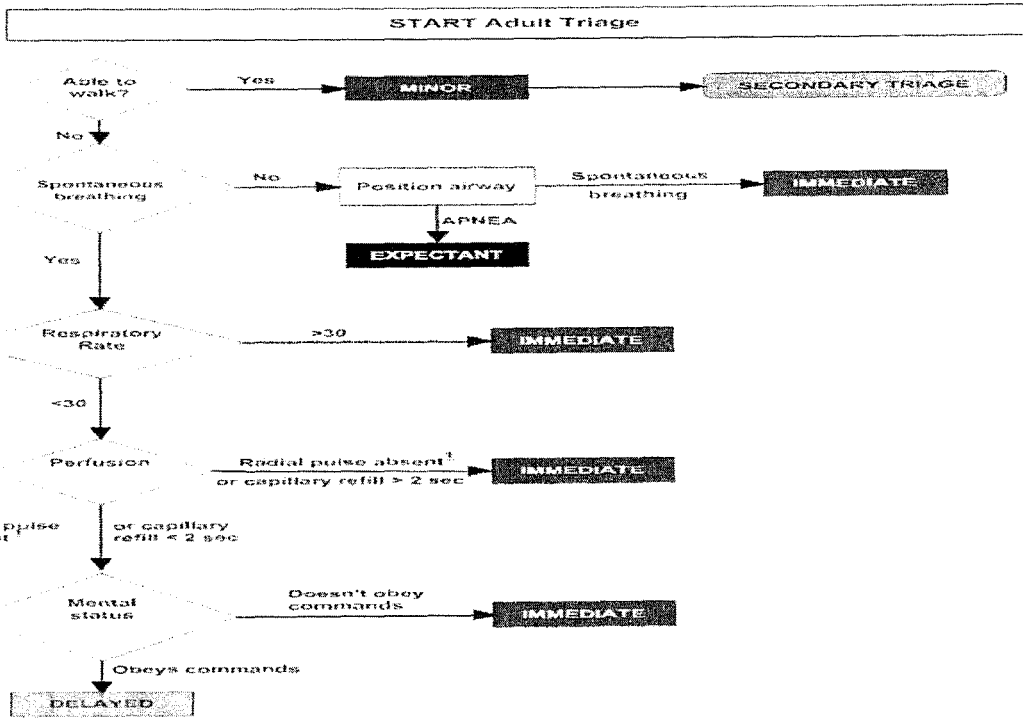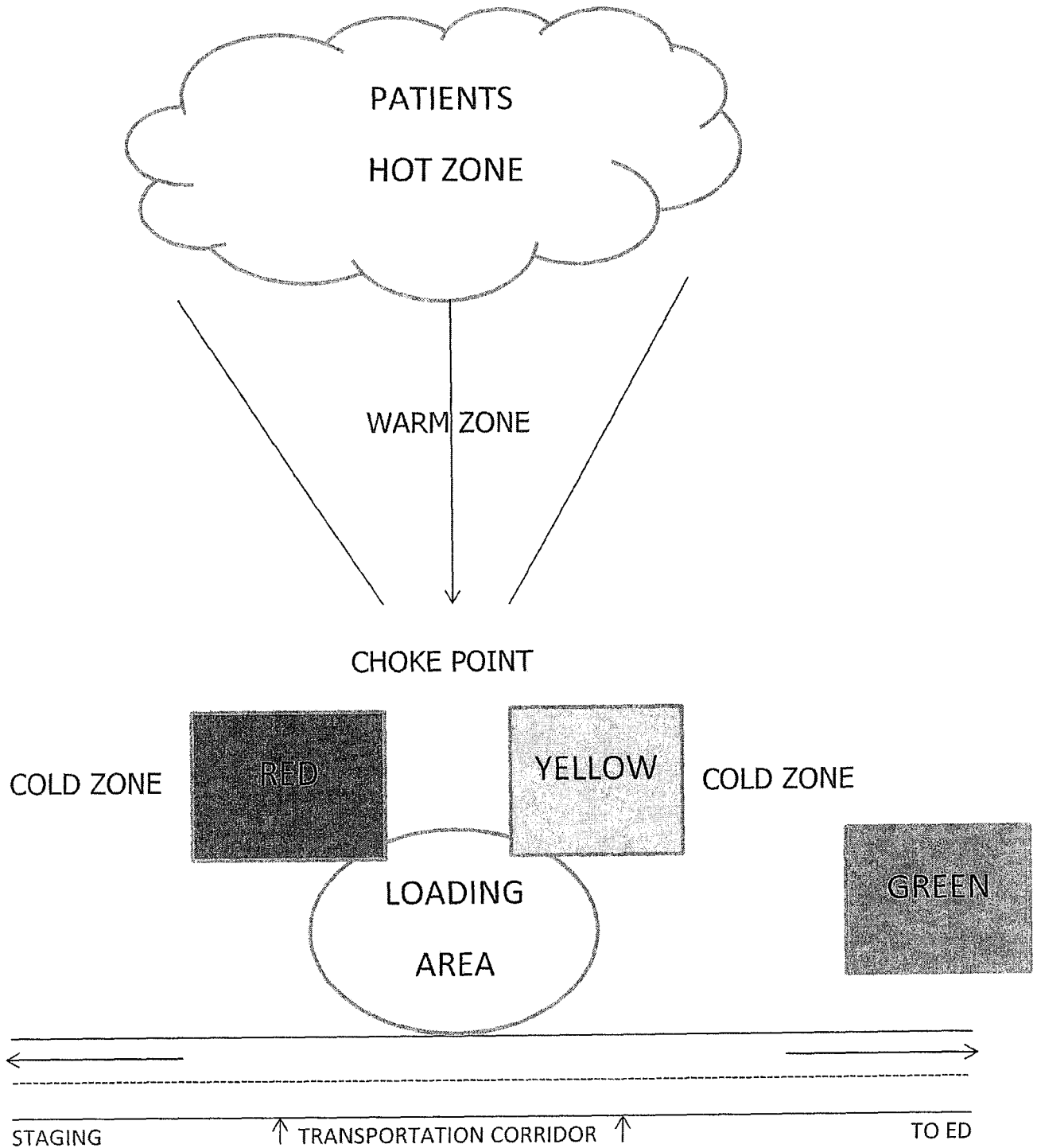**III GREEN (NON – SERIOUS – Minor Care)**

FRONT

BACK

START Adult Triage
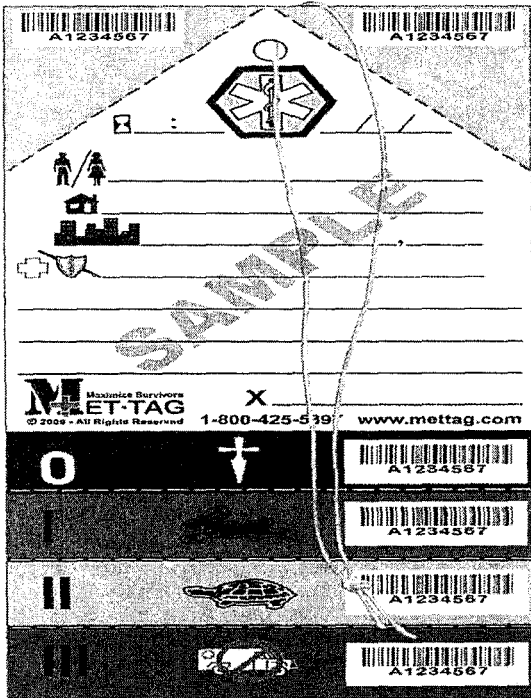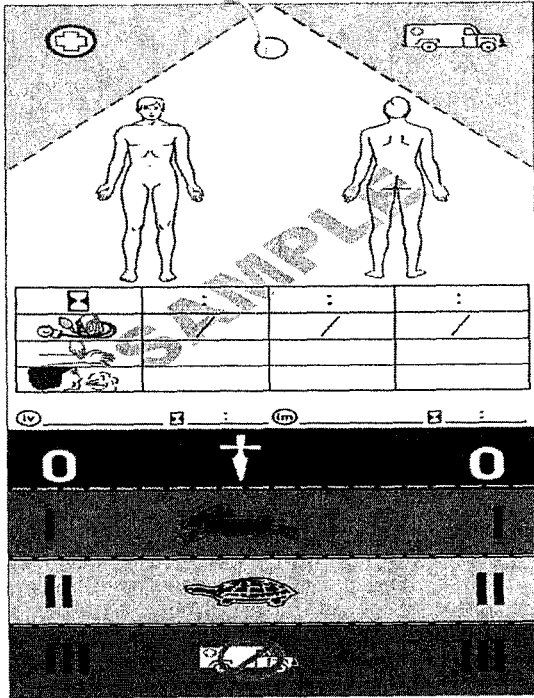
Appendix G: Casualty Collection Point Schematic (EXAMPLE)

PATIENTS

HOT ZONE

WARM ZONE

CHOKE POINT

COLD ZONE   RED   YELLOW   COLD ZONE

GREEN

LOADING

AREA

STAGING   TRANSPORTATION CORRIDOR   TO ED

Appendix H: Full ICS Chart
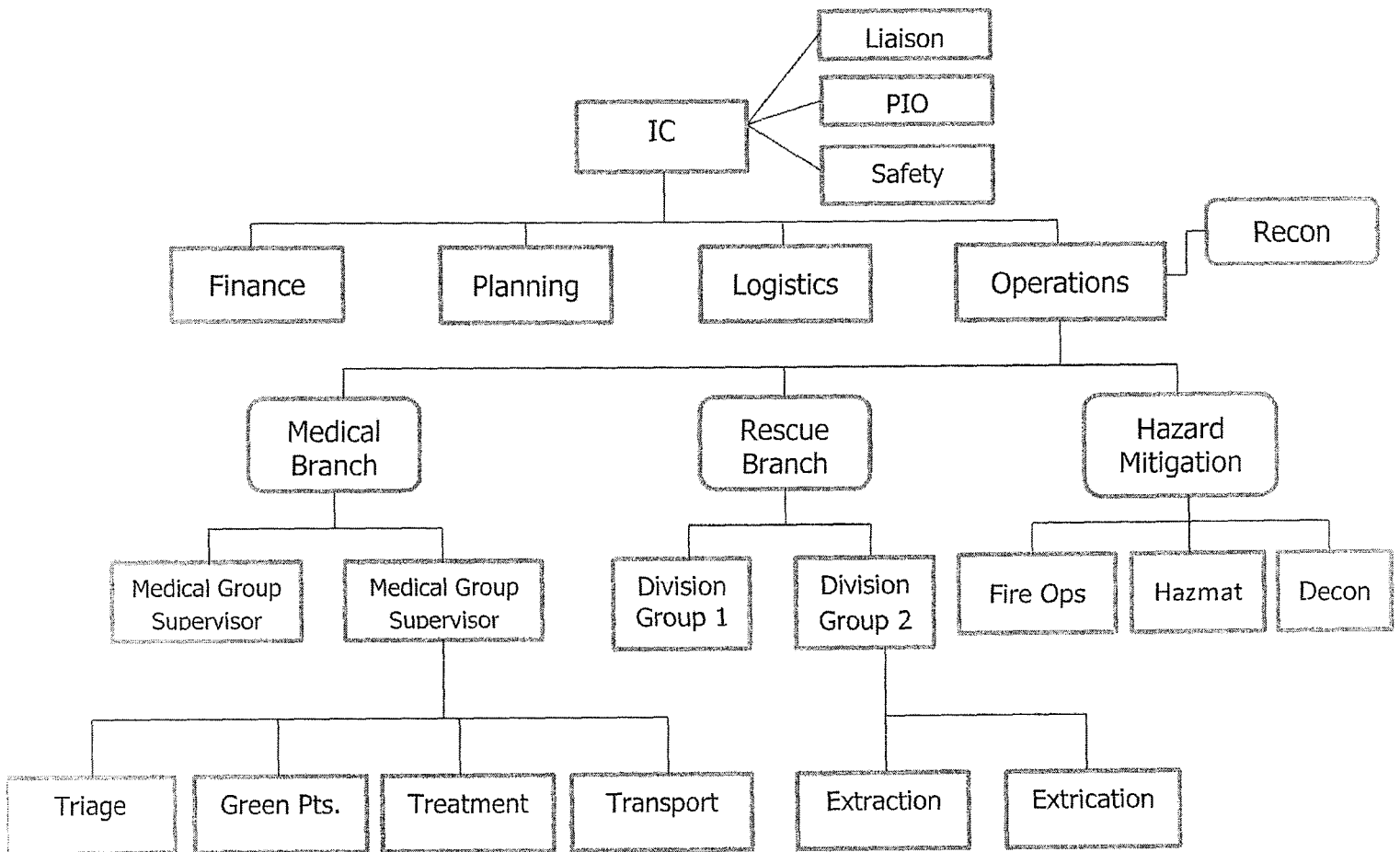
This is the org chart for a large scale incident. As with other incidents, multiple roles may be filled by one individual as span of control and need allow. (e.g. Medical Group Supervisor may fill the roles of Green Patient, Treatment and Transport Team Leader. Geography and work volume may alter this).

THIS CHART IS NOT INTENTED TO IDENTIFY ALL ASPECTS OF ICS AT A LARGE INCIDENT.

Appendix I: Thurston County Fire/EMS Response to Large-Scale Violent Incidents

THURSTON COUNTY FIRE/EMS RESPONSE TO LARGE- SCALE VIOLENT INCIDENTS

Purpose: To guide Fire/EMS agencies in their responses to incidents involving threats or acts of violence in cooperation and coordination with responding law enforcement agencies.

Scope: Any incident requiring law enforcement intervention to render the scene safe prior to entry of Fire/EMS personnel and where the potential for multiple casualties reasonably exists.

Response Guidelines:

1. Initial Response

   a. Resource requests should be initiated through TCOMM by the first-due Officer In Charge (OIC) based on available dispatch information to include appropriate Level of MCI and any specialized resources based on hazard type.

   b. A Level 1 Staging area should be designated and communicated to TCOMM and all responding Fire/EMS units at a distance and location which provides adequate separation, shielding, and capacity for the initial response package.

      i. Special consideration should be given to the possibility of secondary and diversionary threats.

      ii. Level 2 Staging at a greater distance and capacity should be considered for second and subsequent MCI alarm responses.

   c. The first arriving Fire/EMS unit will initiate the Incident Command System and direct the actions of subsequent units. Any transfers of the Incident Commander responsibilities will be clearly identified and transmitted to Dispatch and all assigned units.

   d. Unified command should be sought and established with the primary law enforcement agency as soon as is practical and prior to any intervention by Fire/EMS units. All personnel and activities will be managed utilizing the Incident Command System.

2. Unified Response

   a. The unified command will conduct an assessment to identify the type, number, location, and associated risks of the known and potential hazard types. Mitigation strategies will be jointly developed based on the risk assessment and available resources. These strategies may include but not limited to:

      1. Rescue Team Deployment: to "warm zone" areas from where the identified threat(s) have been isolated or removed and a risk analysis leads to a reasonable belief that viable victims exist and that Team deployment would increase the probability of survival.

      2. Rescue Teams will don and maintain all designated personal protective equipment, remain intact as a team, and in constant communication with their supervision throughout any deployment.

      3. Methods and direction of team movement and communication (e.g. Diamond Formation, Power T, and radio frequencies) will be clearly identified prior to Rescue Team deployment.

      4. The activities of the Rescue Team will be focused on the rapid assessment and triage of victims. Interventions will be limited to those necessary for immediate stabilization of life or limb. Rescue Teams may convert to the role of Extraction Teams based on need, capability, and in coordination with supervision.

      5. Rescue Teams will self-initiate or be ordered by their supervisor to withdraw or abandon any area(s) where the level of threat is recognized to be above acceptable levels for any reason.

         i. Multiple Casualty Response: All casualties outside or removed from "warm zones" will be managed in accordance with the Thurston County Multiple Casualty casualty Incident Response Plan.

         ii. Rescue operations: To stabilize or alter entrapping hazards in order to remove victims or prevent future entrapments. These activities should be conducted under the direct supervision of a Rescue Group Supervisor with the requisite knowledge of hazard type(s) and in accordance with established departmental and/or SORT Team Guidelines.

iii. Fire Suppression: To stabilize existing or potential fire hazards. These efforts must be in coordination with other law enforcement priorities and rescue activities. Suppression activities should be conducted with a focus crime scene preservation whenever possible.

iv. Specialized Responses: Incidents known or believed to involve Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) elements require response, stabilization, and mitigation by qualified Technicians. Fire/EMS personnel activities should focus on the isolation and denial of entry to affected areas and operate only to their level of training and certification. Washington State Patrol is the established Authority Having Jurisdiction over CBRNE incidents and should be consulted on all tactical decisions.

1. Cross decontamination should be established for potentially exposed victims and responders whenever possible.

2. Isolation and intervention strategies should be based on Department Of Transportation (DOT) Emergency Response Guidebook.

3. Post Response/Recovery

    a. The Unified Command will identify prioritized objectives and strategies for the demobilization of initial response units and the subsequent activities associated with investigation and recovery.

    b. No information regarding the incident will be shared with the public or media without the expressed approval of the Unified Command. A Public Information Officer and a Joint Information System should be strongly considered for the coordinated and consistent sharing of information.

Definitions

ACTIVE SHOOTER: One or more subjects who have used, is using or threatening to use a weapon to inflict deadly force on other, and/or continues to do so while having unrestricted access to additional victims. Prior actions demonstrate intent to continuously harm; objective appears to be mass injury or murder.

BARRICADED: A static situation involving an armed suspect, with or without hostages, who has demonstrated, or verbalized the intent to commit, violence. The suspect has fortified a position of advantage in a room or building.

CONCEALED / CONCEALMENT: Protected from observation, not from weapons fire.

CONTACT TEAM: One or more law enforcement officers whose intent is to take action to stop the suspect's deadly actions.

COVER: Protected from observation and weapons fire.

DIVERSIONARY THREAT: A threat that is intended to draw emergency response resources away from the primary target.

DYNAMIC SITUATION: An incident that is evolving with constantly changing tactical challenges.

MASS CASUALTY INCIDENT: An incident in which the emergency medical needs of the patients overwhelm the available resources to the extent that altered standards of care may become necessary.

RESCUE TEAM: A multidisciplinary team of Law Enforcement and Fire/EMS personnel who enter the Warm Zone for the purpose of triage and initial stabilization followed by extrication of viable patients. The configuration of the Rescue Team is intended to mitigate provider risk while forward deploying stabilizing medical care in conditions that might otherwise delay treatment.

SALT TRIAGE: A consensus triage system endorsed by multiple medical and scientific bodies. It allows for stabilizing interventions for life-threatening conditions as well as an additional step that allows providers to consider the entire context of the incident when performing triage. In this context, SALT is used in the warm zone.

START TRIAGE: A method of triage that relies on the assessment of three physiologic Parameters: Respirations, Pulse, and Mentation.

SECONDARY DEVICE: Usually an Improvised Explosive Device (IED) that is designed to detonate after the arrival of first responders, in the hope of disrupting the response.

STAGING AREA: An incident area where resources are gathered prior to engagement.

STATIC SITUATION: The suspect(s) does not appear to be moving. Note that a static situation may become dynamic at any time the suspect escapes containment.

UNIFIED COMMAND: Incident Command entity comprised of Fire/EMS, Law Enforcement, and any other critical stakeholder based on involvement and incident type and/or complexity.

ZONES:

HOT ZONE: An incident area that has the following characteristics:

1) There is a known or suspected active threat in this area.

2) Law enforcement tactical actions are ongoing in this area.

WARM ZONE: An incident area that has the following characteristics:

1) The threat is neutralized, or contained in another area. There is no known, active threat in the defined area.

2) Law Enforcement has established, and maintains, control of the ingress and egress to the area.

3) The area has been searched by Law Enforcement.

4) There are potentially viable patients in the area.

5) There are possible undetected hazards (e.g. IEDs) in the area.

6) Unarmed responders working in this area have continuous, dedicated force protection from Law Enforcement.

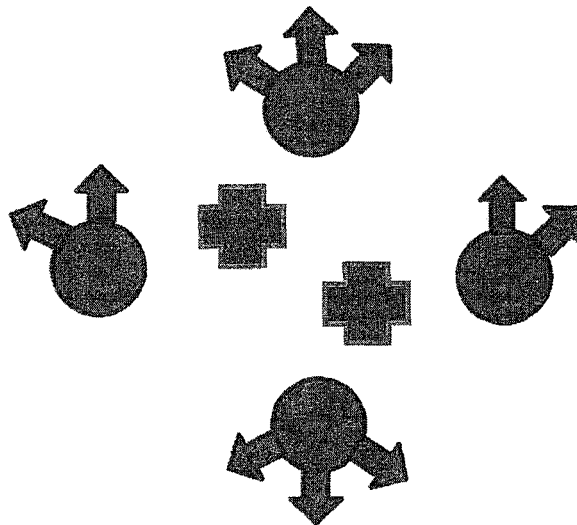COLD ZONE: An incident area that has the following characteristics:

1) There is no known active or suspected threat in this area.

2) Responders working in this area do not require unusual protective measures
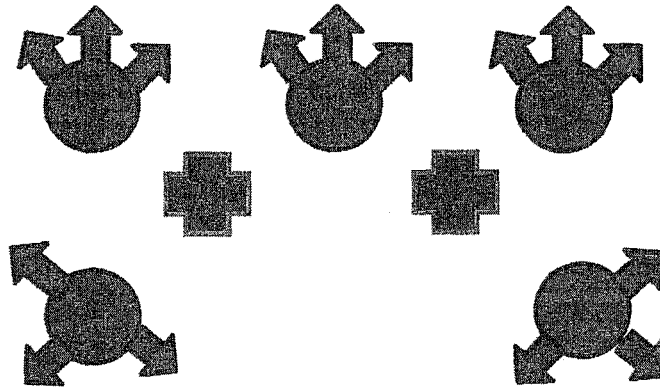
RESCUE TEAM
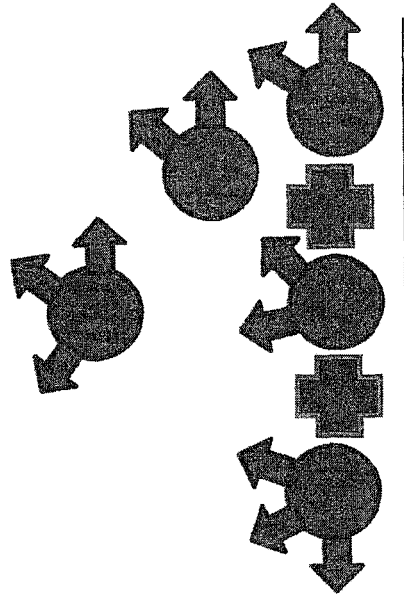
MOVEMENT IN HEAVY HEAD, NEXT TO WALL
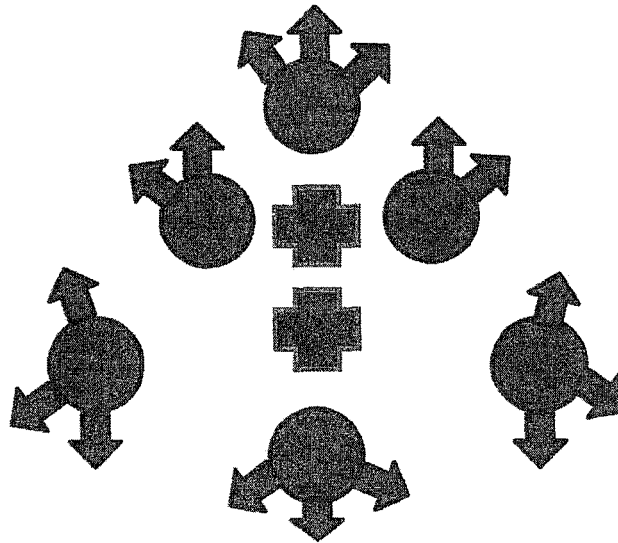
RESCUE TEAM

MOVEMENT IN DIAMOND FORMATION

RESCUE TEAM

MOVEMENT IN "T" FORMATION

RESCUE TEAM

MOVEMENT IN WEDGE FORMATION

Appendix J: Ballistic Vest Example that may be used for Response to Large-Scale Violent Incidents within the "warm zone."

The following items are an example but not limited to the equipment that may be kept within the Ballistic Vest.

> Triage Tags
> CAT Tourniquets
> Israeli Bandages
> Sharpe Pen
> Scissors
> Chest Seals
> IV Needles
> Colored Surveyors Tape (Red, Yellow, Green, Black)