CAL-EMA REGION III

MULTI-CASUALTY INCIDENT FIELD OPERATIONS

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PURPOSE OF THE FIELD OPERATIONS MANUAL

The Field Operations Manual describes the response organization, personnel, equipment, resources, and procedures for field operations that are designed to be utilized by the eleven counties which make up ~~State OES Region IV~~California Emergency Management Agency (Cal-EMA) Region III.

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

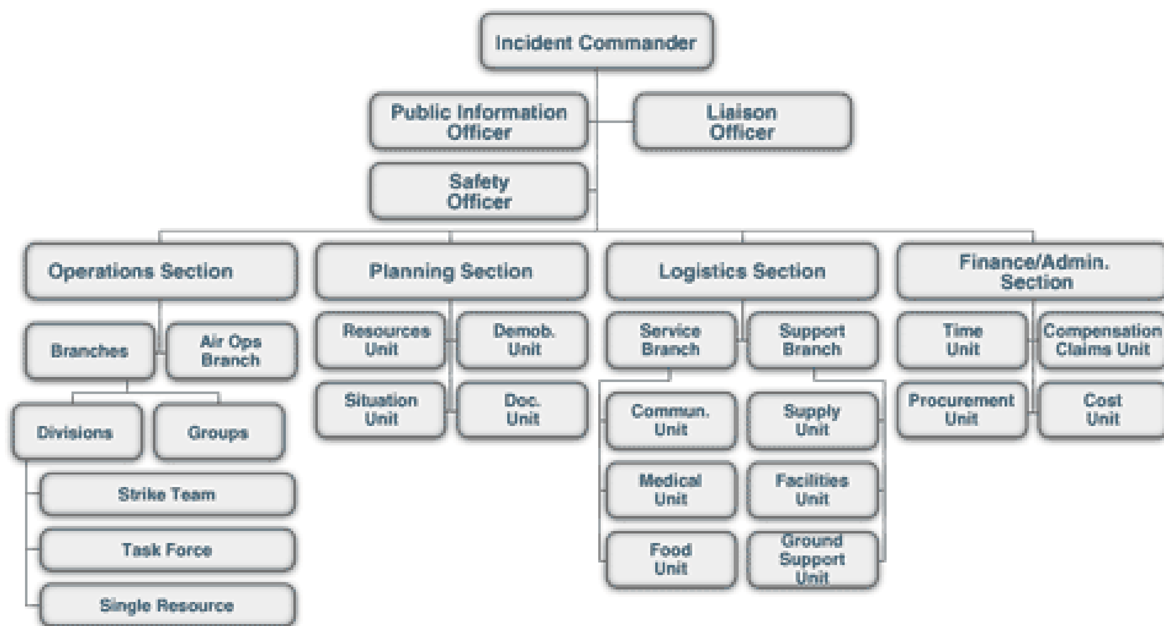
This Field Operations Manual contains standardized position titles, procedures, checklists, forms, and tags in an effort to more efficiently and effectively utilize regional resources during a multi-casualty incident.

SEMS/NIMS Compliant

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

Incident Command System

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



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

SECTION 1: COMMAND & CONTROL

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

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

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

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

* AIRPORT FIRE/POLICE Airports

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

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

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

A SELECTION OF THE "TYPE" OF COMMAND

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

* Single Command: This is a system wherein a person determined by the impacted jurisdiction is given the lead role as Incident Commander. This person will usually be a high ranking official of the fire service or law enforcement as noted above. In the ICS, as the incident progresses in size or scope, the incident command may be turned over to a higher ranking official such as a fire chief.

In some cases, an advisory staff may be established to assist the Incident Commander. This will generally be comprised of officials of the major agencies involved such as fire, law enforcement, public works, and EMS. The EMS representative will be assigned by the Health Officer/EMS Medical Director or his/her designee and will normally be a member of the Health Department/Local EMS Agency or an ambulance service manager.

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

B. FUNCTIONS OF THE INCIDENT COMMANDER

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

* Command: Overall management and setting of objectives.

* Planning: The development of a procedure to deal with operational problems.

* Logistics: The acquisition and distribution of resources.

* Finance: Recording, for purposes of reimbursement, who and what was involved in the incident.

* Operations: The direct control of tactical operations and the implementation of objectives.

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

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

* The Incident Commander will determine when EMS personnel are no longer required and may be released from the incident.

* The Incident Commander or his/her designee will approve any information releases to the media. **Personnel shall not release information to the media without approval.**

SEE INSERT OF MODIFIED INCIDENT COMMAND SYSTEM UNIFIED

SECTION 2: COMMUNICATIONS

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

A. RADIO NETWORKS

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

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

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

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

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

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 predesignated and assigned for use at the incident.

SECTION 3: EQUIPMENT & SUPPLIES

It is imperative that all tools necessary for initial scene organization and patient triage are available to the first-in emergency response units. A Triage Packet (see ENCLOSURE E) and the following vests should be carried on all initial response units of the emergency services agency responsible for EMS field management:

* Incident Commander (Orange)
* Medical Group Supervisor (Kelly Green)
* Triage Unit Leader (Kelly Green)
* Treatment Unit Leader (Kelly Green)
* Patient Transportation Unit Leader (Kelly Green)

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

NOTE: Systems that have generic kelly green vests with velcro on which the appropriate position labels can be attached, may be required to carry only an orange Incident Commander vest and two generic vests on the first in units as long as all the appropriate position labels listed above are available.

SECTION 4: ACTIVATION/NOTIFICATION

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

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

A. MOBILIZATION OF RESOURCES

Three main categories of resources that should be considered are:

* Equipment and Supplies

- Medical Group Implementation Supplies
    - Medical Supply Caches/Disaster Trailers
    - Rescue Equipment
    - Specialized Equipment

* Manpower

- ALS Personnel
- BLS Personnel
- Litter Bearers
- Task Forces
-

* Transportation:

- Ground Ambulances
- Air Ambulances
- Buses
- Ambulance Strike Teams (ALS or BLS)

B. NOTIFICATION OF Control Facility

Enroute

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

On Scene

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

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

Following Scene Size-up, Update CF on:

* Classification of Incident:

- MCI Trauma Surgeon may be required for Immediate victims.

- MCI Medical i.e., chlorine gas inhalation or burns in which a surgeon would not be required at the receiving facility.

- MCI HazMat An incident requiring decontamination.

* Approximate number of victims.

* Name of incident

* Estimated time when triage will be completed.

Following Triage, Update CF on:

* Total number of patients by triage category and major injury, e.g., "A total of ten patients: 2 Immediate Heads, 4 Delayed, and 4 Minors."

* Number and description of transport units, e.g., "2 ALS ground ambulances, 1 BLS ground ambulance, and 1 ALS air ambulance.

SECTION 5: INCIDENT OPERATIONS

A. EMS FIELD MANAGEMENT PERSONNEL

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

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

1. **Medical Group Supervisor** (MGS)

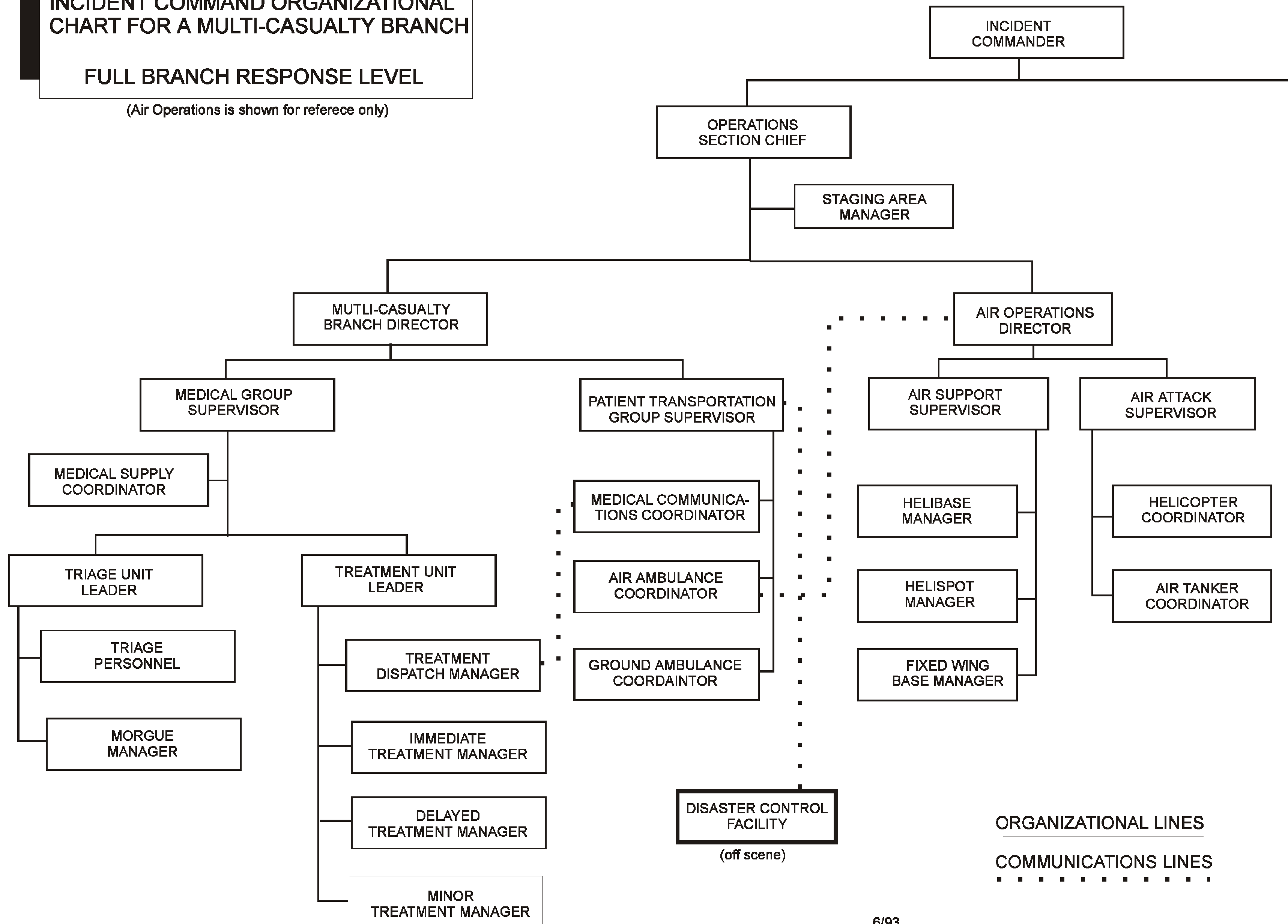
This person is in charge of EMS Field Operations in an initial and reinforced level of response. While formal identification is not necessary on routine calls, on multi-casualty incidents with five (5) or more patients requiring transportation, an identification vest will be used.

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

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

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

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


INCIDENT COMMAND ORGANIZATIONAL CHART FOR A MULTI-CASUALTY BRANCH
FULL BRANCH RESPONSE LEVEL
(Air Operations is shown for referece only)
INCIDENT COMMANDER
OPERATIONS SECTION CHIEF
STAGING AREA MANAGER
MUTLI-CASUALTY BRANCH DIRECTOR
AIR OPERATIONS DIRECTOR
MEDICAL GROUP SUPERVISOR
PATIENT TRANSPORTATION GROUP SUPERVISOR
AIR SUPPORT SUPERVISOR
AIR ATTACK SUPERVISOR
MEDICAL SUPPLY COORDINATOR
MEDICAL COMMUNICA-TIONS COORDINATOR
HELIBASE MANAGER
HELICOPTER COORDINATOR
TRIAGE UNIT LEADER
TREATMENT UNIT LEADER
AIR AMBULANCE COORDINATOR
HELISPOT MANAGER
AIR TANKER COORDINATOR
TRIAGE PERSONNEL
TREATMENT DISPATCH MANAGER
GROUND AMBULANCE COORDAINTOR
FIXED WING BASE MANAGER
MORGUE MANAGER
IMMEDIATE TREATMENT MANAGER
DELAYED TREATMENT MANAGER
DISASTER CONTROL FACILITY
(off scene)
ORGANIZATIONAL LINES
COMMUNICATIONS LINES
MINOR TREATMENT MANAGER
6/93

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

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

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

The Multi-Casualty Branch Worksheet (ICS-MC-305), and the Position Checklist found in Section 9, should be used any time it is appropriate. However, the Worksheet and Position Checklist must be used whenever more than two components of field operations have been assigned to other individuals.

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

- Triage Unit Leader
- Treatment Unit Leader
- Transportation Unit Leader
- Medical Supply Coordinator
- Medical Communications Coordinator

5.1.2 Medical Supply Coordinator

The Medical Supply Coordinator shall acquire and maintain control of appropriate medical equipment and supplies from response vehicles assigned to the Medical and Patient Transportation Group.

5.1.3 Triage Unit Leader

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

- Triage Personnel
- Morgue Manager

I
SEE INSERT OF MODIFIED MEDICAL BRANCH WORKSHEET

5.1.4 Morgue Manage

The Morgue Manager shall be responsible for establishing an on-scene morgue, if not previously established, and maintaining the integrity, security, and identification of deceased victims.

5.1.5 Treatment Unit Leader

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

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

5.1.6 Patient Transportation Unit Leader (PTUL)

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

- Medical Communications Coordinator
- Ambulance Coordinator
-

5.1.7 Medical Communications Coordinator

The Medical Communications Coordinator shall establish and maintain medical communications with the Control Facility and shall select the mode of transport and patient destination based upon the direction of the Control Facility.

5.1. 8 Ambulance Coordinator

The Ground Ambulance Coordinator is responsible for the coordination of incoming personnel and equipment, and reports to the Patient Transportation Unit Leader. The Ambulance Staging Resources Status (Enclosure - J, MCM-404) shall be used to track ambulance availability and activities.

This person will be located at the staging area to organize ambulances or other medical transportation vehicles, medical equipment, and medical personnel and dispatch them to duties at the request of the Patient Transportation Unit Leader. Information to complete applicable sections of the Patient Transportation Summary Worksheet may be requested.

The Ambulance Coordinator shall coordinate operations with the Air Operations Group, keep the Patient Transportation Unit Leader advised of air ambulance availability, capability and complete applicable sections of the Patient Transportation Summary Worksheet.

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

5.2 DESIGNATED AREAS

Locations of designated areas, as detailed below shall be approved by the Incident Commander or one of his/her staff. Once the location has been assigned to EMS, the Medical Group Supervisor or his/her 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 the patients side by side and in groups by triage priority.

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

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

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

* EMS Staging Area

This area will be the gathering point for EMS personnel and equipment. Supervision of this area may be assigned to the first unit which arrives in the Staging Area. Transport vehicles will be maintained in a one way traffic pattern towards the loading area, if possible. Request law enforcement assistance through the Incident Commander if a change of normal traffic pattern is necessary. If necessary, a field inventory will be established at the staging area. In a large incident, the staging area will include many other non-medical components. In this case, the Air/Ground Ambulance Coordinator will handle EMS resources and report to the person in charge of staging for the entire incident. EMS staging may be incorporated in a joint Staging Area if one has been established by the Operations Chief.

* Loading Area

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

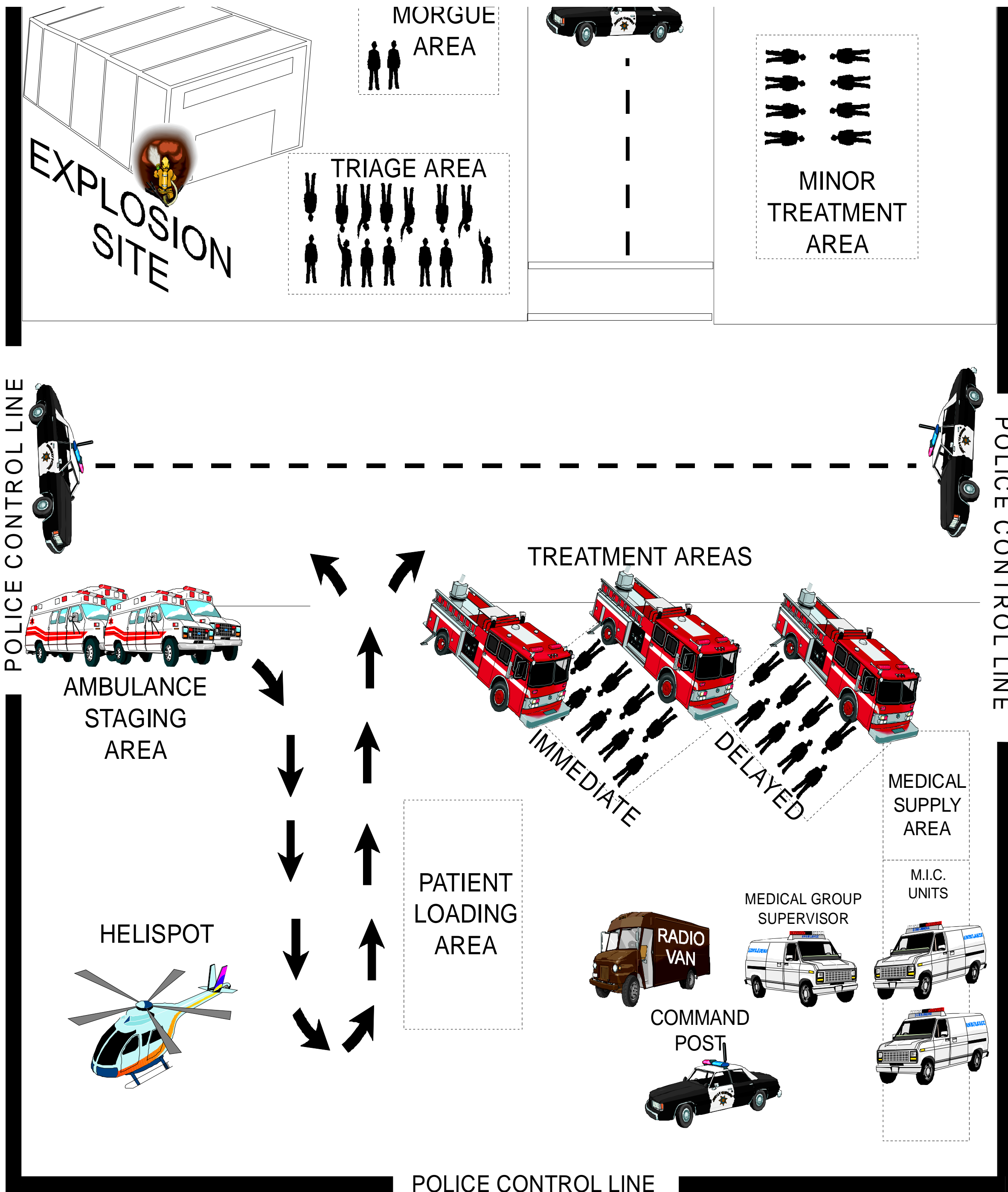
* Morgue Area

In most cases the deceased should not be moved. A Morgue Area should be established only if it becomes necessary to remove deceased patients from the impact site, i.e., to gain access to salvageable patients. This area should be located away from the treatment area(s) and is the responsibility of the Coroner's Office. 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 restraints, the victims may be removed to an area where the Triage Unit Leader or triage teams will triage, tag, or utilize optional flags. See Section 5.3 and direct litter bearers to the appropriate treatment area.


MORGUE
AREA
EXPLOSION
SITE
TRIAGE AREA
MINOR
TREATMENT
AREA
POLICE CONTROL LINE
POLICE CONTROL LINE
TREATMENT AREAS
AMBULANCE
STAGING
AREA
IMMEDIATE
DELAYED
MEDICAL
SUPPLY
AREA
M.I.C.
UNITS
PATIENT
LOADING
AREA
HELISPOT
RADIO
VAN
MEDICAL GROUP
SUPERVISOR
COMMAND
POST
POLICE CONTROL LINE

5.3 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 be supervised by the Medical Group Supervisor. Triage responsibilities may be assigned to a Triage Unit Leader if the demands of the incident warrants such expansion, or if necessary, all available personnel may be assigned to triage initially.

* Treatment prior to triage of all patients shall be restricted to airway establishment and to control hemorrhage.

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

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

* Initial triage should take 30 seconds or less per patient. Initial triage should be performed utilizing the S.T.A.R.T. method (see ENCLOSURE B). Adjustments may be necessary during retriage and when triage is being done by higher trained personnel.

* Triage of patients should occur where they lie only if the area is safe. If a hazard exists, patients should be moved to a safe triage area. Patients should be triaged and tagged prior to leaving the triage area. Do not wait to triage patients until they are placed in a treatment area. This will cause confusion as the patients will have to be rearranged into triage categories.

* Triage personnel will return unused tags to the Medical Group Supervisor or Triage Unit Leader and will, at that time, be reassigned to treatment or transport areas.

5.3.1 Triage Categories

* IMMEDIATE: Critical, life-threatening. Likely to survive if they receive care within thirty (30) minutes.

* DELAYED: Serious, may be life threatening. Likely to survive if care is received in thirty (30) minutes to several hours.

* MINOR: Not considered life threatening. Care may be delayed hours or days. MINOR patients are ambulatory and should be able to wait in a receiving facility's waiting room unsupervised.

* DECEASED: Mortally wounded or expectant. Clinically dead.

5.4 TREATMENT

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

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

assignment of personnel. EMT-Is 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.

* Retriage every fifteen (15) minutes, if possible. If staffing allows, retriage should be more precise than the initial S.T.A.R.T. method.

5.4.1 Immediate

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

5.4.2 Delayed

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

5.4.3 Minor

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

5.4.4 Deceased

Deceased patients should be left in the position they are found, if possible. Do not separate patient from identification. If it is necessary to move deceased patients, a field morgue will be established away from the other areas and under the direction of the Coroner. Movement of deceased patients shall be done only after consultation with the Coroner's Office, if possible.

5.5 EMS RESOURCE MANAGEMENT

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

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

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

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

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

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

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

5.6 TRANSPORTATION/PATIENT DISPERSAL

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

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

* Vehicle loading should be maximized without jeopardizing patient care. Unless it is the only option, two immediate patients should not be transported in the same ambulance. Instead, an immediate may be transported with a delayed patient to better assure that pre-hospital staff can adequately care for patients during transport. Each patient transported must be registered in the Patient Transportation Summary Worksheet (MCM-403). See sample below.

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

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

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

5.7CONTAMINATION

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

PATIENT TRANSPORTATION SUMMARY WORKSHEET				1. INCIDENT NAME:			2. DATE PREPARED	3. TIME PREPARED:	
PATIENT READY	PATIENT STATUS	INJURY TYPE (IE: HEAD)	MODE OF TRANSPORT	HOSPITAL DESTINATION	AMBULANCE CO. AND ID	PATIENT NAME/ TAG NUMBER	OFF SCENE TIME	ETA	HOSPITAL ADVISED
	I D M								
	I D M								
	I D M								
	I D M								
	I D M								
	I D M								
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MCM 403		4. PREPARED BY (PATIENT TRANSPORTATION UNIT LEADER/MEDICAL COMMUNICATIONS COORDINATOR)							

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

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

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

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

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

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

STANDING ORDERS

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

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

* On-Scene:
- Contact should only be made following approval of the Medical Group Supervisor.

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

SECTION 6: RESOURCES & ANCILLARY OPERATIONS

A DAY-TO-DAY MUTUAL AID

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

B MASTER MUTUAL AID

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

C ANCILLARY OPERATIONS

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

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

SECTION 7: DOCUMENTATION

Original ICS-MC & MCM FORMS for use with this manual are found on yellow paper in ENCLOSURE J. An Index is provided listing the most recent form number and date for each form. The yellow originals should be used to make white copies as they are needed for use in the field. Position Checklist form yellow originals are found in Section 9.

NOTE: Do NOT use the yellow original copies in your manual. Make copies of the yellow original forms for use in the field.

A. TRIAGE TAGS

Upon arrival at the scene, the Medical Group Supervisor will distribute tags to qualified triage personnel. The number of tags distributed should be noted to better assess the actual number of patients.

1 **Triage Personnel** should:

- initially tag patients with the S.T.A.R.T. triage method;
- tag only arms and legs - avoid injured areas;
- report to the Medical Group Supervisor or designee;
- return unused tags and ask for further assignment.

2 **Treatment Personnel** should:

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

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

Once the destination facility has been determined, it will be written on the tag. The Patient Transportation Unit Leader will note the tag number on a Patient Transportation Summary Worksheet (MCM-403).
Transporting personnel will note the triage tag number on the patient care record/field assessment form. This will enable information to be obtained at a later time and permit a rapid return to the incident scene.

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

B. FORMS

* **Field Pre-Hospital Care Records**

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

* **Multi-Casualty Branch Worksheet**

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

* **Patient Transportation Summary Worksheet**

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

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

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

* **Ambulance Staging Resource Status**

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

* **Supply Receipt & Inventory Form**

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

MULTI-CASUALTY INCIDENT REVIEW/QUALITY IMPROVEMENT

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