CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES

A Division of the Fresno County Department of Public Health

Manual: Emergency Medical Services Administrative Policies and Procedures	Policy Number: 620 Page: 1 of 12
Subject: Multi-Casualty Incident (MCI) Management - Prehospital Operations	
References: California Health and Safety Code Division 2.5 California Code of Regulations, Title 22, Division 9 FIRESCOPE Fire Service Field Operations Guide ICS 420-1 (July 2007) California Code of Regulations (SEMS), Title 19, Division 2, Section 2400 Government Code Section 8607 (a)	Effective: 9/1/85

I. POLICY

A Multi-Casualty Incident (MCI) is defined as any incident with ***six (6) or more patients.*** The response and management of Multi-Casualty Incidents (MCI) in Fresno, Kings, Madera, and Tulare Counties shall be consistent with the National Incident Management System (NIMS), Standardized Emergency Management System (SEMS), and the Incident Command System (ICS).

II. PURPOSE

This policy establishes standardized emergency management procedures for the management of multi-casualty incidents. It is designed to provide prehospital personnel with the necessary information to successfully manage such incidents in coordination with other public safety response agencies.

III. INCIDENT MANAGEMENT

EMS field operations shall function under the Incident Command System (ICS) (Attachment A). In order to assure effective utilization of resources and coordination of law enforcement, fire, EMS and other public service agencies, there shall be one command system, one command post and one incident commander.

A. Command System

In accordance with SEMS/NIMS, command and coordination actions are managed through the Incident Command System or "ICS". All scenes and actions shall be managed in accordance with standardized ICS principles. The first arriving ambulance shall take medical control of the scene and assess the immediate needs for the incident. The role of Incident Commander may be assumed by the legally responsible jurisdictional representative upon arrival to the scene. The Incident Commander has overall authority of the entire incident.

Approved By: EMS Division Manager	**Daniel J. Lynch** (Signature on File at EMS Agency)	Revision: **10/01/2016**
EMS Medical Director	**Jim Andrews, M.D.** (Signature on File at EMS Agency)	

1. Unified Command

   Under ICS, a unified command structure may be established at an event involving multiple jurisdictions at a single incident command post. In ICS, Unified Command is a unified team effort which allows all agencies with responsibility for the incident, either geographical or functional, to manage an incident by establishing a common set of incident objectives and strategies. This is accomplished without losing or relinquishing agency authority, responsibility, or accountability.

B. Scene Management (California Health and Safety Code, Section 1798.6(c))

Authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition. A priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency medical service personnel or other authoritative health care professionals at the scene in the determination of relevant risks. While this authority does not include direct patient health care management, scene management and patient management should be conducted in a manner, which provides for mutually supportive operations.

Management of the scene includes the coordination of all resources including law enforcement, fire, and EMS resources. As a general rule, the type of incident determines the jurisdictional agency responsible for the incident. Once the agency with jurisdictional responsibility arrives on the scene of the incident they will assume responsibility and management of the incident.

C. Patient Health Care Management (California Health and Safety Code, Section 1798.6(a))

Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of an emergency who is most medically qualified, specific to the provision of rendering prehospital emergency medical care. If no licensed or certified health care professional is available, or until arrival of such personnel, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.

IV. EMS OPERATIONS – Response

A. MCI Dispatch Procedure – When a MCI is recognized, the EMS dispatcher shall provide appropriate information to responding EMS resources to allow for the appropriate EMS management of the incident. The response information shall include the following:

1. Initial Dispatch – Standard response information

   a. Priority of response
   b. Unit Number(s)
   c. Problem
   d. Cross Streets
   e. Address and Business name

   Example: *Priority 1 Medic 305, Medic 310, Medic 325, multi-casualty traffic accident, Manning at Columbia, 985 Manning Avenue*

2. MCI Response Information – MCI information provides additional information to units responding to the MCI for coordination and management of the incident.

   a. Priority of response/Incident type

b. Unit number(s)
c. Problem
d. Cross Street
e. Address / Business Name

If the incident involves the response of **three (3) or more ambulances**, the EMS Dispatcher will also include the following information:

f. Incident Name and Location
   1) EMS dispatch will assign an incident name, which should be consistent with fire and/or law incident names.

g. Primary Response Channel
   1) The primary response channel may be the normal dispatch channel or EMS dispatch may move the incident to a secondary response channel (i.e., Med 10 or a countywide command channel)

h. On-scene Tactical Channel
   1) EMS dispatch will assign the incident a tactical – on-scene channel. The purpose of the tactical channel is to move on-scene communications off of the main command channel and allow the medical group supervisor to communicate directly with on-scene responders.

   2) If assigned a tactical channel, responding EMS units should switch radios to the channel upon arrival at scene. The medical group supervisor or assigned staff will provide further instructions and assignments.

Example #1: *Priority 1 Medic 141, Medic 404, for an evacuation of patients, Huntington at Bush, 5265 E Huntington, Raintree Convalescent,. Respond on Med 11, the TAC channel is Med 13. Contact Raintree Medical Group on Med 13 upon arrival.*

Example #2: *Priority 1 Medic 136, 151, 401, 405, 495, M101, and EMS-04, chemical exposure involving 30 victims, Whitesbridge at San Mateo, 29400 W Whitesbridge, Spreckels Sugar Company. Respond on Med 10, the TAC channel is CALCORD. You will stage at Whitesbridge and the Sprekels entrance. This will be the Spreckels Incident.*

V. EMS OPERATIONS – Command

A. Medical Group Supervisor

1. The first Paramedic or EMT on-scene will assume the role as the Medical Group Supervisor. If an EMT is the first EMS person at the scene and assumes the role as the Medical Group Supervisor, this will be relinquished to the first paramedic that arrives at the scene.

   a. If a field supervisor arrives on the scene, the field supervisor and first on-scene paramedic will make face-to-face contact and briefly discuss the status of the incident. Since the role of the Medical Group Supervisor is primarily management, the first on-scene paramedic and field supervisor should consider re-assigning the Medical Group Supervisor role to the field supervisor in order to use the first on-scene paramedic in another role (e.g. Patient Transportation Unit Leader). In order to assume the role of the Medical Group Supervisor, the field supervisor must be a paramedic.

2. The Medical Group Supervisor shall be identified through the use of a green vest clearly marked with "Medical Group Supervisor" on the front and back. The Medical Group Supervisor shall report to the

Incident Commander, Operations Section Chief or Medical Branch Director, if activated. If an Incident Commander has not been identified, the Medical Group Supervisor will coordinate activities with fire and law enforcement officials until the incident is resolved.

3. The Medical Group Supervisor will be responsible for overall patient care and management of the Medical Group. The Medical Group Supervisor **should not be directly involved in patient care** unless he/she is one of the only rescuers at the scene for extended lengths of time.

   The Medical Group Supervisor should consider all options for patient transport when he/she is the only rescuer and additional ambulances have extended ETAs. This may include transport of Immediate Care (Red) Priority patients while BLS first responder personnel stand by with Delayed (Yellow) and Minor (Green) Priority patients. During the course of a multi-casualty incident with sufficient personnel and resources, the Medical Group Supervisor should be the last medical person to leave the scene.

4. The Medical Group Supervisor shall immediately perform the following actions upon assuming responsibility for EMS Operations:

   a. Report to the Incident Commander (IC) and determine the general nature of the incident and impact area(s) - i.e., hazardous materials, explosives, wind direction, the need for traffic control, scene safety/access, fire control, and crowd control.

   b. In coordination with the IC assign personnel to locate victims, identify patients and triage patients using START/JUMP START triage. (Refer to section VIII for further information on START/JUMP START triage). JUMP START is used for children 8 years old or less.

   c. Determine the need for additional resources, the direction of travel to enter the scene and designate an ambulance staging area (if needed). Communicate with IC and the EMS Communications Center.

   d. Provide initial notification call-in to Base Hospital/DCF

   e. Maintain communication with the Incident Commander or Medical Branch Director on medical operations and resource issues.

5. Depending on the size and nature of the incident, the Medical Group Supervisor should consider making the following assignments:

   a. Assign a Patient Transportation Unit Leader.

   b. Assign a Treatment Unit Leader, (e.g., Immediate Care Priority, Delayed Care Priority, Minor Care Priority, and Morgue Area).

B. Medical Branch Director

The on-scene EMS Duty Officer will serve as the Medical Branch Director. In such a case, the Medical Branch Director will be identified by a green vest and report to the Incident Commander or Operations Section Chief if assigned. The Medical Group Supervisor will continue to direct management of EMS Operations and report to the Medical Branch Director.

VI. EMS OPERATIONS – On-scene Management

Upon arriving on-scene, EMS personnel will switch radio channels to the assigned tactical channel (if assigned) and report to the area assigned by the Medical Group Supervisor or Ambulance Coordinator.

A. EMS Resources

1. An EMS resource ordering point shall be determined between the Medical Group Supervisor and Incident Commander. Once determined this will be communicated to the appropriate communications centers and on scene personnel.

2. All EMS personnel, equipment and supplies shall be directed to the appropriately designated Medical Staging Area, upwind from any hazardous materials, gases, or smoke that may be generated by the incident.

3. Ambulances and EMS resources will be assigned to specific tasks or areas by the Medical Group Supervisor or Ambulance Coordinator (if designated).

4. Transport vehicles will be maintained in a one way traffic pattern toward the loading area, if possible. Request law enforcement assistance through Incident Commander (or designee) if assistance is needed for traffic control.

5. Keep a driver with each vehicle. If drivers are needed for Triage/Treatment, maintain keys in each vehicle.

6. At the request of the Medical Group Supervisor (or Medical Supply Coordinator) remove equipment not necessary for transport. Designate a Medical Supply Coordinator to be responsible for a medical supplies and equipment that can be rapidly moved to the treatment areas as needed. Examples of such supplies would be extra backboards, stretchers, splints, oxygen, and IV supplies.

    a. If a Disaster Medical Support Unit, Disaster Medical Support Trailers, or medical caches are deployed to the incident, they will be the responsibility of the Medical Supply Coordinator.

VII. EMS OPERATIONS - Medical Control & Direction

A. Base Hospital / Disaster Control Facility (DCF)

The Base Hospital or DCF receives information from the disaster site and relays information to other hospitals. The Base Hospital or DCF is responsible for determining the destination of triaged patients to area hospitals.

If the incident involves ***ten (10) or more patients***, contact the appropriate DCF. If communications cannot be established with the designated DCF, contact a Base Hospital. The designated DCFs are:

Designated DCF	Counties
Regional Medical Center (RMC)	Fresno, Kings, Madera
Kaweah Delta Medical Center	Tulare County

B. Paramedics involved in the MCI shall function under radio failure protocols for the duration of the event. For treatments not allowed in radio failure procedures, contact an alternate Base Hospital.

C. Refusal of Medical Care and/or Transport (RMCT) should be completed as in day-to-day practice and in accordance with EMS policy #544 - Criteria for Receiving and Base Hospital Contact. Not all patients requesting RMCT need Base Hospital approval; only patients meeting the requirement for call-in for RMCT require Base Hospital/DCF approval. In larger incidents, the DCF may direct RMCTs to another Base Hospital during a MCI.

D. Field to Hospital Communications

1. If the MCI involves less than 10 patients, contact an appropriate Base Hospital using normal communications procedures.

2. In incidents involving ten (10) or more patients, the appropriate DCF shall be contacted for the incident. The Designated Med Channel for communications with the DCF will be maintained with the disaster site through the Medical Group Supervisor, Patient Transportation Unit Leader, or the Medical Communications Coordinator on one or more of the following channels:

UHF Med Channel	Operational Area Assignment
Med 4	South-East Fresno County - RMC
Med 5	North-East Fresno County - RMC
Med 6	Western Fresno and Kings Counties - RMC
Med 7	Madera County - RMC
Med 8	Kings County - RMC
Med 22	Tulare County - KDMC

NOTE: RMC has the ability to communicate on most Med Channels. It may be necessary to use a different Med channel due to the geographic location of the incident. The EMS Dispatch center can contact RMC and have them switch to a different Med Channel.

Every attempt must be made to utilize radio communications with Base hospital / DCF. This includes switching to alternate channels to establish contact. Cell phones may be used if attempts at radio contact have failed.

3. The Patient Distribution Zone List may be utilized by the DCF or Base Hospitals in Fresno, Kings, Madera, and Tulare Counties as a guideline for patient destination determination in situations involving ***six (6) or more patients*** requiring transport to a hospital.

E. Base Hospital/DCF Communication

1. Notification Call-in

Upon arrival of the first on-scene paramedic to an MCI, the initial notification to the Base Hospital or DCF should occur as soon as possible (prior to patients being prepared for transport). In the initial contact, the Medical Group Supervisor (first EMS unit on-scene) shall report the following information to the DCF to allow hospital disaster procedures to be initiated, if necessary:

a. Identify self by the ambulance unit number, or in incidents that have been assigned an Incident Name, the "{*incident name*} Medical Group Supervisor" (i.e. "Raintree Medical Group)"
b. Location of Incident
c. Nature of Incident (HazMat, Medical, Trauma)
d. Estimate of patients
e. ETA (Only if Immediate Priority patients are enroute to the hospital.)

If any changes or modification occur in the incident, the Medical Group Supervisor or designee will provide an update to the Base Hospital/DCF as the incident progresses.

NOTE: The first three EMS transportation units may transport Immediate priority (Red) patients from the scene prior to initiating the call-in to the Base Hospital/DCF; however, the Call-in shall occur immediately following the initiation of patient transport(s).

2. Transportation Call-in:

When a patient or patients are ready for transport, the Medical Group Supervisor, Patient Transportation Unit Leader, or designee will advise the Base Hospital/DCF of the following:

a. Triage Tag Number (last 4 digits)
b. Age
c. Patient Care Priority Designation (color)
d. Chief Complaint
e. Request destination from Base Hospital / DCF
f. Transporting Ambulance Number

The Base Hospital/DCF shall provide the destination for each transport unit. Once the Medical Group Supervisor, Patient Transportation Unit Leader, or designee is given the destination, they will confirm destination and provide an ETA.

3. Patient Call-In

Paramedics and EMT's treating patients of an MCI shall function under radio failure protocols for the duration of the event. For treatments not allowed in radio failure procedures, contact an alternate Base Hospital.

4. When all patients have been transported from the incident site, the DCF will notify the area hospitals of the "All Clear" status.

VIII. EMS OPERATIONS - Medical Group Positions

When needed, the Medical Group Supervisor will appoint each subordinate position within the EMS Medical Group. Refer to Attachment 'A' for ICS organizational chart. As staffing allows, each position should be staffed by a Paramedic, with the exception of the Medical Supply Coordinator and Ambulance Coordinator, who can be an EMT or firefighter experienced with transportation. All appointed positions shall wear an appropriately labeled green vest. Multi-casualty Checklists for each position in the medical branch are included in Attachment 'B'. The following Medical Group positions can be implemented **as needed**:

A. Patient Transportation Unit Leader

Radio I.D. – "{*Incident Name*} Transportation Leader" (i.e. "*Raintree Transportation Leader*")

The Patient Transportation Unit Leader is responsible for all radio communications with the Base Hospital (DCF) for the purpose of determining patient destination and will also directly supervise the loading of patients into transporting vehicles. This person shall be located at the loading area and will report to the Medical Group Supervisor.

The Transportation Unit is one of the first areas designated due to the time commitment for transport coordination. Additional personnel, such as the Medical Communications Coordinator or the Ambulance Coordinator, may be added to assist the Patient Transportation Unit Leader.

1. The Ambulance Coordinator is the EMS position that is responsible for ambulance staging and reports to the Patient Transportation Unit Leader.

Radio I.D. – "{*incident*} Ambulance Coordinator" (i.e., *"Raintree Ambulance Coordinator"*

B. Triage Unit Leader

Radio I.D. – "{*Incident Name*} Triage Leader" (i.e. "*Raintree Triage Leader*")

The Triage Unit Leader is responsible for the triage of patients and will report to the Medical Group Supervisor. After all patients have been triaged, the Triage Unit Leader will assist the movement of patients to a transportation unit, or treatment area. The Triage Unit Leader may designate a Morgue Manager to be responsible for the re-triage and supervision of deceased victims.

C. Treatment Unit Leader

Radio I.D. – "{*Incident Name*} Treatment Leader" (i.e. "*Raintree Treatment Leader*")

The Treatment Unit Leader reports to the Medical Group Supervisor and will be designated for the Treatment Area. In large incidents, a Treatment Area Manager may be designated for each of the Treatment Areas (i.e., Treatment Area Manager Immediate, Treatment Area Manager Delayed, Treatment Area Manager Minor, etc,). The Treatment Unit Leader will supervise the treatment of patients and prepare patients for transport. The Treatment Unit Leader may designate a Treatment Dispatch Manager to coordinate patients with the Transportation Unit.

D. Medical Supply Coordinator

Radio I.D. – "{*Incident Name*} Medical Supply" (i.e. "*Raintree Medical Supply*")

The Medical Supply Coordinator reports to the Medical Group Supervisor and is responsible for the coordination of all incoming and outgoing medical supplies and equipment in the medical branch. This position will organize medical supplies and equipment and deploy them to areas at the request of the Medical Group Supervisor. An EMT or firefighter can be assigned to this position.

IX. EMS OPERATIONS - Triage

A. Initial Triage

Initial Triage is to determine if a victim is a patient. Based upon the victim's initial complaint (if any), prehospital personnel will determine if the victim will be a patient requiring further assessment, treatment and transportation. Only those victims who are uninjured (or do not have a medical complaint) should be considered as not requiring an assessment. A patient is a person who has a medical complaint needing assessment, medical care or treatment.

1. An initial walk through may be necessary to provide a baseline estimate of patients.

2. Triage should begin immediately. Initial triage will utilize the Simple Triage and Rapid Treatment (START/ JUMP START) method and should take 30 seconds or less per patient. Triage is for the initial categorization of patients only and a complete assessment will be required once initial triage is completed. JUMP START is used for children 8 years old or less. Illustrations of START / JUMP START are included in Attachment 'C'.

3. The Medical Group Supervisor in coordination with the IC shall initially assign available personnel to triage. Make specific triage assignments of vehicles, buildings, or specific areas.

4. Patients should be triaged where they lie, only if the area is safe to enter. In the event a hazard exists, move patients to a secure area. If special precautions are needed to move patients, consult with the

Incident Commander. Only trained and equipped personnel should enter the hazardous area. If patients must be moved prior to triage, triage and tag patients before they enter the treatment area.

5. Prehospital personnel will use the California State Fire Chiefs' Association Triage Tag for the triage assessment of patients in any situation where there are ***six or more patients***.

6. There should be no ALS treatment prior to triage of all patients. The only treatment given during triage is to open an airway and control hemorrhage. CPR should be avoided unless staffing allows for treatment of all critical Immediate Care Priority patients. The Medical Group Supervisor (or Triage Unit Leader) is responsible for stopping CPR when CPR is not appropriate in a multi-casualty situation.

B. Use of the Triage Tag

1. Prehospital personnel will use the California State Fire Chiefs' Association Triage Tag for the triage assessment of patients in any situation where there are ***six or more patients***. The Cal-Chiefs' Triage tag will be utilized, in conjunction with the Simple Triage and Rapid Treatment (START/ JUMP START) System in order to assess ill or injured patients involved in the incident. JUMP START is used for children 8 years old or less. Triage Tape may be utilized in incidents of 25 patients or more in conjunction with a Triage Tag. The Triage Tape does not replace the Triage Tag. **Every patient must have a Triage Tag.**

2. Triage tags will be utilized in order to identify the triage priority of all patients and reduce the possibility of confusion regarding whether the patient has been triaged or not. **The triage tag number shall be included in the documentation of each prehospital care report (PCR).**

3. Patients who are re-triaged to a lower priority than the initial assessment, shall be re-tagged with a new triage tag, noting the time, and initials of the person making the assessment. The initial triage tag should be destroyed.

4. Re-triage all tagged patients every fifteen minutes if possible. If staffing allows, begin a more detailed assessment of patients.

C. Triage Priority Levels

1. Immediate (Red) Care Priority - First priority for extrication, treatment and transportation to a definitive care facility as determined by the START/ JUMP START triage method.

2. Delayed (Yellow) Care Priority – Second priority for treatment and transportation to definitive care facility as determined by START/ JUMP START triage, which is not immediately life threatening but will require further field stabilization and definitive care to prevent an adverse outcome.

   NOTE: Any patient who is non-ambulatory including C-spine precautions is a delayed priority patient unless triaged as an immediate priority patient.

3. Minor (Green) Care Priority "Walking Wounded" – Ambulatory patients with non-life threatening illness or injuries, as determined by START/ JUMP START triage, requiring further triage, treatment or transportation.

4. Morgue (Black) - Dead or no reasonable chance for survival (injuries not compatible with survival).

D. Incident Site Searches for Patients

1. The Medical Group Supervisor, under the direction of the Incident Commander, shall assist in organized searches to locate all victims in wide spread impact areas or incidents with poor visibility (e.g., single person walk through or drive through in a grid search pattern).

2. Coordinate with the Incident Commander to establish search parties.

3. Maintain communication with team members.

4. Establish an initial search pattern.

5. Carefully consider the need to mark searched areas. If searched locations are marked, ensure a consistent mechanism is utilized to re-check or control previously searched areas. Patients in wide spread impact areas looking for shelter and aid may move around and occupy previously marked and searched areas such as vehicles and/or buildings.

6. Coordinate a final walk through in case patients/victims have moved to previously searched areas.

X. EMS OPERATIONS - Treatment

The Medical Group Supervisor may assign the Treatment Unit Leader who will supervise treatment. The Treatment Unit Leader may designate Treatment Area Managers to supervise a specific treatment area.

Immediate Care Priority (Red) patients should be moved directly to a transport unit, if available.

A. Treatment

Once all patients have been triaged, they should be moved to a treatment area or transport unit if available.

1. As a general rule, Treatment Area Managers should be paramedics. Assign medical personnel to specific patients or groups of patients, as necessary. Non-transport paramedics, physicians or registered nurses should be assigned as assisting staff to the Immediate Care Priority (Red) patients. EMT's can be assigned as assisting staff to the Delayed (Yellow) or Minor (Green) Treatment areas.

2. Follow treatment protocols for radio failure on MCI's. For treatments not allowed in radio failure procedures, contact an alternate Base Hospital.

3. CPR should be avoided unless staffing allows for immediate treatment of all critical Immediate (Red) Care Priority patients.

4. Treatment Managers shall ensure re-triage and assessment of all patients in a Treatment Area at least every fifteen minutes or whenever possible with large numbers of patients.

5. Re-assessment and treatment of patients should be completed <u>enroute</u> to the hospital.

6. Treatment Area Managers shall assure that patients are prioritized for transportation.

B. Patient Transport Priorities

1. <u>Immediate (Red) Care Priority</u> should be transported from the scene first. Each transport unit should contain two (2) patients, except in unusual circumstances.

2. Delayed (Yellow) Care Priority patients are transported from the scene after all Immediate Care Priority patients have been transported. Depending on the number of each patient care priority, there may be an occasion for a Delayed Care Priority patient to accompany either an Immediate Care Priority, or a Minor priority patient.

3. Minor (Green) Care Priority patients are the last of the patient priority groups to be transported. Some Minor Care Priority patients may be released by "Refusal of Medical Care and/or Transport". It may be appropriate to transport remaining Minor Care Priority patients by van or bus to an appropriate medical facility.

4. Morgue (Black) Deceased

   a. This area is for victims who are deceased or have injuries that are not compatible with survival. Request the Coroner, and law enforcement to provide security until the Coroner's Office arrives on-scene.

   b. Leave deceased victims in the position they are found with triage tag in clear view. Do not separate victims from their ID. If it is necessary to move these victims, as determined by the Coroner or Incident Commander, a field morgue will be established away from the other areas.

   c. Assign appropriate personnel to recheck all victims.

XI. EMS OPERATION – Destination

The Base Hospital/DCF will determine patient destination during a declared MCI. For EMS transportation units involved in an MCI, the destination policy is temporarily suspended to allow the Base Hospital/DCF the ability to appropriately distribute patients to the local hospitals. However, the Base Hospital/DCF shall attempt to distribute the following patients to appropriate facilities, if the situation allows:

A. Immediate (Red) Priority patients should be considered for transport to a trauma center or the nearest appropriate hospital (if a non-trauma incident).
B. Seriously burned patients should be transported to the Burn Center (RMC)
C. Attempts should be made to keep family members together

As a reminder, the first three EMS transportation units may transport Immediate Priority (Red) patients from the scene prior to initiating the call-in to the Base Hospital/DCF; however, the notification call-in shall occur immediately upon the departure of the first ambulance.

XII. EMS OPERATIONS - Transportation

Patients will be moved from the treatment area to the transporting vehicles. This location will be known as the Loading Area.

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

B. Complete the Medical Transportation Information Log for each patient transported.

C. Once prepared for transportation, the Treatment Unit Leader (or Treatment Dispatch Manager, if assigned) should notify the Patient Transportation Unit Leader of the number and type of priority patients. The Transportation Unit Leader (or Medical Communication Coordinator, if assigned) will request destination determination from the DCF. Immediate Care Priority patients should be the first patients transported from the scene. Minor Care Priority patients are the last of the patient priority groups to be transported. It may

be appropriate to transport remaining Minor Care Priority patients by van or bus to an appropriate medical facility.

1. Requests for alternative transport vehicles (i.e., bus, van, etc) shall be requested through the Incident Commander.

XIII. EMS OPERATIONS – Staging

These areas will be a gathering point for EMS resources, including ambulances, EMS personnel, and equipment.

A. The Ambulance Coordinator will coordinate the staging of ambulance vehicles.

B. Transport vehicles will be maintained in a one way traffic pattern toward the loading area, if possible. Request law enforcement assistance through Incident Commander (or designee) if assistance is needed for traffic control.

C. Keep a driver with each vehicle. If drivers are needed for Triage/Treatment, maintain keys in each vehicle.

D. At the direction of the Medical Supply Coordinator remove any equipment or needed supplies from the ambulance. The Medical Supply Coordinator will create a field inventory at the staging area that can be rapidly moved to the treatment areas as needed. Examples of such equipment or supplies would be extra backboards, stretchers, splints, oxygen, and IV supplies.

XIV. EMS OPERATIONS – Field Treatment Site

A Field Treatment Site is established by the Medical Branch of an incident when there is no capacity at area hospitals or alternative health care facilities to manage the ill and/or injured. The Field Treatment Site may also be used at a Casualty Collection Point while waiting for transport or upon receiving patients from another area. Field Treatment Sites are used as temporary care sites until transport destinations or adequate transportation resources have been identified.

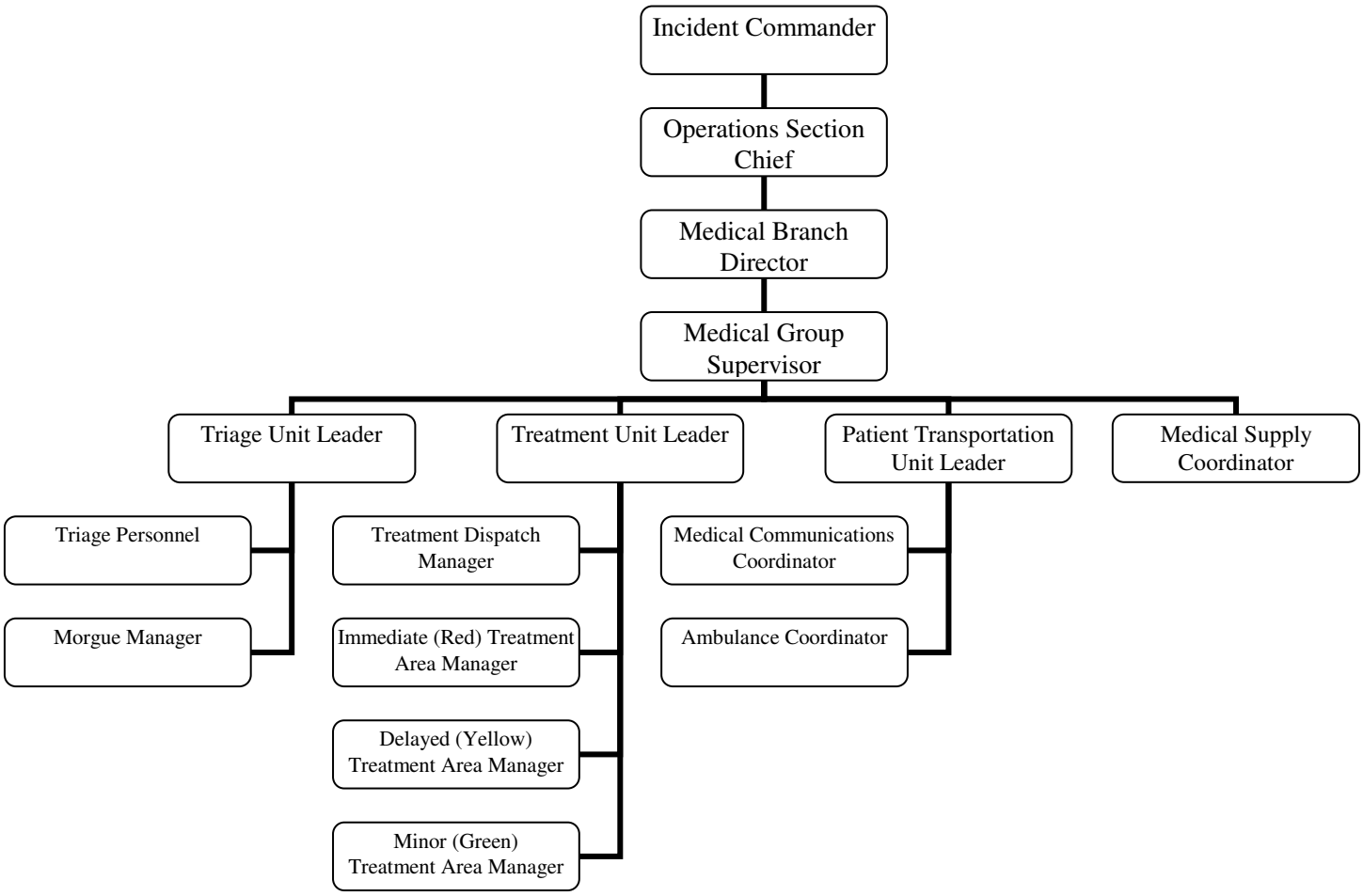
A Field Treatment Site is established in accordance with EMS Policy 621 – Field Treatment Sites. When a Field Treatment site is established, it is staffed with EMS personnel who provide ALS and BLS care in accordance with EMS Policy and Procedure. The Field Treatment Site also has an ICS command structure, similar to a field incident, which includes a Medical Group Supervisor and all of the sub-ordinate positions as needed.

VX. EMS OPERATIONS – Casualty Collection Points

A Casualty Collection Point(s) is a location where patients are gathered for the purpose of transporting them to other areas or receiving them from other areas. Fresno serves as a State designated Casualty Collection Point. In the event of a catastrophic event in other areas of the State, victims of the event could be transported directly to Fresno by Ground or by air. These victims would be received at a Casualty Collection Point where they would be triaged, and transported to appropriate facilities. A Field Treatment Site may also need to be established at the Casualty Collection Point for the provision of basic medical care for the arriving victims.

A Casualty Collection Point can also be used to evacuate victims and/or patients from areas within the CCEMSA. In large events that overwhelm the health care facilities within the area, patients can be transported to an established casualty collection point for transport to other areas in the State.

ATTACHMENT A
MEDICAL BRANCH ORGANIZATIONAL STRUCTURE UNDER ICS



ATTACHMENT B

MULTI-CASUALTY POSITION CHECKLISTS

- MEDICAL BRANCH DIRECTOR'S CHECKLIST
- MEDICAL GROUP/DIVISION SUPERVISOR'S CHECKLIST
- PATIENT TRANSPORTATION UNIT LEADER'S CHECKLIST
  - Medical Communications Coordinator's Checklist
  - Ambulance Coordinator Checklist
- TRIAGE UNIT LEADER'S CHECKLIST
  - Morgue Manager's Checklist
- TREATMENT UNIT LEADER'S CHECKLIST
  - Treatment Dispatch Manager Checklist
  - Treatment Area Manager Checklist
- MEDICAL SUPPLY COORDINATOR CHECKLIST

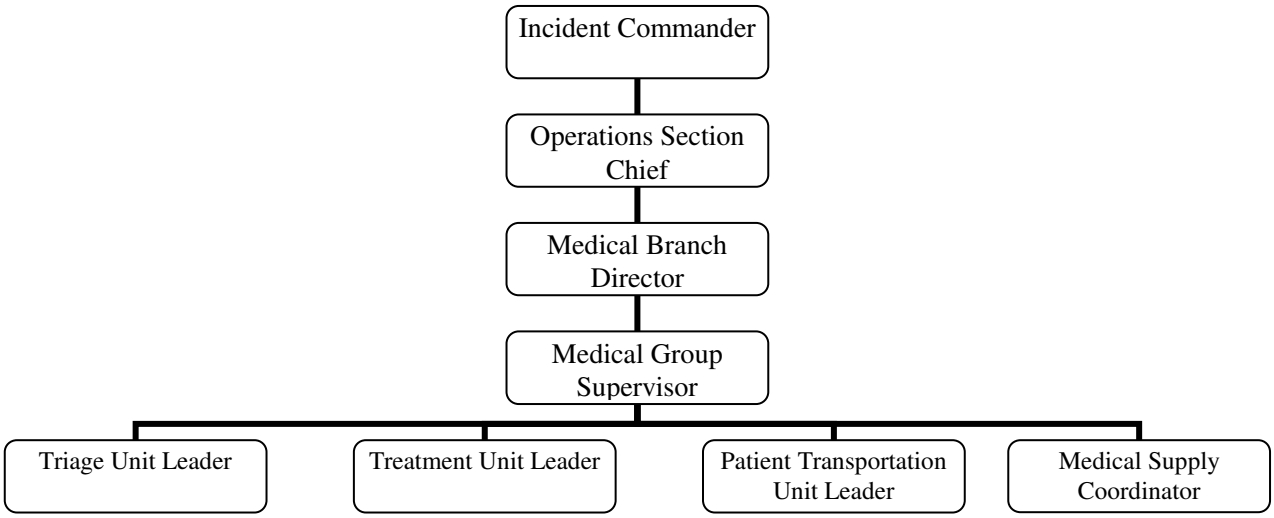
NOTE: Positions with subordinate staff are responsible for all duties until subordinate staff is assigned. Once subordinate staff is assigned, the Position Leader is responsible to oversee the subordinate staff responsibility.

MEDICAL BRANCH DIRECTOR'S CHECKLIST

The Medical Branch Director is responsible for the implementation of the Incident Action Plan within the Branch. This includes the direction and execution of branch planning for the assignment of resources within the Branch.

The Medical Branch Director reports to the Incident Commander or Operations Section Chief

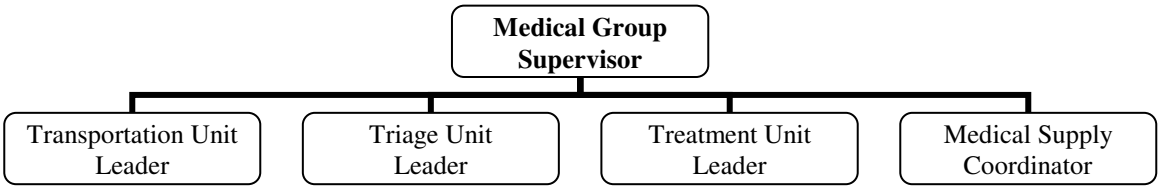
- ☐ Check-in and obtain briefing from the Incident Commander or Operations Section Chief.
- ☐ Review Group/Division Assignments for effectiveness of current operations and modify as needed.
- ☐ Provide input to Incident Commander or Operations Section Chief for the Incident Action Plan.
- ☐ Supervise Medical Branch activities.
- ☐ Report to the Incident Commander or Operations Section Chief on Branch activities.
- ☐ Maintain Unit Log - ICS-214 (Attachment E).



MEDICAL GROUP SUPERVISOR'S CHECKLIST

The Medical Group Supervisor reports to the Medical Branch Director and supervises the Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader and Medical Supply Coordinator. The Medical Group Supervisor establishes command and controls all of the activities within a Medical Group.

- ☐ Assume Role Of Incident Commander if first on scene
- ☐ Check-in and obtain briefing from Medical Branch Director (or Incident Commander if not assigned)
- ☐ Establish Medical Group/Division with assigned personnel; request additional personnel and resources sufficient to handle the magnitude of the incident.
- ☐ Organize Scene and designate Unit Leaders and Treatment Area locations as needed.

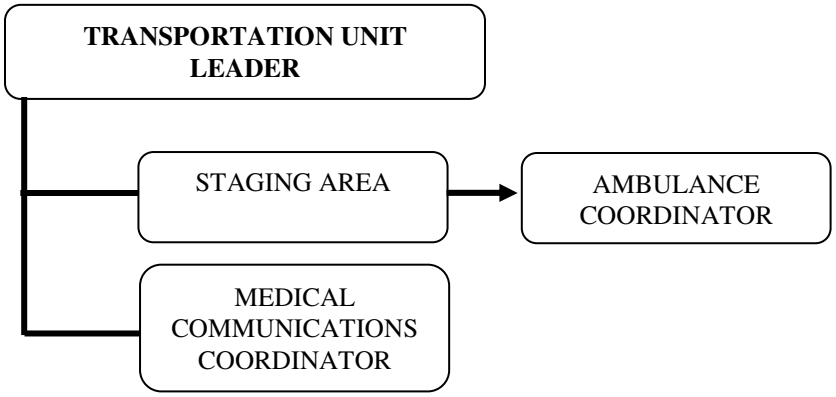


- ☐ Isolate Morgue and Minor Treatment Area from Immediate and Delayed Treatment Areas.
- ☐ Ensure notification of Base Hospital or DCF
- ☐ Establish communication and coordination with assigned unit leaders.
- ☐ Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, cots, backboards, litters).
- ☐ Direct and/or supervise on-scene personnel from agencies such as, first responders, Coroner's Office, Red Cross, law enforcement, ambulance companies, county health agencies, and hospital volunteers.
- ☐ Request law enforcement/coroner involvement through ICS channels as needed.
- ☐ Ensure proper security, traffic control, and access for the Medical Group/Division area.
- ☐ Participate in Medical Branch/Operations Section planning activities.
- ☐ Maintain Unit Log - ICS-214 (Attachment E).

PATIENT TRANSPORTATION UNIT LEADER'S CHECKLIST

The Patient Transportation Unit Leader reports to the Medical Group Supervisor and supervises the Medical Communications Coordinator, and the Ambulance Coordinator. The Patient Transportation Unit Leader is responsible for the coordination of patient transportation, communications with the Base Hospital/DCF, and maintenance of records relating to the patient's identification, condition, and destination.

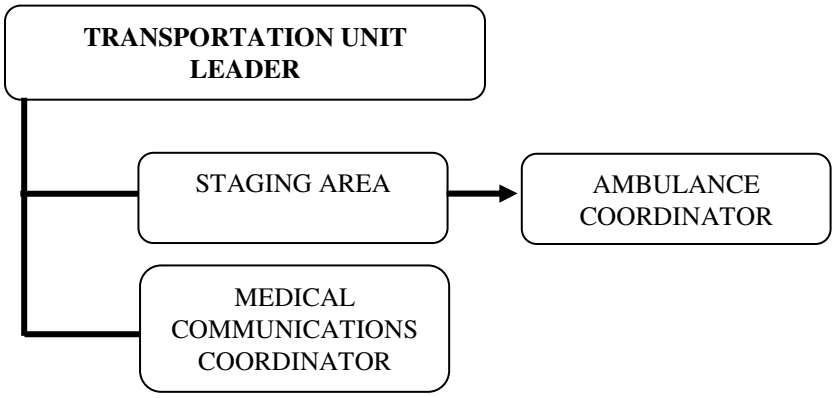
- ☐ Check-in and obtain briefing from the Medical Group Supervisor.
- ☐ Designate ambulance staging area(s) and Ambulance Coordinator (if needed).
    - Establish communications with Ambulance Coordinator (if assigned).
- ☐ Establish communications with Base Hospital or DCF.
    - Designate a Medical Communications Coordinator, if needed.
- ☐ Coordinate and organize the loading of patients into ambulances
    - Assure that patient information and destination is recorded (Attachment E).
- ☐ Request additional ambulances, as required, through the Medical Group Supervisor
- ☐ Notify Ambulance Coordinator(s) of any additional ambulance requests.
- ☐ Coordinate requests for air ambulance transportation through the Medical Branch and Incident Commander.
    - Establish Air Ambulance Helispot with the Medical Branch Director and Incident Commander (if needed).
- ☐ Maintain Unit Log - ICS-214 (Attachment E).



MEDICAL COMMUNICATIONS COORDINATOR'S CHECKLIST

The Medical Communications Coordinator reports to the Patient Transportation Unit Leader, and is responsible for all communications between the incident and the Base Hospital/DCF regarding patient transport and destination.

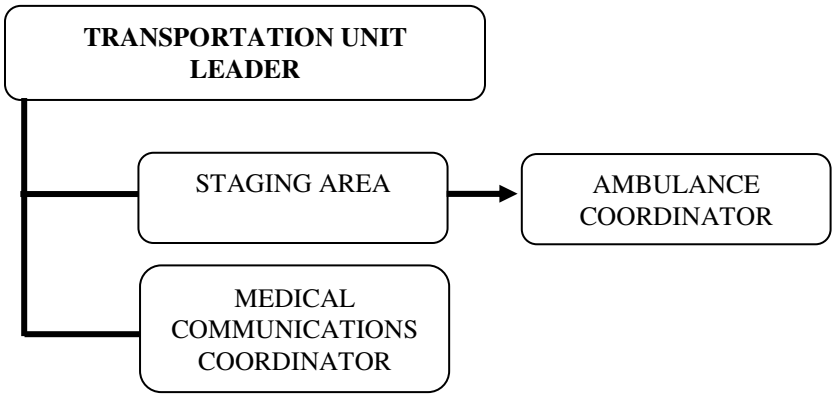
- ☐ Check-in and obtain briefing from Patient Transportation Unit Leader.
- ☐ Establish communications with Base Hospital/DCF.
- ☐ Receive basic patient information and status from Treatment Unit Leader (or Treatment Dispatch Manager, if assigned).
- ☐ Coordinate patient incident destination with Base Hospital/DCF.
- ☐ Communicate patient transportation needs to Ambulance Coordinator base upon requests from Treatment Unit Leader.
- ☐ Maintain appropriate records (Attachment F).



AMBULANCE COORDINATOR CHECKLIST

The Ambulance Coordinator reports to the Patient Transportation Unit Leader, manages the Ambulance Staging Area(s), and dispatches ambulances as requested:.

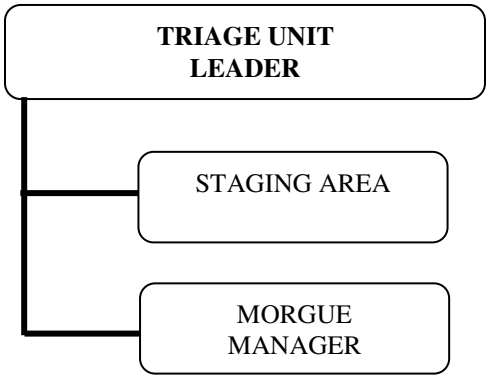
- ☐ Check-in and obtain briefing from Patient Transportation Group Supervisor.
- ☐ Establish appropriate Staging Area for ground ambulances.
- ☐ Establish routes of travel for ambulances for incident operations.
- ☐ Establish immediate contact with ambulance agencies at the scene.
- ☐ Establish and maintain communications with the Transportation Unit and provide ambulances upon request.
- ☐ Assure that necessary equipment is available in the ambulance for patient needs during transportation.
- ☐ Request additional transportation resources as appropriate.
- ☐ Maintain records as required.



TRIAGE UNIT LEADER'S CHECKLIST

The Triage Unit Leader reports to the Medical Group Supervisor and supervises Triage Personnel/Litter Bearers and the Morgue Manager. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the triage area. When triage has been completed, the Unit Leader may be reassigned as needed

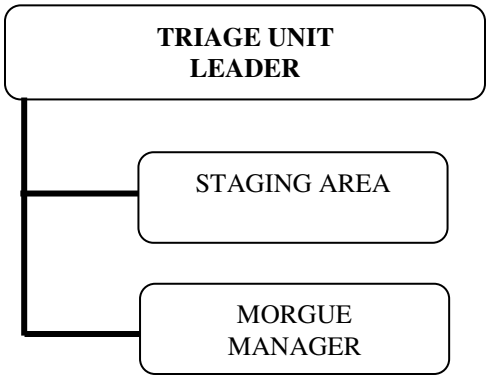
- ☐ Check-in and obtain briefing from Medical Group Supervisor.
- ☐ Organize and coordinate triage personnel and assignments.
- ☐ Implement Triage Process.
- ☐ Establish Morgue and designate a Morgue Manager, as needed (can be an EMT or Firefighter).
- ☐ Coordinate movement of patients from the Triage Area to the appropriate Treatment Area or Transport Unit Loading Area (as appropriate).
    - In larger incidents, patients may be moved to a treatment area before being moved to the Transportation Unit Loading Area.
- ☐ Re-triage victims and patients every 15 minutes or as time allows.
- ☐ Perform a final walk through of the scene once triage area is clear to confirm all patients have been cared for.
- ☐ Inform Medical Group Supervisor of resource needs.
- ☐ Maintain security and control of the Triage Area.
- ☐ Give periodic status reports to Medical Group Supervisor.
- ☐ Maintain Unit Log - ICS-214 (Attachment E).



MORGUE MANAGER'S CHECKLIST

The Morgue Manager reports to the Triage Unit Leader and assumes responsibility for Morgue Area functions until relieved by law enforcement or coroner.

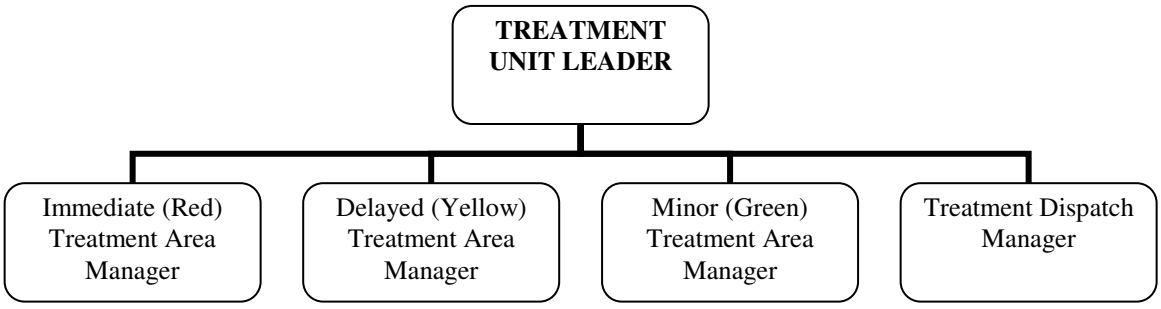
- ☐ Check-in and obtain briefing from Triage Unit Leader.
- ☐ Coordinate all Morgue Area activities.
- ☐ Keep area off limits to all but authorized personnel.
- ☐ Assess resource/supply needs and order as needed.
- ☐ Keep identity of deceased persons confidential.
- ☐ Coordinate with law enforcement and assist the Coroner's Office as necessary.



TREATMENT UNIT LEADER'S CHECKLIST

The Treatment Unit Leader reports to the Medical Group Supervisor and supervises Treatment Managers and the Treatment Dispatch Manager. The Treatment Unit Leader assumes responsibility for treatment, preparation for transport, and directs movement of patients to loading location(s).

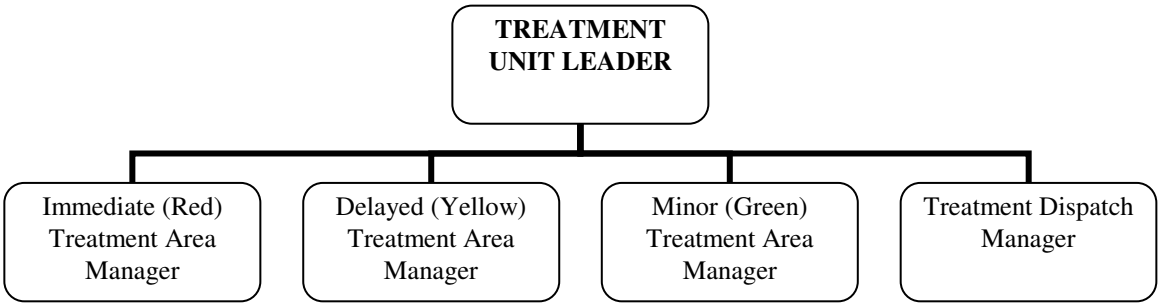
- ☐ Check-in and obtain briefing from Medical Group Supervisor.
- ☐ Organize and coordinate treatment personnel and assignments.
- ☐ Coordinate movement of patients from Triage Area to Treatment Areas.
    - o If treatment areas not designated, move patients to Loading Area
- ☐ Establish communications and coordination with Patient Transportation Unit Leader.
- ☐ Assign treatment positions as needed:
    - o Treatment Area Manager(s) – can expand to one manger for each treatment area (Immediate (Red), Delayed (Yellow), Minor (Green))
    - o Treatment Dispatch Manager – to coordinate patients with Transportation Unit
- ☐ Ensure continual triage of patients throughout Treatment Areas.
- ☐ Request sufficient medical caches and supplies as necessary.
- ☐ Give periodic status reports to Medical Group Supervisor.
- ☐ Maintain Unit Log - ICS-214 (Attachment E).



TREATMENT DISPATCH MANAGER CHECKLIST

The Treatment Dispatch Manager reports to the Treatment Unit Leader and is responsible for coordinating with the Patient Transportation Unit Leader the transportation of patients out of the Treatment Areas:

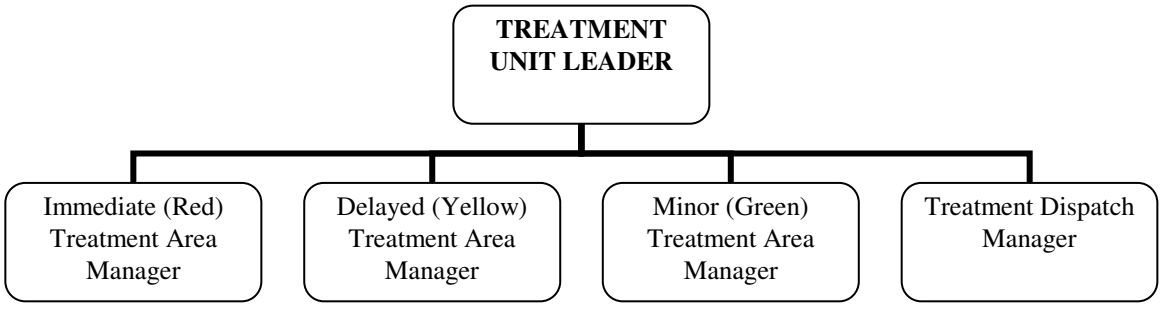
- ☐ Check-in and obtain briefing from Treatment Unit Leader.
- ☐ Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
- ☐ Establish communications with Patient Transportation Unit.
- ☐ Verify that patients are prioritized for transportation.
- ☐ Advise Medical Communications Coordinator of patient readiness and priority for dispatch.
- ☐ Coordinate transportation of patients with the Transportation Unit Leader (or Medical Communications Coordinator, if assigned).



TREATMENT AREA MANAGER CHECKLIST

The Treatment Area Manager reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to Immediate Treatment Area

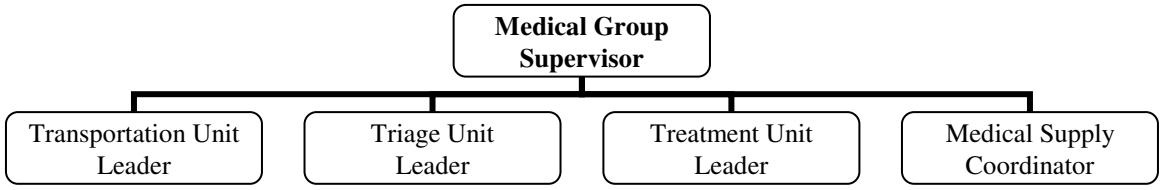
- ☐ Check-in and obtain briefing from Treatment Unit Leader and brief subordinates.
- ☐ Assign treatment personnel to patients received in Treatment Areas.
- ☐ Ensure treatment of patients triaged to Treatment Areas.
- ☐ Assure that patients are prioritized for transportation.
- ☐ Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
- ☐ Notify Treatment Unit Leader when patients condition requires them to be moved to a different treatment area.
- ☐ Request or establish Medical Teams as necessary.
- ☐ Coordinate, as appropriate, volunteer personnel/organizations through Agency Representatives and Treatment Unit Leader.



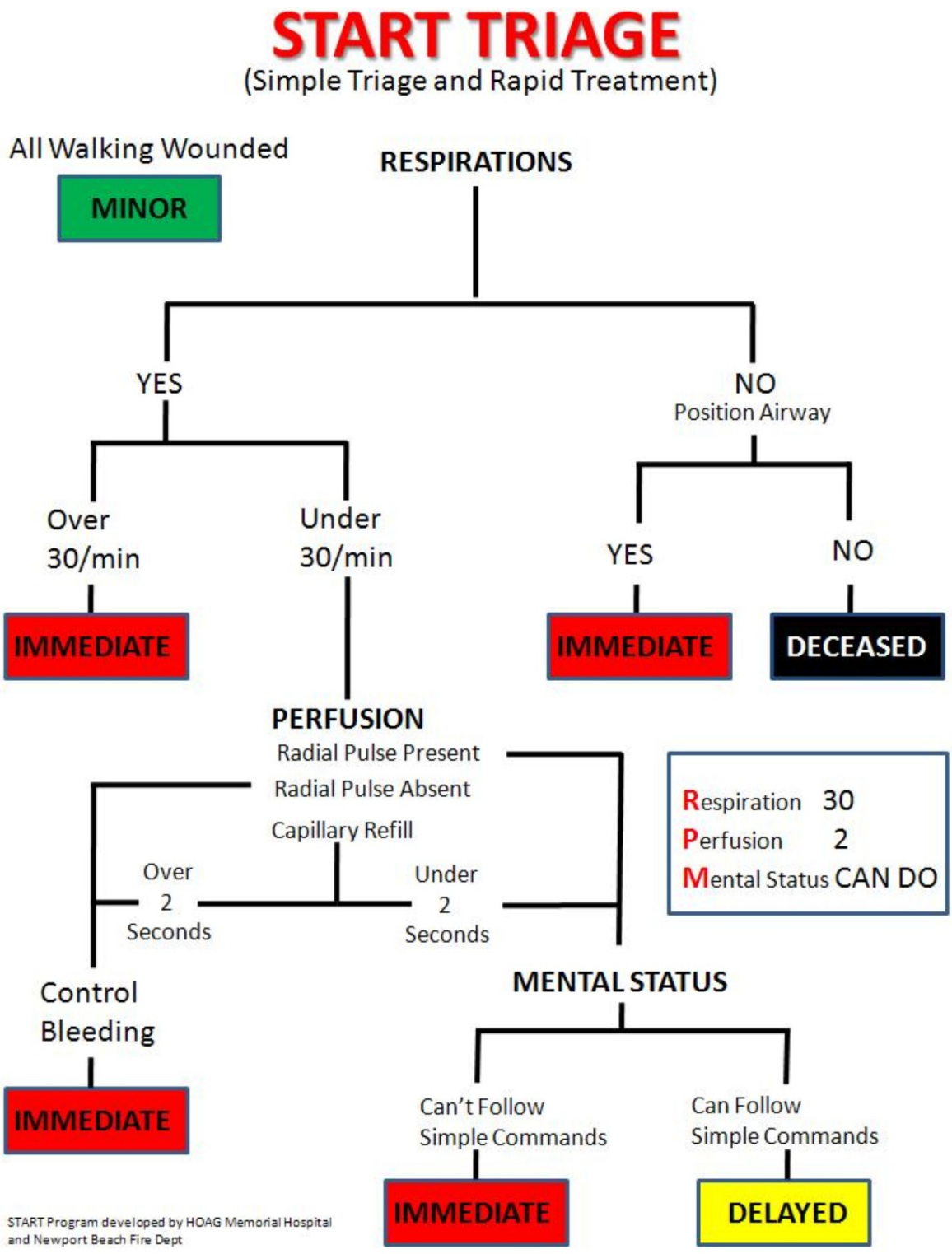
MEDICAL SUPPLY COORDINATOR CHECKLIST

The Medical Supply Coordinator reports to the Medical Group Supervisor and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group.

- ☐ Check-in and obtain briefing from Medical Group Supervisor.
- ☐ Distribute medical supplies to Treatment and Triage Units, as requested.
- ☐ Acquire, distribute, and maintain status of medical equipment and supplies within the Medical Branch.
- ☐ Request additional medical supplies (medical caches) as needed.
- ☐ Maintain Unit Log - ICS-214 (Attachment E).

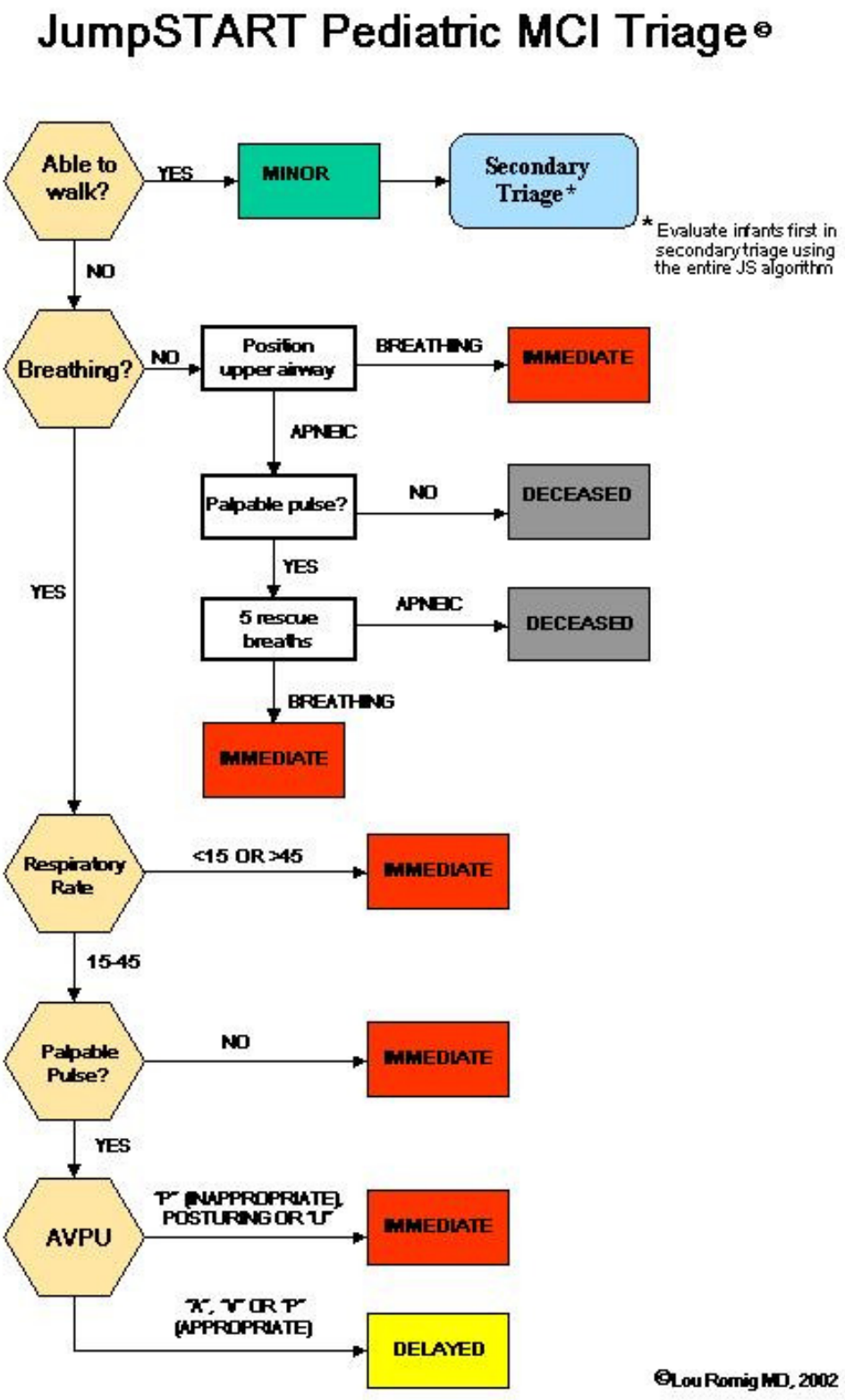


ATTACHMENT – C-1



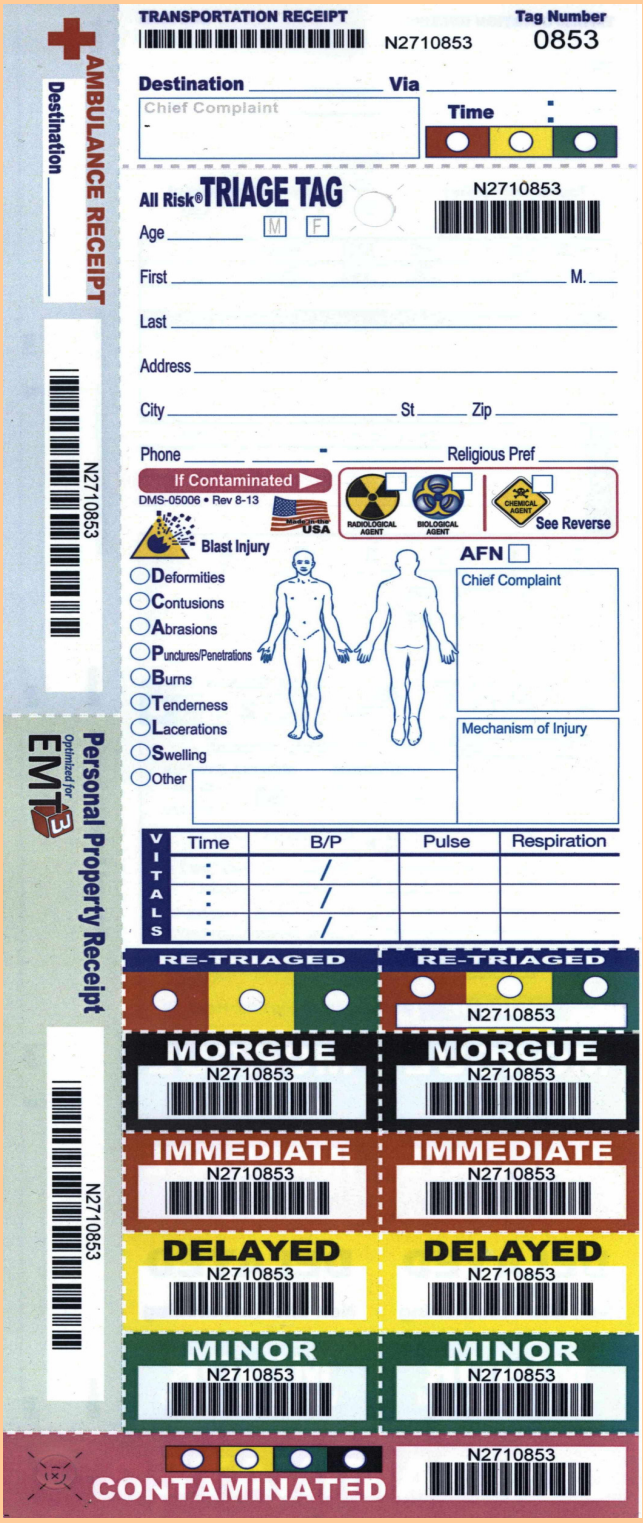
ATTACHMENT – C-2

JUMP START is used for children 8 years old or less.

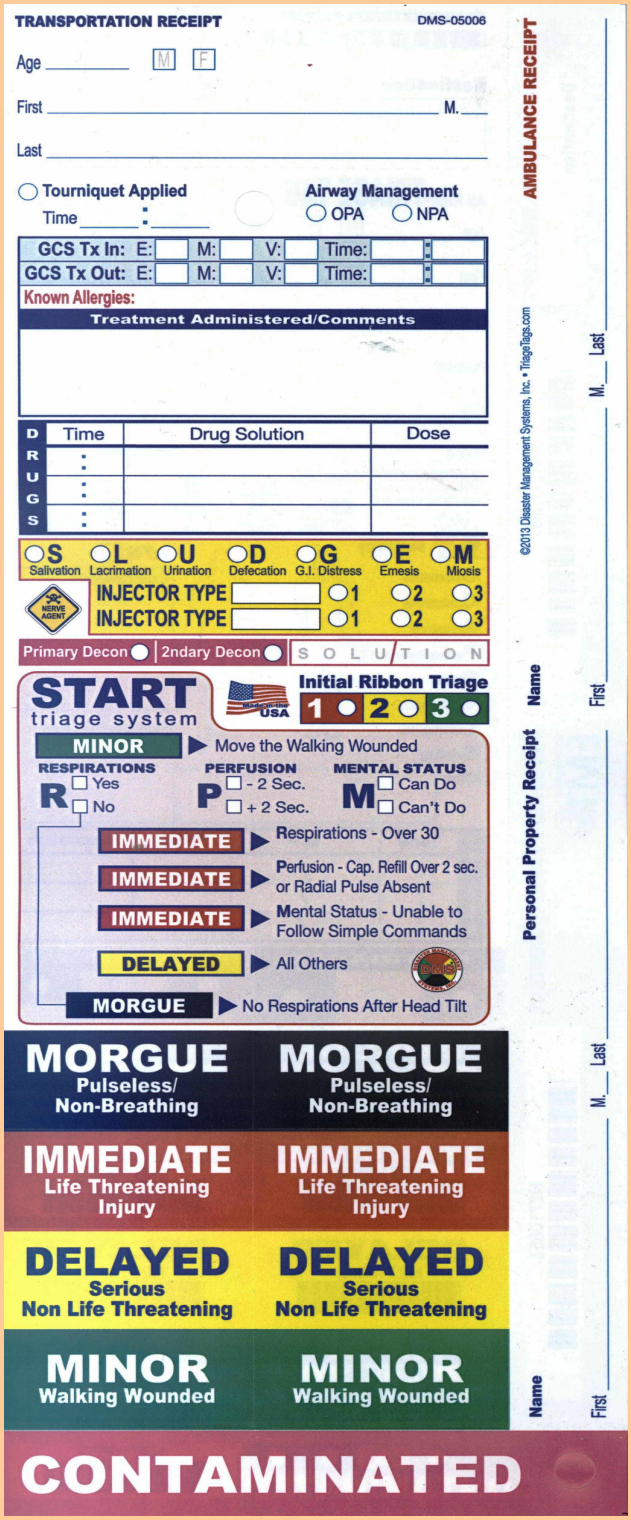


ATTACHMENT - D
CALIFORNIA STATE FIRE CHIEFS' ASSOCIATION TRIAGE TAG

FRONT



BACK



ATTACHMENT E
UNIT/ACTIVITY LOG – FORM ICS 214

UNIT/ACTIVITY LOG ICS 214 5-94	1. Incident Name	2. Date Prepared	3. Time Prepared
4. Organization Position	5. Leader Name	6. Operational Period	

7. Personnel Roster Assigned		
Name	ICS Position	Home Base

8. Activity	
Time	Major Events

9. Prepared by (Name and Position)

Attachment F
MEDICAL TRANSPORTATION INFORMATION LOG

Field Form #_____
Nature _____
Location _____

Date:_____
Base:_____
MD/MICN:_____
PARAMEDIC/EMT:_____

NO.	METTAG #	AGE	PRIORITY/COLOR CHIEF COMPLAINT	DESTINATION	AMBULANCE	TIME
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