ANNEX C: MASS CASUALTY EMS PROTOCOL

This Annex describes the emergency medical service protocol to guide and coordinate actions during initial mass casualty medical response activities.

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I. Introduction

A. Purpose

Outline incident protocol in providing a uniform initial emergency medical response to a Mass Casualty Incident (MCI). Facilitate a common understanding in terminology, procedures and participation.

Pre-hospital care providers will operate in accordance with medical control authority standard operating procedures.

B. Definitions

Incident Commander (IC): The IC is the individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. EMS will typically fall under the IC through a subordinate Branch, Division or Group.

Section Chief: A Section Chief may be assigned to Operations, Logistics, Planning, or Administration/Finance depending on the size of the incident. Not all incidents will require all 4 sections to be assigned.

Branch Director: A Branch Director may be assigned under the Operations Section Chief. Branch Directors are responsible for managing a specific discipline including Fire, EMS, Law Enforcement, Public Works, Public Health, etc.

Division Supervisor: A Division Supervisor is assigned to an area that is separated by a barrier. Examples of a Division would be a multi-level structure, include separated by a river, etc. Numbers are primarily used to identify divisions.

Group Supervisor: A Group Supervisor functions within the Operation Section and is assigned to a specific group. Letters of the alphabet are primarily used to identify groups.

Unit Leaders: Units can be assigned to the Command and General Staff or within a Group or Division.

Medical Unit Officer: The Medical Unit Officer is the individual responsible for the management of incident responder medical treatment and rehab.

Safety Officer: The IC shall appoint a Safety Officer who will ensure safety of responders and victims during the incident operations. With the concept of Unified

Incident Command there is valid reasoning to have Assistant Safety Officers to include all disciplines involved in the operation. The Safety Officer appointed by the IC shall have the authority designed within the Incident Command System with the input and advice of all Assistant Safety Officers.

Deputies: Deputies are used within the Command and General Staff or Sections of the ICS. A Deputy may be a higher-ranking responder that assists the IC or Section Chief however does not assume Command.

Coordinating Resource: the entity within the local EMS system responsible for the notification and coordination of the mass casualty response. Examples include: medcom, resource hospital, MCA, medical control, dispatch

Regional Medical Coordination Center: The MCC serves as a regional multi-agency coordination entity as defined by the National Incident Management System (NIMS). The MCC serves as a single regional point of contact for the coordination of healthcare resources. The MCC is intended to optimize resource coordination among hospitals, EMS agencies, medical control authorities and other resources. The MCC serves as a link to the State Health Operations Center (SHOC).

State Health Operations Center: The SHOC serves as a statewide multi-agency coordination entity as defined by NIMS. SHOC is intended to coordinate state-level healthcare and public health resources, to serve as a central point of contact for regional MCC's, and to serve as a resource to the State EOC. SHOC is expected to be activated following a major disaster or other public health emergency and should be operational within hours of activation.

Incident Command System: The ICS organizational structure develops in a top-down fashion that is based on the size and complexity of the incident, as well as the specific hazard environment created by the incident.

Unified Command: In incidents involving multiple jurisdictions, a single jurisdiction with multi-agency involvement, or multiple jurisdictions with multi-agency involvement, unified command can be implemented. Unified command allows agencies to work together effectively without affecting individual agency authority, responsibility, or accountability.

II. Situation & Assumptions

A. Situation

The mass casualty incident will be determined by the type and degree of a disaster, the needs of the population(s) impacted and the resources available. The Columbia County Multi-Hazard Mitigation plan outlines the hazard risks of concern within the county. It is

important to note that all hazards can result in a need for medical care, shelters, housing, food, and/or other human services.

Considerations include but are not limited to:

- Emergencies and disasters may disproportionately impact people who are poor, have limited proficiency, are aged or disabled because they are less likely to have natural supports in their communities upon which they may rely for assistance and are dependent on government services for help.
- The size and complexity of the disaster must be considered to determine if the incident can be handled locally or if a multi-jurisdictional response is required.
- Communication plans and back-up plans need to be functional to ensure populations can request help, responders can provide situational awareness and communicate needs, connections can be made between various support systems, and safety and resource information can be communicated to whoever may need the information at any given time.
- Knowledge should be gained to determine who are the impacted populations, evacuees, or people living in other areas that may be impacted. And, whether there are any specific medical, linguistic, functional, access, religious, cultural or legal needs.

B. Assumptions

Mass care operations and logistical support requirements will be given high priority by the county Emergency Coordination Center (ECC) staff and support agencies. Mass care shelter facilities will receive priority consideration for structural inspections to ensure safety of occupants.

Shortages of emergency response personnel will exist creating a need for auxiliary fire, police, search and rescue, emergency medical, transit, public works, utilities, health, shelter management and support personnel. Private sector and voluntary organization support may be needed to augment disaster response and recovery efforts.

Public, private, and nonprofit organizations, institutional providers (medical and residential), and the general public will have to use their own resources and be self-sufficient for a minimum of three to seven days, possibly longer. No single agency or organization will be able to satisfy all emergency resource requests during a major emergency or disaster.

Large numbers of spontaneous volunteers in the affected area and around the state or country will require a planned recruitment strategy and operational training effort.

Some medical facilities will be so overwhelmed that accurate record keeping on treated, released, hospitalized and transferred individuals may be disrupted. Many of the more seriously injured will be transported to hospitals outside the event area, some of them hundreds of miles away.

Larger disasters will likely require more agencies to respond, some of which are requested and some who self-deploy offering resources and services to the community in a manner which may or may not be consistent local protocols.

A disaster may produce mass casualties and missing people, requiring the need for medical support alongside mass care and way to report missing people.

Individuals in need of disaster response assistance may include those who: have disabilities; live in institutionalized settings; are elderly; are children; who are from diverse cultures; have limited English proficiency or are non-English speaking or are transportation disadvantaged. People with disabilities or functional needs before, during and after a disaster may require support to maintain independence, communicate, access transportation or may require supervision and/or medical care. People with disabilities or other functional needs who cannot be adequately met in a general population shelter may need to be transported to other suitable accommodations.

People impacted by the disaster will likely include a range of ages, languages, cultures, religions, medical needs, disabilities, and resources. Children are impacted by disasters differently than adults and likely have different needs.

Companion and/or service animals that belong to survivors will be impacted by the disaster and may need shelter, veterinary service, food, rescue or need to be located.

There will be people impacted by the event, potentially including responders who are not direct survivors of the disaster, but have ESF 6 support needs.

Immediately after the disaster, people will attempt to contact each other to communicate whether they are safe. Communication systems may be overwhelmed or inoperable. Services facilitating communication (such as battery charging) may be needed. The restoration of communications systems, disrupted by damages and overloads, may take weeks. Surviving telephone service into and within the event area will be either inadequate or prioritized to emergency uses to the extent that it will be unable to handle disaster welfare inquiries.

Survivors may be impacted emotionally and possibly physically by the disaster. This may result in needs that are more important to the survivors than what is initially

recognized, possibly beyond the scope of services offered, and may complicate the survivors' and community(s) ability to recover.

Resources may be in short supply, unavailable or non-existent.

The County will make efforts to provide equitable geographic distribution of shelter and service locations within the county, balancing a number of factors including available facilities and affected populations.

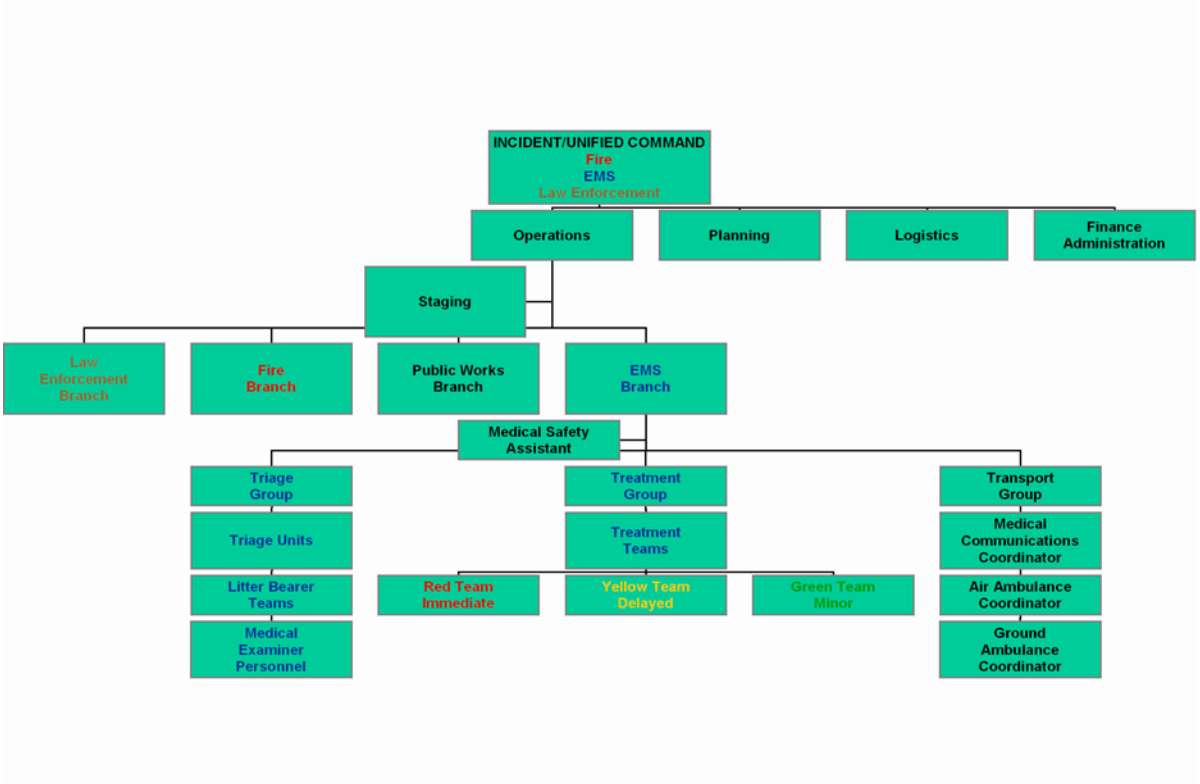
Incident protocols are likely to change over time as situational awareness is gained in regard to survivor needs.

Clear and timely communication to support agencies and to the public regarding goals, resources and services, will need to include multiple strategies and means.

III. Concept of Operations

A. Organization

An Incident Command System (ICS) or Unified Incident Command System (UICS) will evolve in a mass casualty incident. The ICS/UICS is a dynamic way to bring a management structure to a disaster situation. The first EMS responder shall assume the role of EMS Branch Director/Group Supervisor and will identify him/herself to the Incident Commander and become liaison with ICS/UICS and medical elements in the Triage, Treatment, and Transportation areas as EMS personnel converge and are assigned these roles. The Incident Commander will assume command and secure the mass casualty incident. The Incident Commander will have access to special equipment, expertise and communications to support the medical aspects of an MCI. Implement the ICS/UICS as soon as possible and utilize it.



B. Personnel Accountability

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EMS personnel responding to an incident should report to the designated staging area unless otherwise directed while in route to the incident.

- Off duty personnel should report to their own agency for assignment and not to the scene.
- Personnel Identification badges should be worn so they are visible at all times.

It is the IC's responsibility to establish a personnel accountability system and maintain the ability to account for all personnel at all times

Personnel should have their credentials validated prior to utilization in a disaster. Credentialing may be accomplished through pre-designated local response plans.

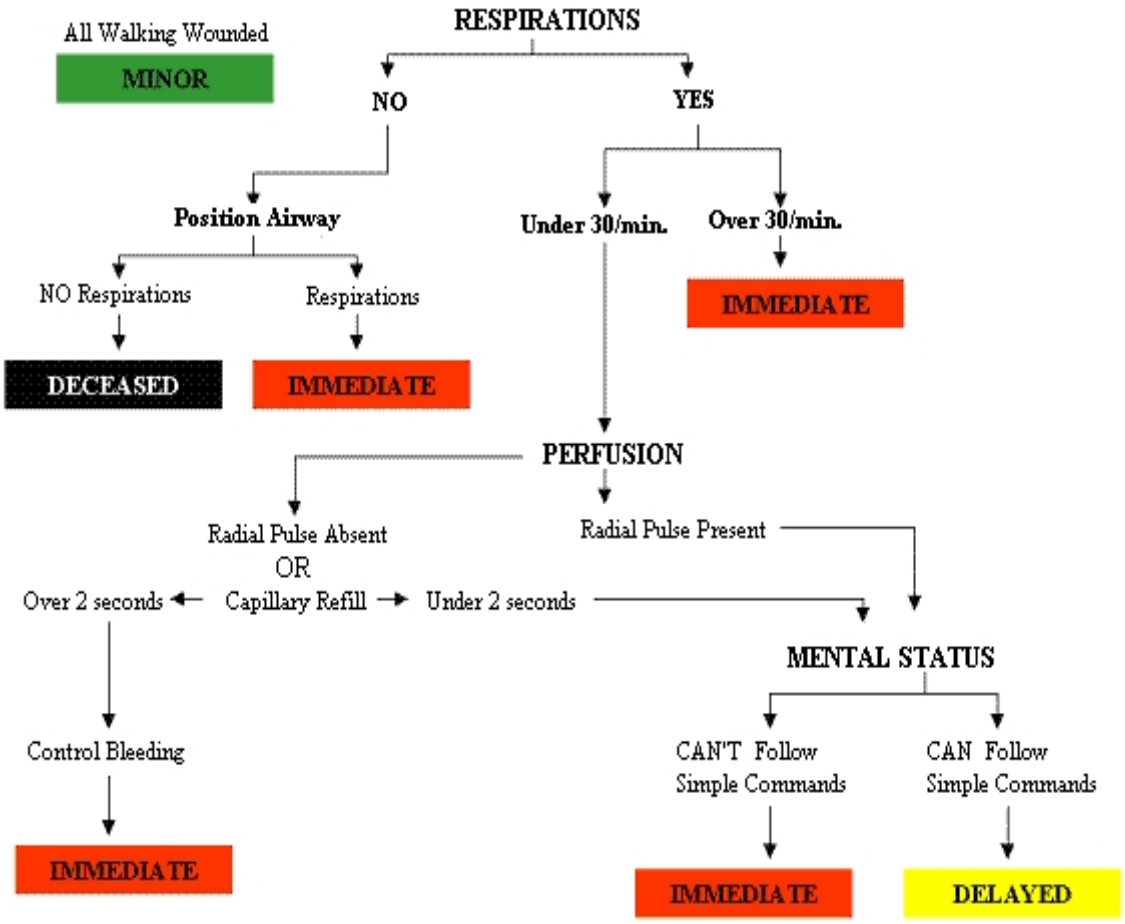
C. Scene Management

EMS personnel should accomplish the following actions upon arrival.

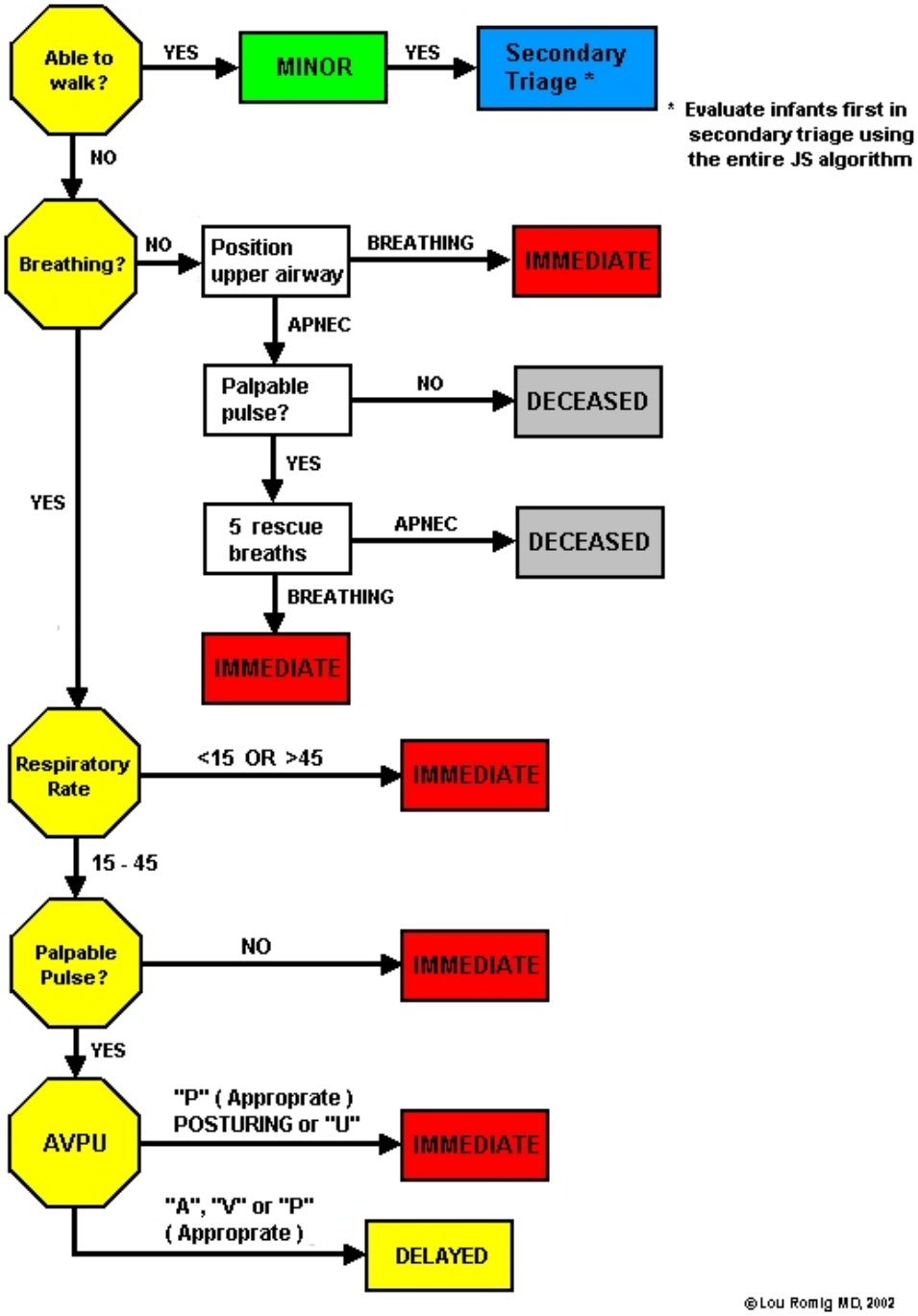
- Survey the scene
- If Incident Command has not been established the senior EMS personnel shall assume the role of IC. The IC shall assume to role of all other elements of the ICS until she/he as assigned other personnel to their roles.

- Advise dispatch who has assumed command and who has EMS Branch Director/Group Supervisor and their exact location.
- Organize the scene and ensure an effective response including:
  - Securing the area and limiting access to nonessential personnel
  - Determining whether the incident scene is safe to enter and whether decontamination is required
  - Assigning personnel to the necessary tasks and roles
  - Establishing staging, triage, treatment, and transportation areas
  - Establishing communication between areas
  - Establishing traffic pattern that provided for the smooth flow of patients and vehicles
  - Ensure that appropriate record-keeping takes place
- Call for additional resources
  - EMS personnel
  - Any specialized equipment
  - MEDDRUN
  - CHEMPACK
  - Regional Medical Coordination Center (MCC)
  - Other available resources
- Inform the "Coordinating Resource" of nature and scope of incident
  - Begin primary triage

START Triage (JUMPSTART for Pediatrics)



JumpSTART Pediatric MCI Triage ®



- Assign roles to arriving EMS personnel
  - Triage Leader Role
    - Report to EMS Branch Director / Group Supervisor
    - Coordinates rapid triage process

- Treatment Leader Role
  - Within EMS Branch Operations, establish treatment areas
  - Assigns personnel to treatment areas
  - Supervise care in treatment areas
  - Document care given
  - Requests additional personnel needs to EMS Branch Director/Group Supervisor

- Transportation Leader Role
  - Prioritize transportation of patients from scene
  - With information from coordinating resource, assigns destination hospital
  - Maintains log of patients transported

D. Patient Management

Primary Triage

- Identify and manage immediate life threats. Necessary care will be limited to:
  - Positioning airway
  - Attempt hemorrhage control

- Identify patients for priority evacuation to treatment area.
  - Priority Red (one): Life-threatening
  - Priority Yellow (two): Life or limb threat but no immediate danger. Care might be delayed 1-2 hours.
  - Priority Green (three): Medical treatment can be delayed
  - Priority Black (four) Dead or expectant injuries

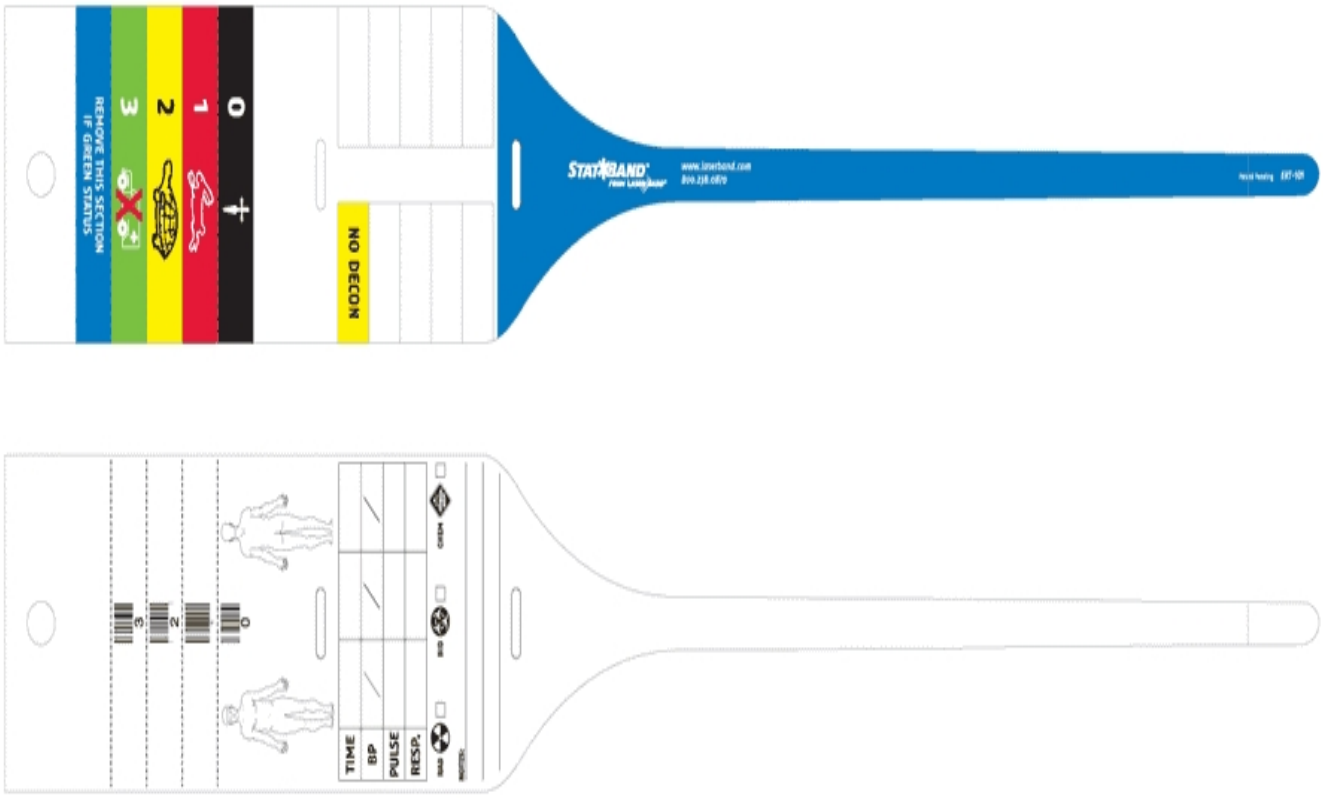
- The triage information (e.g. tag or colored strip) should be attached to the body and the appropriate section removed to indicate priority by the last remaining section.
- Triaged patients (except black category) are taken or directed to corresponding treatment area.
- Notify the "coordinating resource" of number, general injury type, and priority of patients when primary triage information is available.
  - Updating the "coordinating resource" as primary triage information is updated is imperative.

Treatment

- Perform secondary triage within each treatment area
- Identify and treat potential life-threatening injuries / illnesses in treatment area in accordance with established patient care protocols.
- Do the most good for the greatest number of patients as resources permit
- Stabilize and prepare for transport on a priority basis to hospital(s).

Transport

- EMS personnel assigned to transport activities should report to the transport group leader
- Transport personnel will be assigned patients and destination hospitals.



Critical Incident Stress Management (CISM)

Critical Incident Stress Management may be utilized as necessary both during and post event.

E. Demobilization

The IC should remain cognizant of the resources available and needed. An assessment must be performed for each operational period. Review of the Incident Action Plan (IAP) must be performed to determine the necessary resources. Resources that are in staging and not needed should be demobilized until it is later determined they are needed.

IV. Responsibilities

A. All Levels of Pre-hospital Providers

1. EMS Branch Director/Group Supervisor

The first pre-hospital emergency medical services provider (MFR, EMT, EMT-Specialist, or Paramedic) on scene takes charge of medical care. This position may only be relinquished to another pre-hospital care EMS provider when:

- The mass casualty incident is more appropriately within another jurisdiction; and
- The new pre-hospital branch director has the same or higher qualifications of current EMS Branch Director/Group Supervisor;
- Responsibilities:
    - Survey the scene
    - Call for back-up
    - Notify the "coordinating resource" of the nature and scope of the MCI and identify any potentially hazardous materials
    - Begin primary triage and tag patients for priority evacuation to treatment.
    - Status update to the "Coordinating Resource" when initial triage is complete.
    - The first licensed pre-hospital EMS provider on the scene is the EMS Branch Director/Group Supervisor in charge of the Medical Operations, and
        - Designates staging, triage, treatment and transport areas consistent with the ICS or UICS structure;
        - Assigns responding EMS and other health care personnel to designated functional areas as needed.
        - Establish Medical Communications with coordinating resource;
        - Will transfer charge to:
            - A pre-hospital EMS provider of higher license level within the medical control authority
            - Pre-hospital EMS provider in whose jurisdiction the MCI occurs and who is at least the same level of licensure.

B. Regional Medical Coordinating Center (MCC)

MCC Responsibilities

- Maintain communications with all involved entities
  - EMS Branch Directors
  - EMS Division/Group Supervisors
  - EMS Unit Leaders
  - Hospitals
  - Local EOCs (when activated)
  - SHOC (when activated)
  - MEMS sites (when activated)
  - Other Regional MCCs (as appropriate)

- Provide initial and update alerts via available communications resources
- Provide frequent updates to on-scene EMS Branch Directors / Group Supervisors regarding hospital casualty care capacity
- May relay casualty transport information to receiving facilities
- May relay urgent and routine communications to appropriate entities
- May assist in coordination and distribution of resources
- Other appropriate tasks as necessary for an effective regional medical response

C. State Health Operations Center

Operated by MDCH Office of Public Health Preparedness

EMS Personnel should be aware of the existence of SHOC but are not expected to directly interface with SHOC.

V. Resource Requirements

Logistics support will be provided through the activation of the Logistics section of the ECC and it is expected for smaller isolated incidents that resources will be obtained in sufficient quantities locally and through mutual aid agreements. For larger scale incidents logistics support will be requested through the SHOC.

Fire District 3 Resource Capabilities	
Equipment	
BLS Ambulance	2
Aid Unit	1
Personnel	
EMT	6
EMT IV	6
EMR	5