SANTA BARBARA COUNTY

MULTI-CASUALTY INCIDENT (MCI)

RESPONSE PLAN

Santa Barbara County
Emergency Medical Services Agency
Updated August 22, 2013

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SECTION 1.0: MCI PLAN ADMINISTRATIVE ELEMENT

1.1 SCOPE

This plan is limited to Multi-Casualty Incidents within the Santa Barbara County Operational Area.

1.2 OBJECTIVES and AUTHORITY

- To ensure adequate and coordinated efforts to minimize loss of life and disabling injuries.
- Establish a common organizational and management structure for the coordination of emergency response by multiple agencies to an MCI in Santa Barbara County using the Incident Command System (ICS), FIRESCOPE, and California's Standardized Emergency Management System (SEMS).
- Identify the equipment and personnel resources necessary to effectively manage the incident.
- Develop strategy or strategies of care and transportation that will provide for the survival of the greatest number of casualties.

The California Health and Safety Code, Division 2.5, Chapter 4—Local Administration provides authorities for the development and implementation of this plan by the Santa Barbara County Emergency Medical Services Agency. The authorities include sections 1791.204, 1791.250, 1797.103, and 1797.252. This plan is developed in concert with local, regional, state, and federal agencies. It outlines the scope of responsibility for each agency that responds to a multi casualty incident however, it does not detail all the duties entrusted to a particular organization.

The Santa Barbara County Emergency Medical Services MCI Plan is an approved policy of the Public Health Department - EMS Agency. EMS provider organizations shall comply with the operational roles and standards as defined in the MCI Plan. This includes all EMS providers, dispatch centers, hospitals, and relevant Emergency Operations Center or departmental operations center command staff.

Due to the nature of MCI incidents and the resulting effects from an incident on resources, communication, and transportation corridors, MCI operations may not always follow the exact response outlined in this plan. The MCI After Action Checklist in Attachment I should be used by the incident commander after every incident to provide information for after action meetings and continuous quality improvement review (CQI). This form should also document and describe the reasons for an operational response different than that described in this MCI plan.

1.3 TRAINING and EXERCISES

A. All EMS provider organizations shall provide annual training and updates for their staff on this Santa Barbara County Emergency Medical Services MCI Plan and participate in regular exercises of that plan with other EMS system participants.

B. EMS provider organizations shall provide training to relevant staff to ensure proficiency in the following:

1. First Receiver (Hospitals Only)

    a. Hospital Incident Command System
    b. Hospital Incident Command System Hazardous Materials Awareness
    c. Incident Command System (FEMA IS-100 HCa and IS-200 HCa for healthcare)
    d. National Incident Management System (NIMS) IS-700
    e. Working knowledge of Santa Barbara EMS Agency Policies and Procedures
    f. EMS related communication tools (radios, ReddiNet) as required in EMS policy.

2. All Field First Responders

    a. Simple Triage and Rapid Treatment (START) and JUMPSTART
    b. California Standardized Emergency Management System (SEMS)
    c. Incident Command System (minimum of ICS 200 level)
    d. Hazardous Materials First Responder Awareness
    e. Hazardous Materials First Responder Operations (Fire agencies only)
    f. Working knowledge of FIRESCOPE Field Operations Guide, MCI (Attachment C)
    g. Working knowledge of Santa Barbara EMS Agency Policies and Procedures (All EMS providers)

3. Ambulance Strike Team Leader

    a. Incident Command System (up to ICS 300 level)
    b. Ambulance Strike Team Leader Training (State EMS Authority course)
    c. Ambulance Strike Team Provider Training (State EMS Authority course)
    d. EMS related communication tools (radios, ReddiNet, etc.) as required in EMS policy.

4. On-Scene Command Staff

    a. Incident Command System (up to ICS 400 level)
    b. EMS related communication tools (radios, etc.) as required in EMS policy.

5. Assigned EOC or DOC Command Staff

    a. City and County Emergency Response Plans
    b. City and County Departmental Emergency Response Plans
    c. Provider Emergency Operations Plan (ambulance or other private provider DOC staff)
    d. ICS 100, 200, 700, Introduction/Advanced DOC/EOC for your jurisdiction/agency
    e. EMS related communication tools (radios, ReddiNet, etc.) if in EMS DOC/EOC positions.

1.4 AN MCI DIFFERS FROM A MEDICAL DISASTER

- Under an MCI all casualties originate from the same scene (as opposed to a widespread incident, such as an earthquake or flood).
- Under an MCI medical resources have not been damaged or otherwise disabled by the incident (except in the case of a hospital fire, explosion or similar cause).
- During an MCI, operational management is maintained at the scene of the incident.
- An MCI is limited in scope. The number of casualties is generally known or can be estimated from the onset of the incident.

1.5 MCI LEVELS IN Santa Barbara COUNTY

MCI LEVEL 1 **5-14 patients** (approximately) A suddenly occurring event that overwhelms the routine first response assignment. The number of patients is greater than can be handled by the usual initial response. Depending on the severity of the injuries the system may have adequate resources to respond and transport the patients. Duration of the incident is expected to be less than 1 hour. Examples: Motor vehicle accident, active shooter.

MCI LEVEL II **15-50 patients** (approximately) A suddenly occurring event that overwhelms the first response assignment and, potentially, additional resources requested within the Operational Area and neighboring counties. Regional medical mutual aid system is activated. An adequate number of additional ambulances are not likely to be immediately available, creating a delay in transporting patients. The duration of incident is expected to be greater than an hour. Examples: Bus crash, train accident, active shooter, improvised explosive device (IED).

MCI LEVEL III **50 + patients** (approximately) A suddenly occurring event that overwhelms the first response assignment, additional resources requested within the Operational Area, and mutual aid from neighboring counties **(approximately 50+ victims).** It is not possible to respond with an adequate number of ambulances to the incident and promptly respond to other requests for ambulance service. Regional medical mutual aid system is activated. Air and ground ambulance and other resources from outside the county will need to be requested. Not only will ambulance service be inadequate but receiving hospitals will be overwhelmed. In an incident of this size the operational area EOC and disaster plan may be activated. Examples: Commercial airline crash, building collapse, active shooter.

SECTION 2.0: OPERATIONAL ELEMENT

2.1 PRE-ARRIVAL ACTIVATION OF MCI PLAN:

The report of a multi casualty incident will typically be made to a public safety dispatch center in one or more of the following manners:

- Witness report via 9-1-1 (PSAP)
- Direct report from law enforcement/Fire/EMS provider

Role of Dispatch Centers
In situations where Public Safety Dispatch Center personnel suspect there is a potential for multiple patients, the dispatch personnel will relay that information to the responding resources. Examples of such situations include:

- Reports of vehicular collisions with multiple injuries.
- Large-scale hazardous-materials or a CBRNE incident.
- Fires in heavily occupied structures.
- Multiple injuries at an active shooter scene
- Multiple injuries or illnesses at a special event, business, school, etc.
- Commercial aviation emergency landings or plane crashes.
- Maritime fires or damage (i.e., visiting Cruise Liners).
- Passenger train or bus accidents.
- Hostage or terrorism situations with the potential for large numbers of casualties.

Dispatch of Ambulances
All ambulances will be dispatched from the Santa Barbara County (SBC) Public Safety Dispatch Center.

Dispatch Notification of Agencies
Dispatch agencies will notify all lead agencies according to dispatch protocols and will give notification of a possible MCI along with an estimate of casualties (if available) to all responding personnel.

Designated MCI Dispatch Center
The dispatch agency in the jurisdiction where incident occurred will continue to operate as the lead dispatch agency for public safety for the incident except in a level III incident or as requested by the IC.
Santa Barbara County (SBC) Public Safety Dispatch Center is the designated MCI Dispatch Center in Santa Barbara County for all level III incidents or at other levels as requested by the IC.

If the SBC Public Safety Dispatch Center is unable to provide the MCI dispatching service (due to physical or infrastructure disruption, power loss, etc.) the following back up order shall be used:
Note: None of these dispatch centers have the ability to communicate on MED 10 so all ambulance traffic must be moved to a common fire radio frequency.

Santa Maria/Guadalupe areas:	City of Santa Maria Dispatch Center
Lompoc/VAFB areas:	City of Lompoc Dispatch Center
Santa Barbara/Goleta areas:	City of Santa Barbara Dispatch Center
Montecito/Carpinteria areas:	South Coast Dispatch Center

2.2 ON SCENE MCI ACTIVATION:

Activation Authority

The following have the authority to activate the MCI plan:
The agency vested with incident commander responsibility

Activation Guidelines for Personnel on Scene

The initial arriving first responder shall:

- ✓ Conduct a scene size-up to include an estimate of the number of casualties
- ✓ Communicate the location, estimated number of victims, and known hazards to dispatch.
- ✓ Communicate needs for additional resources.
- ✓ All requests for resources shall be approved by the incident commander.

SECTION 3.0: MCI ACTIVATION RESPONSE LEVEL I, II, or III

3.1 COMMUNICATION AND NOTIFICATIONS:

Santa Barbara County Public Safety Dispatch:

- ✓ Dispatch appropriate resources from your jurisdiction
- ✓ Request Mutual Aid fire resources under any preplanned response matrix or at the request of the IC.
- ✓ Inform all responding personnel of a possible MCI and, if known, the potential number of patients.
- ✓ Notify the contract ambulance provider field supervisor
- ✓ Inform all ambulance responders of radio fire channel designated by IC.
- ✓ Notify all ambulances of MCI Level – I, II, or III.
- ✓ Inform EMS Agency duty officer (MHOAC) of MCI.
- ✓ Dispatch additional ambulances as requested by the IC.
- ✓ Note: Ambulance field supervisor in consultation with the IC may activate regional ambulance strike teams as needed in response to IC resource requests. PHD/EMS Agency MHOAC will be informed and will request additional medical mutual aid from Region 1 in coordination with ambulance provider.
- ✓ Coordinate communication between response agencies if requested.
- ✓ Notify Office of Emergency Management for Level II or III MCI

Local Jurisdictional Dispatch Centers' Responsibilities:

- ✓ Dispatch appropriate resources from your jurisdiction
- ✓ Request Mutual Aid fire resources under any preplanned response matrix or at the request of the IC.
- ✓ Coordinate communication between response agencies if requested.
- ✓ Request all ambulances resources from Santa Barbara County Public Safety Dispatch
- ✓ Notify Office of Emergency Management for Level II or III MCI

3.2 FIELD OPERATIONS

Incident Command
The Fire agency responsible for first response assumes the Incident Commander position, consistent with agency policy, at the scene of an MCI, though in some instances (such as an active shooter or highway incident) this may be a law agency. Unified Command may be established as appropriate.

The first responder agency vested with IC responsibility to arrive at scene shall:

- ✓ Assume incident command and establish or participate in unified command with other responding agencies (law, fire, EMS, other agency). (Attachment B)
- ✓ Size up the situation by determining the nature and magnitude of the incident and the estimated number of injured and severity of injuries.
- ✓ Confirm the MCI status and activate the MCI plan.
- ✓ Assign appropriate ICS roles to responding personnel using MCI job action sheets, vests (if available and warranted) and appropriate documentation forms. (Attachment C)
- ✓ Establish initial priorities and immediate resource requirements.
- ✓ Complete the 201 and other ICS forms as appropriate to the scope or complexity of the incident.
- ✓ The IC shall coordinate with the appropriate position (i.e. Medical Group Supervisor, Transportation Unit) regarding patient transportation resource needs.
- ✓ Order appropriate medical management resources from fire agencies or the DMSU (50 patient BLS in Santa Maria) from AMR.
- ✓ Work with the EMS Agency Duty Officer when a Level II or Level III MCI is declared, to request additional needed ambulance resources such as Ambulance Strike Teams, via medical mutual aid from Region 1.
- ✓ Establish ambulance staging area, triage and treatment areas and morgue area as appropriate.
- ✓ Determine if an Air Operations position will need to be activated and resources required to manage landing zone/s.
- ✓ Consider deployment of Disaster Medical Support Unit (DMSU) or other disaster resources (see Attachment G for a list of resources).
- ✓ In Level II or III events consider establishment of an agency representative from the ambulance contractor to coordinate ambulance resources through a liaison officer.

MCI ALS Roles

- ✓ The first ALS provider on-scene shall report directly to the IC for assignment to a role i.e: Medical Group Supervisor, Patient Transport Unit Leader, Medical Communications Coordinator, Ambulance Coordinator, Immediate Treatment Manager. (See Position Checklists in Attachment C)

Transportation Staging

- ✓ Transportation, ambulance, and other resource staging area will be located away from ingress and egress pathways for ground/air resources for the operation.
- ✓ Additional ambulance(s) shall report, as directed, to the established staging area or to the IC if a staging area has not been established. .

Additional Personnel

- ✓ Additional personnel shall report to the IC or designated staging area as directed.

Triage and Treatment

- ✓ Simple Triage and Rapid Treatment (START/ JUMP START) System will be used by initial on-scene responders (Triage Unit) in order to assess ill or injured patients involved in the incident. (Attachment D)
- ✓ JUMP START will be used for children 8 years old or less. (Attachment D)
- ✓ Patients will be placed in "immediate", "delayed" and "minor" categories.
- ✓ Re-triage all tagged patients every fifteen minutes if possible. If staffing allows, begin a more detailed assessment of patients.
- ✓ Treatment Unit Leader is an ALS provider when possible. Treatment Unit personnel will include ALS providers.
- ✓ A treatment area will be established when necessary for the incident and patient care needs. In some scenarios, patients may not be moved to the treatment area due to need for extrication, access to medical transport from their location, or other circumstance.
- ✓ After initial triage, ALS personnel will use criteria specified in the SB EMS Trauma Triage Criteria and Patient Destination Policy and the MCI Destination Decision Algorithm to identify all trauma patients who will require transport to a designated trauma hospital. (See algorithm Attachment E)
- ✓ Patients are managed in the field by EMS personnel; with patient care focused upon life stabilizing treatments and expeditious transport of victims to appropriate hospitals and trauma centers.
- ✓ The SBC EMSA currently approved patient triage tags will be used in an MCI of 5 or more patients.
- ✓ Pre-hospital care personnel shall ensure that an adequate supply of tags is available during their shift. Engine Companies should carry at least ten (10) tags per vehicle and ambulances should carry at least fifteen (15) tags per unit..
- ✓ Level I MCI: Triage Tag and PCR. The triage tag number shall be included in the documentation for each prehospital care report (PCR).
- ✓ Level II and III MCI: In a Level II or III MCI, triage tags may be used in lieu of a patient care report (PCR) if necessary due to large number of patients. Any care provided will be documented on triage tag.
- ✓ 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. Care should be taken that the new triage tag number recorded and used on all communication.
- ✓ Receiving Hospitals shall monitor and retrieve all triage tags utilized to identify patients brought in from the MCI. The triage tag, when used, will be saved as the medical record of prehospital care.

Patient Destinations

- ✓ Upon notification of an MCI, and prior to arrival at scene, the ambulance provider field supervisor will initiate a ReddiNet poll of hospitals to determine number and type of beds/services available from trauma and non-trauma hospitals, both in and out of county.
- ✓ The ambulance provider field supervisor will initiate radio communication with the IC on scene to report "This is the AMR supervisor enroute to the scene. I have launched the ReddiNet poll to determine ED bed availability."
- ✓ Transportation Unit Leader and Medical Communications Coordinator positions will be filled with qualified and trained personnel, who may be ambulance provider staff or fire agency staff, as designated by the IC.
- ✓ If ambulance provider staff with ReddiNet access is on site and in the Medical Communications Coordinator role they will monitor the ReddiNet poll to identify in and out of county designated trauma hospitals destinations for patients meeting trauma triage criteria.
- ✓ Treatment Unit personnel will use step criteria specified in the SB EMS Trauma Triage Criteria and Patient Destination Policy to identify all trauma patients who will require transport to a designated trauma hospital. The MCI Destination Decision Algorithm will be used for Level I, II, and III MCI's to determine destination.
    - Every effort will be made to transport trauma patients to a designated trauma hospital. In a Level II or III MCI transport to a designated trauma center may not always be possible.
- ✓ The Transportation Unit Leader, in coordination with Med Comm Coordinator, will determine transportation methods and destinations and advise receiving hospitals via ReddiNet, If the ReddiNet system is not available, one of the methods in section **4.1 Field/Hospital Communication** will be utilized
- ✓ Where possible, and secondary to patient care requirements, attempt shall be made to transport family members to the same hospital.

3.3 EMS AGENCY ROLE

In level II and III MCI's:

- ✓ The EMS Agency will assess hospitals, ambulance providers, and other healthcare providers to establish the degree of functionality.
- ✓ The EMS Agency will activate the Medical Health Operational Area Coordinator (MHOAC) role to request needed resources from outside the Operational Area via the regional medical mutual aid plan of the Regional Disaster Medical Health System (RDMHS) and report situation status to medical and health regional and state agencies
- ✓ Overwhelming numbers of victims may require non-traditional medical resources such field treatment sites (FTS), local clinics, urgent care centers, in order to provide initial emergency medical assistance. EMS Agency may activate Field Treatment Sites (FTS) for treating non-critical patients.

3.4 HOSPITAL ROLES

- ✓ The hospital shall assure that qualified staff trained in ReddiNet are available to monitor ReddiNet and the 400 MHz (field to hospital) or 800 MHz (PHD DOC to hospital and clinics) radios.

- ✓ Respond to ReddiNet MCI poll and indicate a realistic number and types (immediate, delayed) of patients that can be accepted.
- ✓ Immediately provide essential additional information regarding hospital resources via a ReddiNet message (CT not available, neuro specialty physicians available/not available).
- ✓ The hospital shall prepare to receive multiple patients from the MCI.
- ✓ Hospitals that are proximal to the scene of the MCI should prepare for walk-inpatients who left the scene prior to the arrival of the EMS personnel.
- ✓ Hospitals will be notified via ReddiNet of the number of patients and classifications prior to their arrival and may be given a minimal accounting of the patient's injuries.
- ✓ Prepare to provide medical consult to the field as requested.
- ✓ Hospitals shall track patients and add patient names and triage tag numbers into ReddiNet as they arrive
- ✓ Activate Surge Plan (as determined by hospital protocol) and consider the activation of their disaster plan and Hospital Incident Command System (HICS) roles for large events.
- ✓ Hospitals shall maintain EMS triage tag from scene in patient's medical record.

3.5 LAW ENFORCEMENT

Law enforcement responsibilities may include:

- ✓ Incident Commander, leading or joining unified command
- ✓ Assuring communication with responding fire, EMS, and other agencies
- ✓ Law enforcement operations
- ✓ Scene/perimeter control, traffic control, crime scene identification and evidence preservation, and search and rescue
- ✓ Morgue operations. Coroner mutual aid activation.

3.6 TERMINATION OF THE MCI ACTIVATION

3.6.1 As soon as the condition has been mitigated and/or is under control, the incident commander (IC) should terminate the MCI activation via a declaration by radio to dispatch agency where the incident occurred and other affected dispatch centers.

3.6.2 If during an initial activation for an MCI the IC determines that the MCI declaration is not necessary the IC may cancel the activation. Communication of the termination of the MCI or the cancellation of an MCI activation is identical.

3.6.2 Fire Comm and Santa Barbara County Public Safety Dispatch Center will broadcast the termination of the MCI operation or the cancellation of the MCI declaration and notify all previously notified agencies.

3.6.3 Upon notification the Medical Communications Coordinator will issue a ReddiNet message stating that the MCI is cancelled or ended to all affected hospitals in and out of the county area. If ReddiNet is not available notification will be performed via phone and 400 MHz radio.

3.6.4 As soon the the IC has officially ended or cancelled the MCI, the ambulance provider will "end" the MCI in the ReddiNet system. When all data entry is complete for an MCI operation the ambulance provider will "close" the MCI in the ReddiNet system.

SECTION 4.0: COMMUNICATION

4.1 FIELD/HOSPITAL COMMUNICATION

Upon notification of an MCI, and prior to arrival at scene, the ambulance provider field supervisor will:

- Initiate a ReddiNet poll of hospitals to determine number and type of beds/services available from trauma and non-trauma hospitals, both in and out of county.

- Initiate radio communication with the IC on scene to report "This is the AMR supervisor enroute to the scene. I have launched the ReddiNet poll to determine ED bed availability."

If ReddiNet is not available onsite to the Medical Communications Coordinator, they will use one of the following to determine patient destinations:

- Cellular phone, fire radio, or 400 MHz radio to communicate with the ambulance supervisor monitoring the ReddiNet poll off-site
- Cellular phone or 400 MHz radio to communicate with a local receiving hospital who can also view the poll to establish patient destinations.
- Cellular phone, 400 MHz radio, or fire radio to communicate with SBC Public Safety Dispatch, who can communicate information relayed from the ambulance supervisor monitoring the ReddiNet poll.
- If ReddiNet is not available cellular phone or 400 MHz radio will be used to call a hospital who will act as a base hospital to determine ED patient destinations and communicate to the field or to request Santa Barbara County Public Safety Dispatch to poll the hospitals.

4.2 TRANSPORT/HOSPITAL COMMUNICATION

4.2.1 During Transport

All transporting ambulances shall provide a brief radio report to the receiving hospital, as early as possible, to include:

- Number of patients being transported
- Age and sex of the patient(s)
- Chief complaint/mechanism of injury and primary impression
- Patient level of consciousness and respiratory status
- Code of transport and ETA

4.2.2 Notification of Hospitals

It is imperative that paramedics, whether or not involved in the MCI, notify those hospitals receiving MCI related patients as early as possible of any patient transports to their facility, to allow for adequate hospital preparation for incoming patients. Hospitals will be notified via ReddiNet, radio, or phone of the numbers and types of patients they will receive.

4.2.2 Base Station Contact

It is recommended that standing orders be used as much as possible during a declared MCI. Base station contact should generally be reserved for those situations requiring Base Station Physician orders.

SECTION 5.0: TRANSPORTATION OF THE INJURED

5.1 REQUESTING AMBULANCE AND TRANSPORTATION RESOURCES

- All requests for ambulance and transportation resources must originate from the IC or designee. The EMS Agency Duty Officer can activate the MHOAC role to request ambulances via the medical mutual aid system.

- The IC will determine if an Air Operations position will need to be activated and resources required to manage landing zone/s.

- Medical Group Supervisor or Patient Transport Unit Leader will communicate with the incident commander any recommendations for resource requests for air and ground medical transport resources.

EMS resource requests shall include at a minimum:

- Number of ambulances required
- Service types and mode (BLS, ALS, Air, Bus, etc.)
- Staging area location
- Radio frequency/channel (to be used for coordination with the Incident's
- Transportation Group Supervisor)
- Numbers and types of patients/casualties
- (IMMEDIATE/DELAYED/MINOR)
- Factors (Trauma/HazMat/Medical) that may affect transport decisions

Use of appropriate EMS Air Response Units is recommended to transport patients who meet County criteria for air transport.

5.2 AMBULANCE REQUEST GUIDELINES:

- During an MCI, care must be taken to balance the required number of ambulances to manage the MCI considering the need to maintain ambulance coverage in the county.
- When ambulances respond into Santa Barbara County from other counties for mutual aid purposes, these out-of-county ambulances will be assigned to the MCI incident or county coverage as appropriate to the incident.
- The incident commander should work with the Santa Barbara County ambulance provider or the EMS Agency Duty Officer when a Level II or Level III MCI is declared to request additional ambulance resources such as Ambulance Strike Teams.
- Medical Mutual Aid System: The EMS Agency will activate the Medical Health Operational Area Coordinator role to request needed medical resources (such as ambulance strike teams) from outside the Operational Area via the regional medical mutual aid plan of the Regional Disaster Medical Health System (RDMHS).

5.3 INITIAL CALCULATION OF THE REQUIRED NUMBER OF AMBULANCES

This guideline is meant to provide general guidance to determine the initial estimate for the number of transport ambulance units required to respond to an MCI based on the number of immediate patients. As a determination of the number of delayed and minor patients is made, additional ambulances or other transport vehicles, such as a bus, may be required.

The request for additional transport vehicles, such as ambulance, bus, etc. should be made as early as possible.

A general rule-of-thumb for determining how many ambulances should initially be requested by first-arriving personnel can be calculated using the following formula:

REQUIRED AMBULANCES = NUMBER OF IMMEDIATE PATIENTS
DIVIDED BY TWO (2) + PLUS ONE (1)

Example: $\frac{\text{Ten (10) Immediate Patients}}{2} + 1 =$ **Six (6) ALS Units/Ambulances**

AIR UNITS=Consider early polling, activation, and integration into transportation plan

5.3.2 The number of required ambulances should be adjusted based upon the following considerations:

- Distance from the receiving hospitals
- Number of critical patients
- Hospital "turn-around" time
- Total number of patients
- Availability of alternative transport vehicles

5.3.3 Identifying and Assigning EMS Resources

- The Emergency Medical Dispatcher will identify and assign local EMS resources.
- If needed, the dispatch agency will coordinate resource requests under established medical mutual aid agreements with the Medical and Health Operational Area Coordinator (EMS Agency Duty Officer) and the ambulance provider.

5.4 PROVISIONS FOR EQUIPMENT

5.4.1 Treatment Areas

In certain MCIs, it will be necessary to establish treatment areas. The primary function of treatment areas is to provide an area where patients can be accounted for and stabilized/treated with available resources until transport is available. In events when patients will be not be able to be transported for an extended period of time it will be necessary to establish a cache of equipment on site to treat these patients.

5.4.2 Equipment and Supply Resources

Equipment and supply resources can be provided to the incident through the following resources:

- Fire units may be equipped with both ALS and BLS supplies.

- American Medical Response (AMR) maintains one DMSU unit in Santa Maria with BLS supplies to treat fifty (50) injured patients. See Attachment G for locations and inventory.
- All Santa Barbara County Fire Agencies maintain back-up medical supplies at their respective stations or logistics warehouse.
- All Santa Barbara County Ambulances are equipped with both ALS and BLS supplies. Out of county ambulances may have only BLS supplies.
- Ambulance supervisor units should carry BLS and ALS supplies.
- Equipment cache trailers/trucks: Santa Barbara City Fire (BLS), Lompoc City Fire (BLS), and Santa Maria City Fire (BLS). See Attachment G for locations and inventory.

5.4.3 Ambulance Medical Equipment

Ambulances should not provide equipment such as the heart monitor or portable oxygen tank to a treatment area when it would make the ambulance unable to provide patient care during transport or to another patient should that ambulance be assigned to a separate incident.

SECTION 6.0: HANDLING THE DECEASED

Sheriff Coroner should direct on-site morgue operations.

If it becomes necessary to move bodies in order to accomplish rescue/extrication and/or treatment of casualties, protect the health and safety of others, or to prevent further damage to the bodies, the following procedures should be followed:

- Do not remove any personal effects from the bodies;
- Tag the bodies with approved triage tags to indicate death;
- Bodies must be secured and safeguarded at all times; personnel should be assigned to monitor morgue areas.
- No variations to these procedures are authorized without the approval of the Morgue Manager, Sheriff-Coroner, or their representative.

7.0: POST INCIDENT REVIEW

The MCI after action checklist (Attachment I) will be completed for all incidents. The MCI After Action Checklist should be used by the incident commander after every incident to provide information for after action meetings and continuous quality improvement review (CQI). This form should also document and describe the reasons for an operational response different than that described in this MCI plan.
The checklist will be submitted to the EMS Agency by the IC within 24 hours of the event.

All agencies involved in any MCI should plan to attend an operational debrief of the incident response. The IC's parent agency is designated as the agency responsible for scheduling and hosting the operational debrief and will solicit participation from other responding agencies in coordination with the EMS Agency. The elapsed time between the incident and the operational debrief is at the discretion of the host agency, however, it is recommended that the operational debrief be held as soon as practical after the incident, ideally within one week following the termination of the MCI.

The operational debrief will be facilitated by the agency vested with IC responsibility and a designated representative of the EMS Agency, and will follow the Santa Barbara County EMS Agency's Quality Improvement Program Guidelines to ensure confidentiality, to promote positive and frank feedback, and identify lessons learned for training improvements. The debrief shall be conducted following an established debriefing format to facilitate such a review.

Representatives of all agencies involved in the incident should be invited to the operational debrief, including all dispatchers who participated in the incident's communications. It is further recommended that, to the extent possible, all incident participants attend the operational debrief.

An "AFTER-ACTION REPORT" may be prepared by the agency vested with IC responsibility in consultation with Santa Barbara County EMS Agency for distribution to all involved agencies. The purpose of the report is to identify the operations that went well and opportunities for improvements of the MCI Plan, and develop a Plan of Action and Milestones to correct identified deficiencies and improve patient care.

SECTION 8.0: MCI PLAN REVISIONS

As needed, and in consultation with first responder agencies, the Multi-Casualty Incident (MCI) Plan may be revised and/or updated by the Santa Barbara County EMS Agency; based upon current medical knowledge, technology, procedure, and trends in prehospital care.

Attachment A:

OPERATIONAL CONSIDERATIONS

1) The Patient Transportation Unit Leader is responsible for managing patient transportation and is usually the first ambulance paramedic arriving on scene.
2) All incoming personnel shall assume support roles based upon assignment/mission designated by the Incident Commander (IC). All personnel shall report to staging for direction unless instructed otherwise.
3) All personnel with an assigned ICS position should be easily identified through the use of ICS position vests.
4) All personnel should have job action sheets for their assigned position. (Attachment C)
5) Complete ICS forms as appropriate to the scope or complexity of the incident. (ie: 201,202,203, 214, etc.)
6) During the MCI, all onsite agencies shall request additional resources through the Incident Commander or his/her designee. The IC shall communicate with the Medical Group Supervisor or Transportation Unit regarding patient transportation resource needs.
7) The IC should consider personnel needs to manage triage, patient movement, and patient management in the treatment areas when requesting resources.
8) Personnel shall continue to follow Santa Barbara County EMS policies and protocols
9) Upon notification of an MCI, and prior to arrival at scene, the ambulance provider field supervisor will initiate a ReddiNet poll of hospitals to determine number and type of beds/services available from trauma and non-trauma hospitals, both in and out of county.
10) The ambulance provider field supervisor will initiate radio communication with the IC on scene to report "This is the AMR supervisor enroute to the scene. I have launched the ReddiNet poll to determine ED bed availability."
11) Triage and use of Triage Tags will be performed according to Section 3.2 of the SBC MCI Plan.
    - Criteria specified in the SB EMS Trauma Triage Criteria and Patient Destination policy and the Patient Destination Algorithm will be used to assure that all appropriate trauma patients are identified for transport to a designated trauma hospital. Both in and out of county designated trauma hospitals will be utilized.
        i. Every effort will be made to transport trauma patients to a trauma center. In a Level II or III MCI transport to a designated trauma center may not always be possible.
    - Transportation Unit Leader/Medical Communications Coordinator will determine transportation methods and destinations and advise receiving hospitals via ReddiNet. This position may be filled by the ALS ambulance provider staff.
    - Patient destination considerations may include: Destination of patients from another MCI, MCI patients who self-report to the hospital(s), distance, number of transport vehicles, etc.
12) Use of air ambulance is encouraged to transport patients who meet criteria for trauma center destinations.
13) Consideration should be made to reallocate personnel from the extrication and triage areas to the treatment area as patients are triaged and moved to the treatment areas.
14) It is important to reassess patients in the treatment area and during transport.
15) The IC or designee, when requested by the Incident's Medical Branch Director, orders all EMS aircraft, assigns the heli-spot manager and safety officer, and designates the landing zone(s).
16) The IC or designee should request Critical Incident Debriefing (CID) as soon as a need is identified.
17) Receiving hospital notifications should be brief and include the following information:
    - Age and sex of patient
    - Chief complaint/mechanism of injury
    - Patient level of consciousness and respiratory status
    - Code of transport and estimated time of arrival (ETA).
    - Contact of base hospital by ALS personnel, whether involved in the MCI or not, should routinely be limited to instances where treatment is restricted to physician order only

Attachment B

COMMAND STRUCTURE AND AUTHORITY

SINGLE JURISDICTION

The incident command authority lies with the responsible legal jurisdictional agency.
The legal jurisdictional agency will build a command structure based on the Incident Command System (ICS) and FIRESCOPE.

MULTI-AGENCY/JURISDICTION

For multi-agency and/or multi-jurisdictional incidents, a unified command structure may be established with the incident command responsibilities being jointly provided by those agencies (e.g. law, fire, EMS Agency, public health, other agencies) sharing legal jurisdiction and/or contributing to the process of:

- Determining the overall incident objectives;
- Selection of tactical strategies;
- Approving the joint-plan and tactical activities;
- Management of assigned resources;
- Processing and dissemination of information;
- Conducting integrated tactical operations; and
- Effectively and efficiently employing all assigned/available resources.

In incidents involving multi-agencies, there may be a critical need for integrating management of resources into one operational organization that is managed and supported by one command structure. In the ICS, employing what is known as Unified Command fills this critical need.

FIRESCOPE Field Operations Guide, ICS-420, 2007 describes unified command as follows:

- *Unified Command is a team effort that allows all agencies with jurisdictional responsibility for an incident, either geographical or functional, to participate in the management of the incident. Developing and implementing a common set of incident objectives and strategies demonstrate this participation that all can subscribe to, without losing or abdicating agency authority, responsibility or accountability.*
- *Those organizations that participate in Unified Command should have statutory responsibility for some portion of the incident or event.*
- *Assisting and cooperating agencies with no statutory responsibility that nonetheless contribute resources to the incident should not function at the Unified Command level. These agencies should instead, assign Agency Representative to effectively represent their agencies and resources through the Liaison Officer.*
- *In these ways, the principles that define Unified Command provide all of the necessary mechanisms for organizational representation and interagency management within a multi-agency incident response.*

<u>Assisting and cooperating agencies could include</u>: school entity, American Red Cross, business representative, or other agency representative. These agencies and entities may assist or provide

necessary information for operations such as floor plans, employee/student accounting, security system information, hazardous material information, etc.

COMMAND AUTHORITY PRINCIPLES

- The Incident Commander (IC) will be a designated representative from a Law Enforcement, Fire Agency, or Health Department having jurisdictional, investigative, or legal authority for the incident.

- The first arriving personnel of any agency may function as the IC implementing the necessary actions until the role can be relinquished to the appropriate agency.

- Agencies that are assisting or providing mutual aid in support of an incident will function under the direction of the designated IC or Unified Command.

- In multi-agency and/or multi-jurisdictional incidents, a Unified Command may be established at a single (site) command post (location).

- MCI ICS positions: Only those ICS positions required, due to the size and nature of the incident need be filled. See **Attachment C** for position checklists for each MCI medical group or branch position.

- Any large event (incident) may need to have several divisions and/or branches under one director. See **Attachment C** for the FIRESCOPE organizational chart as the guide to establish appropriate ICS structure and positions for the incident size.

Attachment C: FIRESCOPE MCI

MCI Organizational Charts and Job Action Sheets

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MEDICAL BRANCH

DEFINITION

The Medical Branch structure is designed to provide the Incident Commander with a basic, expandable system to manage a large number of patients during an incident. If incident conditions warrant, Medical Groups may be established under the Medical Branch Director. The degree of implementation will depend upon the complexity of the incident. As the complexity of an incident exceeds the capacity of the local medical health resources, additional response capabilities may be provided through provisions of the Public Health and Medical Emergency Operations Manual (EOM) through the Medical Health Operational Area Coordinator (MHOAC).

MODULAR DEVELOPMENT

A series of examples for the modular development of the Medical Branch within an incident involving mass casualties are included to illustrate one possible method of expanding the incident organization.

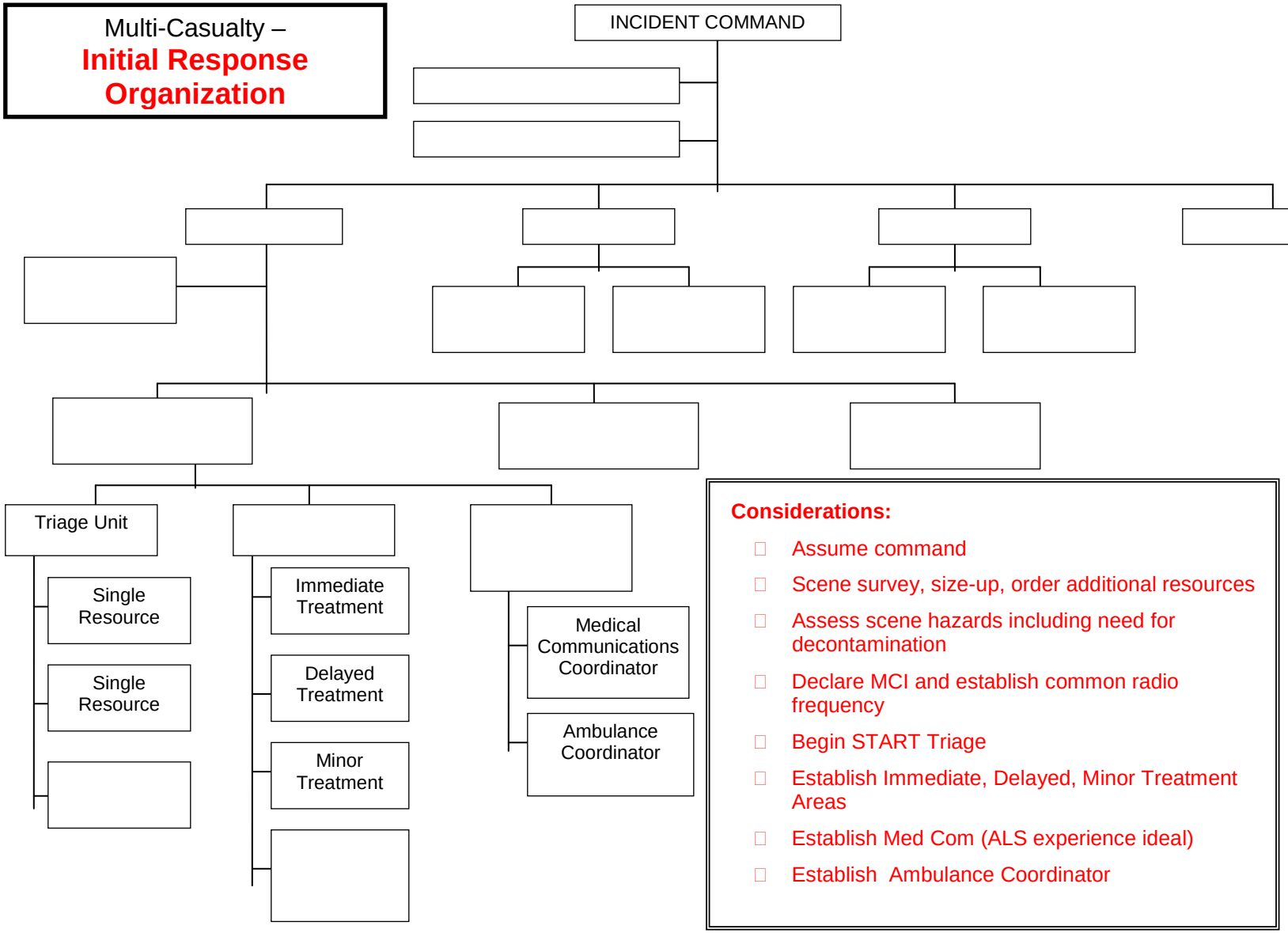
Initial Response Organization: The Incident Commander manages initial response resources as well as all Command and General Staff responsibilities. The Incident Commander assigns the resource with the appropriate communications capability to the Medical Communications Coordinator to establish communications with the appropriate hospital or other coordinating facility, and assigns other first arriving resources to the Triage Unit Leader, treatment areas, and Ambulance Coordinator.

Reinforced Response Organization: In addition to the initial response, the Incident Commander establishes a Safety Officer, a Treatment Unit Leader, a Patient Transport Unit Leader and Ambulance Coordinator. Patient treatment areas are established and staffed. Ambulance Strike Teams (AST) may be requested via the MHOAC to support local resources.

Multi-Group Response: All positions within the Medical Group are now filled. The Air Operations Branch is shown to illustrate the coordination between the Patient Transportation Unit and the Air Operations Branch. A Rescue Group is established to free entrapped victims. May consult with MHOAC/LEMSA for additional hospital and ambulance resources such as Ambulance Strike Teams (AST's).

Multi-Branch Incident Organization: The complete incident organization shows the Medical Branch and other Branches. The Medical Branch now has multiple Medical Groups due to incident complexity, but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals or other medical facilities.
As the complexity of an incident exceeds the capacity of the local medical health resources, additional response capabilities may be provided through provisions of the Public Health and Medical Emergency Operations Manual (EOM) through the Medical Health Operational Area Coordinator (MHOAC).

Multi-Casualty –
Initial Response Organization

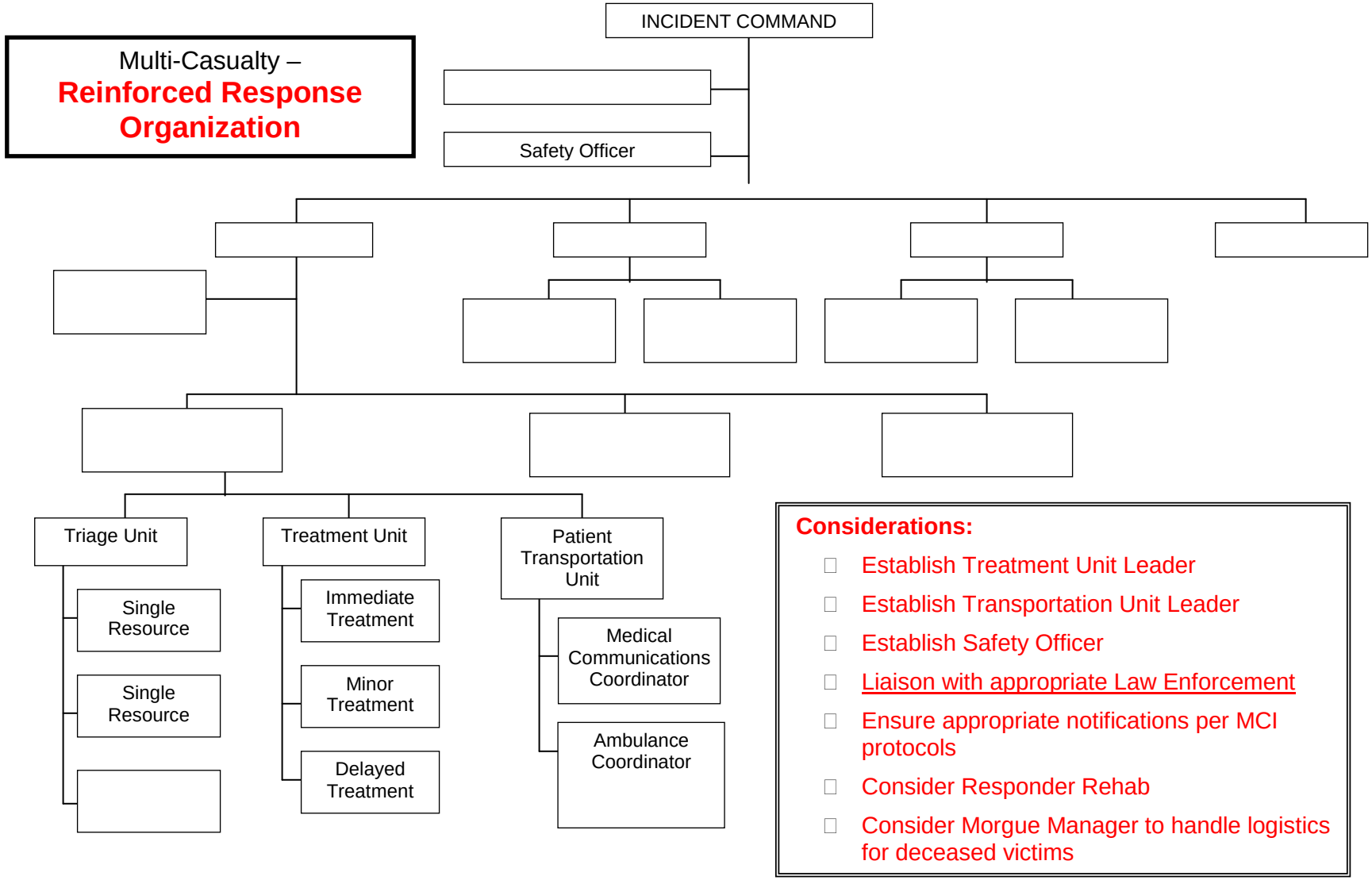


Considerations:

- Assume command
- Scene survey, size-up, order additional resources
- Assess scene hazards including need for decontamination
- Declare MCI and establish common radio frequency
- Begin START Triage
- Establish Immediate, Delayed, Minor Treatment Areas
- Establish Med Com (ALS experience ideal)
- Establish Ambulance Coordinator

Initial Response Organization: The Incident Commander manages initial response resources as well as all Command and General Staff responsibilities. The Incident Commander assigns the resource with the appropriate communications capability to the Medical Communications Coordinator to establish communications with the appropriate hospital or other coordinating facility. In addition, the Incident Commander assigns a Triage Unit Leader, establishes treatment Areas, and assigns an Ambulance Coordinator.

Multi-Casualty –
Reinforced Response Organization

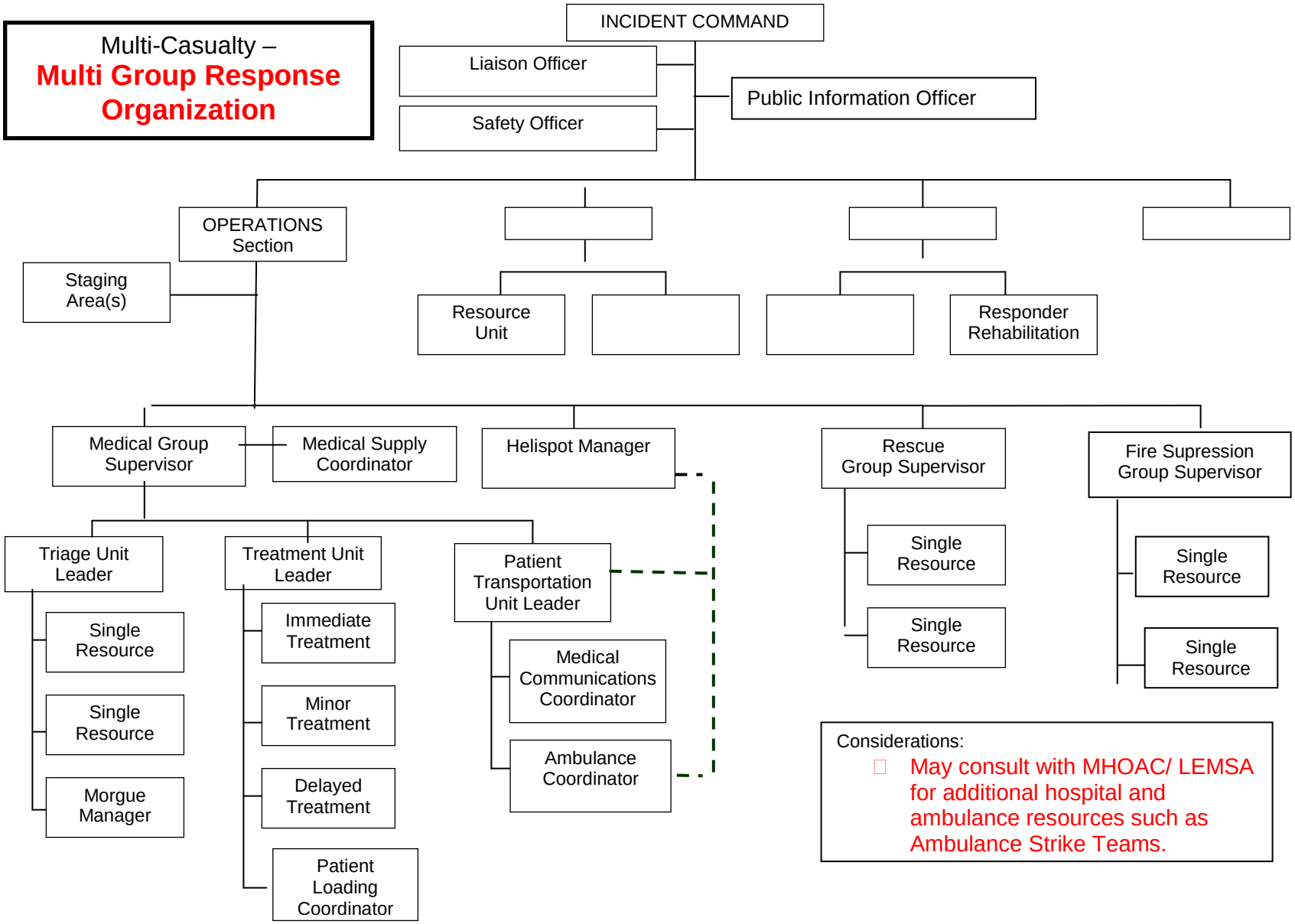


Considerations:

- Establish Treatment Unit Leader
- Establish Transportation Unit Leader
- Establish Safety Officer
- Liaison with appropriate Law Enforcement
- Ensure appropriate notifications per MCI protocols
- Consider Responder Rehab
- Consider Morgue Manager to handle logistics for deceased victims

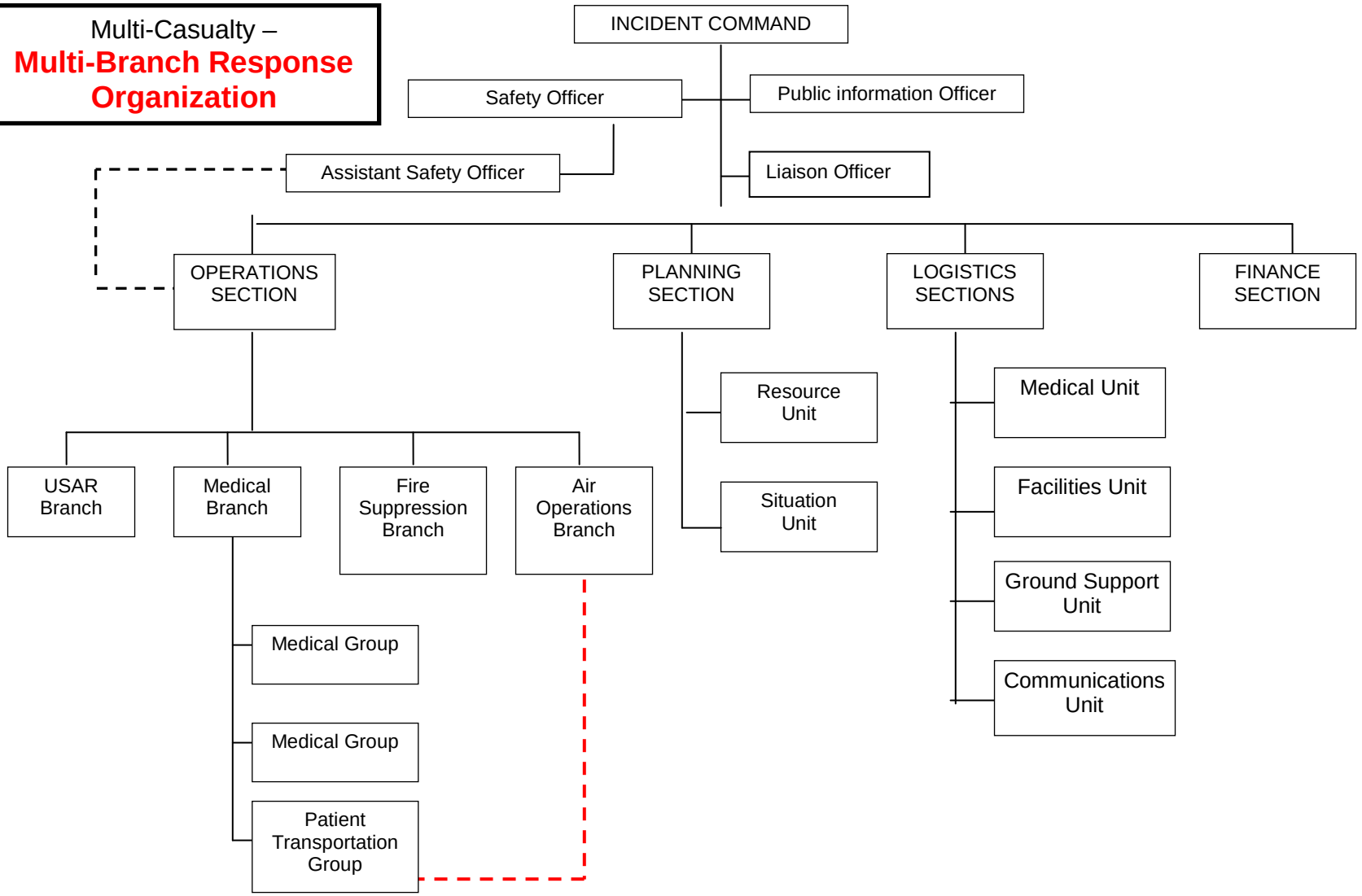
Reinforced Response Organization: In addition to the initial response, the Incident Commander establishes a Safety Officer, Treatment Unit Leader, Patient Transport Unit Leader and Ambulance Coordinator. Patient treatment areas are established and staffed.
LEMSA may have increased responsibilities for patient transportation resource ordering . Example: Ordering Ambulance Strike Teams (AST)

Multi-Casualty –
Multi Group Response Organization



Multi-Group Response: All positions within the Medical Group are now filled. The Air Operations Branch is shown to illustrate the communication between the Patient Transportation Unit and the Air Operations Branch in determining transportation to distant facilities and types of aircraft. Rescue Group may be established to free entrapped victims. Fire/Hazard Control Group may be established to control any fire or hazardous conditions.

Multi-Casualty –
Multi-Branch Response Organization



Multi-Branch Incident Organization: The complete incident organization shows the Multi-Casualty Branch and other Branches. The Multi-Casualty Branch now has multiple Medical Groups (geographically separate) but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals or other medical facilities. As an incident escalates, the MHOAC/ LEMSA may assist with determining hospital and ambulance resource utilization.

INCIDENT COMMANDER
Job Action Sheet

Specific IC MCI Checklist:

Description

Refer to FIRESCOPE Field Operation Guide, Chapter 1, page 1-2, Common Responsibilities and Chapter 5, page 5-3, Incident Commander checklist of major responsibilities.

- ☐ Refer as needed to the Santa Barbara County EMSA MCI Plan
- ☐ Assume incident command and establish or participate in unified command with other responding agencies (law, fire, EMS, other agency).
- ☐ Size up the situation by determining the nature and magnitude of the incident, the estimated number of injured, and severity of the injuries.
- ☐ Confirm and communicate a declaration of the MCI status and MCI level (I, II, or III) to dispatch and activate the MCI plan.
- ☐ Assign appropriate ICS roles to responding personnel using MCI job action sheets, vests (if available and warranted) and appropriate documentation forms located in MCI kits. MCI kits are on all fire battalion chief vehicles and ambulance supervisor vehicles.
- ☐ Establish the ambulance staging area, triage and treatment areas and morgue area as appropriate.
- ☐ Establish initial priorities and immediate resource requirements.
- ☐ Coordinate with the appropriate position (i.e. Medical Group Supervisor, Transportation Unit) regarding patient transportation resource needs.
- ☐ Determine if an Air Operations position will need to be activated and the resources that will be required to operate landing zone/s.
- ☐ Assure that communication via Fire radio has been established with ambulance provider Field Supervisor running the ReddiNet ED capacity poll.
- ☐ Order appropriate medical management resources from fire agencies or the DMSU vehicle (50 patient BLS/ALS no medications, in Santa Maria) from AMR. (Resource List: Attachment G in MCI Plan)
- ☐ Work with the EMS Agency Duty Officer when a Level II or Level III MCI is declared, to request additional needed ambulance resources such as Ambulance Strike Teams, via medical mutual aid from Region 1.
- ☐ In Level II or III events consider establishment of an agency representative from the ambulance contractor to coordinate ambulance resources through a liaison officer.
- ☐ Complete the 201 and other ICS forms as appropriate to the scope or complexity of incident.

MEDICAL BRANCH DIRECTOR
Job Action Sheet

Description

The Medical Branch Director is responsible for the implementation of the Incident Action Plan within the Medical Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group(s) and the Patient Transportation function (Unit or Group). Patient Transportation may be upgraded from a Unit to a Group based on the size and complexity of the incident:

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Review Group Assignments for effectiveness of current operations and modify as needed.
- ☐ Provide input to Operations Section Chief for the Incident Action Plan.
- ☐ Supervise Branch activities and confer with Safety Officer to assure safety of all personnel using effective risk analysis and management techniques.
- ☐ Report to Operations Section Chief on Branch activities.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

MEDICAL GROUP SUPERVISOR
Job Action Sheet

Description

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 the activities within a Medical Group:

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Participate in Medical Branch/Operations Section planning activities.
- ☐ Establish Medical Group with assigned personnel, request additional personnel and resources sufficient to handle the magnitude of the incident.
- ☐ Designate Unit Leaders and Treatment Area locations as appropriate.
- ☐ Isolate Morgue and Minor Treatment Areas from Immediate and Delayed Treatment Areas.
- ☐ Request law enforcement to provide proper security, traffic control, and access for the Medical Group areas.
- ☐ Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, backboards, litters, and cots).
    - Consider need to order DMSU unit maintained by AMR in Santa Maria with BLS supplies to treat fifty (50) injured patients.
- ☐ Ensure activation or notification of appropriate hospital or other coordinating facility/agency.
- ☐ Coordinate with assisting agencies such as law enforcement, coroner, public health, and private ambulance companies. . Law enforcement/ coroner shall have responsibility for crime scene and decedent management.
- ☐ Coordinate with agencies such as Red Cross and utilities.
- ☐ Ensure adequate patient decontamination and proper notifications are made (if applicable).
- ☐ Consider responder rehabilitation.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

TRIAGE UNIT LEADER
Job Action Sheet

Description
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 and all the patients have been moved to the treatment areas, the Unit Leader may be reassigned as needed:

- ☐ Review Common and Unit Leader Responsibilities (FIRESCOPE).
- ☐ Develop organization sufficient to handle assignment.
- ☐ Inform Medical Group Supervisor of resource needs.
- ☐ Implement triage process.
- ☐ Maintains security and scene control
- ☐ Establish the number of involved vs. the number of injured
- ☐ Initiate triage as soon as possible. Triage is usually performed by initial responding units.
- ☐ Assures that START triage tags will be used on all MCI's
- ☐ Assures that START (adults) and JUMPSTART (pediatric patients) triage procedures are used
- ☐ Completes Triage Area Worksheet for patient tracking
- ☐ Receives and maintains all triage tag stubs until passing these to Treatment Unit Leader
- ☐ Coordinate movement of patients from the Triage Area to the appropriate Treatment Area.
- ☐ Ensure adequate patient decontamination and proper notifications are made (if applicable).
- ☐ Assign incident personnel to be litter bearers/triage personnel.
- ☐ Give periodic status reports to Medical Group Supervisor.
- ☐ Maintain security and control of the Triage Area.
- ☐ Establish a temporary morgue area in coordination with law enforcement/coroner if necessary.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

TRIAGE PERSONNEL
Job Action Sheet

Description

Triage Personnel report to the Triage Unit Leader and triage patients and assign them to appropriate treatment areas:

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Report to designated on-scene triage location.
- ☐ Triage and tag injured patients. Classify patients while noting injuries and vital signs if taken.
- ☐ Provides update on patient number and status to Triage Unit Leader
- ☐ Gives Triage Unit Leader triage tag stubs, with final count, sorted by category
- ☐ Direct movement of patients to proper Treatment Areas.
- ☐ Provide appropriate medical treatment to patients prior to movement as incident conditions dictate.
- ☐ Once initial triage is completed, Triage Personnel may be reassigned to Litter Bearers or Treatment Area at the direction of the Triage Unit Leader.

LITTER BEARER PERSONNEL
Job Action Sheet

Description

Litter Bearer Personnel report to the Triage Unit Leader and move patients to the appropriate treatment areas.

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Secure sufficient litters or gurneys to move patients.
- ☐ Report to designated on-scene triage location.
- ☐ Move patients based on triage category to the appropriate treatment area.

MORGUE MANAGER
Job Action Sheet

Description

The Morgue Manager reports to the Triage Unit Leader and assumes responsibility for temporary Morgue Area. Coordinates the handling of deceased persons with law enforcement and coroner and functions until properly relieved:

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Assess resource/supply needs and order as needed.
- ☐ Coordinate all Morgue Area activities with investigative authorities.
- ☐ Keep area off limits to all but authorized personnel.
- ☐ Keep identity of deceased persons confidential.
- ☐ Maintain appropriate records.

TREATMENT UNIT LEADER
Job Action Sheet

Description

The Treatment Unit Leader reports to the Medical Group Supervisor and supervises Treatment Managers and the Patient Loading Coordinator. The Treatment Unit Leader assumes responsibility for treatment, preparation for transport, and is responsible for the movement of patients to loading location(s). *Whenever possible the unit leader will be an ALS provider; however it may be a BLS provider with ALS reporting personnel conducting treatment and trauma triage.*

- ☐ Review Common and Unit Leader Responsibilities (FIRESCOPE).
- ☐ Develop organization sufficient to handle assignment.
- ☐ Direct and supervise Patient Loading Coordinator, Immediate, Delayed, and Minor Treatment Areas.
- ☐ Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
- ☐ Ensure adequate patient decontamination and proper notifications are made (if applicable).

- ☐ Maintain record of all patients status
- ☐ Receives triage tag stubs from Triage Unit Leader and inserts these in the Triage Tag Receipt Holder.
- ☐ Maintains Treatment Unit Leader Count Worksheet and notes trauma patients.
- ☐ Establish communications and coordination with Patient Transportation Unit Leader.
- ☐ Assure that Med Comm receives basic patient information and condition from Treatment Area Managers and/or Patient Loading Coordinator.
- ☐ Coordinate with Immediate Treatment Area Manager to communicate patient air transportation needs to Med Comm.
- ☐ Ensure continued assessment of patients and re-assess/ re-locate as necessary throughout Treatment Areas.
- ☐ *Ensure that ALS Treatment Unit personnel will use criteria specified in the SB EMS Trauma Triage Criteria and Patient Destination policy to assure that all appropriate trauma patients are identified for transport to a designated trauma hospital.*
  - o *Every effort will be made to transport trauma patients to a trauma center. In a Level II or III MCI transport to a designated trauma center may not always be possible.*
- ☐ Assign incident personnel to be litter bearers/treatment personnel.
- ☐ Responsible for the movement of patients to ambulance loading areas.
- ☐ Request sufficient medical caches and supplies including DMSU or support trailers.
- ☐ Give periodic status reports to Medical Group Supervisor.
- ☐ Request specialized medical resources through the MHOAC. (ex. DMAT, DMORT, MRC)
- ☐ Maintain Unit/Activity Log (ICS Form 214).

PATIENT LOADING COORDINATOR
Job Action Sheet

Description

The Patient Loading Coordinator reports to the Treatment Unit Leader and is responsible for coordinating with the Patient Transportation Unit Leader (or Group Supervisor if established), the transportation of patients out of the Treatment Areas:

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
- ☐ Establish communications with the Patient Transportation Unit Leader.
- ☐ Verify that patients are prioritized for transportation.
- ☐ Advise Medical Communications Coordinator of patient readiness and priority for transport.
- ☐ Coordinate transportation of patients with Medical Communications Coordinator.
- ☐ Ensure that appropriate patient tracking information is recorded.
- ☐ Coordinate ambulance loading with the Treatment Managers and ambulance personnel.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

IMMEDIATE TREATMENT AREA MANAGER
Job Action Sheet

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

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Assign treatment personnel to patients.
- ☐ Provide assessment of patients and re-assess/relocate as necessary.
- ☐ Report patient status to Treatment Unit Leader
- ☐ Ensure that ALS Treatment Unit personnel use criteria specified in the SB EMS Trauma Triage Criteria and Patient Destination policy to assure that all appropriate trauma patients are identified for transport to a designated trauma hospital.
  a. Every effort will be made to transport trauma patients to a trauma center. In a Level II or III MCI transport to a designated trauma center may not always be possible.
- ☐ Ensure appropriate level of treatment is provided to patients.
- ☐ Ensure that patients are prioritized for transportation.
- ☐ Coordinate transportation of patients with Patient Loading Coordinator.
- ☐ Coordinate with Unit Leader to assure that Med Comm receives basic patient information and condition
- ☐ Coordinate with Unit Leader to assure that patient air transportation needs are communicated to Med Comm.
- ☐ Notify Patient Loading Coordinator of patient readiness and priority for transportation.
- ☐ Ensure that appropriate patient information is recorded.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

DELAYED TREATMENT AREA MANAGER
Job Action Sheet

Description

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

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Assign treatment personnel to patients.
- ☐ Provide assessment of patients and re-assess/relocate as necessary.
- ☐ Report patient status to Treatment Unit Leader
- ☐ Ensure appropriate level of treatment is provided to patients.
- ☐ Ensure that ALS Treatment Unit personnel use criteria specified in the SB EMS Trauma Triage Criteria and Patient Destination policy to assure that all appropriate trauma patients are identified for transport to a designated trauma hospital.
  a. Every effort will be made to transport trauma patients to a trauma center. In a Level II or III MCI transport to a designated trauma center may not always be possible.
- ☐ Coordinate with Unit Leader to assure that Med Comm receives basic patient information and condition
- ☐ Ensure that patients are prioritized for transportation.
- ☐ Coordinate transportation of patients with Patient Loading Coordinator
- ☐ Notify Patient Loading Coordinator of patient readiness and priority for transportation.
- ☐ Ensure that appropriate patient information is recorded.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

MINOR TREATMENT AREA MANAGER
Job Action Sheet

Description

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

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Assign treatment personnel to patients.
- ☐ Provide assessment of patients and re-assess/relocate as necessary.
- ☐ Report patient status to Treatment Unit Leader
- ☐ Ensure appropriate level of treatment is provided to patients.
- ☐ Ensure that patients are prioritized for transportation.

- ☐ Coordinate with Unit Leader to assure that Med Comm receives basic patient information and condition

- ☐ Coordinate transportation of patients with Patient Loading Coordinator
- ☐ Notify Patient Loading Coordinator of patient readiness and priority for transportation.
- ☐ Ensure that appropriate patient information is recorded.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

PATIENT TRANSPORTATION UNIT LEADER
Job Action Sheet

Description

Reports to the Medical Group Supervisor.
Supervises: Medical Communications Coordinator, Ambulance Coordinator.
Responsible for the coordination of patient transportation and maintenance of records relating to the patient's identification, condition, and destination.
May be initially established as a Unit and upgraded to a Group based on incident size or complexity:

- ☐ Review Common Responsibilities and Unit Leader Responsibilities in FIRESCOPE
- ☐ Designate Ambulance Staging Area(s).
    a. Assure that ambulance staging area is **away from ingress and egress pathways for ground/air resources for the operation**

- ☐ Ensure the establishment of communications with the appropriate hospital or other coordinating facility/agency via ReddiNet or other method if ReddiNet not available.
- ☐ Ensure that bed availability from hospitals is communicated to Med Comm including trauma bed availability from designated trauma hospitals.
- ☐ Ensure that Med Comm tracks available beds in and out of county for victims of incident using Hospital Availability Worksheet.
    a. Every effort will be made to transport trauma patients to a trauma center. In a Level II or III MCI transport to a designated trauma center may not always be possible.

- ☐ Direct the off-incident transportation of patients as determined by the Medical Communications Coordinator.
- ☐ Maintain or assure that Ambulance Coordinator maintains Transportation Receipt Holder with receipts from triage tags for patients that have been transported from the scene.
- ☐ Establish communications with the Ambulance Coordinator and the Helispot Manager.
- ☐ Coordinate the establishment of the Helispot(s) with the Medical Group Supervisor and the Helispot Manager
- ☐ Request additional medical transportation resources (air/ground) as required.
- ☐ Notify the Ambulance Coordinator of ambulance requests.
- ☐ Maintain Unit/Activity Log (ICS Form 214).

MEDICAL COMMUNICATIONS COORDINATOR
Job Action Sheet

Description
The Medical Communications Coordinator reports to the Patient Transportation Unit Leader, and establishes communications with the appropriate hospital or other coordinating facility/agency to maintain status of available hospital beds to ensure proper patient destination:

- ☐ Review Common and Unit Leader Responsibilities (FIRESCOPE).
- ☐ Establish communications with the appropriate ambulance supervisor with ReddiNet access or hospital *via ReddiNet* or other coordinating facility/agency.
  - o Determine and maintain current status of hospital/medical facility bed availability and capability to accept trauma/non-trauma patients.
  - o Provide pertinent incident information and periodic updates to hospitals via Reddinet.
- ☐ **Identify designated trauma hospital availability. If necessary to accommodate trauma patients, identify out of county designated trauma hospital availability.** Criteria specified in the SB EMS Trauma Triage Criteria and Patient Destination policy will be used to assure that all appropriate trauma patients are transported to a designated trauma hospital.
  - o Every effort will be made to transport trauma patients to a trauma center. **In a Level II or III MCI transport to a designated trauma center may not always be possible**.
- ☐ Receive basic patient information and condition from Treatment Area Managers and/or Patient Loading Coordinator.
- ☐ Coordinate patient destination with the appropriate hospital or other coordinating facility/agency.
- ☐ Communicate patient transportation needs to the Ambulance Coordinator based upon requests from Treatment Area Managers and/or Patient Loading Coordinator.
- ☐ Communicate patient air transportation needs to the Ambulance Coordinator based on requests from the Treatment Area Managers and/or Patient Loading Coordinator.
- ☐ Maintain Hospital Availability Worksheet and other appropriate records
- ☐ Maintain Unit/Activity Log (ICS Form 214).

AMBULANCE COORDINATOR
Job Action Sheet

Description

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

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Establish appropriate Staging Area for ambulances.
- ☐ Establish routes of travel for ambulances for incident operations.
  a. Assures that ambulance staging area is **away from ingress and egress pathways for ground/air resources for the operation**

- ☐ Requests additional ambulances as required
- ☐ Coordinates requests for air ambulance transport
- ☐ Assures hospital communications via ReddiNet or other coordinating facility/agency with pertinent incident information
- ☐ Maintains Transportation Receipt Holder with receipts from triage tags for patients that have been transported from the scene.
- ☐ Establish and maintain communications with the Helispot Manager regarding air transportation assignments.
- ☐ Establish and maintain communications with the Medical Communications Coordinator and Patient Loading Coordinator.
- ☐ Provide ambulances upon request from the Medical Communications Coordinator.
- ☐ Ensure that necessary equipment is available in the ambulance for patient needs during transportation.
- ☐ Establish contact with ambulance providers at the scene.
- ☐ Request additional ground transportation resources as appropriate.
- ☐ Consider the use of alternate transportation resources such as buses or vans based on local policy.
- ☐ Provide an inventory of medical supplies available at ambulance Staging Area for use at the scene.
- ☐ Maintain records as required and Unit/Activity Log (ICS Form 214).

MEDICAL SUPPLY COORDINATOR
Job Action Sheet

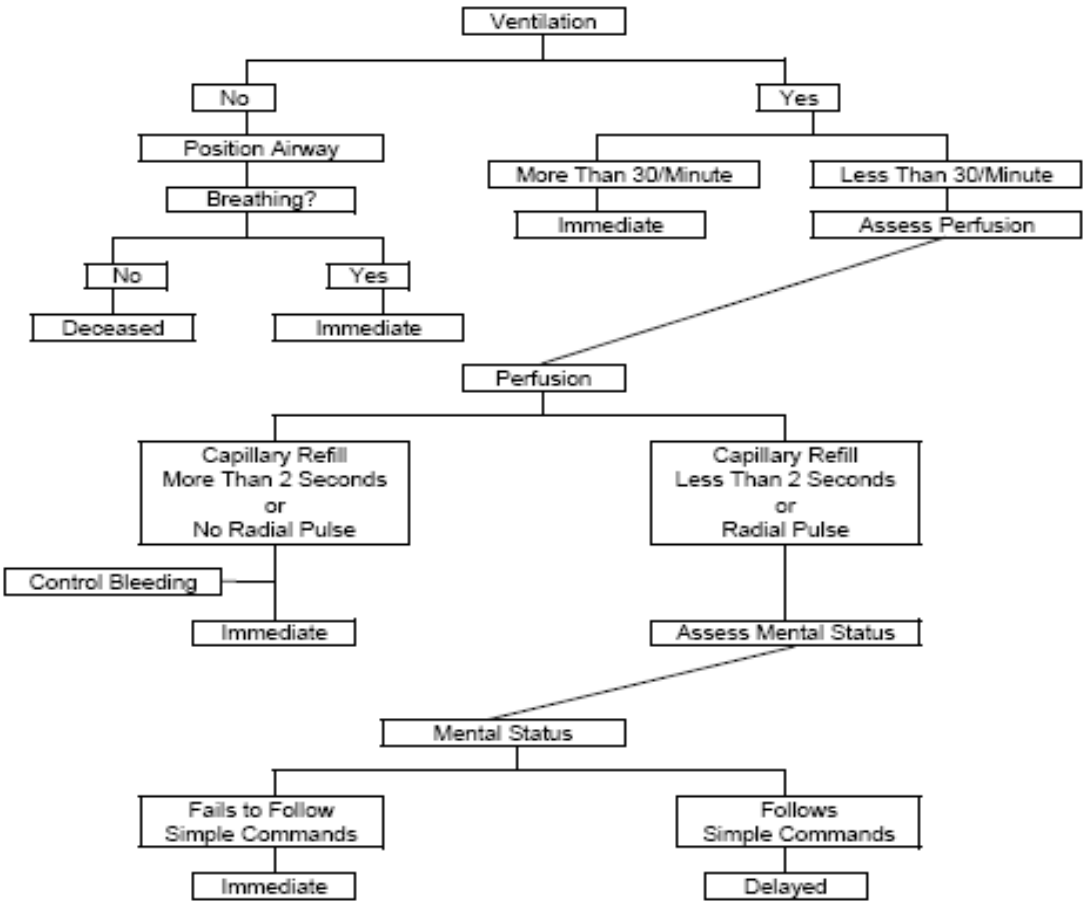
Description

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:

- ☐ Review Common Responsibilities (FIRESCOPE).
- ☐ Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group.*
- ☐ Request additional medical supplies.*
- ☐ Distribute medical supplies to Treatment and Triage Units.
- ☐ *Consider the utilization of a Disaster Medical Support Unit (DMSU) or incident support trailers. See Attachment G for EMS disaster medical caches.*
- ☐ Maintain Unit/Activity Log (ICS Form 214).

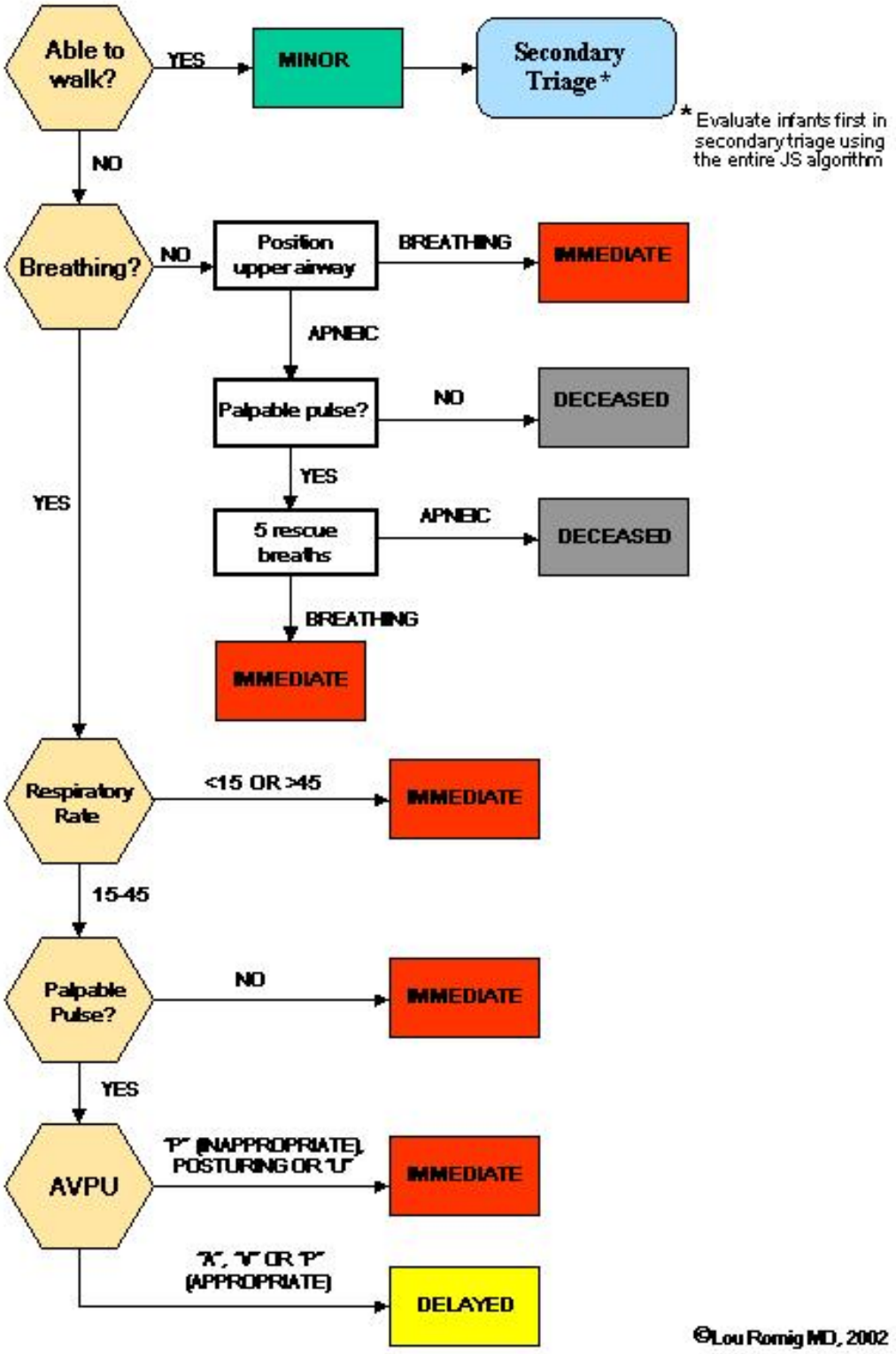
* If the Logistics Section were established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader.

SIMPLE TRIAGE AND RAPID TREATMENT (START) SYSTEM FLOWCHART



NOTE: Once a patient reaches a triage level indicator in the algorithm (i.e., IMMEDIATE TAG box), triage of this patient should stop and the patient should be tagged accordingly.

JumpSTART Pediatric MCI Triage©



MCI DESTINATION DECISION ALGORITHM including TRAUMA TRIAGE

LEVEL I MCI
FULL ePCR & TRIAGE TAGS

START/JumpSTART Triage

RED TAG

YELLOW TAG

GREEN TAG

Establish a treatment area for all MCI's

Perform a focused exam and begin to perform treatment as resources allow

Secondary Triage
TRAUMA TRIAGE STEP CRITERIA (Policy 510) for destination decision will be used for all patients with traumatic injuries

- **RED TAG** → **ANY TRAUMA STEP- TRANSPORT TO A TRAUMA CENTER (CONSIDER OUT OF COUNTY [O.O.C], CONSIDER AIR TRANSPORT)**
- **YELLOW TAG** → **STEPS 1,2,3 TRANSPORT TO A TRAUMA CENTER (CONSIDER O.O.C.) STEP 4 OR NO STEP, TRANSPORT TO A NON TRAUMA HOSPITAL**
- **GREEN TAG** → **STEP 3 CONSIDER TRAUMA CENTER (CONSIDER O.O.C) STEP 4 OR NO STEP, TRANSPORT TO A NON TRAUMA HOSPITAL**

LEVEL II or III MCI
Patient documentation on triage tag

START/JumpSTART Triage

RED TAG

YELLOW TAG

GREEN TAG

Establish a treatment area for all MCI's

Perform a focused exam and begin to perform treatment as resources allow

Secondary Triage
TRAUMA TRIAGE STEP CRITERIA (Policy 510) for destination decision will be used for all patients with traumatic injuries

- **RED TAG** → **TRANSPORT TO A TRAUMA CENTER WHENEVER POSSIBLE (CONSIDER O.O.C., CONSIDER AIR TRANSPORT)**
  - For level II/III MCI events, red tag patients with traumatic injuries exhibiting the following criteria should be prioritized to a trauma center:
    1. Significantly decreased GCS with evidence of neurological trauma
    2. Penetrating or blunt injury with signs and symptoms of shock
    3. Penetrating wounds to the neck and/or torso
- **YELLOW TAG** → **TRAUMA CENTER PREFERRED, IF POSSIBLE (CONSIDER O.O.C.)**
- **GREEN TAG** → **TRANSPORT TO A NON TRAUMA HOSPITAL**

When trauma center capacity at local and neighboring county trauma centers has been exhausted, transport to a non-trauma hospital

TRIAGE COUNT WORKSHEET

Triage Count Worksheet

Incident _____ Comm Plan Tac# _____

Recorder Name _____ Agency _____ Date / / Time :

Triage Unit Members

Last Name	Agency	Last Name	Agency	Last Name	Agency	Last Name	Agency

Initial Count

Location _____ Time _____

ADULTS

	Tally from Triage Teams	Total
I	IMMEDIATE	
D	DELAYED	
M	MINOR	
	MORGUE	

PEDIATRICS

	Tally from Triage Teams	Total
I	IMMEDIATE	
D	DELAYED	
M	MINOR	
	MORGUE	

MedCom Advised ☐ PT Total _____

Secondary Count

Location _____ Time _____

ADULTS

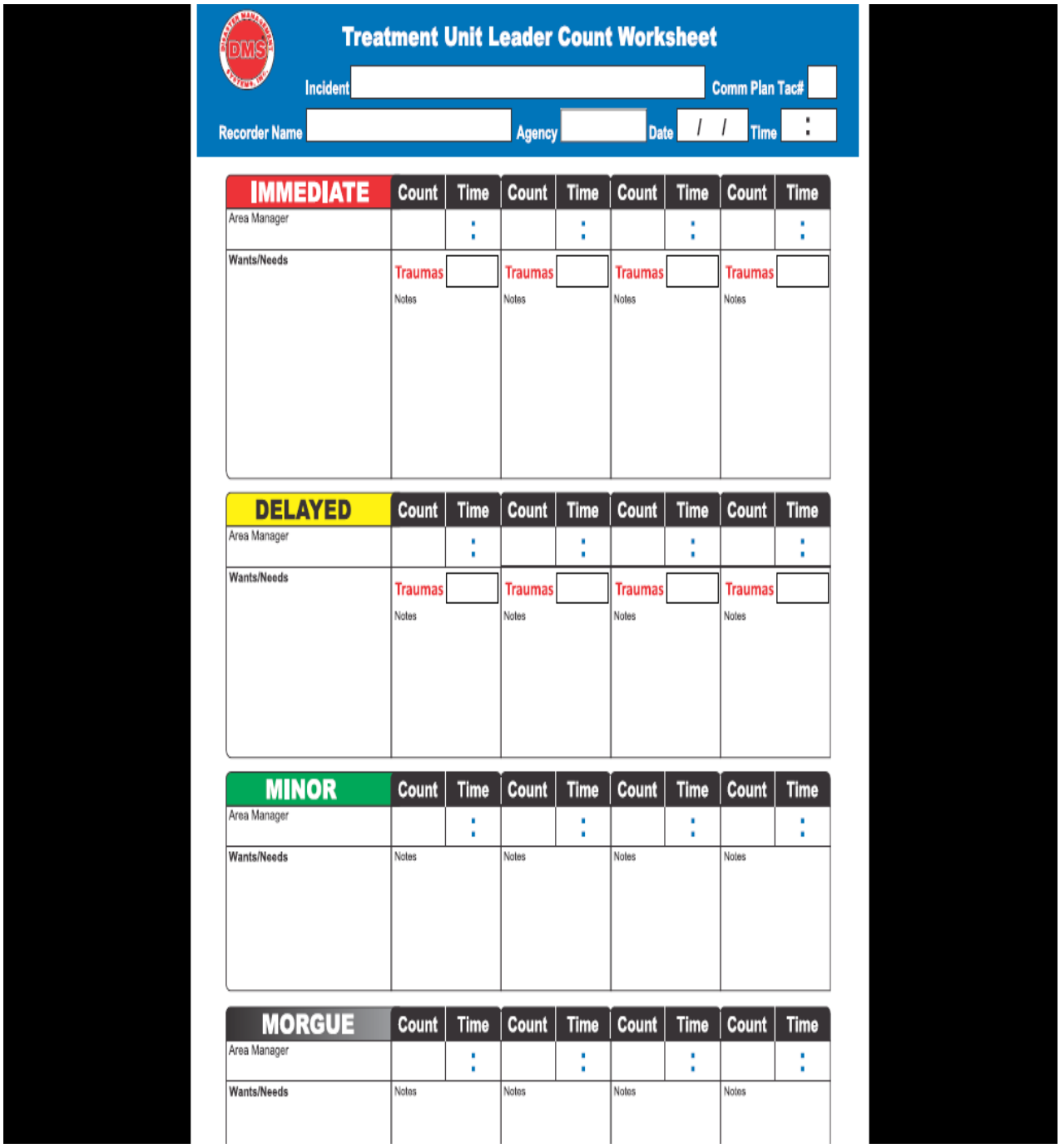
	Tally from Triage Teams	Total
I	IMMEDIATE	
D	DELAYED	
M	MINOR	
	MORGUE	

PEDIATRICS

	Tally from Triage Teams	Total
I	IMMEDIATE	
D	DELAYED	
M	MINOR	
	MORGUE	

MedCom Advised ☐ PT Total _____

Treatment Unit Leader Count Worksheet



Treatment Unit Leader Count Worksheet

Incident _____ Comm Plan Tac# _____

Recorder Name _____ Agency _____ Date / / Time :

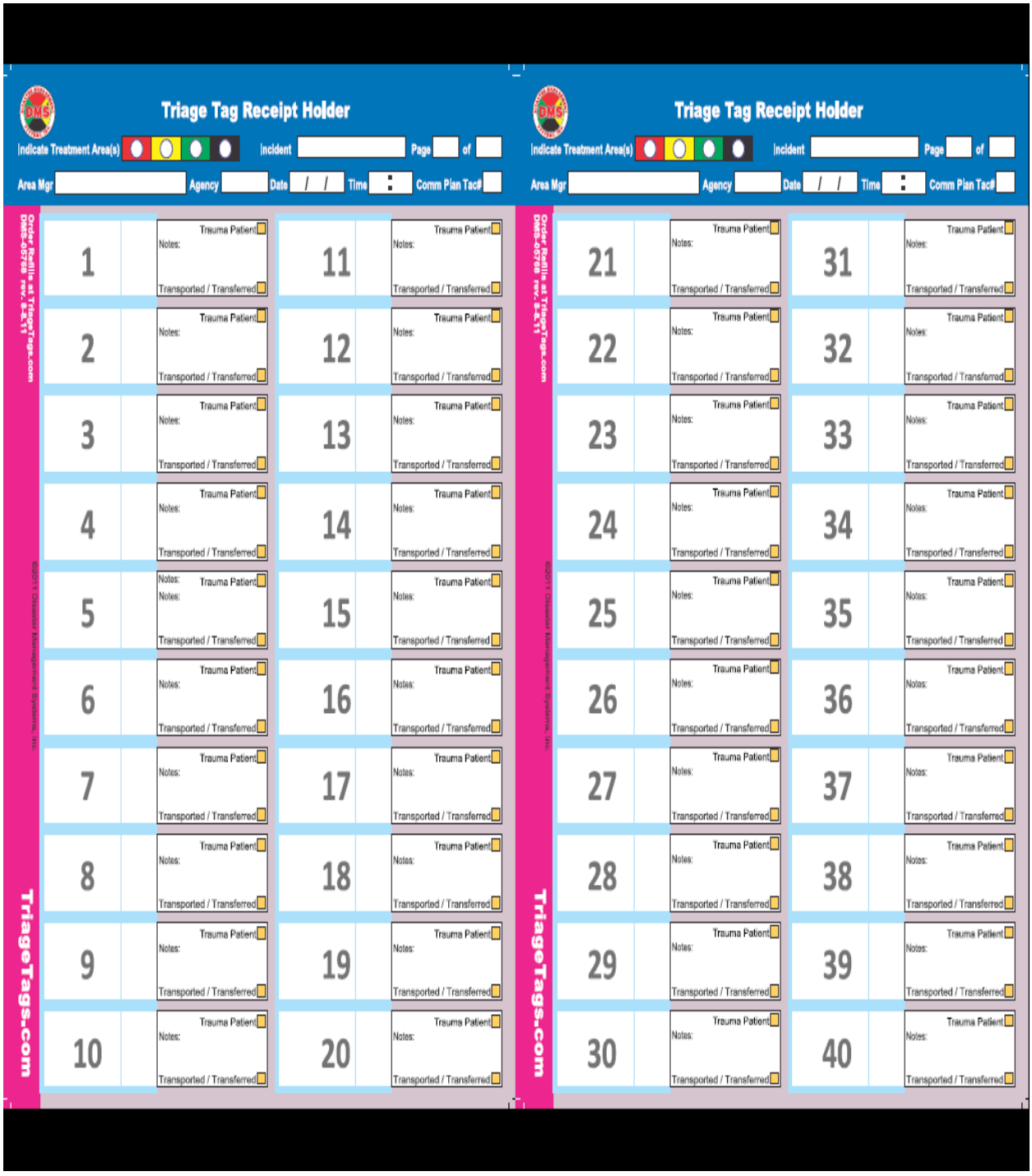
IMMEDIATE	Count	Time	Count	Time	Count	Time	Count	Time
Area Manager		:		:		:		:
Wants/Needs	Traumas		Traumas		Traumas		Traumas	
	Notes		Notes		Notes		Notes	

DELAYED	Count	Time	Count	Time	Count	Time	Count	Time
Area Manager		:		:		:		:
Wants/Needs	Traumas		Traumas		Traumas		Traumas	
	Notes		Notes		Notes		Notes	

MINOR	Count	Time	Count	Time	Count	Time	Count	Time
Area Manager		:		:		:		:
Wants/Needs	Notes		Notes		Notes		Notes	

MORGUE	Count	Time	Count	Time	Count	Time	Count	Time
Area Manager		:		:		:		:
Wants/Needs	Notes		Notes		Notes		Notes	

Treatment Unit Leader
Triage Tag Receipt Holder



Triage Tag
TRANSPORTATION RECEIPT HOLDER

SANTA BARBARA COUNTY MCI PATIENT TRACKING AND DESTINATION WORKSHEET

MCI Hospital Availability Worksheet

Incident Name:			Time		Estimated Victims				
	Immediat	Immed Trauma	Delayed	Delayed Trauma	Minor	Expired			
Total Patients:									
Time:									▸
	Avail	Used	Avail	Used	Avail	Used	Avail	Used	Total Used
Hospital Name									
1 MMC									
Immediate Trauma									
Immediate									
Delayed									
Minor									
2 LVMC									
Immediate									
Delayed									
Minor									
3 SYCH									
Immediate									
Delayed									
Minor									
4 SBCH									
Immediate Trauma									
Immediate									
Delayed									
Minor									
5 GVCH									
Immediate									
Delayed									
Minor									
6 Out of County:									
Immediate									
Delayed									
Minor									
7 Out of County:									
Immediate									
Delayed									
Minor									
Total Available Beds:									
Total Patients Transported:									

Santa Barbara County MCI Medical Cache Resources

Cache Type	Unit Designation	Estimated Patients:	Requesting Via:	Owner: Location
BLS/ ALS	Medic 91: Ambulance w/ MCI supplies	5 pts. ALS 20 pts. BLS	SB County Dispatch	Montecito Fire Protection District: Fire Station 1 – 595 San Ysidro Rd, Montecito, CA 93108
BLS	Truck	20 pts. BLS	Santa Barbara City Dispatch	Santa Barbara City Fire: Fire Station 8 – 40 Hartley Pl., Goleta 93117
BLS	Disaster Trailer	25 pts. BLS (depending on extent of injuries)	Lompoc City Dispatch	Lompoc City Fire: 115 S. G St. Lompoc, CA 93436
BLS	Breathing Support Unit: Truck w/ air, lighting and BLS supplies.	50 pts. for 2 hours BLS	Santa Maria Dispatch	Santa Maria City Fire: Station 1- 314 West Cook Street, Santa Maria, CA 93458
BLS/ ALS no meds	(DMSU) Disaster Medical Support Unit	50+ Patients - 72 hours BLS/ALS, no meds	Request to on-duty AMR Supervisor via SB County Dispatch	AMR: Station 8 - 3130 Skyway Drive # 72, Santa Maria, CA 93455

Additional Resources: Alternate Care Site Caches (ACS) contains ALS supplies but is NOT easily mobilized for immediate transport.

Organization	ACS	Vent	Pallets	Location
SB County Fire			2	4410 Cathedral Oaks Road Santa Barbara, CA 93110
SB City / Fire	1		21	30 South Olive St. Santa Barbara, CA
SM City Fire	1		24	Station 42: 2637 South College Drive Santa Maria, CA 93455
ARC SM	1			ARC Warehouse 3030 Skyway Drive, 93455 928-0778
Lompoc City	1		20	300 N E St. Lompoc, CA 93438
LVMC		4		1515 East Ocean Avenue Lompoc, CA 93436
SYCH	1		20	2050 Viborg Rd. Solvang, CA 93463
DRI/PHD	1		1	Goleta
AMR		23		240 E Highway 246 #300 Buellton
AMR			1	7200 Hollister Ave Suites 1A & 2A
AMR			2	3130 Skyway Drive #702 Santa Mari
UCSB	1		21	Student Health Service El Colegio Rd. BLDG 588, UCSB

DEFINITIONS

***Advanced Life Support (ALS*):** Those medical services that may be provided within the scope of practice of a person licensed as a paramedic (EMT-P) or RN.

Ambulance: Any vehicle or aircraft which is specially designed, constructed, maintained, supplied, or equipped for transporting sick, injured, infirm or otherwise incapacitated persons, and which is capable of supporting BLS or a higher level of care.

Base Hospital: The Base Hospital is the hospital authorized by the EMS Medical Director to provide medical control to Santa Barbara County paramedics.

Basic Life Support (BLS)*:* Those medical services that may be provided within the scope of practice of a person certified as an EMT-1 (Basic), First Responder, and public safety first aid.

Chemical, Biological, Radiation, Nuclear, and Explosive (CBRNE): Also known as Weapons of Mass Destruction (WMD). Response to a CBRNE incident requires specialized equipment, personnel, training, and medical treatment.

Disaster Medical Support Unit (DMSU): The DMSU is cargo van type vehicle (Ford E-450 chassis) which comes fully configured and equipped with medical supplies, emergency equipment and other items to support the initial response to a large scale medical disaster incident. As equipped, the unit is capable of providing necessary medical supplies to care for up to 50 patients. Supplies and equipment include triage support equipment, basic life support and advanced life support trauma kits, splinting/bandaging supplies, spinal immobilization equipment, oxygen and airway management supplies, infection control and personal protective equipment, patient litters, portable generator and flood lights, portable radio and communications equipment, and emergency vehicle lighting and warning equipment.

Emergency: An emergency means a condition or situation in which an individual has a need for immediate medical attention, or where emergency personnel or a public safety agency perceives the potential for such need.

EMS Dispatcher: The individual(s) who dispatches ambulance resources, provides pre-arrival instructions, and coordinates emergency response activities with Santa Barbara County Emergency Communications.

EMS Dispatch: Is staffed and maintained by the Primary Ambulance Provider and is co-located in the Santa Barbara County SBC Public Safety Dispatch Center.

EMS Agency Duty Officer: EMS Agency personnel designated as “on-call” foremergency notifications such as the declaration of an MCI. The EMS Duty Officer is or works under the Medical and Health Operational Area Coordinator and coordinates local, regional, state EMS resources. The EMS Agency Duty Officer or EMS Agency staff may respond to an MCI to assist with management of the MCI or as an Agency Representative.

Fire Communications (Fire Comm.): Is a division of Santa Barbara County SBC Public Safety Dispatch Center that provides Fire Dispatch to the majority of the fire agencies in Santa Barbara County.

Medical Disaster Communications System (MDCS): The MDCS (**800 MHz Radio**) allows emergency management, ambulance management, and hospitals to coordinate emergency response efforts.

Medical Network (MedNet) Communications: Assigned communication frequencies for dispatch, command and control, and tactical coordination.

Santa Barbara County Emergency Communications: The primary and centralized public safety answering point (9-1-1 Dispatch) for fire, law enforcement, and EMS for Santa Barbara County.

Multi-Casualty Incident (MCI): An incident that produces more casualties than can be managed by the usual EMS response of one or two ambulances.

Level - l MCI Activation: Is any incident in which the volume of patients overwhelms the initial responders, but the system has adequate resources to respond, treat, and transport. (Approximately 5-14) Notification should be made to the ambulance supervisor and EMS Agency Duty Officer.

Level - 2 MCI Activation (Multi-Causality Overload): An incident with multiple patients where there is a need for additional resources from within or outside the operational area. (Approximately 15-50)The ambulance supervisor and EMS Agency Duty Officer should be requested to support management of the incident. Consideration should be made to request the DMSU and/or fire-based MCI trailers for prolonged incidents (greater than two hrs). Ambulance resources may be requested from outside of the County via the medical mutual aid system activated by the MHOAC in coordination with the ambulance provider.

Level - 3 MCI Activation: This describes a large-scale incident, such as a large airline crash or a building collapse. (Approximately 50+) All the resources in a jurisdiction become overwhelmed, from the responders to the receiving hospitals. This is a localized incident differing from a Medical Disaster. However, the local disaster plan may be activated, enabling a regional resources response. Level – 3 activation should initiate a response from the DMSU and from outside the operational area.

1.3.19 ***Medical Disaster*****:** A widespread incident or multiple incidents with significant numbers of casualties. The local disaster plan is likely to be activated. Resources from outside Santa Barbara County will likely be required to fully manage the incident(s).

1.3.20 ***Medical Health Operational Area Coordinator (MHOAC)***. The Director of Health and the EMS Director have jointly designated the Director of the Santa Barbara County Emergency Medical Services (EMS) as the Medical and Health Operational Area Coordinator (MHOAC). The primary responsibilities of the MHOAC is to manage disaster medical resources, including personnel, equipment, and supplies; request mutual aid; activate hospital notifications and communication systems; survey EMS resources (hospitals and transportation providers); orchestrate patient distribution; coordinate evacuation and patient tracking; effectively and efficiently process all medical and health information, and report status to local, regional and state health and medical agencies.

Santa Barbara County EMS Agency MCI AFTER ACTION CHECKLIST

Date of MCI_____Unit(s)#_____Incident Commander_____

Level of MCI declared:_____ # of patients:_____

	YES	NO
1. The IC declared an MCI and the dispatch center was notified	☐	☐
2. The AMR supervisor was notified by dispatch of a potential MCI based on number of casualties in initial call(s)	☐	☐
3. The EMS Agency Duty Officer was notified by dispatch of an MCI/potential MCI	☐	☐
4. The AMR supervisor initiated a ReddiNet alert and polled hospitals	☐	☐
5. The AMR supervisor made radio contact with the IC and informed him of the ReddiNet alert and transport resources available	☐	☐
6. The IC utilized form 201, was a copy forwarded to EMS	☐	☐
7. AMR staff checked in with the IC for assignment to an MCI position	☐	☐
8. All resources were ordered through the IC	☐	☐
9. Triage & Treatment areas were set up	☐	☐
10. On scene patient care and transport destinations reviewed for appropriateness	☐	☐
11. MCI positions were assigned to fire and AMR personnel following the ICS org chart	☐	☐

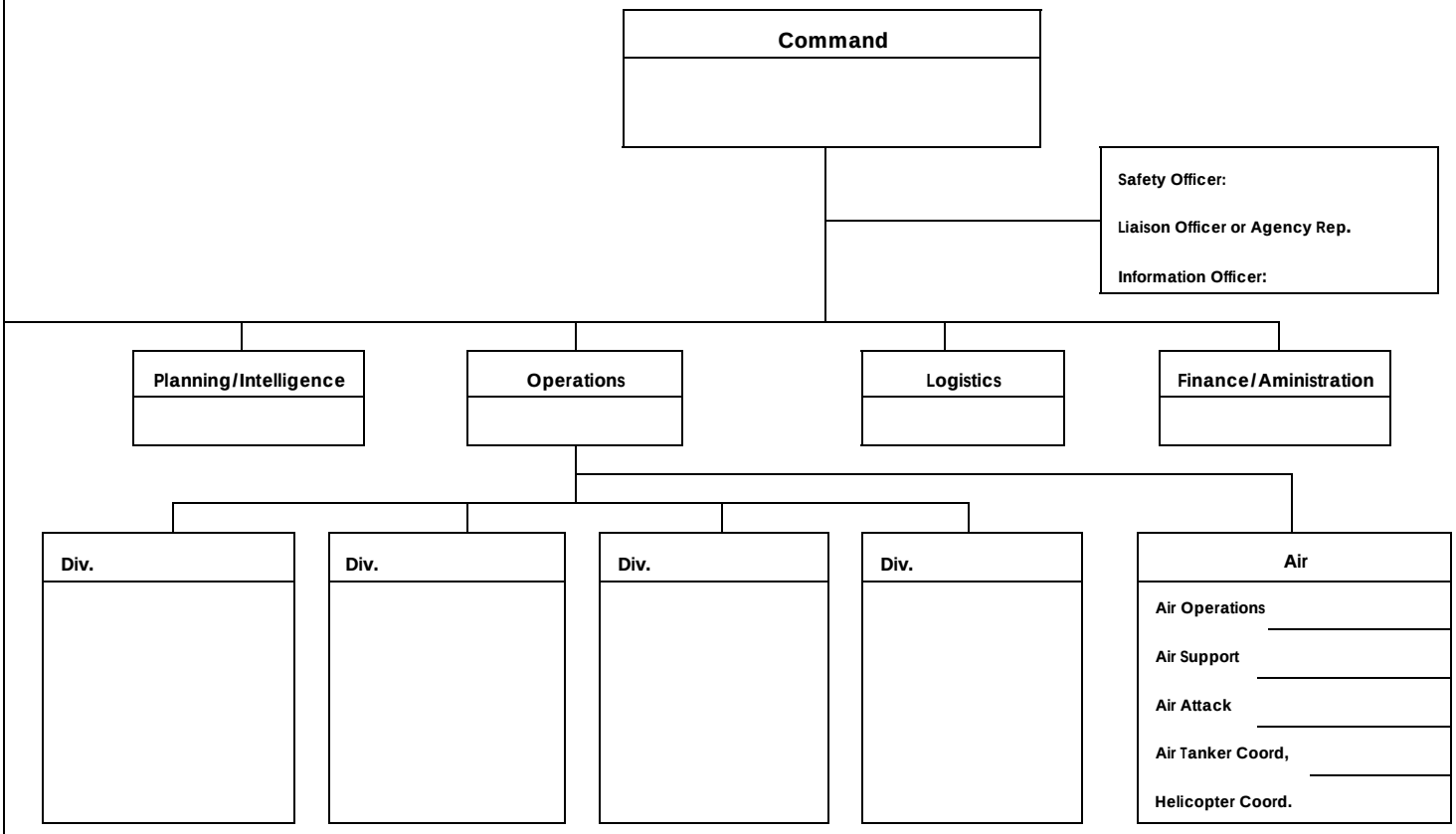
Was the operational response different than that described in the SB County MCI plan? If so describe any resource limitations or other reason that the plan could not be followed:

Fax or email this form to the Santa Barbara County EMS Agency within 24 hours of the MCI to 805-681-5142

INCIDENT BRIEFING	1. Incident Name	2. Date	3. Time

4. Map Sketch

5. Current Organization



Page 52 of	6. Prepared by (Name and Position)

6. Resources Summary				
Resources Ordered	**Resource Identification**	**ETA**	**On Scene**	**Location/Assignment**

7. Summary of Current Actions

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