Clark County Mass Casualty Incident Plan

Created 2002
Reviewed 2004
Revised 2005
Reviewed 2010
Revised 2014

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INTRODUCTION

Purpose

This plan provides guidelines for response to Mass Casualty Incidents (MCI) throughout Clark County. This involves the rescue, triage, treatment, and transport of emergency patients.

There are essential concepts of a mass casualty response that must be universally accepted and applied. Application of these concepts will enable all of the many agencies involved to work in an effective and coordinated manner. All universal systems of incident management are to be applied in a MCI event as well, such as the Incident or Unified Command System and Responder Accountability Plans.

Objectives

1. To minimize the loss of life, disabling injuries and human suffering by providing effective emergency medical assistance through the efficient utilization of resources in the event an incident results in multiple casualties.
2. To ensure the provision of adequate and integrated resources needed to mobilize teams effectively to manage casualties while maintaining the capability and resources to respond to other emergencies within the community.
3. To ensure responder safety and provide a common organizational structure to accomplish effective incident mitigation. To assist in responder safety, the Clark County Accountability System will be established and utilized throughout the MCI.

Scope

This plan, using the principles of the Incident Command System (ICS) and SALT triage, will serve as the primary guideline for MCI response in Clark County during the preliminary stages when first on scene.

Definition of Terms

Mass Casualty Incident (MCI)

A MCI is an incident with multiple casualties that overwhelms the resources of the responding agencies. There is no predetermined number of patients that triggers a Mass Casualty Incident response, or that may require significant additional resources or time to adequately manage, control, or mitigate the incident.

Mass Casualty Types

A sample model is provided to help commanders and agencies anticipate operational strategy, resource needs, and incident structure. This model includes separating incidents into terms of small, medium, or large. Refer to Figure 1 – Mass Casualty Types Chart for details.

Figure 1 - Mass Casualty Types Chart

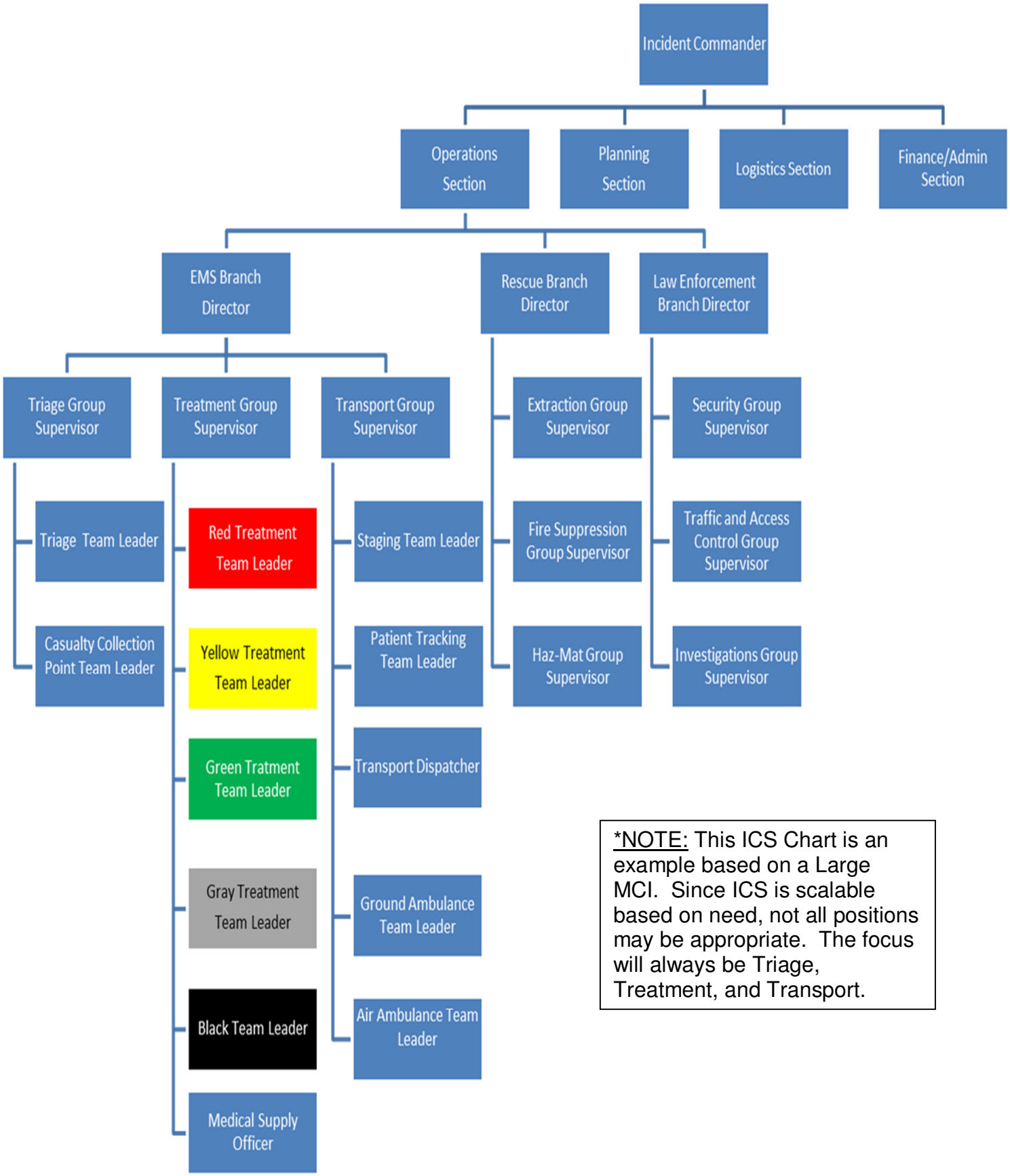
Type	Characteristics	Operational Strategy
Small **Up to 30**	• Up to 30 patients (all categories included) • Patient count can be easily and quickly established • Likely ICS elements include Groups, Teams, and Crews • Examples: Bus crash, pipe bomb, or house collapse	• Triage and transport directly to **area** hospitals • Treatment area, if established, will be short-lived • Patient distribution important
Medium **Up to 60**	• 31 to 60 patients (all categories included) **or** where patient count is unknown or not easily established • Likely ICS elements include Branches, Groups, Divisions, Teams, and Crews • Examples: A small airplane crash, backpack IED, or building collapse	• Most severe patients transported directly to **area** hospitals • Treatment Area will be established and utilized • Patient distribution to more distant hospitals will be very important • Alternative transport (buses) utilized for YELLOW and GREEN patients • May require EOC activation
Large **60+**	• More than 60 patients (all categories included) • Patient count is unknown or not easily verified • Likely ICS elements include Branches, Divisions, Groups, Teams, and crews • Examples: A large airplane crash, tornado strike, high-rise collapse	• Most severe patients transported directly to SRMC • Establish a Treatment Area • Patient distribution to more distant hospitals will be crucial • Forward movement of patients to more distant hospitals • Establish a Staging Area immediately • Will require activation of the EOC

INCIDENT COMMAND SYSTEM

During an MCI, the Incident Command System (ICS) shall include a functional division within the Operations Section that will have a primary responsibility to direct the medical management of the incident patients. The specific organizational structure established for any given incident will be based on the management needs of the incident, and established by the Incident Commander (IC).

The functional division of labor will be divided into three Branches. The EMS, Rescue, and Law Enforcement Branches managed under the Operations Section Chief may consist of any combination of positions. Refer to Figure 2 – Incident Command Organizational Chart for an example of an expanded ICS structure.

Figure 2 - Incident Command Organizational Chart



*NOTE: This ICS Chart is an example based on a Large MCI. Since ICS is scalable based on need, not all positions may be appropriate. The focus will always be Triage, Treatment, and Transport.

INCIDENT SCENE

Complex Incidents

Mass Casualty Incidents may be complicated by the sheer size of their footprint, specific geographic barriers, jurisdictional boundaries, multiple scenes, and other factors.

1. Incidents with significant geographic challenges (such as opposite sides of a river with no bridge) may benefit by dividing the response along logical geographic divides such as a North Division/Branch and a South Division/Branch, with the geographic barrier (street, river, etc.) as the dividing line;
2. It may sometimes be beneficial to maintain functional Groups and make geographic assignments within the Group. For example, the Triage Group could have a West Triage Team and East Triage team.
3. Resist the temptation to fragment the incident with Branch, Division, or Group assignments that are overly detailed or complex. Each assignment requires a supervisor which reduces the number of responders available to treat and transport patients.
4. If at all possible attempt to maintain a single Transport Officer since multiple Transport Officers will require significant coordination to assure correct patient movement and routing.

When these factors impede incident management, the commander should utilize the flexibility allowed within ICS to adapt the organization to the needs of the incident.

Incident Locations

The following locations are based in approximate order of set up. Refer to Figure 3 – Incident Scene Layout for Complex Incidents for a sample scene lay-out.

Incident Command Post (ICP)

- A fixed, clearly marked on-scene location where the Incident or Unified Command makes decisions and coordinates all scene operations.
- Position away from the operations areas of the incident.
- Outside of a potential hazard area.
- Only one command post shall be used.
- It may be a specialized vehicle, but any location may serve as the command post as long as it is well marked with a green light or flag and is clearly visible to in-coming participants.
- Clark County EMA has a Mobile Incident Command Post (MICP) that can be used for extended operations.

Rescue/Extraction Area

- Located as close to the incident site as possible.
- Responsible for scene and responder safety.
- Removal of patients from immediate physical danger.

Decon Area

- Set up close to the incident location.
- Decon extracted patients with orange ribbons prior to their entry into the Casualty Collection Point and subsequent Triage and Treatment Areas.

Initial Triage Area

- Located at the accident site (subject to scene safety).
- Attach ribbons to patients where they lay.
- If hazardous materials are present, or extrication is problematic, set up the Triage Area should be set up adjacent to the site; and triage is performed as patients are removed and/or decon-ed.

Casualty Collection Point Area (CCP)

- Set up between the Incident Scene (or decon if appropriate) and the Treatment Areas.
- Located as close to the Triage Area as possible as safety and working conditions permit.
- Designed to re-triage patients from ribbons to tags.
- Designed also to assess “walking wounded” where patients are directed to assemble for initial triage.
- Coordinate movement into specified Treatment Areas.
- May function as a gathering point.

Treatment Areas

- Located as close as possible to the Casualty Collection Point.
- Location site of the Mass Casualty Trailer.
- Should be well-mark with colored tarps and flags (accessed from the MC Trailer).
- Should provide easy access for both incoming patients from the CCP and for patients’ removal by ambulance from the Loading Area.
- May not be outdoors, especially under poor weather conditions – look around for a building that might be appropriate with sufficient open floor space.
- The first-in ambulances should off-load their equipment near the Treatment Area.
- The Mass Casualty trailer will be brought to the scene and set up in the Treatment Area to provide medical supplies and equipment.
- Additional supplies, including Hospital Disaster Packs, may also be brought in by ambulances returning from hospitals.

Loading Area

- Located as close to the exit of the Treatment Area as possible to expedite the movement of patients from the Treatment Area to local care facilities.

Staging Area

- Provides for immediate EMS available resources to await active assignments for treatment or transport.
- Vehicles used for transporting patients should be as close as possible to the Loading Area.
- All incoming ambulances *must* first report to the Staging Area for assignment.
- Transport Teams are to stay together with their ambulances.
- Large enough to accommodate multiple ground ambulances for both ingress and egress.
- Far enough away from operations so as not to interfere with the Transport Group.
- Use the Clark County Accountability Plan.

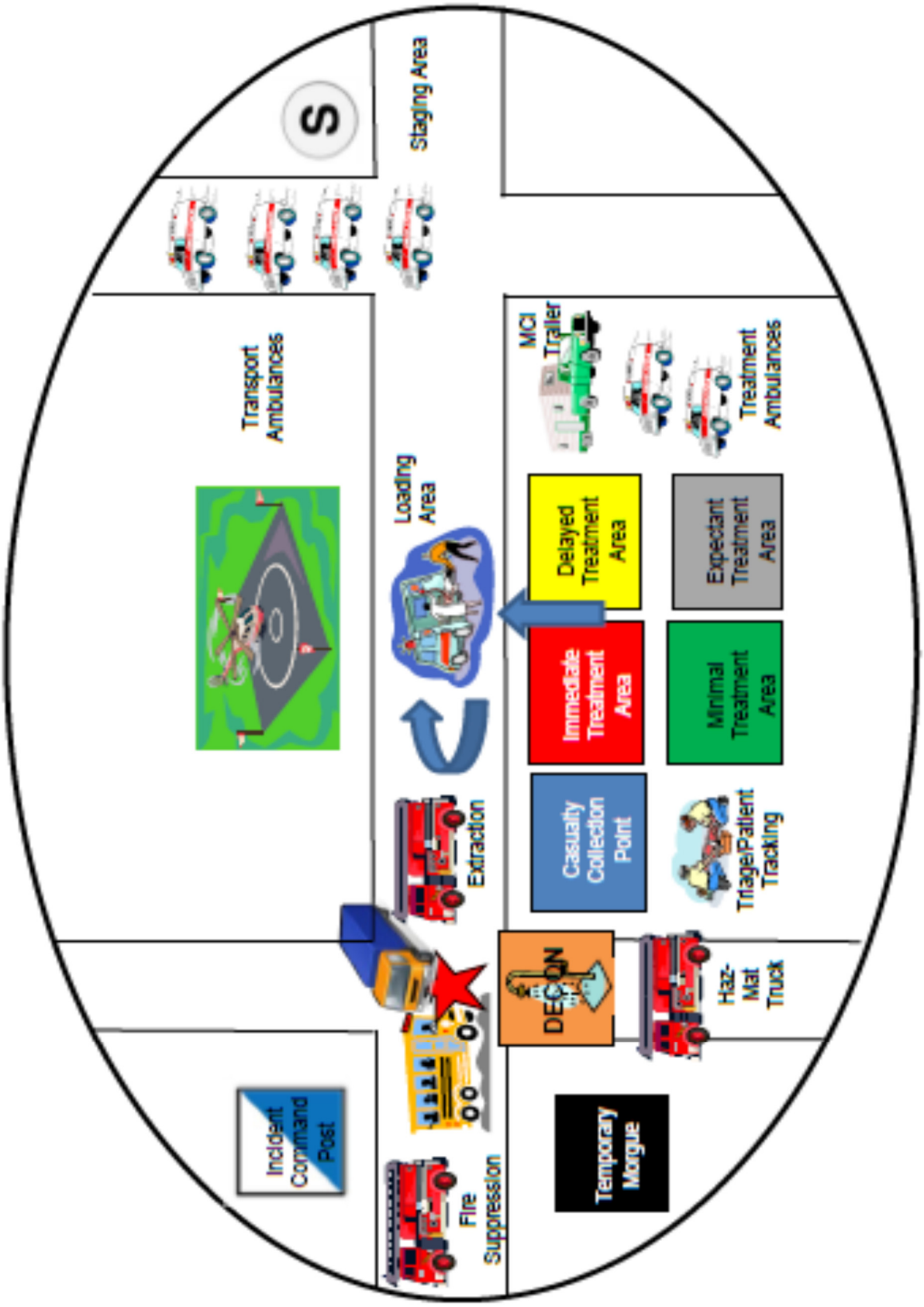
Helispot

- Landing conditions will dictate the location of the Helispot.
- The Landing zone should be 100' x 100' and free from obstructions.
- People should stay 200' away during landing operations, and emergency vehicles should be parked 100' away.

Temporary Morgue Area

- Remote from the Triage Area.
- Not be readily available to other patients.
- It should be accessible to vehicles.
- Access BLACK tarps and flags from the Mass Casualty Trailer.

Figure 3 - Incident Scene Layout for Large Incidents



MCI OPERATIONS

Incident Authority

Command and incident management authority legally lies with the jurisdictional fire department (except in cases of active shooters or potential criminal intent, in which case, the local law enforcement agency in whose jurisdiction the incident occurs has command authority). When the incident is multi-jurisdictional, or multi-discipline, a Unified Command structure should be established in accordance with ICS/NIMS principles.

Establishing Incident Command

The first unit on scene with jurisdictional authority will function as IC, implementing the necessary actions until the role can be assumed by the appropriate agency or individual. It will be the responsibility of the first-in unit to relay information on the scope and location of the incident. Overall operations on the scene shall be under the direction and control of the IC.

1. The Fire Chief or authorized representative shall be in charge on-scene and establish Incident Command.
2. The Incident Commander should appoint Command Staff, Branch Directors, and Division Supervisors as necessary.
3. The EMS Branch should be immediately divided into the functional areas of Triage, Treatment, and Transport.
4. Dispatchers will assist with initial incident communications and resource acquisition.
    - IC can request EMA resources to assist with both communications (COMML/COMMT) and equipment (radio cache) and serve as a single resource ordering-point to alleviate dispatcher workload.
5. Scene safety must be established before allowing any rescuers to enter the area. The senior law enforcement officer should be stationed at the Command Post and should request additional help as needed.
    - Law Enforcement will establish a police control line, maintain scene security, and order the traffic flow based on the Incident Commander's recommendations for hazard and scene control.
    - Traffic routes in and out of the area should be established for emergency vehicles. All EMS vehicles should be directed to the proper Staging or Transport Area.

Dispatcher Procedures

Upon verification from the Incident Commander that a Mass Casualty Incident exists, the dispatcher should begin making notifications of responders.

1. Request mutual aid Fire and EMS departments.
   - Advise them to bring the following items from their station:
     *ALL THEIR BACKBOARDS.
     *ALL THEIR CERVICAL COLLARS.
     *MASS CASUALTY CACHE.
2. Request the Mass Casualty Trailer via Bethel Township FD or the Clark County EMA 937-605-0576.
3. Notify responding companies of the appropriate staging areas and designated radio frequencies established by the Incident Commander.
4. Assign a mutual aid department(s) to pick up the Hospital Disaster Packs (including IV solutions) from SRMC. While at the hospital ask them to pick up all the backboards, straps, cervical collars, left in the emergency room(s).
5. Request Law Enforcement for scene security.
6. Notify Hospitals using the Regional Hospital Notification System (RHNS).
7. Contact two additional dispatchers to come to your location. The first dispatcher handles the radio. The second dispatcher handles the phone. The third dispatcher coordinates activity between the first two.

Notification of a Mass Casualty Incident

The local hospitals must be one of the first institutions notified of a Mass Casualty Incident. Given notification, they will be able to prepare for the influx of patients, either by clearing the emergency department or by activating their Internal Disaster Plan.

Fire Departments and Dispatchers can notify all hospitals in the GDAHA network area at once through the Regional Hospital Notification System (RHNS) at 937-333-8727. Request to speak with the Supervisor, request activation of RHNS, and be prepared to provide the following information:

1. Name of the agency making the request.
2. Nature of the emergency.
3. Location of the emergency.
4. General statement on severity, such as approximate number of patients.
5. Any other information necessary.
6. Return contact name, phone number, and radio frequency or talk group.

Incident Radio Communications

Radio communication during major incidents is almost always overburdened and confused. To help reduce confusion, the following guidelines should be followed:

1. When possible, communication should take place face to face. If radio transmissions are required, messages should be brief and to the point. If a long

conversation or message is required, a runner should be sent or a meeting requested at the Command Post.

2. No one but the IC should have radio contact with the dispatcher or the EOC.
3. Radio assignments will be made by the Incident Commander. The local fire jurisdiction frequency will be considered the main incident frequency. A second frequency may be assigned for EMS operations.
4. The IC should maintain radio contact with the operations supervisors.
5. The Patient Tracking Team Leader (if established, otherwise the Transport Group Leader) should be the only one communicating with area hospitals.
6. Ambulances transporting patients from the scene should NOT make a radio report to the hospital. This will be done by the Patient Tracking Team.
7. Ambulances responding to the scene may notify the dispatcher of their response, but after that no other contact should be made with dispatch.
8. Communication between the scene and hospitals should be accomplished using the EMS frequency or Amateur Radio Operators when possible.
9. The Air Ambulance Team Leader must have radio contact with incoming helicopters.
10. Ambulances not involved in the MCI should refrain from making radio reports to the hospitals when transporting other medical emergencies.

*NOTE: At a Mass Casualty Incident, Branch Directors and Group Supervisor should have at least one aide assigned to assist with record-keeping, monitoring radio talkgroups or channels, logging messages and orders, recording patient information, etc. These aides may be non-paramedic personnel or civilians who are able to help.

At the Hospital

After arrival at the hospital, the patients are treated according to the facility's internal procedures. All field triage tags are saved and made a part of the patient's record.

As patients are identified, their names and general condition will be relayed to the American Red Cross point of contact at the care facility. The Red Cross will act as a clearinghouse to assist families in locating patients if they show up at the wrong location. Communication between the Red Cross the Patient Tracking Team Leader is crucial for accomplishing this mission.

Handling the Dead

Care should be taken **NOT** to move a victim from the scene. All DOA patients should be left in place at the incident site unless movement of the victim is needed to treat viable patients. When possible, cover the victims with sheeting. Establish a Temporary Morgue for those victims who need moved immediately. The Temporary Morgue will also be used for patients who expire in the Treatment Areas.

It may be some time before bodies can be collected and cared for by the Clark County Coroner, therefore, the following guidelines have been prepared to aid in handling DOA victims until the Coroner and/or his staff arrives. When it becomes necessary to remove bodies from disaster sites due to rescue work or the health and safety of others, these procedures must be followed:

1. If possible, document the position of the body with photographs before removal. Ideally, both distant and close-up photos should be obtained.
2. Do not remove any personal effects from the body. The personal effects must remain with the body at all times.
3. Attach tag or label to the body with the following information:
    - Date and time found.
    - Name and address of decedent, if known.
    - If identified, how and when.
    - If body is contaminated.
    - Exact location found.
    - Name/phone of person making identity or filling out tag.
4. Place the body in a disaster pouch or in plastic sheeting and securely tie to prevent unwrapping. Attach a second tag to the sheeting or pouch.
5. If personal effects are found and thought to belong to a body, place them in a separate container and tag them. Do not assume any loose effects belong to the body that they were found next to.
6. Use a red surveyor's flag (in the Clark County MCI Trailer) to mark the location where a body/part was removed. Write the Triage Tag Number on the flag.
7. Move the properly tagged body with their personal effects to an established Temporary Morgue, i.e., garage or other cool building, preferably one with refrigeration. *NOTE: Portable air-conditioning may be obtained or self-contained refrigerated van/trucks or rail cars can be used. Do not use a vehicle or storage area with floors that can be permeated with body fluids or liquids.
8. Keep insects and other animal life away from the body. In case of extreme heat or direct sunlight, move the body to a cool area or refrigerated room promptly.
9. Bodies must be safeguarded at all times until the arrival of the Coroner's Office.

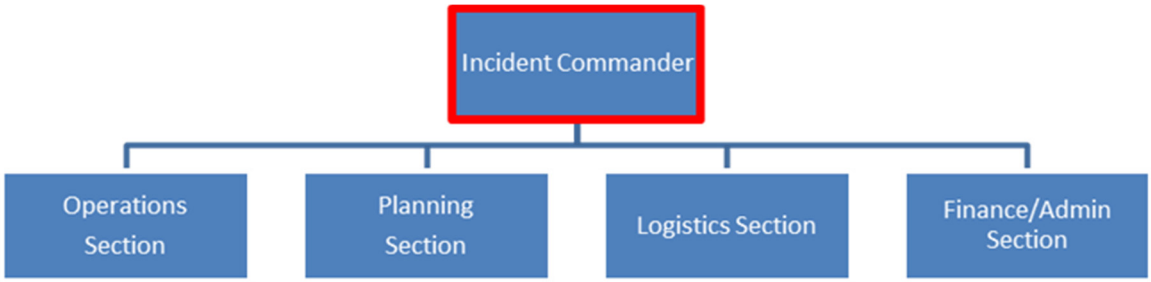
Other Important Concerns

1. At any time during the incident, an evacuation of the emergency scene may be ordered by the Incident Commander or the Safety Officer. The signal for evacuation will be three consecutive rounds of three blasts on the air horn.
2. A press area should be established away from the Command Post by the Public Information Officer. The press should not be allowed inside the perimeter without permission of the Incident Commander. Request Countywide PIO from EMA.
3. A Critical Incident Stress Debriefing Team should be at or near the incident site to informally greet participants as they are relieved of duty. A more formal CISD should be scheduled for later.

MCI POSITION DISCRIPTION

Incident Command

Refer to Checklist 1 – Incident Command and First-in Units.



A member from the first unit on-scene should formally take command and begin to provide tactical assignments for personnel and apparatus and request additional resources. The IC assigns resources as they become available, first building on the key functions of Triage, Transport, and Treatment.

In general, as the incident grows more resources become available. Teams may grow to become Groups or Divisions. Branches may be utilized to reduce span of control or manage incident complexities. Each of key functions must be established, assigned a Director or Supervisor, and given sufficient resources.

The IC should establish a command structure to manage current resources and then strengthen and fortify that structure as more resources become available. The positions should be roughly filled in this order:

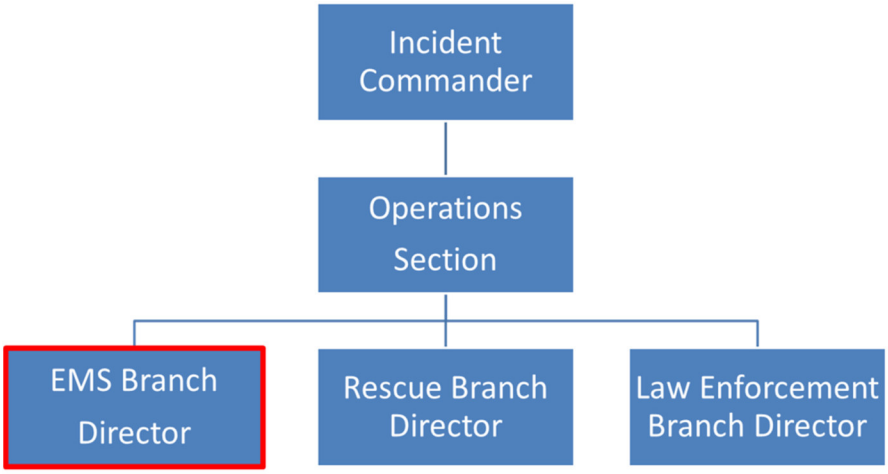
1. Incident Commander
2. Triage Team Leader
3. Transport Team Leader
4. Staging Officer
5. Treatment Team Leader
6. Medical Supply Officer
7. EMS Group Supervisor

Until enough personnel and resources arrive, it may be necessary to combine some functions. Potentially effective combined functions include the following:

1. The IC nearly always functions as Operations Section at first.
2. With extremely limited options and personnel, the IC might also function initially as both EMS Branch Director and Triage Group Supervisor.
3. One person could initially function as Supervisor for both the Transport and Treatment Groups.

EMS Branch Director

Refer to Checklist 2 – EMS Branch Director



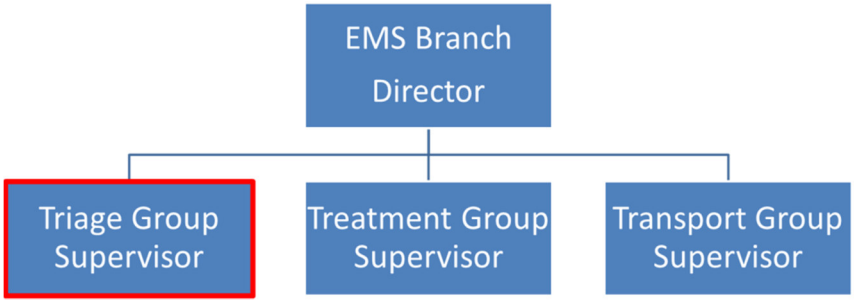
Responsible for all the EMS Operations during the incident and further delegates and assigns duties to the Triage, Treatment, and Transport Groups. The EMS Branch Director is created in large scale events to manage span of control and receives direction from the IC, or if established the Operations Section Chief.

Responsibilities are as follows:

1. Establish and supervise the medical response.
2. Ensure resources are sufficient to handle the magnitude of the incident.
3. Appoint Triage, Treatment, and Transport Group Supervisor personnel.
4. Designate appropriate on-scene locations.
5. Ensure hospital notification and communication.
6. Determine amount and types of additional medical resources, supplies, and specialized resources from hospitals (medical caches, helicopters etc.).
7. Establish liaisons with on-scene agencies, such as Coroner's Office, Red Cross, Law Enforcement, EMA, County Health Dept., ambulance companies, etc.
8. Ensure that proper security, traffic control, and access have been established.

Triage Group Supervisor

Refer to Checklist 3 – Triage Group Supervisor.



Responsible for initiating and directing the Triage Group which is responsible for the rapid assessment and categorization of all patients. The Triage Group Supervisor receives direction from the EMS Branch Director, if fully expanded, otherwise from the Operations Chief.

Triage allows the IC to gauge the scope and size of the incident. Triage must begin immediately by establishing a Triage Team to continue tagging patients in the location found. As mutual aid EMS personnel arrive, they should be assigned to assist.

The first available paramedic should be assigned to supervise the Triage Group. Additional paramedics will be formed into Triage Teams sufficient to process the scene. Non-paramedics may be assigned to documentation or attaching tags to the patients.

*NOTE: Once triage is complete, these resources can be re-assigned.

If transport units are immediately available, some critical patients may need to go directly from the Triage Area to the Loading Area for priority transport. The Triage Group Supervisor must coordinate with Transport Group Supervisor (or Patient Tracking Team) to make this a smooth process.

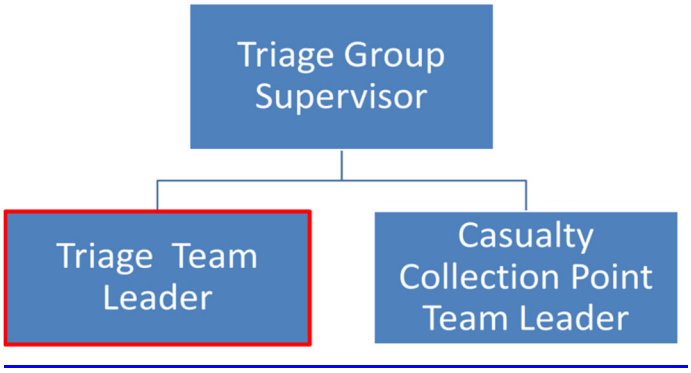
*NOTE: If a patient by-passes the Treatment Area for immediate transport, each patent stills needs issued a triage tag (not just a ribbon) at Transport Area. If decon is necessary, NO ONE can by-pass the decon system.

Responsibilities are as follows:

1. Implement and supervise Triage Teams as necessary.
2. Acquire/coordinate medical supplies from the Treatment Team for Triage Areas. Example: backboards, stretchers, triage tags, etc.
3. Coordinate with Treatment Officer to assure proper patient designation.
4. Continually review triage operations.
5. Coordinate and identify other medically trained personnel within the Triage Area.

Triage Team Leader

Refer to Checklist 4 – Triage Team Leader.



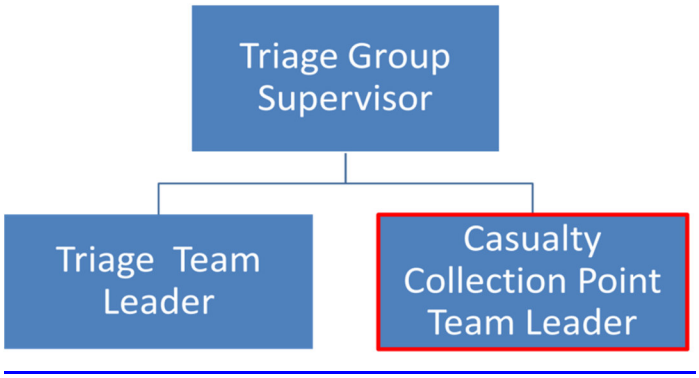
Responsible for performing on-scene triage with ribbons and assigns patients to the Casualty Collection Point or Treatment Areas. This group works closely with the Rescue/Extraction Group and reports to the Triage Group Supervisor.

Responsibilities are as follows:

1. Perform initial triage with ribbons to the injured on-scene.
2. Direct movement of patients to proper CCP or Treatment Areas.
3. Provide basic medical treatment (ABC's) to patients prior to movement as incident conditions allow.

Casualty Collection Point Team Leader

Refer to Checklist 5 – Casualty Collection Point Team Leader.



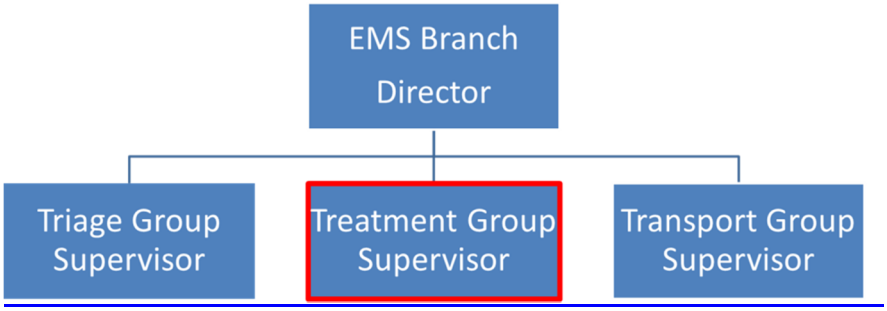
Responsible for re-assessing and placing triage tags (from ribbons) on patients who were initially assessed by the Triage Team; and those patients who were assigned to the CCP as a holding area (Walking Wounded), or those who were recently extracted from on-scene. The CCP Team then assigns patients to the appropriate Treatment Area. This team reports to the Triage Group Supervisor.

Responsibilities are as follows:

1. Triage and tag injured patients.
2. Direct movement of patients to proper Treatment Areas.
3. Provide basic medical treatment (ABC's) to patients prior to movement as incident conditions allow.

Treatment Group Supervisor

Refer to Checklist 6 - Treatment Group Supervisor



Responsible for assigning and maintaining Treatment Areas for all triage categories; initiating and directing the Treatment Group, as well as assigning additional personnel and ordering and maintaining appropriate amounts of medical supplies. The Treatment Area in particular will need a lot of medical supplies. A separate Medical Supply Unit may be established through Command, for items such as IV supplies, backboards, dressings, etc. The Treatment Group Supervisor receives direction from the EMS Branch Director if fully expanded, otherwise from the Operations Section Chief.

The Treatment Group Supervisor is responsible for establishing a "field hospital" where patients can be stabilized before transport to primary hospitals. When there are sufficient ambulances at the scene, treatment may be conducted by the paramedics themselves. In that case, patients may effectively bypass the Treatment Area, but they MUST NOT bypass the Transport Area, where they would receive a Triage Tag, be documented, and have a hospital assigned.

Do not assume a Treatment Area must be outdoors, especially under poor weather conditions – look for a building that might be appropriate with sufficient open floor space, such as a storage facility or aircraft hangar.

Use scene tape and traffic cones to define the Treatment Area and define corridors from Triage to the Transport Area. There should be designated tarps to quickly visualize Treatment Areas. Patients' status must be monitored while in the Treatment Area and their condition continually re-assessed. They may be moved to a lower or higher triage status. The Treatment Area will also need one or more triage personnel at the entrance to handle walkup patients who have not yet been triaged and to perform secondary triage as patients are brought in.

The Treatment Group Supervisor must maintain command and control of the Treatment Area and should limit access to qualified and necessary medical personnel.

Those needing the earliest transport (RED) should be placed nearest to the Transport Area to reduce carrying patients over and around others. Patients should be arranged with space in between for personnel to work.

Communication, especially with the Transport Group, will be a major task. The Treatment Group Supervisor should, as soon as possible, select aides from non-paramedic personnel and use them to monitor radios and maintain logs. If the number of patients in the Treatment Area is large, consider assignment of a Treatment Dispatcher to coordinate with the Transport Group (or Transport Dispatcher) on the priority movement of patients.

Responsibilities are as follows:

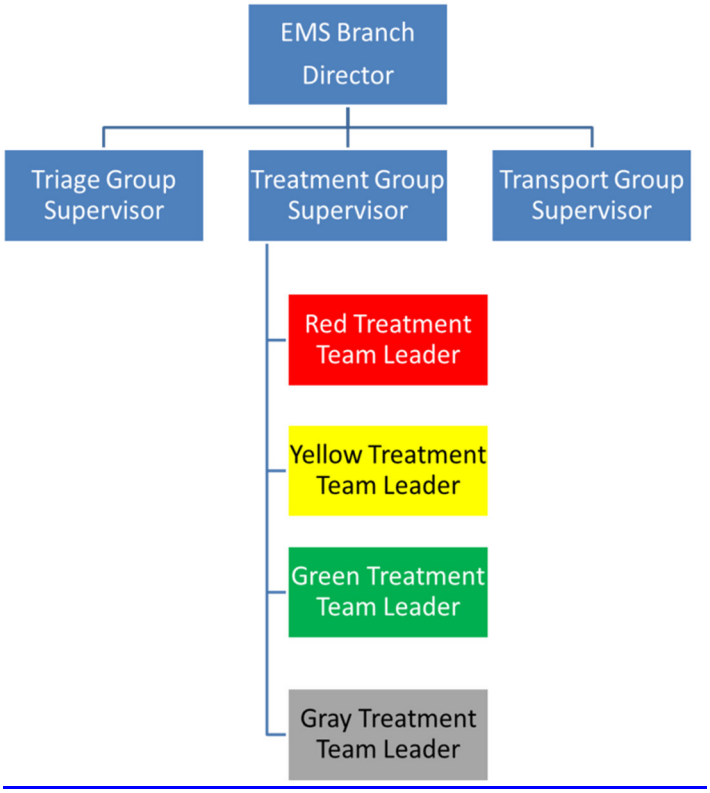
1. Establish Treatment Areas of sufficient size.
2. Request sufficient Treatment Teams and qualified emergency medical personnel to staff Treatment Areas.
3. Implement and supervise Treatment Areas.
4. Assign a Temporary Morgue Leader.
5. Assign Medical Supply Officer
6. Request medical equipment, oxygen tanks, and supplies as necessary.
7. Maintain triage assessment of patients throughout Treatment Areas.
8. Assure appropriate use of all other medical personnel.
9. Documentation of patients and treatments.

Medical Equipment Checklist

This form is designed to provide an assessment of the supplies for the Medical Supply Officer in the Treatment Area. Additional supply needs are relayed to the Treatment Group Supervisor and then forwarded to the EMS Branch Director for ordering. Refer to Checklist 7 – Medical Equipment and Supplies Checklist for tracking when ordering.

(Red, Yellow, Green, Gray) Treatment Team Leaders

Refer to Checklist 8 – (Red, Yellow, Green, Gray) Treatment Team Leader Checklist.



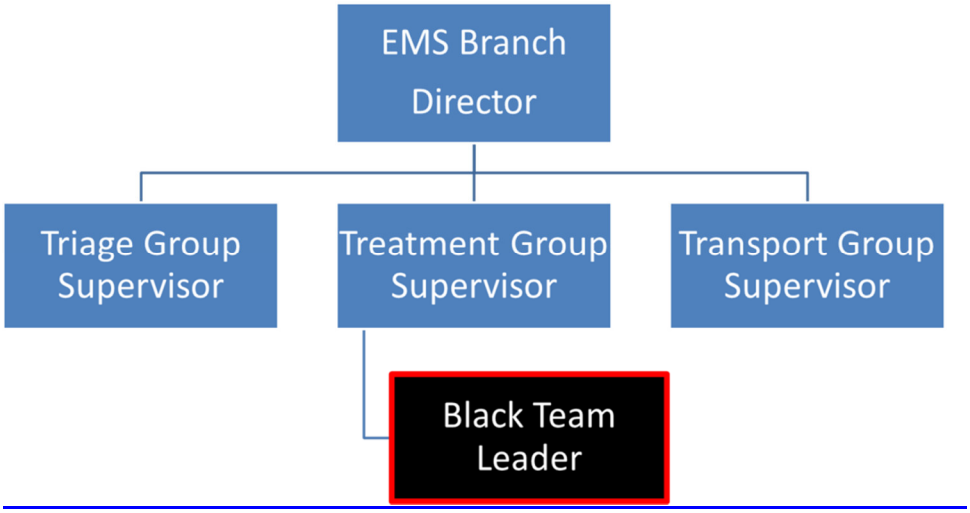
Responsible for all treatment activities within the patient Treatment Area. The Treatment Team Leader receives direction from the Treatment Group Supervisor.

Responsibilities are as follows:

1. Provide treatment to patients assigned to the Treatment Area.
2. Ensure re-triage of patients by Triage Team assigned to Treatment Area.
3. Assure patients are prioritized for transportation.
4. Coordinate movement of patients with Transportation Group Supervisor.
5. Assure that appropriate patient information is recorded on Triage Tags.
6. Report changes in patient status to appropriate Treatment Group Supervisor.

Black Team Leader

Refer to Checklist 9 – Black Team Leader.



Responsible for identifying and securing a sheltered location. The Black Team Leader coordinates with Clark County Coroner personnel and law enforcement, secures a temporary morgue and other forensic capabilities, documents identification and condition of victims, secures personal possessions, and coordinates removal to permanent facilities. All personal information and identifications must be kept confidential. The Black Team Leader receives direction from the Treatment Group Supervisor.

During initial triage, it is essential that any and all human remains be left "where found" at any incident site. Exceptions are permitted if moving the body is the only means of reaching viable patients, or if existing hazards preclude leaving the remains "where found".

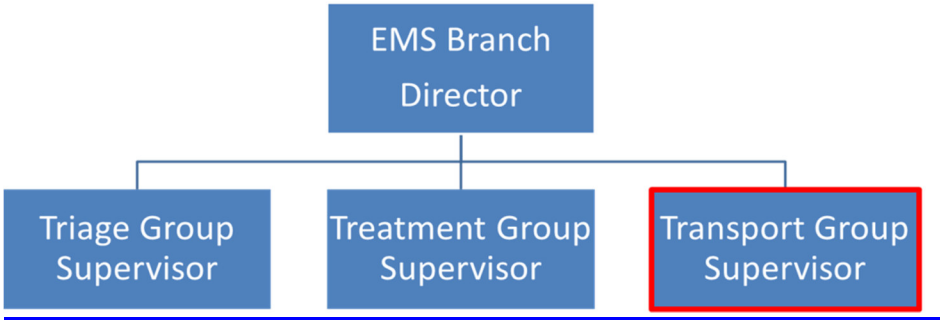
Bodies should be initially triaged with ribbons. Then, all possible data concerning where and how the patient was found should be noted on a triage tag after all survivors have been transported from the scene.

Responsibilities are as follows:

1. Keep area off limits to all personnel, except those needed.
2. All DOA patients should be left in place at the incident site.
3. Coordinate with law enforcement and assist the Coroner's Office.
4. Establish temporary morgue location.
5. Maintain records on each victim.
6. Conform to Clark County Coroner's Mass Fatality Plan.

Transport Group Supervisor

Refer to Checklist 10 – Transport Group Supervisor Checklist.



Responsible for all patient movement from the Treatment Area to the appropriate care facilities. The Transport Group Supervisor assigns personnel (as they become available) to Transport Teams; Staging, Patient Tracking, Transport Dispatch, Ground and Air Ambulances. As soon as possible, transport logs should be initiated. The Transport Group Supervisor receives direction from the EMS Branch Director if fully expanded, otherwise from the Operations Chief.

It is preferable to have a single Transport Group coordinating patient removal through a single command and communication point, even if transporting from more than one loading area. This provides a single point of contact to the hospitals, including additional hospital capacity, and the ability of air transport services, and temporary morgue facilities. A single Transport Group also ensures that patients are appropriately distributed to multiple hospitals, rather than overwhelming a few facilities.

The Transport Group Supervisor organizes the flow of ambulances and transport units from the Staging Area to the Loading Area and then to the hospitals. The Transport Group moves patients in the priority determined by Treatment Group, and allocates them to hospitals according to capacity and capability. Communication to hospitals needs to be established early as they may need to bring in off-duty staff.

Distribution of patients among various hospitals is one of EMS' most crucial tasks. During that process, the Transport Group must take into consideration that many individuals will self-report to nearby hospitals; therefore EMS should consider transporting to further hospitals that are not overloaded.

Ambulance crews must not be permitted to leave their vehicles to assist with treatment or otherwise freelance on the scene. They have one job – transport. Working with the Treatment Group Supervisor, the Transport Group Supervisor may trade off personnel to maintain treatment of particular patients and replace personnel from the Treatment Group that accompany patients during transport. Ambulances may need to make multiple round trips to and from the scene.

The Transport Group Supervisor must coordinate clearly with the Staging Team Leader to maintain both an orderly and timely flow of transport units into Loading Areas, especially if a one way in and out route is not available. A Transport Dispatcher may be assigned specifically to get the patients matched with the right level of transport (ALS, BLS, and airlift) to the right hospital, and moved out in the correct order of triage by working with their counterpart, the Treatment Dispatcher (if assigned).

Responsibilities are as follows:

1. Work with EMS Branch Director to designate incident locations for the Transport Group and assign personnel to those areas.
2. Establish and maintain a vehicle route in and out of the loading area.
3. Coordinate priority of transports with Treatment Group Supervisor.
4. Coordinate transportation of patients as determined by Treatment Officer.
5. Assure patient information and destination is recorded.
6. Assure hospital communications are established.
7. Ensure patient information is transmitted to hospital.
8. Assign patients to transport units, and assign transport units to hospitals.
9. Monitor hospital capacity and maintain patient flow accordingly.
10. Designate a Transport Dispatcher if needed. If the Transport Group Supervisor is NOT a paramedic, the Transport Dispatcher must be.
11. Request additional ambulances, as required.

Transportation Destination Worksheet

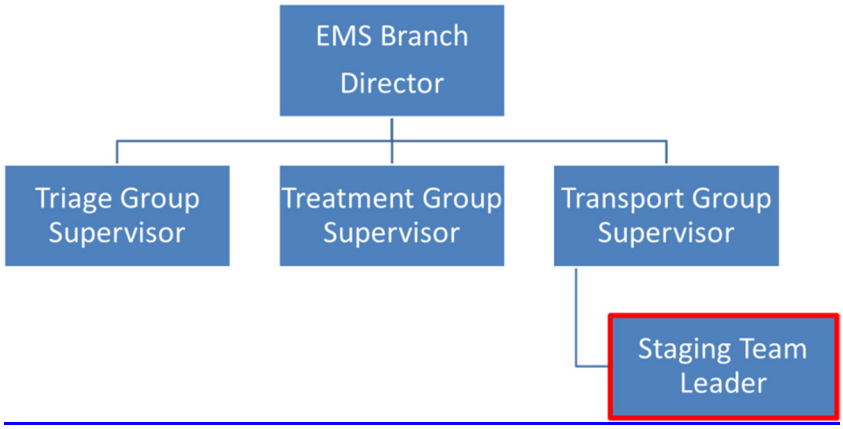
This worksheet helps the Transport Group quickly track bed availability for care facilities. The left side lists hospitals. Fill in what each hospital is currently able to receive by triage category (there is a diagonal line through each box so that you can put in an updated number as hospitals gear up and increase their capacity). The right side lets you use tally marks or hash marks to quickly keep track of how many patients went to each facility in each category. Refer to Checklist 11 – Transportation Destination Worksheet.

Transportation Log

The Transportation Log documents each patient by Triage Tag number and name (if available), along with sex, triage category, whether the patient was decon-ed, the receiving hospital, unit providing transport, and the time of departure. Categories of agency, date, and location can be filled out after the fact. For the Transport Group to document faster and be prepared for implementing forward movement of patients there is a list of regional hospitals and abbreviations for each, as well as major centers close to our region. When printed, the sheet was flipped on the short side so that you can easily look at the second side when it is on a clipboard. The second side also includes a list of Transport Group Duties. Refer to Checklist 12 - Transportation Log.

Staging Team Leader

Refer to Checklist 13 – Staging Team Leader Checklist.



Responsible for the check-in of all in-coming transport units, the request of additional transport resources, and the dispatch of those resources at the request of Transport Group Supervisor. The first task of the Staging Team Leader, in consultation with the Transport Group Supervisor, is to identify one or more Staging Areas and Loading Areas with adequate road access to allow a clear traffic flow. This will ideally be a one way ingress and one way egress route to avoid bottlenecks. Law enforcement resources may need to secure routes in the vicinity of the incident to assist in this flow. If an off-road area is used, be sure of the ground condition. Landing conditions will dictate the location of the Helispot.

Ideally the Loading Area should be fairly near the Treatment Area so patients do not have to be moved long distances. However, may have to be compromised for the more pressing concerns of traffic flow or terrain.

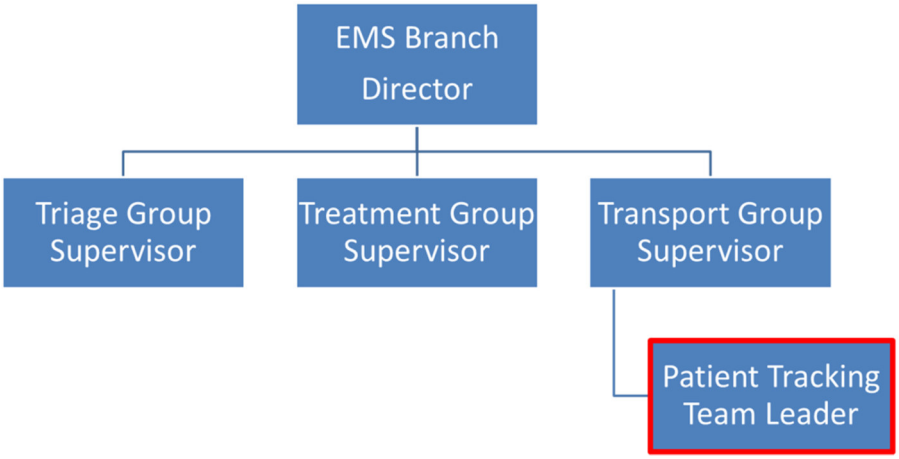
The Staging Team Leader must have radio contact with incoming ground and air ambulances, and keep the Transport Group Supervisor (or Transport Dispatcher) advised of status of ambulances' arrivals and departures. Also ensure that each ambulance is properly staffed and equipped.

Responsibilities are as follows:

1. Identify and secure a Staging Area with clear avenues in and out of Loading Areas.
2. Coordinate with law enforcement for traffic control.
3. Organize apparatus in Staging Area for ease of exit to prevent congestion.
4. Track all resources in Staging and report inventory to Transport Group Supervisor.
5. Allocate staged resources in response to requests.
6. Maintain personnel accountability.
7. Advise Transport Group Supervisor when resources of a particular type are minimal.

Patient Tracking Team Leader

Refer to Checklist 14 – Patient Tracking Team Leader Checklist.

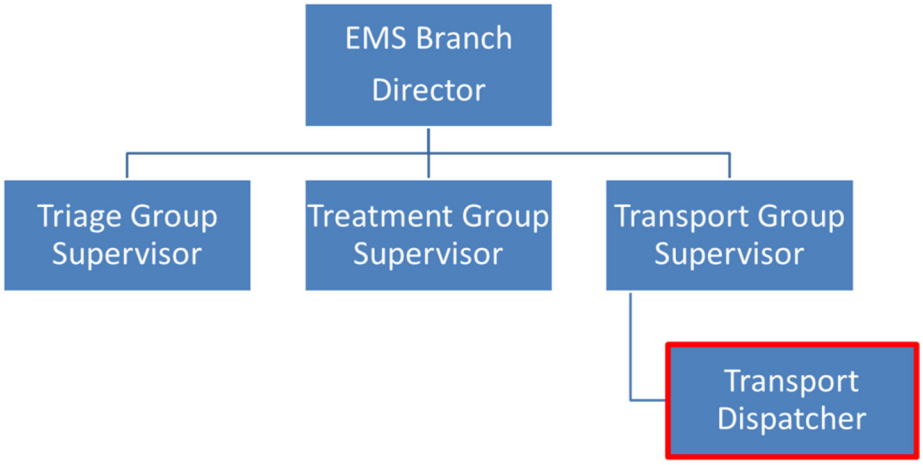


Responsible for the account of each patient, and the recording of the status and tracking of patients from inception through acceptance at a care facility. This position is often combined with the Transport Dispatcher. However, if separated the Transport Dispatcher focuses on radio communications while the Patient Tracking Team Leader focuses on documentation. Further duties include communicating patient medical information to care facilities and family reunification. This team receives direction from the Transport Group Supervisor.

The Clark County Amateur Radio Association and the American Red Cross can assist with family reunification. For this process to work properly, both entities need to be called to the scene, as well as to the care facilities where patients will be transported. The communications link that they establish will assist in the accurate reunification of their loved one. A designated point of contact from each agency will report to the Patient Tracking Team Leader.

Transport Dispatcher

Refer to Checklist 15 – Transport Dispatcher.



Responsible for maintaining communications with the receiving hospitals and Patient Tracking Team Leader. This position is often combined with Patient Tracking Team Leader. However, if separated the Transport Dispatcher focuses on radio communications while the Patient Tracking Team Leader focuses on documentation. The Transport Dispatcher receives direction from the Transport Group Supervisor.

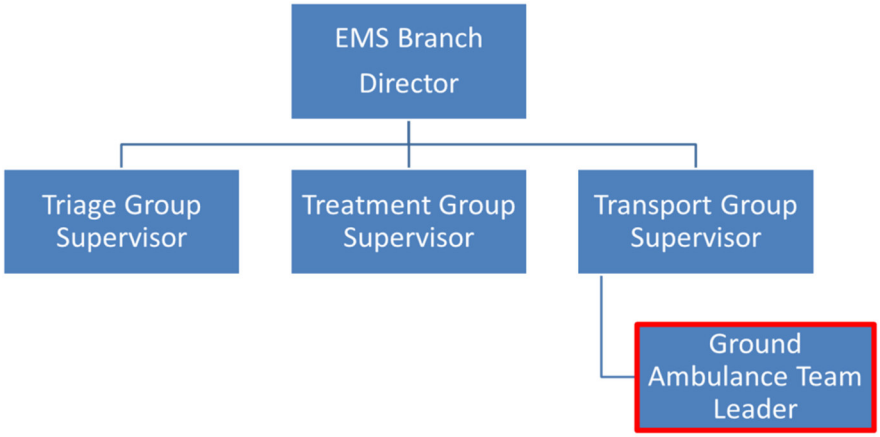
Additional duties include:

1. Monitoring current status of hospital availability and rerouting.
2. Communicating and coordinating with Treatment and Transport Group Supervisors for the transport of patients.
3. Notify receiving hospitals of all incoming patients and keep tabs on the remaining capacity of each facility.

Mutual aid responders may have different communications capabilities. The Transport Dispatcher should request additional resources, such as extra radios or a communications vehicle to maintain interoperability.

Ground Ambulance Team Leader

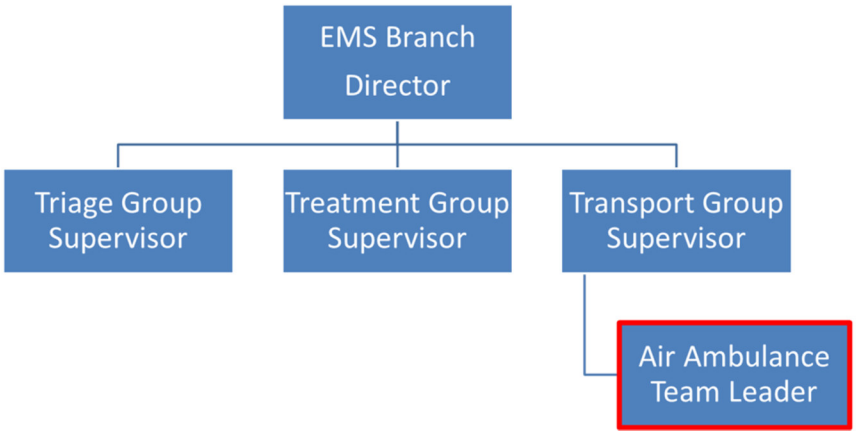
Refer to Checklist 16 – Grand Ambulance Team Leader.



Responsible for all patient movement, including patient loading, from the treatment area to the receiving hospitals. This team receives direction from the Transport Group Supervisor.

Air Ambulance Team Leader

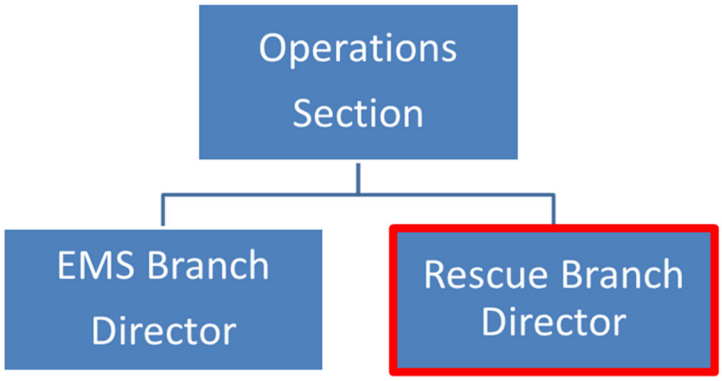
Refer to Checklist 17 – Air Ambulance Team Leader.



Tasks of the Air Ambulance Team Leader include landing zone selection, communications with arriving aircrews, providing for security, assisting in patient loading onto the aircraft, and assist with the coordination with the Patient Tracking Team Leader. This team receives direction from the Transport Group Supervisor.

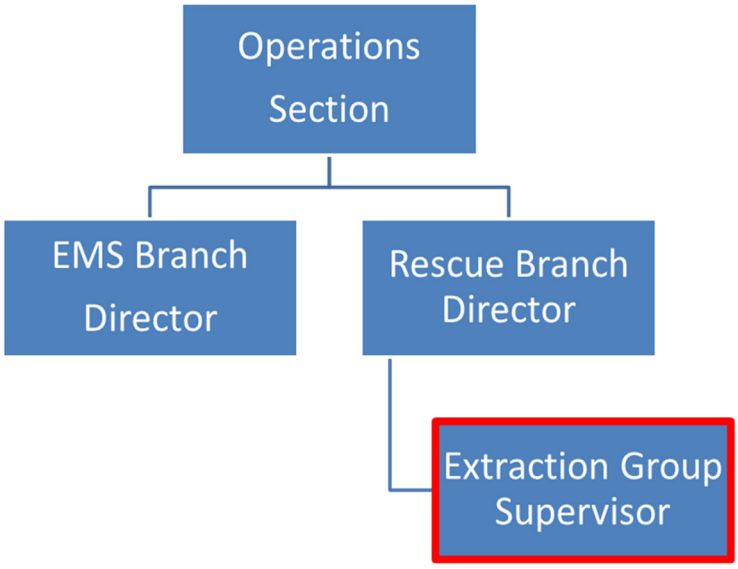
The first priority for air lifting casualties will be given to patients who have been triaged as RED, and who are physically and mentally fit for air transportation.

Rescue Branch Director



Responsible for the mitigation of the incident including coordination of the rescue efforts, hazard control, disentanglement, extraction, fire suppression and decontamination. Additional responsibilities could include serving as the Safety Officer for overall responder and scene safety. The Rescue Branch Director receives direction from the Operations Section Chief (or IC if Section Chief has not been established).

Extraction Group Supervisor

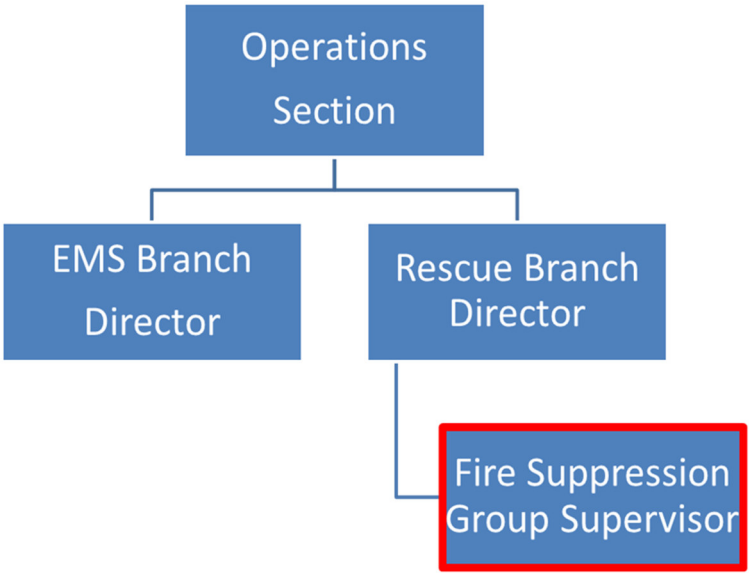


Responsible for the disentangling and extraction of patients that may still be in physical danger because of their location. The first priority following scene safety is to locate patients and remove them from any immediate physical danger into a CCP. “Where they are found” could be within a “hazard zone”, that is within a vehicle(s), an aircraft, a HazMat situation, or a collapsed building. Trapped victims requiring prolonged extrication should receive advanced life support care as required and feasible. The Extrication Group Supervisor and the Safety Officer are responsible for the safety of all those within any hazard zone.

Further responsibilities include movement of patients to the Casualty Collection Point, Triage, or Treatment Areas. The Extraction Group Supervisor needs to coordinate closely with the Triage Team Leader.

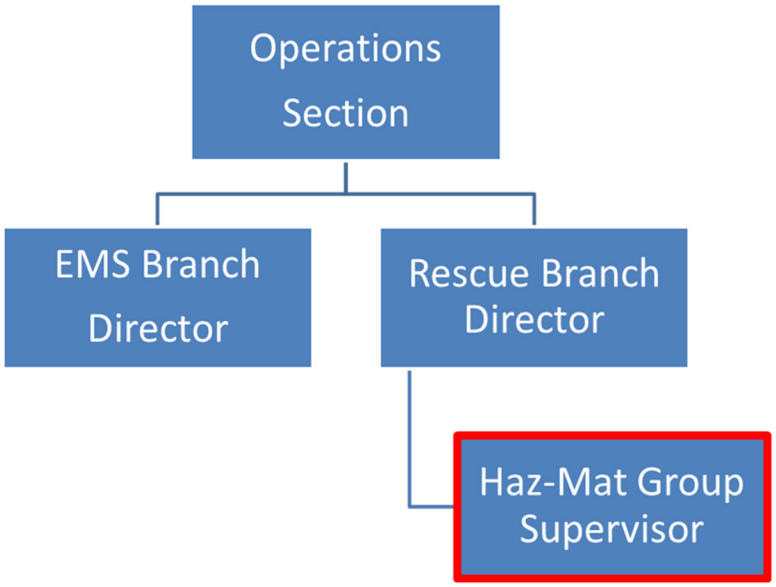
The Leader coordinates closely with the Triage Unit leader for initial ribbon triage of patients. The Extraction Group Supervisor Group receives direction from the Rescue Branch Director (or IC if Section Chief has not been established).

Fire Suppression Group Supervisor



Responsible for suppressing any fire cause by the incident. The Fire Suppression Group receives direction from the Rescue Branch Director (or IC if Section Chief has not been established).

Haz-Mat Group Supervisor



Responsible for hazard control at the scene and decontamination of patients prior to entry into the Casualty Collection Point, Triage, Treatment, or Transport Areas. This Group receives direction from the Rescue Branch Director (or IC if Section Chief has not been established).

SALT TRIAGE SYSTEM

SORT, ASSESS, LIFE-SAVING INTERVENTION, TREATMENT/TRANSPORT (SALT) Use SALT triage to assess any significant number of patients rapidly. It can be used easily and effectively by all EMS personnel. Triage is a process, not a one-time event. Patients must be reevaluated, including the "walking wounded," once initial triage is completed. Secondary triage occurs in the Treatment Area(s) and determines the transport priority. Triage is an ongoing process as patient status may change while awaiting transport.

SALT Considerations

Triage ribbons must be used to expedite initial triage. Triage ribbons are applied by color to the right arm or leg. This will actually get patients sequenced into Treatment Areas more quickly. Triage tags should be applied at the Casualty Collection Point (CCP) before moving patients into the Treatment Areas. If not, they must be filled out and applied in the Treatment or Transport Areas. No patient leaves the scene without a Triage Tag.

Re-assign personnel once the initial triage is complete and all patients have been accounted for and have cleared the Triage Area. These personnel may be reassigned after a period of rest and recovery. They will be most useful in the Treatment Area.

Primary and secondary triage prior to transport

1. Initial Triage - Use triage ribbons (color coded strips), not triage tags, during initial triage. Tie to an upper extremity in a VISIBLE location (the right wrist if possible).
   RED – Immediate
   YELLOW - Delayed
   GREEN - Minimal
   GRAY – Expectant* (not dead)
   BLACK (Zebra) - Dead
   ORANGE (Polkadot) – Contaminated Patients (use in combination with the categories above)
   - Move as quickly and safely as possible, making quick decisions, as the patient will be re-triaged prior to transport.
   - Be cautious of over triage, it can be as harmful as under triage and delay someone else getting properly transported and treated.
   - If the patient is unlikely to survive given the current resources available, treatment and transport should be delayed until more resources are available. If delays are in the field, consider requesting orders for palliative care and pain medications if time and resources allow.

2. Secondary Triage - Must be performed on all patients prior to transport.
    - Patients should be reassessed periodically, including when moved to a CCP, or when their condition or resources change.
        - Utilize Triage Tags and complete all available information on the tag.
        - Affix the tag securely to the patient.
    - Tags are applied after patients enter the Treatment Area or CCP, or by the Transport Group if the patient is being directly removed without going to the Treatment Area.
    - ORANGE ribbons are removed during decon.
        - Fire and EMS always has responsibility for performing primary decontamination prior to transport, however, the hospital must be aware of both contamination and decontamination.
        - When contaminated patients are discovered, each of those patients initially receives two ribbons: one with a colored triage category (RED, YELLOW, GREEN, GRAY) and the other an ORANGE polka-dot ribbon.
        - Make sure to decon under the ribbons.
        - Triage Tags for such patients get two check marks on the Orange strip: both Dirty and Decontaminated. That way the hospitals know the patient has had field decon, but may still be somewhat "dirty".
        - Notify hospitals of an MCI involving patient contamination.
    - Use Triage Tags with individual barcodes consistent with the Ohio Patient Tracking System (OHTrac).
3. Priority for transport is determined in the Treatment Area or by the Transport Group.
4. Distribution of patients among various hospitals, is one of EMS' most crucial tasks.
    - Do not overload any hospital, regardless of transport distance to other hospitals.
    - In an MCI, many trauma patients will need to be transported to non-Trauma Centers. All hospitals will accept and stabilize trauma patients during MCIs.
    - As Transport assigns patient allocation, consider the likelihood that the closest hospital(s) may be overwhelmed by patients who were not transported by EMS.
    - In large scenarios, consider using the Forward Movement of Patients Plan.

SALT Process

Refer to Figure 4 – SALT Triage Assessment for a flow chart of the process.

S – Sort

1. Global Sorting: Action 1
    - Action: "Everyone who can hear me please move to [designated area] and we will help you" (use loud speaker if available).
    - Goal: Group ambulatory patients using voice commands'
    - Result: Those who follow this command – last priority for individual assessment (GREEN).

- Assign someone to keep them together (e.g., PD, FD, or a bystander) and notify Incident Command or EMS Branch of number of patients and their location. ***Do not forget these patients.*** Someone must re-triage them as soon as possible.
- In smaller incidents, such as a motor vehicle crash with a few patients where you do not want any of them to move on their own, skip Action 1, and go to Global Sorting Action 2

2. Global Sorting: Action 2
   - Action: "If you need help, wave your arm or move your leg and we will be there to help you as soon as possible"
   - Goal: Identify non-ambulatory patients who can follow commands or make purposeful movements.
   - Result: Those who follow this command – second priority for individual assessment.
3. Global Sorting: Result - Casualties are now prioritized for individual assessment
   - Priority 1: Still, and those with obvious life threat
   - Priority 2: Waving/purposeful movements
   - Priority 3: Walking
4. Begin assessing all non-ambulatory patients where they lie, performing the four Life Saving Interventions (LSIs) as needed, but only within your scope of practice, and only if the equipment is readily available.
5. Each patient must be triaged as quickly as possible.

A - Assess

1. Is the patient breathing?
   - If not, open the airway. In children, consider giving two rescue breaths.
   - If the patient is still not breathing, triage them to BLACK using a zebra-striped ribbon. Do not move the patient except to gain access to a living patient.
   - If patient is breathing, conduct next assessment.
2. Assess for the following:
   - Can the patient follow commands or make purposeful movements?
   - Does the patient have a peripheral pulse?
   - Is the patient not in respiratory distress?
   - Is hemorrhaging under control?
     - If the answer to **any** of those questions is **no** and the patient **is likely** to survive given current resources, tag them as RED.
     - If the answer to **any** of those questions is **no** and the patient **is NOT likely** to survive given current resources, tag them as GRAY - Expectant.
     - If the answer to **all** of those questions is **yes** but injuries are **not minor** and require care, tag patient as YELLOW - Delayed. YELLOWs have serious injuries and need care, though not as urgently as REDs. On secondary triage, some YELLOWs will need higher priority transport than others.

- If the answers to **all** of those questions is **yes** and the injuries **are minor**, tag patient as GREEN.

3. Mnemonics for the four assess questions C.R.A.P.

   C=Follows Commands
   R=No Respiratory Distress
   A=No (uncontrolled) Arterial bleeding
   P=Peripheral Pulse Present

   - A second mnemonic is the use of good or bad. Don't be confused by the double negatives in two of the questions. Instead, think of the questions in terms of "bad" or "good". If the answer to the questions is "bad" (i.e., can't follow commands, absent peripheral pulse, respiratory distress, or uncontrolled hemorrhage are all "bad"), then the patient is tagged either RED or GRAY.

L - Life Saving Interventions

Only correct life-threatening problems during triage:

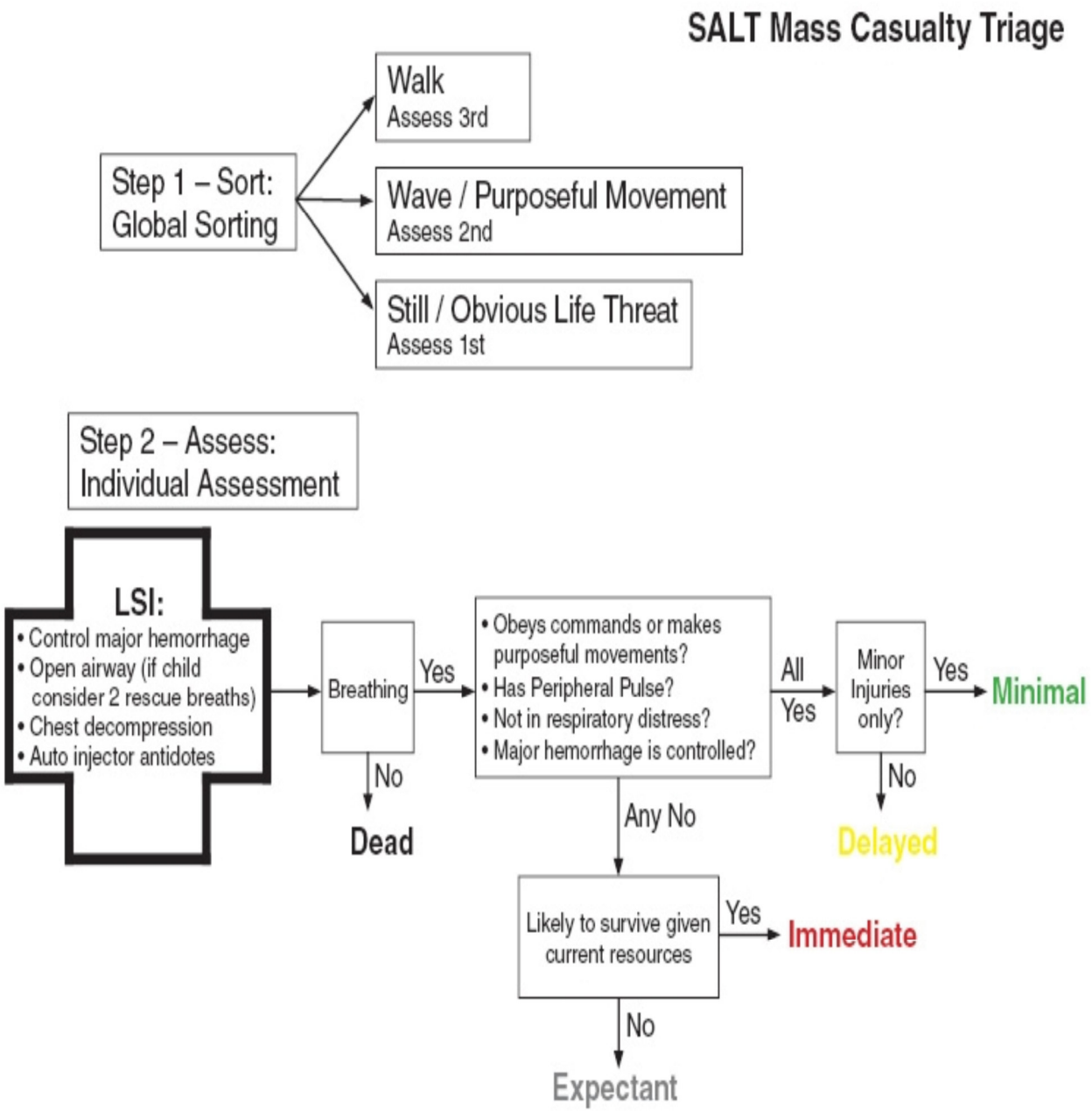
1. Control major hemorrhage
2. Open airway (if child, consider giving two rescue breaths)
3. Needle chest decompression
4. Auto injector antidotes

T – Treatment/Transport

Priority is typically given to:

1. RED - Immediate
2. YELLOW - Delayed
3. GREEN - Minimal
4. GRAY - Expectant patients should be treated and transported as resources allow. Patients should be reassessed periodically, including when moved to the CCP, or when their condition or resources change.
5. **Special Considerations:** Even after applying Triage Tags, the main indicator of patient condition is the Triage Ribbon. If the patient's condition or the triage priority changes, indicate that on the tag. **Continue to use the same tag, even if the condition changes repeatedly, changing the ribbon to indicate the patient's current condition.**

Figure 4 - SALT Triage Assessment



Triage Tags

Refer to Figure 5 - Triage Tags for the following.

Triage Tag - Main Section - Front

1. The main section includes space for the patient's Name, M/F, Allergies, and Age.
2. Below that are body diagrams and the Injury Key.
   - Mark a 1 on the body diagram then put information about the injury or medical problem in the 1 blank on the Injury Key.
   - Use the other number blanks for additional problems. Always print legibly, using a permanent marker if possible.
3. Below the diagram are checkboxes to indicate if the patient is "Dirty" or "Decontaminated".
   - On the orange stripe: Check both Dirty and Decontaminated once field decon is complete.
4. Following that is space for vital signs and triage categories
   - Mark the category with an "X" through it.

*NOTE: Although there are spaces that allow you to change the patient's triage category twice, the primary way to indicate triage category is by the Triage Ribbon. Change the ribbon color as often as necessary, but keep the same tag.

Triage Tag - Main Section – Back

1. The second side has space to indicate IV fluids and other treatments as well as time.
2. There is space for a narrative (if you have time)
3. Add in location of where the patient was found at the appropriate blank.

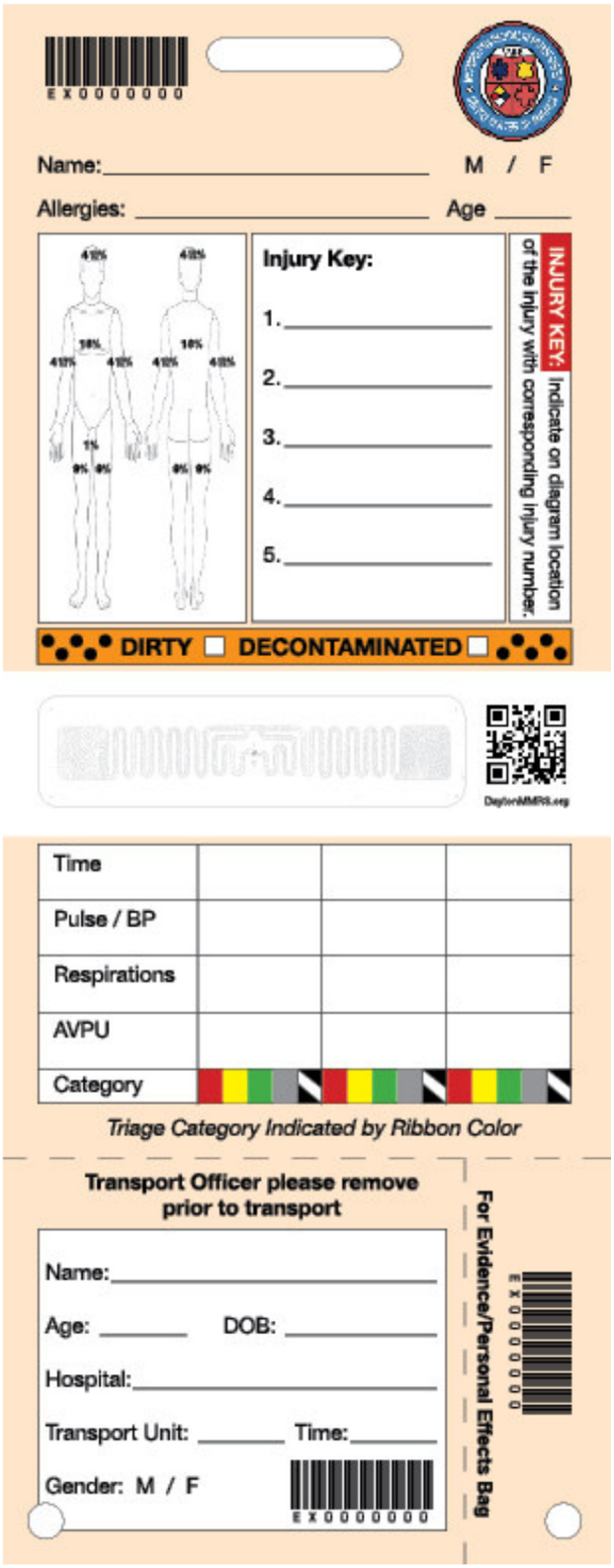
Triage Tag - Section Below Perforation – Front

1. Just above the statement, "Transport Officer please remove prior to transport" the tag is perforated into two sections.
2. The first has demographic information for the patient and space to indicate which ambulance or other unit transported the patient, and to what hospital.
3. That perforated section should be removed at the time of the patient's transport and clipped on the carabiner to help the Transport Group keep track of them.
4. The other section may not be needed for all patients. It is simply a tag that uses the same bar code and triage tag number, and can be clipped onto an evidence bag or a bag with the patient's personal belongings.

Triage Tag - Section Below Perforation – Back

1. The opposite side simply has space to check the patient's triage category at the time of transport.

Figure 5 - Triage Tag



SPECIALIZED MEDICAL RESOURCES

Medical Professionals

It may be beneficial to have hospital personnel (physicians and nurses) respond to the scene. Their help at the scene must be balanced against the loss of their services at the hospital. Therefore, the use of hospital teams outside of the Clark County area is encouraged.

*NOTE: Any physicians or nurses that respond to the scene should be assigned to the patient treatment area. Remember that their expertise is in patient care and they may be unfamiliar with the organizational structure of a Mass Casualty Incident.

Medical Reserve Corps (MRC)

- MRC volunteers have received 20 hours of emergency preparedness training to include, disaster triage, disaster psychology, and basic disaster medical operations
- Request through Clark County EMA at 937-605-0576

Wright State Emergency Medicine Residency Program

- Emergency and disaster trained physicians are available for on-scene response
- WSU Program: 937-333-8727
- Request through Clark County EMA at 937-605-0576

Ohio Disaster Medical Assistance Team (DMAT)

- Federal team that provides on-site medical teams and supplies
- Request through Clark County EMA at 937-605-0576

Ohio Fire Emergency Response Plan (ERP)

- Once activated can provide additional personnel, equipment, and supplies
- Personnel resources can also serve to backfill area departments who are involved in on-scene operations
- Ohio Fire Chief's ERP: 888-822-4900
- Request through Nick Heimlich (County Coordinator): 937-765-1018

Medical Equipment and Supplies

For Medium to Large MCI's, supplies can be brought in from around the local area and throughout the region.

LOCAL RESOURCES

Private (Ground) Ambulance Services

- Can provide additional personnel for treatment areas
- Can provide mutual aid for transporting to hospitals
- Ambulettes used for transporting less critical patients
- Quality Care Transport: 937-324-9041
- Med-Trans: 937-325-4926

Clark County Mass Casualty Trailer

- The Clark County EMA maintains a Mass Casualty Trailer located at Bethel Township FD. There are enough supplies to treat 50 patients. The basic supplies and equipment included are:
  - Airway Supplies
  - Advanced Airway Supplies
  - Back Boards
  - Body Bags
  - Circulation Kits
  - Emergency Blankets
  - Flashlights
  - Generator/Heater
  - Gloves
  - Immobilization Kits
  - Patient Litter/Sleds
  - Patient Movers
  - Miscellaneous Supplies
  - Oxygen Tanks/Supplies
  - Scene Tape
  - Shelter (EZ-up/Zumro Tents)
  - Triage Ribbons/Tags
  - Triage Tarps/Flags

AND MORE

Springfield Regional Medical Center (SRMC) Disaster Cache

- Portable equipment that may be useful in a MCI is available at SRMC
- SRMC/ED: 937-523-1000
- Request through Clark County EMA at 937-605-0576

SRMC Hospital Disaster Packs

- SRMC/ED has on hand a Disaster Pack with supplies to treat 10 critical patients
- SRMC/Central Supply has the inventory for this pack and can quickly compose others as the need arises
- Ambulances responding to a MCI from the hospital should transport as many of these packs as necessary

- *NOTE: IV Solutions are not included in the inventory of the pack and will have to be inserted at the time of the incident
  - 20 - 1000 ml bags NS IV solution
  - 10 - 500 ml bags NS IV solution

SRMC Disaster Pack Inventory

Airway

- (1) complete set of oropharyngeal airways
- (2 each) #6, #7, #8 Endotrol endotracheal tubes
- (2 each) Endotracheal tubes #4, #5, #6 uncuffed
- (10) cc syringes
- (1) Tube lubricating gel
- (2 each) Disposable adult and pedi Ambu-bags
- (2) #10, (2) #12,(4) #14, (4) Yankauer suction catheters

Breathing

- (10) Adult non-rebreather oxygen masks with tubing
- (8) Pedi non-breather oxygen masks with tubing
- (Multiple) packs of defibrillation packs (non-porous dressings)

Circulation

- (20) ABD dressings, 20 4x4 dressings, 20 - 3" Kling
- (10 each) #14, #16, #18, #20, #22, #24 angiocaths
- (10) Setups of blood/maxi-drip tubing
- (1) Box non-sterile gloves
- (10) IV boards/splints
- (Multiple) Non-leur lock syringes
- (Multiple) Tourniquets
- (Multiple) Cravats
- (Multiple) Alcohol preps
- (Mulitple) Rolls of 2" transpore tape

Mass Casualty Incident Management Kit

- Each EMS department in Clark County has on hand a Disaster Kit designed to aid in the management of a Mass Casualty Incident
- Each department is responsible for maintaining this Kit in good condition and transporting them to a Mass Casualty Scene
- The Kit has four (4) basic components:
  - Command Vests
  - Marker Flags
  - Command Portfolios
  - Triage Tags

Mass Fatality Equipment

- Montgomery County Coroner's Office has resources for Mass Fatality
- Request through Clark County Coroner Office: 937-328-2560

REGIONAL RESOURCES

Mass Casualty Trailers

- Several other public safety agencies also house mass casualty trailers available regionally for mutual aid use
- Dayton Fire (100 patients)
- Darke County EMA (50 patients)
- Union County EMA (50 patients)
- Request through Clark EMA: 937-605-0576

Air Ambulances

- Teams from Dayton or Columbus hospitals can be transported to an incident scene in Clark County within minutes after the request is made
- CareFlight (Dayton): 800-251-2273
- MedFlight (Columbus): 800-222-5433

Pediatric Mobile ICU Ambulance

- Dayton Children's Medical Center has four (4) Mobile ICU Ambulances
- Dayton CMC: 937-641-4385

Dayton Metropolitan Medical Response System (MMRS)

- MCI resources available:
  - Antidotes for exposure to cyanide, organophosphates, carbamates, and nerve agents
  - Drugs for respiratory difficulty
  - Anti-radiation drugs
  - Antibiotics for bioterrorism for first responders such as anthrax, plague, and others
  - Technical Assistance for forward movement of patients, appropriate use of antidotes or antibiotics, and management of Chempacks.
- MMRS: 937-333-8727

Wright State's Modular Emergency Medical System (MEMS)

- Assists with resources and supplies need for patient surge to local hospitals.
- *Acute Care Center (ACC):* Provides several 50 bed units capable of treating critical care, including trauma patients. MEMS has 5 ACC units available.
- *Neighborhood Emergency Help Center (NEHC):* Capable of caring for up to 1,000 patients, including 5 critical care bed areas.
- Request through Clark County EMA: 937-605-0576

Search and Rescue Team (and Equipment)

- Region Three Rescue Strike Team (R3RST) provides additional assistance for entry, triage, and patient movement
- R3RST: 937-333-3473
- Request through Clark County EMA: 937-605-0576

OTHER MCI CONCIDERATIONS

EMS Documentation Considerations

Many EMS agencies consider that, during a large mass casualty incident, the triage tag will be the only documentation required. Two issues should be considered by the agency in determining their policy:

1. If the Triage Tag is the only documentation, after the emergency is over, it is recommended that the agency try to obtain photocopies of the front and back of the Triage Tags from the hospitals so that the agency has some record of the patients they treated or transported.
2. ICS forms should be used for resource ordering, tracking, status, and communications, etc. Refer to Checklist 18 - ICS 214 Unit Log.

Hospitals as Triage Areas

Hospitals near the incident area can expect to be inundated with patients who have come to the hospital on their own, bypassing the EMS treatment/transport system. If this occurs, the hospital must quickly realize that all of these patients cannot be processed in a routine manner. Hospital staff may then resort to the use of triage tags, treatment teams, and priority transport to other facilities.

Shelter in Place

If necessary, stabilized patients can be sheltered in place. Incident Command should consider the nearby community resources that may be utilized as a holding area for transportation. Consider patient and rescuer comfort needs. Areas that can be considered for a shelter in place include:

1. Churches
2. Schools
3. Public and/or private meeting places
4. Recreation halls
5. Community health clinics
6. Urgent care and free standing or emergency care clinic's

If a medical facility is located within or very close to a MCI, it could act as an EMS triage area with only patient stabilization performed before transport to another facility.

Mass Transportation

The Transportation Officer may transport patients who do not require immediate medical attention, such as GREEN or "walking wounded" via mass transportation resources. Consider utilizing the following resources for mass transportation:

1. Public forms of transportation
2. School buses

Forward Movement of Patients

Transporting to more distant hospitals should be considered in MCI to reduce over-crowding of local facilities and avoiding "relocating the disaster to the hospital." Hospitals (especially those closest to the incident) are likely getting patients not only via EMS, but also walk-ins and the "worried well," in addition to their normal patient load.

There are two levels of Forward Movement. The first is implemented by the Transport Group Supervisor, and means transporting patients to hospitals slightly more distant than those used on a daily basis, but still in the Greater Dayton Area Hospital Association (GDAHA) region (or possibly transporting to local alternative medical sites). A second level of Forward Movement involves patient transport to a wider swath of hospitals, such as in Columbus, Cincinnati, or Cleveland.

The Transport Group Supervisor may need to assign additional personnel to the Patient Tracking Team to communicate with the hospitals regarding the need for Forward Movement.

Burn Patients

If a large number of patients need burn care, Miami Valley Hospital (MVH) has a plan in place for receiving and redistributing burn patients to centers in and out of state. As many as possible should be transported to MVH where they perform this funcation as conditions warrant. If you are transporting numerous burn patients to MVH, most other patients should be transported elsewhere.

Crisis Standards of Care in Large Events

Some incidents are so large as to require extraordinary EMS procedures. Those scenarios are sometimes referred to as Mass Casualty Events (MCEs), instead of MCIs. This section introduces EMS procedures that may be utilized in very large emergency scenarios, or incidents with extended duration.

Crisis Standards of Care (CSC) uses altered standards during triage. CSC during an MCE may be partially issued by the State, and could result in a temporary expansion of the EMS scope of practice. EMS may be authorized to transport selected patients to other healthcare facilities. These could include Urgent Care Centers, an Acute Care Center (ACC) or a Neighborhood Emergency Help Center (NEHC) established in conjunction with a hospital, or a Disaster Medical Assistance Team (DMAT) facility.

In the event of an MCE, the Greater Miami Valley EMS Council (with the approval of the Regional Physicians Advisory Board), may promulgate “Just in Time Standing Orders” (JITSO). With approval from Ohio Department of Public Safety, these orders might include triage standards for transport to other healthcare facilities and other crisis standards of care; possibly exceeding the standard scope of practice for EMS.

Functional Needs Sheltering

The regional protocol for Functional Needs Shelter Triage should be used to help determine whether individuals with functional needs can be safely sheltered in a Red Cross Shelter during a disaster.

This Shelter Triage Protocol is a pre-approved Just-In-Time Standing Order (JITSO), authorized by the RPAB for use by an EMS agency assisting the Red Cross with shelter triage. It is intended to be printed and given to paramedics, nurses, and other healthcare personnel at the time of a shelter operation.

At the option of local fire chiefs and medical directors, the Shelter Triage Protocol can be used during a disaster to determine patients who would be more appropriate for transport to open Red Cross Shelters than to hospitals. EMS should contact the shelter before transporting. If locations or contact information for shelters is not known, contact the County EMA at 937-605-0576 or the Red Cross at 937-399-3872. When transporting these non-emergency patients to shelters, it is critical that the patients bring their medications and medical equipment with them.

Search and Rescue

Search and rescue functions during a wide-spread MCI should use teams within assigned geographical areas. Search Teams should also have a triaging component in order to conduct initial ribbon triaging of any patients found for the Rescue Team to prioritize extraction.

Search Teams should proceed with a consistent plan of execution establishing scene safety as the highest priority:

1. Site Survey.
2. Collapse surface search.
3. Void Search.
4. Selected debris removal.
5. Tunnel/trench to specific locations – ONLY with oversight by a (technical) Rescue Team.

The initial search should not proceed beyond void search unless a patient is encountered. If rescue efforts are needed, a Technical Rescue Team **must** be formed so that the Search Team may proceed through the area.

UNDER NO CIRCUMSTANCES SHOULD TUNNELING, OR TRENCHING BE INITIATED WITHOUT TRAINED TECHNICAL SEARCH AND RESCUE PERSONNEL.

Emergency Operations Center (EOC) Activation

When a MCI event is medium to large in scale activate the Clark County EOC to assist with the overall Common Operating Picture, coordination of additional outside resources, coordination of interdepartmental communications, and to serve as the single point ordering system. To activate the EOC call 937-605-0576.

Active Shooter and Mass Casualty Incidents (AS/MCIs)

These situations require extraordinary efforts on the part of the local fire/rescue and EMS agencies. Although these attacks usually end within a few minutes from the time they begin, the incident and response actions may play out over an extended period of time. Also, they may include a "direct threat" or "hot zone" with an ongoing active shooter(s) and a 'warm zone" where the victim lie in the wake creating multiple casualties requiring extensive triage, treatment and transportation efforts.

A Rescue Task Force made up of specially trained and equipped EMTs that will go into a "warm zone" are available in the County. To access the task force call 937-328-2560.

AS/MCIs usually involve a perpetrator trying to maximize casualties, so responders need to exercise caution en-route to the incident as well as after arrival. A single ICP is crucial. Law enforcement should always maintain a presence at the Incident Command Post to coordinate operations and ensure the safety of all personnel operating on the incident, even if the situation shifts from LE to fire/rescue/EMS.

Refer to Figure 6 – Active shooter Considerations in a MCI for additional guidance.

Mass Decontamination (Decon)

Patients need to be removed from the hot zone prior to initial triage and decon. Examples may be a Hazmat or WMD incident where a toxic atmosphere exists. In such cases, a Casualty Collection Point (CCP) must be established where Haz-Mat or Rescue personnel will bring the patients to be given orange ribbons and assigned a casualty triage color. All patients need to be decontaminated prior to entry into the Treatment Areas.

Refer to Figures 7 - 16 for Mass Decontamination set-up, processes, and procedures.

APPENDIX

Checklist 1 - Incident Command and First-in Unit

Incident Command and First-in Unit Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Park vehicle and position yourself and other responders uphill and upwind at a safe distance
	2. Put on Incident Commander vest
	3. Announce location of Incident Command Post
	• Use green light or flag to indicate ICP
☑ First in Report	
	1. Identify yourself and your unit via radio
	2. Give the "First in Report" via radio to include the following information:
	• Description and exact location of the incident
	• Possibility of chemical exposure (and whether an intentional release), presence of fire, spilled liquids, vapor leaks, or other hazards
	• Type(s) of structures and vehicles involved
	• Estimated number of injuries or casualties
	• Any need for public evacuation
☑ Establish Command	
	1. If first agency to arrive, state that you are assuming command by identifying yourself and naming command – or integrate into Unified Command if already established
	2. Give exact location of Incident Command Post
	3. Appoint ICS positions based on initial size-up
	4. Establish incident locations; Staging and Treatment Areas, etc
	5. Direct responding units as to the appropriate access routes that should be used
	6. Coordinate with Law Enforcement to establish a control perimeter
	7. Consult with the EMS Branch Director to establish staffing and equipment needs
	*NOTE: ORDER BIG & ORDER EARLY

	8. Request any additional resources needed immediately; • Bomb Squad, Haz-Mat, Search and Rescue, Rescue Task Force, Medical Teams, Ambulances, Law Enforcement, Traffic Control Measures
	9. Identify Staging Area location
	10. Identify route of approach for other responders
	11. Request responding units maintain radio silence and report to Staging Area for face-to-face assignments
	12. Request initial notification to SRMC
	13. Request notification to RHNS
	14. Assess need for ICS Branches, Divisions, Groups, etc.
	15. Designate radio frequencies for on-scene use
☑ Incident Assessment	
	1. Determine safety hazards
	• Stay out of contamination zone
	*If EMS personnel cannot enter the area due to potential hazard, assess the situation from a safe distance
	• Determine need for immediate evacuation, identify safe egress routes
	• Determine type of contaminate – by placard, witness, container, etc
	• Determine medical, fire, explosion implications
	• Establish perimeters and isolation zones per ERG
	• If contaminated, take care of responders immediately
	2. Estimate the scope of magnitude of the incident
	• How many injuries
	• Severity of injuries
	• Nature of injuries (burns, blast trauma, etc.)
	• Entrapment of patients
	3. Determine immediate priorities
☑ Initial Actions	
	1. The first-in ambulances should off-load their equipment to be used in the Treatment Area until other units arrive and a Treatment Area is established
	2. The first-in ambulance begins the process of initial triage and patient care activities
	3. Maintain Unit Log (ICS 214)

Checklist 2 - EMS Branch Director

EMS Branch Director Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from IC or Ops Section Chief
☑ Initial Duties	
	1. Size up incident area, including safety
	2. Put on EMS Branch Director vest
	3. Read through Checklist (and all Checklists under EMS Branch)
	4. Maintain communications with IC (or Ops Chief)
	• Ensure radio interoperability
	5. Assure that mutual aid departments have been assigned to pick up the Hospital Disaster Packs (including IV solutions) from SRMC
	6. Create Triage, Treatment, and Transport Groups (if not already established)
	• Assign, brief, and direct Supervisors of Groups
	• Assign resource personnel into Groups
	• Supervise Group Leaders
	• Ensure radio interoperability with all Groups
	7. Determine, set up, and mark Treatment &Transport Areas
	• Ensure Areas are free of hazards
	• Isolate Morgue from Treatment Areas
	• Include Medical Supply Area
	• Include Helispot Landing Zone
	8. Ensure on-scene security and limit access control in all Medical Areas
	9. Establish, direct, or supervise on-scene liaisons with support agencies (Coroner's Office, Law Enforcement, Red Cross, EMA, Ambulance Companies, County Health Dept., etc)
	• Direct medically trained personnel to appropriate Group Supervisor
	10. Request patient count, including the number of pediatric patients, by triage color from Triage Group Supervisor
	• Relay information to Transport Supervisor
	• Notify Hospitals
	• Estimate the number of transport units needed, including non-EMS, make request to IC (or Ops Chief)

☑ Other Duties	
	1. Anticipate and request additional medical supplies as needed
	• Consider Mass Casualty Trailer
	• Consider specialized medical resources
	2. Request additional ambulances if needed
	3. Estimate and request additional personnel from IC (or Ops Chief)
	• Indicate the type and function needed
	4. Request status updates from the Triage, Treatment, and Transport Supervisors
	• Provide updates to IC (or Ops Chief)
	5. Request Coroner's Office and communicate need for temporary morgue (if needed)
	6. Monitor personnel for rehabilitation and replacement
	7. Report to IC (or Ops Chief) when Triage, Treatment and Transport duties are completed.
	8. Maintain Unit Log (ICS 214)
	9. Demobilize as directed by IC (or Ops Chief)
	10. Forward all records/reports to IC (or Ops Chief)

Checklist 3 - Triage Group Supervisor

Triage Group Supervisor Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from EMS Branch Director (or Ops Chief if Branch is not established)
☑ Initial Duties	
	1. Size up incident area, including safety
	2. Put on Triage Group Supervisor vest
	3. Read through the Checklist (and all Checklists under Triage Group)
	4. Maintain communications with EMS Branch Director
	• Ensure radio interoperability
	5. Create contact with Treatment Group Supervisor
	6. Coordinate with the Extraction Group Supervisor for triage of entrapped patients
	7. Assign Triage Team and Casualty Collection Point Leaders
	• Teams should be made up of paramedics if possible
	• Ensure safety of all personnel under your command
	8. Select, set-up, and mark a Casualty Collection Point
	• In most cases, the Treatment Area is the CCP
	• Announce “Anyone who is able to walk is to get up and move to the Collection Point” (or GREEN Treatment Area)
	9. Assemble and supervise Triage Teams
	• Each patient is triaged using the SALT triage system
	• Do not move DOA patients unless needed to extract or treat viable patients
	• Perform initial triage using colored ribbons
	• Place triage ribbons visibly
	• Triage Team Leader reports patient count to Triage Group Supervisor
	• Re-triage with tags as necessary
	10. Estimate patient count, including the number of pediatric patients, by triage color
	• Report count to the EMS Branch Director (or Ops Chief)
	11. Inform EMS Branch Director (or Ops Chief) of resource needs
	• Coordinate with Medical Supply Officer, if established
	12. Coordinate with Treatment Group Supervisor for anticipated medical care needs in Treatments Areas

☑ Other Duties	
	1. Establish system to move patients from Triage to CCP and/or Treatment Area
	2. Request additional personnel to provide for movement of patients from Triage and/or CCP Areas to Treatment Area
	3. Monitor the availability of triage supplies, tags, and marking system
	4. Request status updates from the Triage Teams
	• Provide updates to EMS Branch Director (or Ops Chief)
	5. Monitor personnel for rehabilitation and replacement
	6. Report to EMS Branch Director (or Ops Chief) when initial Triage is complete
	• Triage personnel may be re-assigned to Treatment Group
	• Maintain a Triage Team in the CCP/Treatment Areas
	7. Maintain Unit Log (ICS 214)
	8. Demobilize as directed by EMS Branch Director (or Ops Chief)
	9. Forward all records/reports to EMS Branch Director (or Ops Chief)

Checklist 4 - Triage Team Leader

Triage Team Leader Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Triage Group Supervisor
☑ Initial Duties	
	1. Size up incident area, including safety
	2. Put on Triage Team Leader vest
	3. Read through the Checklist
	4. Procure and don Triage Ribbon Kit
	5. Maintain communications with Triage Group Supervisor
	• Ensure radio interoperability
	6. Assess situation
	7. Coordinate with the Extraction Group Supervisor for triage of entrapped patients
	8. Triage patients and apply appropriate colored ribbons according to SALT triage principals
	• Announce “Anyone who is able to walk, move to the Collection Point” (or GREEN Treatment Area)
	• Perform initial triage using color ribbons
	• Place triage ribbons visibly
	9. Direct movement of patients to proper CCP or Treatment Areas
	• Deceased patients should not be moved unless necessary to triage entrapped patients
	• Provide appropriate medical treatment to patients prior to movement as conditions dictate
	10. Triage Team Leader reports patient count to Triage Group Supervisor
	11. Re-triage with tags as necessary in CCP and/or Treatment Areas
	12. Inform Triage Group Supervisor of any resource needs
☑ Other Duties	
	1. Report to Triage Group Supervisor when Triage is completed
	• Triage personnel may be re-assigned to Treatment Group
	2. Maintain Unit Log (ICS 214)
	3. Demobilize as directed by Triage Group Supervisor
	4. Forward all Team records/reports to Triage Group Supervisor

Checklist 5 - Casualty Collection Point Leader

Casualty Collection Point Leader Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Triage Group Supervisor
☑ Initial Duties	
	1. Size up incident area, including safety
	2. Put on CCP Team Leader vest
	3. Read through the Checklist
	4. Secure triage tags
	5. Maintain communications with Triage Group Supervisor
	• Ensure radio interoperability
	6. Coordinate with the Extraction Group Supervisor for triage of entrapped patients
	7. Triage and apply appropriate tags according to SALT triage principals
	• Place triage tags visibly
	• Ensure full completion of triage tags
	8. Direct movement of patients from CCP to proper Treatment Areas
	• Provide appropriate medical treatment to patients prior to movement as conditions allow
	9. CCP Leader reports patient count to Triage Group Supervisor
	10. Inform Triage Group Supervisor of any resource needs
☑ Other Duties	
	1. Coordinate with Extraction Group to ensure all patients have been moved to CCP
	2. Report to Triage Group Supervisor when initial triage tagging is completed
	• Maintain CCP presence in Treatment Areas for continuous re-triaging
	3. Maintain Unit Log (ICS 214)
	4. Demobilize as directed by Triage Group Supervisor
	5. Forward all Team records/reports to the Triage Supervisor

Checklist 6 - Treatment Group Supervisor

Treatment Group Supervisor Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from EMS Branch Director (or Ops Chief) if Branch is not established
☑ Initial Duties	
	1. Size up incident area, including safety
	2. Put on Treatment Group Supervisor vest
	3. Read through the Checklist (and all Checklists under Treatment Group)
	4. Maintain communications with EMS Branch Director
	5. Create contact with Triage and Transport Group Supervisors
	6. Assemble and supervise Treatment Areas and Teams
	• Set up Treatment Areas, include tarps, flags, MCI Kits, etc.
	• Maintain 3 feet of working space between patients
	• Designate Treatment Area entrances and exit
	• Announce locations of Treatment Areas
	7. Prioritize care of patients consistent with resources
	8. Work with CCP Triage Team to continually re-triage/assess
	9. Ensure proper medical care procedures are followed
	10. Request and direct specialized medical personnel to scene
	11. Ensure proper documentation of each patient's treatment
	12. Establish a Medical Supply Area and Officer
	13. Coordinate with Triage Group Supervisor for anticipated medical care needs in Treatments Areas
	• Coordinate with Medical Supply Officer, if established
	14. Request sufficient medical resource needed. Use Checklist 7 - Medical Equipment and Supplies Checklist
	15. Coordinate movement of patients from Triage or CCP Area into the Treatment Area
	16. Coordinate movement of patients from Treatment Area into the Transport Area (Loading Area) based on priority

☑ Other Duties	
	1. Request status updates from the Triage and Transport Teams
	2. Provide updates to EMS Branch Director of the number and category of patients in Treatment Areas
	3. Monitor personnel for rehabilitation and replacement
	4. Report to EMS Branch Director when Treatment is completed
	5. Maintain Unit Log (ICS 214)
	6. Demobilize as directed by EMS Branch Director
	7. Forward all records/reports to the EMS Branch Director

Checklist 7 - Medical Equipment and Supplies

Medical Equipment and Supplies Checklist				
Time supplies checked & ordered				**Medical Equipment and Supplies**
				Adhesive tape
				Airway maintenance equipment
				Backboards, straps
				Bag valve mask devices
				Blankets
				BP cuffs/stethoscopes
				Burn sheets, supplies
				CATS
				Chest seals
				Cold and heat packs
				Decompression needles
				Hospital Disaster Pack: SRMC
				IV solutions, supplies, angiocaths, administration sets
				MAST suits
				Medications
				Obstetrical kits
				Occlusive dressings
				Spinal and cervical immobilization devices
				Oxygen tanks, administration devices
				Patient mover
				Roller gauze
				Soft stretcher
				Splints and splinting supplies
				Suction units, supplies
				Supplies from Mass Casualty Trailer
				Surgical/exam gloves
				Trauma dressings and gauze dressings

Checklist 8 - (Red, Yellow, Green and Gray) Treatment Team Leaders

(Red, Yellow, Green, and Gray) Treatment Team Leaders Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Treatment Group Supervisor
☑ Initial Duties	
	1. Put on Treatment Team Leader vest (color appropriate)
	2. Read through the Checklist
	3. Maintain communications with Treatment Group Supervisor
	• Ensure radio interoperability
	4. Create contact with Triage and Transport Group Supervisors
	• Ensure radio interoperability
	5. Assign Treatment Team personnel to patients received in the color appropriate area
	6. Supervise assigned Treatment Area Teams in your color appropriate area
	• Maintain 3 feet of working space between patients
	7. Prioritize care of patients consistent with resources
	8. Ensure proper medical care procedures are followed
	9. Work with CCP and Triage Teams to continually re-triage and re-assess patients
	10. Request and supervise specialized medical personnel in the Treatment Area (color appropriate) as needed
	11. Ensure proper documentation of each patient's treatment
	12. Coordinate additional resources with the Medical Supply Officer, if established, or with the Treatment Group Supervisor
	13. Coordinate movement of patients from Treatment Area into the Transport Area (Loading Area) based on priority
	• Assist with movement and loading of patients for transport
☑ Other Duties	
	1. Request status updates from the Triage and Transport Teams
	2. Provide updates to Treatment Group Supervisor of the number and category of patients in Treatment Area
	3. Monitor personnel for rehabilitation and replacement
	4. Report to Treatment Supervisor when Treatment is completed
	5. Maintain Unit Log (ICS 214)
	6. Demobilize as directed by Treatment Group Supervisor
	7. Forward all records/reports to the Treatment Group Supervisor

Checklist 9 - Black Team Leader

Black Team Leader Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Treatment Group Supervisor
☑ Initial Duties	
	1. Put on Bleak Team Leader vest
	2. Read through the Checklist
	3. Maintain communications with Treatment Group Supervisor
	• Ensure radio interoperability
	4. Create contact with Triage Group Supervisor
	• Ensure radio interoperability
	5. Create contact with Corner's Office and law enforcement to establish mortuary resources and services.
	6. Allow no one to remove a body, body part, or personal effects from the scene without authorization of the Coroner's Office
	• Cover bodies on-scene with a sheet
	• Do not move bodies, body parts, or personal effects without identifying the original location (photos, grid drawings, etc)
	7. If necessary, move bodies and established temporary morgue;
	• Keep area off limits to all except authorized personnel
	• Remote from triage area
	• Not readily available to other patients
	• Accessible to vehicles- ambulance, law enforcement and the Coroner's Office
	• Do not remove any personal effects from the body
	• Do not assume any loose effects belong to a body
	• Personal effects found and thought to belong to a body should be placed in a separate container and tagged
	8. If patients expire while in Treatment Area, leave all medical interventions in place; IV, bandages, etc
	9. Supervise assigned Morgue Team personnel
	10. Coordinate resources or supplies needed with Medical Supply Officer, if established, or with the Treatment Group Supervisor
	• Secure body bags and tags
	11. Ensure proper documentation of each victim
	• Date and time
	• Patient's identity (if known)

	• How identity was obtained
	• Name of person making the identification
	• Exact location where the victim was found
	• Condition of victim
	12. Keep identity of deceased patients confidential until next of kin have been notified
	13. Stay with the bodies at all times
	14. Never leave the Morgue Area unattended
☑ Other Duties	
	1. Monitor personnel for rehabilitation and replacement
	2. Report to Treatment Group Supervisor status of Morgue Area
	3. Maintain Unit Log (ICS 214)
	4. Demobilize as directed by Treatment Group Supervisor
	5. Forward all records/reports to the Treatment Group Supervisor

Checklist 10 - Transport Group Supervisor

Transport Group Supervisor Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from EMS Branch Director (or Ops Chief)
☑ Initial Duties	
	1. Put on Transport Group Supervisor vest
	2. Read through the Checklist (and all Checklists under Transport Group)
	3. Maintain communications with EMS Branch Director (or Ops Chief)
	• Ensure radio interoperability
	4. Create contact with Treatment Group Supervisor
	5. Coordinate with Law Enforcement Branch to designate transport routes and points of entrance and exit
	6. Designate Staging Area and appoint a Staging Manager
	• Maintain proper ingress and egress
	• Avoiding backing of transport units
	7. Designate a helispot and appoint Air Ambulance Team Leader and determine appropriate helicopter landing zone
	8. Designate patient Loading Area and appoint a Ground Ambulance Team Leader
	• Assemble patient movement personnel
	9. Designate Patient Tracking Officer (or Team Leader) and Transport Dispatcher (these 2 positions can be combined if personnel resources are scarce)
	10. Confirm with the Incident Commander that necessary ambulances are in route
	• Request buses for removal of GREEN patients
	11. Coordinate with Staging Area to bring ambulances to the Loading Area
	12. Establish communications with SRMC: notify them of approximate number of patients
	• Ascertain current hospital capability
	13. Request dispatch use RHNS to alert surrounding hospitals and gather their capabilities for surge
	14. Rotate patients equally among hospitals
	15. Transport patients in priority order as determined by the Treatment Officer. Work face-to-face with the Treatment Group Supervisor to ensure accuracy
	16. Transport to the closest hospitals working outward
	• Do not overload any hospital, regardless of transport distance to other hospitals

	• Consider likelihood that closest hospital(s) may be overwhelmed by patients who self-transported
	• Trauma patients may need to go to non-Trauma Centers.
	17. Monitor hospital capacity and maintain patient flow accordingly, using the Checklist 11 - Transportation Destination Worksheet.
	18. Use Checklist 12 - Transportation Log to log patient destination and status from the triage tag perforated sections
	19. Keep a record of each person's name, triage tag number and color, transporting ambulance, and hospital destination
	20. Request ambulances from Staging Area, as necessary
	21. Advise ambulance personnel that further hospital contact should be avoided
	22. Notify hospitals of incoming patients
	• Provide brief report with minimum required information
	23. Direct movement of patients from Transport Area to transport vehicles
	• Stretchers/cots must be matched with their home vehicle for transport safety
	24. Instruct transport personnel to return to Staging Area for a new assignment when patient transport has been completed
☑ Other Duties	
	1. Request status updates from the Treatment Teams
	2. Provide updates to EMS Branch Director (or Ops Chief)
	3. Monitor personnel for rehabilitation and replacement
	4. Report to EMS Branch Director (or Ops Chief) when initial transport is complete
	5. Maintain Unit Log (ICS 214)
	6. Demobilize as directed by EMS Branch Director (or Ops Chief)
	7. Forward all records/reports to the EMS Branch Director

Checklist 11 - Transportation Destination Worksheet

Transportation Officer's Destination Worksheet

Use Regional Hospital Notification System (RHNS). 937-333-USAR (8727) Ask for DISPATCH SUPERVISOR and request: "REGIONAL HOSPITAL NOTIFICATION"

PROVIDE FOLLOWING INFORMATION: Name of your Agency, Nature of Emergency, Location of Emergency, Number of Victims, Decon, and any other Info.

		ABLE TO RECEIVE					SENT			
		Hospital Status Check: 1st & 2nd Round					Use Tally or Hash marks to indicate how many pt's have been transported for that category.			
HOSPITAL	CITY	Green	Yellow	Red	Gray	Hospital Identifier	Green	Yellow	Red	Gray
Atrium Medical	Middletown					AMC				
Dayton Children's	Dayton					DCH				
Good Sam Hospital	Dayton					GSH				
Grandview Hospital	Dayton					GVH				
Greene Memorial	Xenia					GMH				
Huber Health Center	Huber Heights					HHC				
Joint Twp Medical	St. Mary's					JTM				
Kettering Medical	Kettering					KMC				
Madison Co Hospital	London					MCH				
Mary Rutan Hospital	Bellefontaine					MRH				
Mercy Hospital	Urbana					MH				
Miami Valley Hospital	Dayton					MVH				
MVH Jamestown	Jamestown					MVJ				
Miami Valley South	Centerville					MVS				
Reid Hospital	Richmond Ind.					RH				
Soin Medical Center	Beavercreek					SCM				
Southview Hospital	Centerville					SVH				
Springfield Reg. Med.	Springfield					SRC				
Sycamore Medical	Miamisburg					SMC				
Upper Valley Medical	Troy					UVM				
VA Medical Center	Dayton					VA				
Wayne Hospital	Greenville					WAY				
Wilson Memorial	Sidney					WMH				
WPAFB Hospital	Fairborn					WP				
		Green	Yellow	Red	Gray		Green	Yellow	Red	Gray

User Guide and Out of Region Trauma Centers Hospitals List on the back.

Out of Region Adult and Pedi: Level 1 - 2 Trauma Centers

		ABLE TO RECEIVE Hospital Status Check: 1st & 2nd Round					SENT Use Tally or Hash marks to indicate how many pt's have been transported for that category.			
HOSPITAL	CITY	Green	Yellow	Red	Gray	Hospital Identifier	Green	Yellow	Red	Gray
Cincinnati Children's	Cincinnati					CCMCi				
UC Trauma Center	Cincinnati					UCMCi				
OSU Trauma Center	Columbus					OSUCo				
Grant Medical	Columbus					GMCCo				
Mount Carmel West	Columbus					MCWCo				
Riverside Methodist	Columbus					RMCCo				
Nationwide Children's	Columbus					NCHCo				
St. Rita's Medical	Lima					RMCLi				
Clarian Methodist	Indianapolis					CMHIn				
Indiana University	Indianapolis					IUMIn				
Riley Children's	Indianapolis					RCMIn				
		Green	Yellow	Red	Gray		Green	Yellow	Red	Gray

Other Out of Region Hospitals

Hospital Identifier	Hospital	City
Butler County		
FMH	Fort Hamilton	Hamilton
MHMH	McCullough-Hyde	Oxford
MHF	Mercy Fairfield	Fairfield
WCMC	West Chester Med	West Chester
BBCH	Bethesda Butler	Hamilton
CCLC	Children's Liberty	Liberty
Clinton County		
CMH	Clinton Memorial	Wilmington
Fayette County		
FCMH	Fayette County	Washington CH
Indiana, Randolph County		
SVRH	St. Vincent Randolph	Winchester
Warren County		
BASH	Bethesda-Arrow	Lebanon

User Guide

1	Notify Regional Hospital Notification System (See Box on top of reverse side).
2	Contact the Nearest Hospitals for Hospital ER Surge capability. (G,Y,R).
3	Write that number in the First Diagonal side of the Box for each Color.
4	Work from closest hospitals outwards until Patient Numbers are reached.
5	As Patients are removed, Use Tally or Hash Marks to indicate who went where and the Category of their condition, in the SENT section of this form.
6	Use the Hospital Identifier Code on the removed Bottom of Triage Tag.
7	Use the Transportation Log to record all removals.
8	Use the second side of the diagonal boxes to re-check hospital status, mid-way through the incident.
9	**Re-check is IMPORTANT: Patients WILL transport themselves to ERs.**
10	Note: Hospitals that are Out of the Region may be closer.
11	DO NOT overload Hospitals or Trauma Centers. Out of region Centers may be a better choice for timely patient treatment.

Created by Dayton MMRS and provided with funds from the U.S. Department of Homeland Security.

Checklist 12 - Transportation Log

SALT – **S**ort, **A**ssess, **L**ife-Saving Intervention, **T**reat /**T**ransport

Red - Immediate
Yellow – Delayed
Green – Minimal
Grey - Expectant
Black - Dead
Orange - Contaminated

Agency: _____

TRANSPORTATION LOG

Incident /
Date:_____ **Location:**_____

Triage Tag #	Pt. Name and/or description	M / F	Tag Color (R, Y, G, Gy, or Zebra)/ General Condition	Decon Y/N	Hospital or Other Destination	Trans-port Unit	Time To Hospital

Hospital Key:

Atrium Medical Middletown	**AMC**	**Huber Health Center** Huber Heights	**HHC**
Dayton Children's Hospital Dayton	**DCH**	**Joint Twp. Medical** St. Mary's	**JTM**
Good Samaritan Hospital Dayton	**GSH**	**Kettering Medical** Kettering	**KMC**
Grandview Hospital Dayton	**GVH**	**Madison County Hospital** London	**MCH**
Greene Memorial Xenia	**GMH**	**Mary Rutan Hospital** Bellefontaine	**MRH**

Mercy Hospital Urbana	**MH**	**Springfield Reg. Med.** Springfield	**SRC**
Miami Valley Hospital Dayton	**MVH**	**Sycamore Medical** Miamisburg	**SMC**
MVH Jamestown Jamestown	**MVHJ**	**Upper Valley Medical** Troy	**UVM**
Miami Valley South Centerville	**MVS**	**VA Medical Center** Dayton	**VA**
Reid Hospital Richmond, Ind.	**RH**	**Wayne Healthcare** Greenville	**WAY**
Soin Medical Center Beavercreek	**SCM**	**Wilson Memorial** Sidney	**WMH**
Southview Hospital Centerville	**SVH**	**WPAFB Hospital** Fairborn	**WP**

Out of Region: Level 1 & 2 Trauma Centers (grouped by city)

Cincinnati Children's Cincinnati	**CCMCi**	**Nationwide Children's** Columbus	**NCHCo**
UC Trauma Center Cincinnati	**UCMCi**	**St. Rita's Medical** Lima	**RMCLi**
OSU Trauma Center Columbus	**OSUCo**	**Clarian Methodist** Indianapolis	**CMHIn**
Grant Medical (Trauma) Columbus	**GMCCo**	**Indiana University** Indianapolis	**IUMIn**
Mount Carmel West Columbus	**MCWCo**	**Riley Children's** Indianapolis	**RCMIn**
Riverside Methodist Columbus	**RMCCo**		

Transport Group has many duties. Set up early!

Transport obvious and serious red category patients as quickly as possible, but each MUST be logged with Transport. Patient allocation (distribution of patients among various hospitals) is one of EMS' most crucial tasks!

Transport Group Duties:

- Establishes and maintains a vehicle route in and out of the loading area.
- Requests EMS and Police resources from EMS Branch as needed.
- **Ensures that every transported patient has a Triage Tag and Ribbon.**
- Assigns patients to transport units.
- **Assigns transport units to hospitals.**
  - **Do not overload any hospital**, regardless of transport distance to other hospitals.
  - Consider likelihood that closest hospital(s) may be overwhelmed by patients who self-transported.
  - In an MCI, many trauma patients need to be transported to non-Trauma Centers.
- **Monitors hospital capacity and maintains patient flow accordingly**, using the Transportation Officer's Destination Worksheet. Designates a Transport Dispatcher if needed.
- Coordinates priority of transports with Treatment supervisor.
- Maintains communications with hospitals
  - Designates a Medical Communications Aide or unit as needed.
  - Notifies receiving hospitals of all incoming patients with brief reports:
    - the number of patients,
    - their triage level,
    - their condition,
    - the unit transporting them.
- Uses Transportation Log to log patient destination and status from the Triage tag perforated sections. May designate a Documentation Aide.
- Strips supplies and equipment from staged and transport medic units as needed for the Treatment Area.
  - May assign a **Medical Supply Manager** to coordinate this activity.
  - Requests additional resources as needed.
- Coordinates with Staging to bring EMS vehicles to the loading area.

Provided by Dayton MMRS with funds from the U.S. Department of Homeland Security

Checklist 13 - Staging Team Leader

Staging Team Leader Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Transport Group Supervisor
☑ Initial Duties	
	1. Put on Staging Manager vest
	2. Read through the Checklist
	3. Maintain communications with Transport Group Supervisor
	• Ensure radio interoperability
	4. Maintain status of number and types of resources in the Staging Area
	• Advise Transportation Group Supervisor of ambulance capacities
	5. Recommend additional staffing, equipment, and resources when necessary
	6. Order all personnel to remain with their units until assigned
	• One member of the transport unit must remain with the vehicle at all times
	7. Control and document all resources entering and leaving the Staging Area
	8. Ensure unimpeded access and egress to/from Staging Area
	9. Coordinate security for Staging Area
	10. Direct ambulance crews to leave stretchers in ambulances unless needed for patient movement
	11. Maintain communications with Ambulance Team Leader(s) in the Loading Area
☑ Other Duties	
	1. Monitor personnel for rehabilitation and replacement
	2. Maintain Unit Log (ICS 214)
	3. Demobilize as directed by Transport Group Supervisor
	4. Forward all records/reports to the Transport Group Supervisor

Checklist 14 - Patient Tracking Team Leader

Patient Tracking Team Leader Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Transport Group Supervisor
☑ Initial Duties	
	1. Put on Patient Tracking Team Leader vest
	2. Read through the Checklist
	3. Maintain communications with Transport Group Supervisor
	• Ensure radio interoperability
	4. Position yourself at the assigned patient egress point in the Loading Area
	5. Determine whether or not a Transport Dispatcher is needed. If not, communicate the following with hospitals;
	• Determine and maintain current status of hospitals and care facilities availability and capabilities
	• Number of patients
	• Triage level
	• Condition
	• Ambulance transporting them
	• For example: "SRMC, you're getting one RED chest trauma on Ambulance 74, and two YELLOWS with extremity trauma on Ambulance 58. How many more can you handle in each category?"
	• Advise Transport Dispatcher of patient readiness and priority of transport for hospital communications
	6. Coordinate patient destination with Transportation Group Supervisor
	7. Complete Checklist 12 - Transportation Log for each patient
	• Collect Triage Tag stubs
	• Record the following;
	○ Triage Tag number
	○ Triage Category
	○ Destination
	○ Types of injury
	○ Mode of Transportation (Vehicle ID)
	○ Time departed the scene
	8. Request and supervise Amateur Radio Operator and Red Cross Liaison to scene
	• Amateur Radio Operator will relay information on Transportation Log to the Red Cross for family reunification

	• Inform hospitals that Red Cross has been activated; operators can defer/direct reunification questions
	• Inform Dispatch that Red Cross has been activated, operators can defer/direct reunification questions
☑ Other Duties	
	1. Assist the Transportation Group Supervisor with documentation
	2. Maintain Unit Log (ICS 214)
	3. Demobilize as directed by Transport Group Supervisor
	4. Forward all records/reports to the Transport Group Supervisor

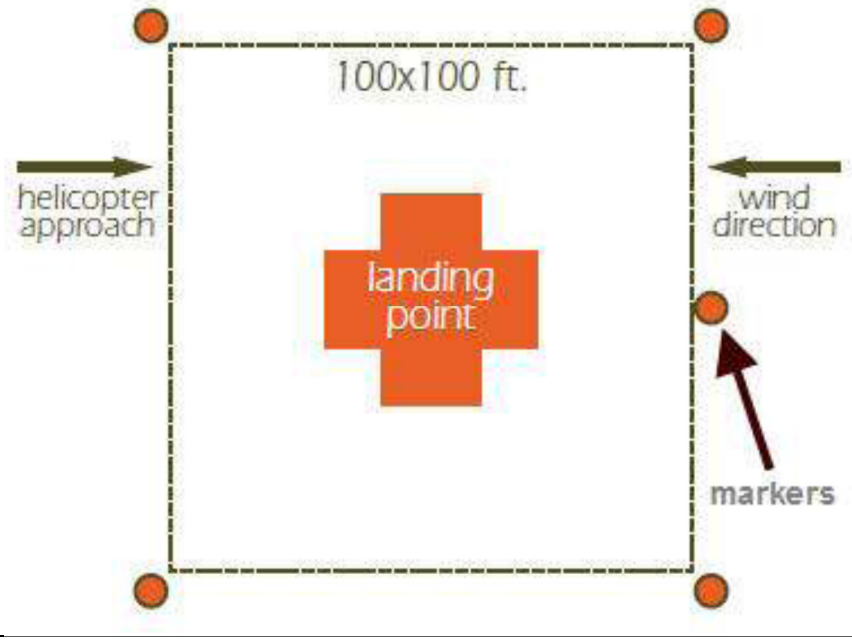
Checklist 15 - Transport Dispatcher

Transport Dispatcher Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Transport Group Supervisor
☑ Initial Duties	
	1. Put on Transport Dispatcher vest
	2. Read through the Checklist
	3. Maintain communications with Transport Group Supervisor and Patient Tracking Team Leader
	• Ensure radio interoperability
	4. Position yourself at the assigned patient egress point in the Loading Area with the Patient Tracking Team
	5. Determine and maintain current status of hospitals and care facilities availability and capabilities though RHNS via Dispatch Center
	6. Coordinate patient destination with Transportation Group Supervisor
	7. Notify designated hospitals with the following
	• Number of patients
	• Triage level
	• Condition
	• Ambulance transporting them
	• For example: "SRMC, you're getting one RED chest trauma on Ambulance 74, and two YELLOWs with extremity trauma on Ambulance 58. How many more can you handle in each category?"
	8. Request and supervise Amateur Radio Operator and Red Cross Liaison to the scene
	• Amateur Radio Operator will relay information on Transportation Log to the Red Cross for family reunification
	• Inform hospitals that Red Cross has been activated, operators can defer/direct renunciation questions
	• Inform Dispatch that Red Cross has been activated, operators can defer/direct renunciation questions
☑ Other Duties	
	1. Maintain Unit Log (ICS 214)
	2. Demobilize as directed by Transport Group Supervisor
	3. Forward all records/reports to the Transport Group Supervisor

Checklist 16 - Ground Ambulance Team Leader

Ground Ambulance Team Leader Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Transport Group Supervisor
☑ Initial Duties	
	1. Put on Ground Ambulance Team Leader vest
	2. Read through the Checklist
	3. Maintain communications with Transport Group Supervisor and Staging Manager
	• Ensure radio interoperability
	4. Designate a Loading Area close to the Treatment Area
	• Closest to the RED Treatment Area is preferable
	• Area should have adequate one-way traffic flow from staging to outbound routes
	• Area should have adequate room to maneuver patients with treatment interventions already in place
	5. If the Loading Area is some distance from the Treatment Area, consider using a stretcher from a committed ambulance to move patients to the receiving units
	• Ensure the necessary equipment is available in the ambulance for patients' needs during transportation
	• Inform ambulance crews of the destination hospital/Emergency Department.
	• Provide travel directions to the receiving hospital/Emergency Department
	• Obtain maps or directions to area hospitals for distribution to ambulance crews.
	• Remind ambulance crews that they do not contact receiving facility unless there is significant deterioration in the patient's condition, or if they need physician's orders
	• Remind crews to return to the Staging Area upon completion of their assignment unless otherwise directed
	6. Ensure patients selected for transportation are ready for transport and safely loaded
	7. Ensure all patients being loaded have triage tags attached and the transport stub has been removed
	8. Notify Staging Area when ready for rotating ambulances into the Loading Area
☑ Other Duties	
	1. Maintain Unit Log (ICS 214)
	2. Demobilize as directed by Transport Group Supervisor
	3. Forward all records/reports to the Transport Group Supervisor

Checklist 17 - Air Ambulance Team Leader

Air Ambulance Team Leader Checklist	
Checklist	**Tasks to Complete**
☑ Arrival	
	1. Obtain briefing from Transport Group Supervisor
☑ Initial Duties	
	1. Put on Air Ambulance Team Leader vest
	2. Read through the Checklist
	3. Maintain communications with Transport Group Supervisors
	• Ensure radio interoperability
	4. Establish location of Helispot with Transportation Group Supervisor
	• Assure location is at least 100'x100' in size
	• clear of overhead wires
	• free from debris
	• level/flat and on firm surface
	• If possible, water down dry dirt and sand
	• Clearly mark the area with five weighted cones, flares, or beacons.
	• <u>*NOTE:</u> Locate helispot at least one mile upwind from HAZMAT incident sites when explosives, gases, vapors, or chemicals are in danger of exploding or burning on sites, or when a plume is present. For radioactive materials incidents with no steam or smoke the helispot can be located ¼ mile upwind from the incident site. 

	5. Establish and maintain direct contact with the inbound helicopter
	• Request helicopter to switch to the assigned tactical frequency
	• Don't radio helicopter during the last 30 seconds before landing except to report an immediate hazard. Then state "Abort landing" or "Go around."
	6. Have information ready for helicopter pilot
	• Landing zone location
	• How landing zone is marked (flares, strobes)
	• Any nearby obstruction
	• Wind speed and direction
	• Your location (you should be in front of the helicopter)
	• Advise the pilot of any plume location and direction BEFORE landing at any HAZMAT incidents
	7. Don't shine lights on helicopter
	8. Wear Eye protection, crouch down and cover your face as the helicopter lands
	9. DO NOT approach the helicopter unless the pilot indicates you to do so by hand signal
	• ALWAYS approach the helicopter from the front
	• Keep all personnel clear of tail rotor at all times
	10. Ensure patients selected for transportation are ready for transport
	• Ensure there are no loose objects on the patient or medical personnel
	• Ensure all patients being loaded have triage tags attached and the transport stub has been removed
	11. If the Loading Area is some distance from the Treatment Area, consider using a stretcher from a committed ambulance to move patients to the receiving units
	12. Verify with Air Ambulances if they need to return for additional patient pick-ups
	13. Maintain Helispot/landing zone security, request law enforcement assistance if needed
	• Control entry of medical personnel for loading/unloading of patients
	• No smoking allowed in the Landing Zone
☑ Other Duties	
	1. Maintain Unit Log (ICS 214)
	2. Demobilize as directed by Transport Group Supervisor
	3. Forward all records/reports to the Transport Group Supervisor

Checklist 18 - ICS 214 Unit Log

1. Incident Name	2. Operational Period (Date/Time) From: To:	UNIT LOG ICS 214-CG
3. Unit Name/Designators	4. Unit Leader (Name and ICS Position)	

5. Personnel Assigned

NAME	ICS POSITION	HOME BASE

6. Activity Log (Continue on Reverse)

TIME	MAJOR EVENTS

7. Prepared by: **Date/Time**

1. Incident Name	2. Operational Period (Date/Time) From: To:	UNIT LOG (CONT.) ICS 214-CG

6. Activity Log (Continue from Front)

TIME	MAJOR EVENTS

7. Prepared by:	Date/Time:

Figure 6 - Active Shooter Considerations in a MCI

Active Shooter Considerations in a Mass Casualty Incident
1. Establish Unified Command (UC) with Law Enforcement (LE) as lead operational component. The UC/LE lead determines the objectives and operations.
2. LE "on-scene" radio report should not be construed to imply that the scene is secure or safe. A scene is not considered secure until a detailed deliberate search of the entire area is concluded.
3. Past practice has involved staging assets at a safe distance (usually out of line-of-sight) until a perimeter is established and all threats are naturalized. But, considerations may be made for more aggressive EMS operations in areas of higher but mitigated risk to ensure casualties can be rapidly retrieved, triaged, treated, and evacuated. Rapid triage and treatment are critical to survival. a. Request a Tactical Medic Unit from Clark County Dispatch.
4. Consider turning off emergency lights and warning devices before arrival. Many frightened citizens may be fleeing the event and are likely to act in an unsafe manner, so use extreme caution. Clarify this procedure with LE authorities since there have been reports where the perpetrator ends the threat when they hear or see public safety personnel or units arrive on-scene.
5. Consider/Investigate the use of apparatus' solid parts such as motor, pump, water tank and wheels as cover in the hot zone. Understand the difference between cover (protection from direct fire) and concealment (protection from observation).
6. Remove patients from the danger zone in a manner consistent with predetermined agency training and standards of practice. LE officers may bypass casualties in order to eliminate the threat.
7. Use internal Casualty Collection Points (CCPs) for large area facilities with multiple casualties where evacuation distances are long. Point-of-wounding medical stabilization should occur prior to evacuation to the CCP, which should provide cover to the injured and responders and be secured by LE officers. Identify people at CCP for accountability and protection of staff.
8. For larger geographic incidents or incidents with travel barriers, consider the use of multiple staging, triage and other supporting setup areas.
9. The Staging Area should provide hard cover and concealment from perpetrators.
10. Be aware that responders may be wearing uniforms and civilian attire, so exercise caution in identifying individuals.
11. Assign extra communications personnel to monitor inbound intelligence from responders. These types of incidents provide a tremendous amount of radio traffic with real time updates coming from fleeing civilians and responders. Due to the critical time factors involved in getting intelligence back to the entry team personnel, extra communications personnel should be allocated to receive, analyze and rebroadcast (per the UC) the many data transmissions received.

Figure 7 - Decon and Triage Decision Making Guide

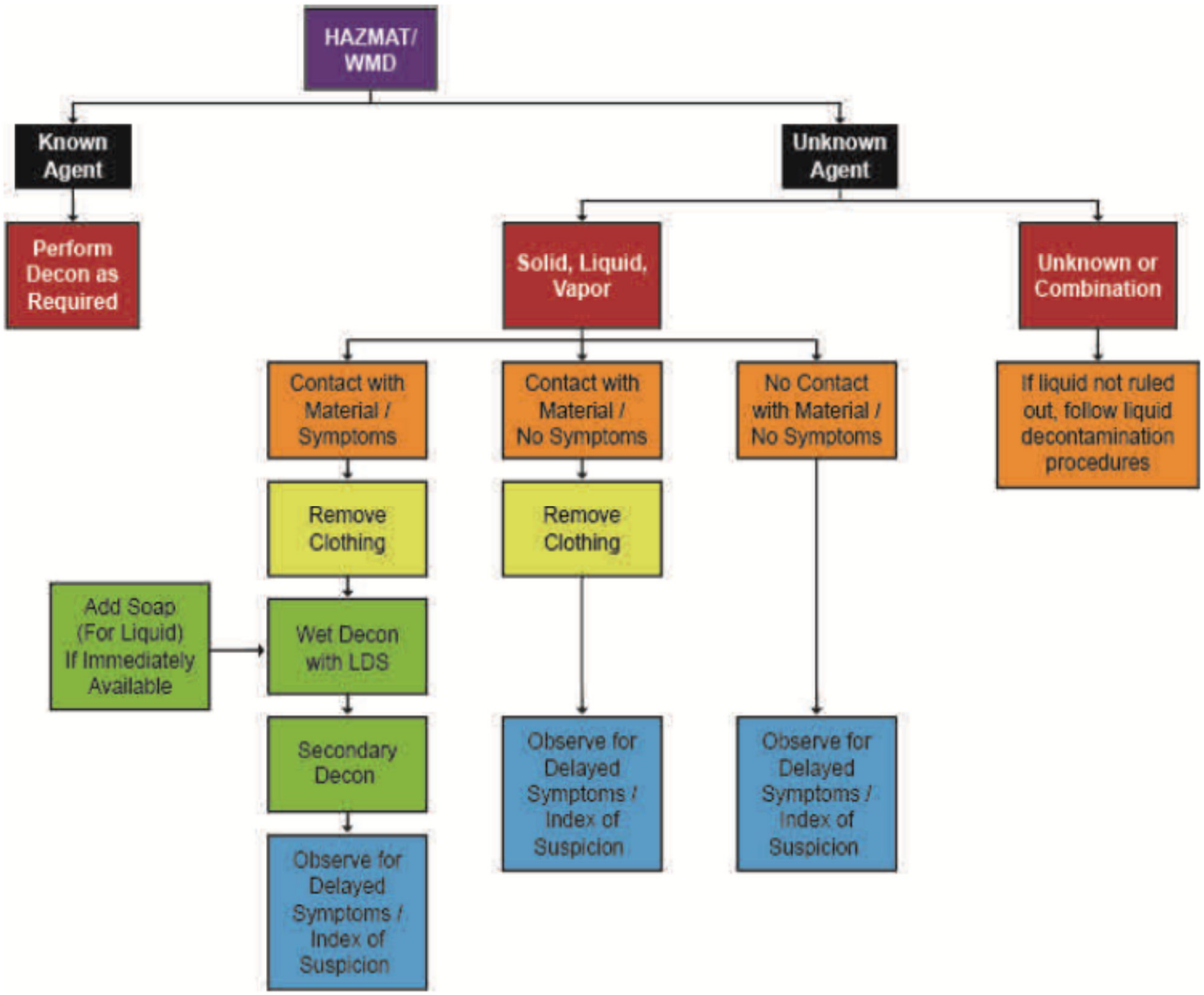


Figure 8 - Mass Decon Process

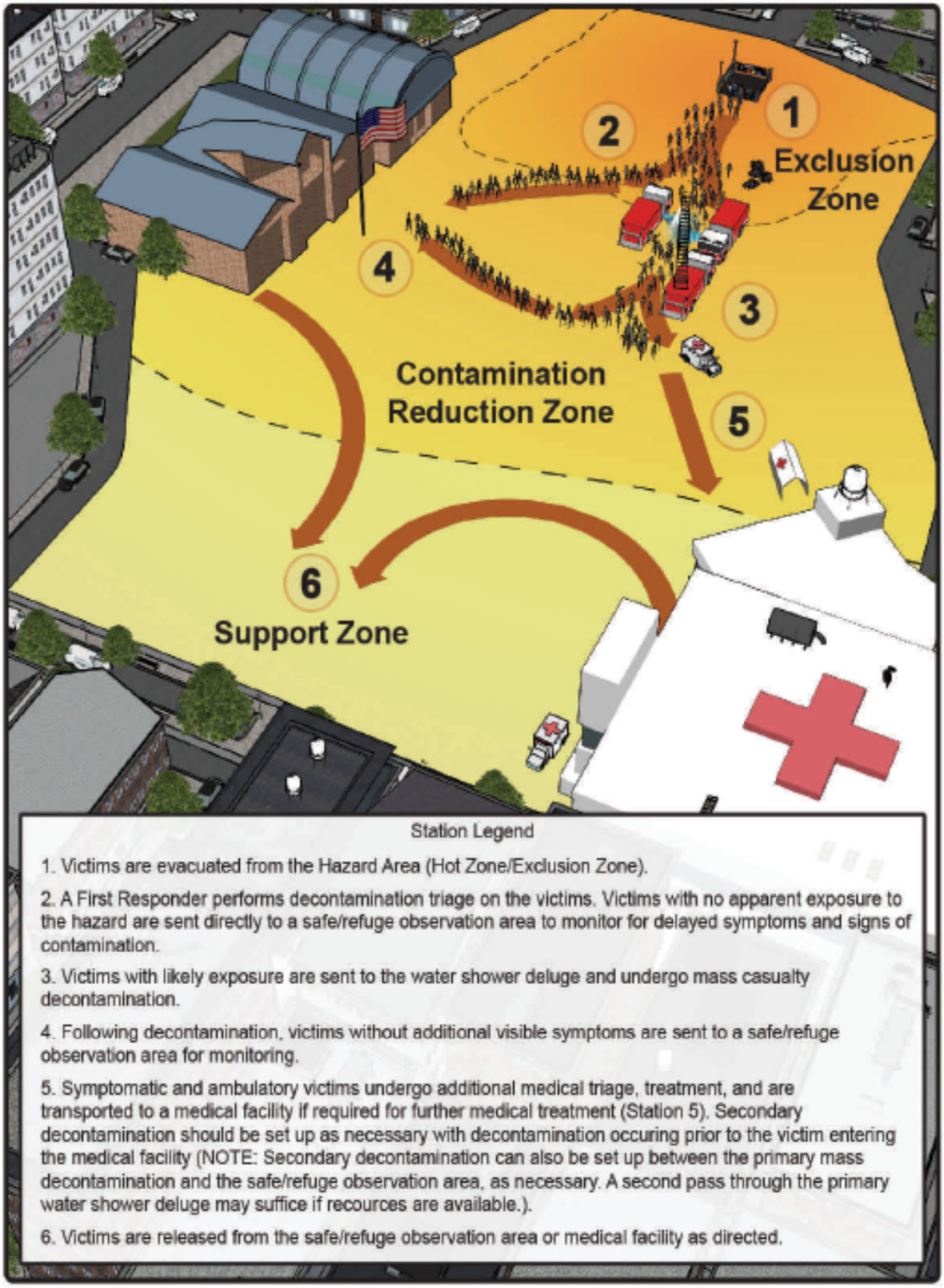


Figure 9 - Patient Control for Decon Triage

Figure 10 - Proper Removal of Clothing

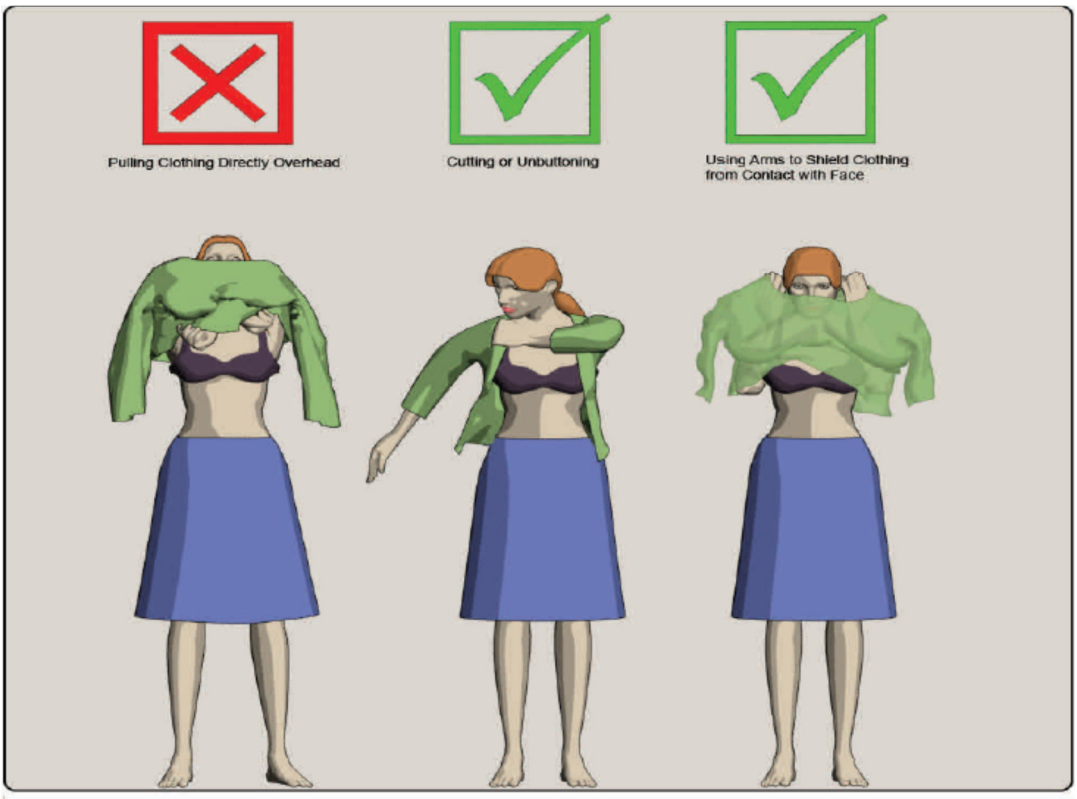


Figure 11 - Ladder Pipe Decon System

Figure 12 - Proper Decon Corridor Procedure

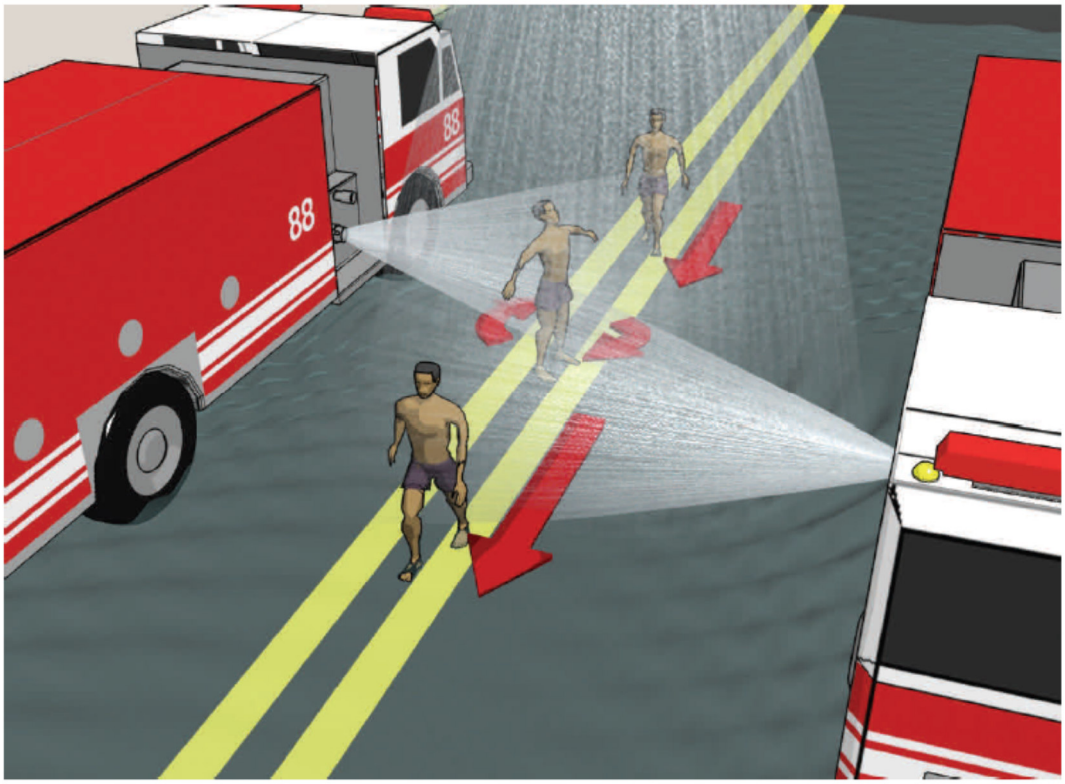


Figure 13 - Mass Decon Corridor

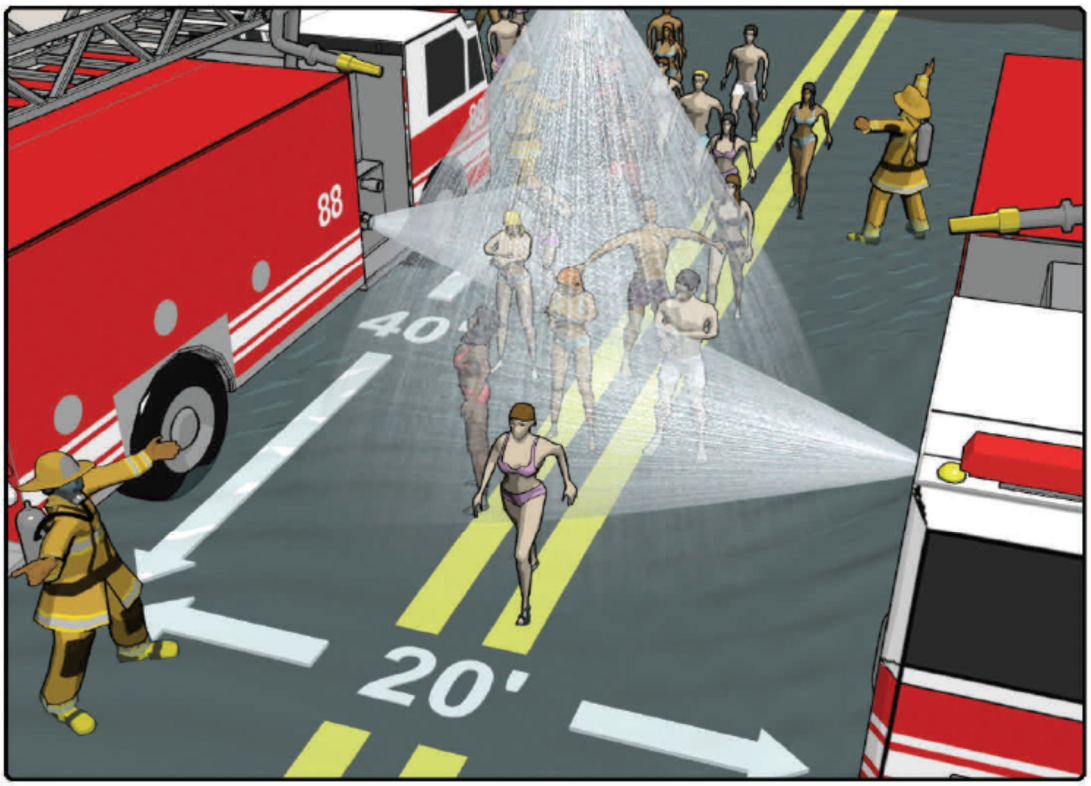


Figure 14 - Proper Body Positioning

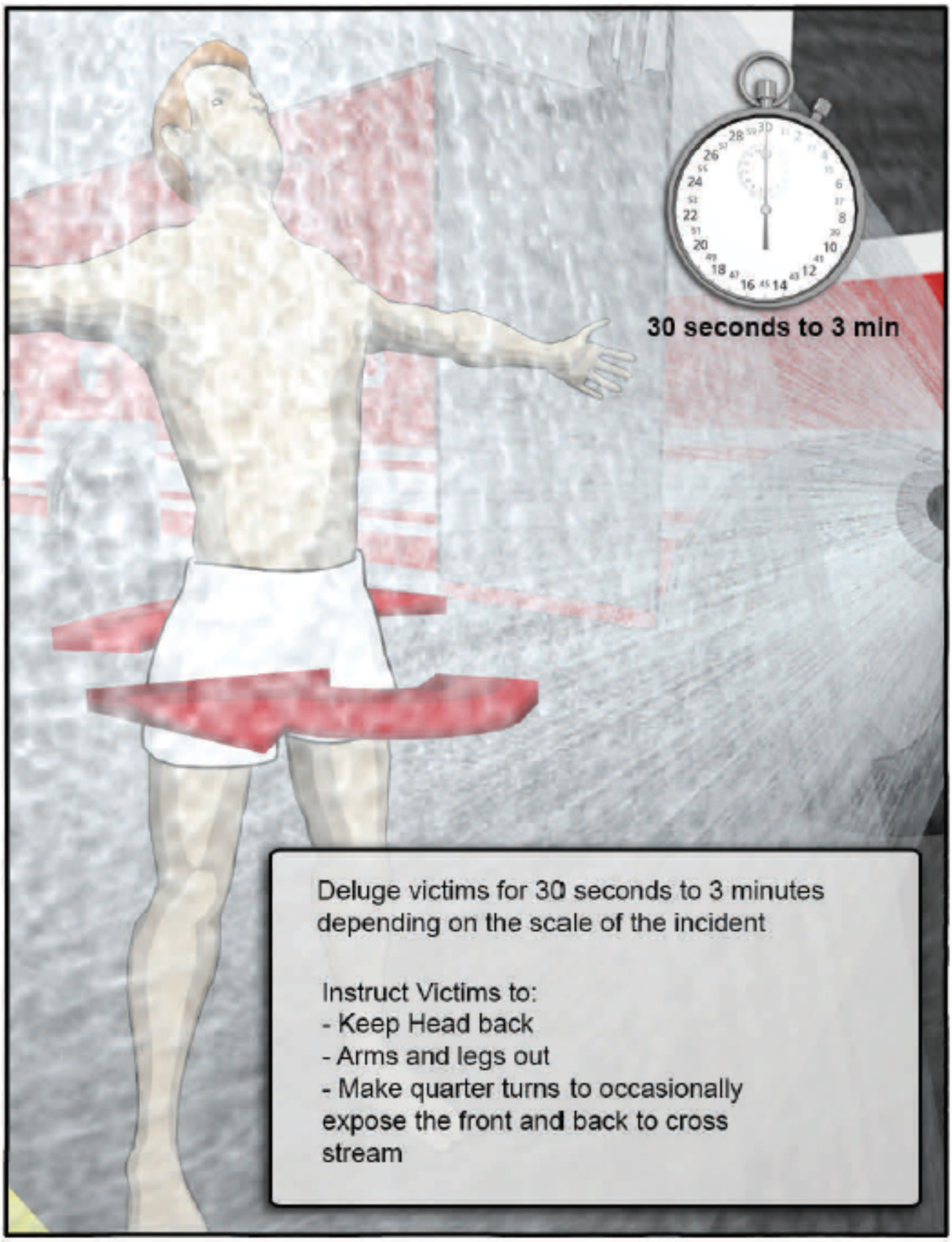


Figure 15 - Dry Decon Technique

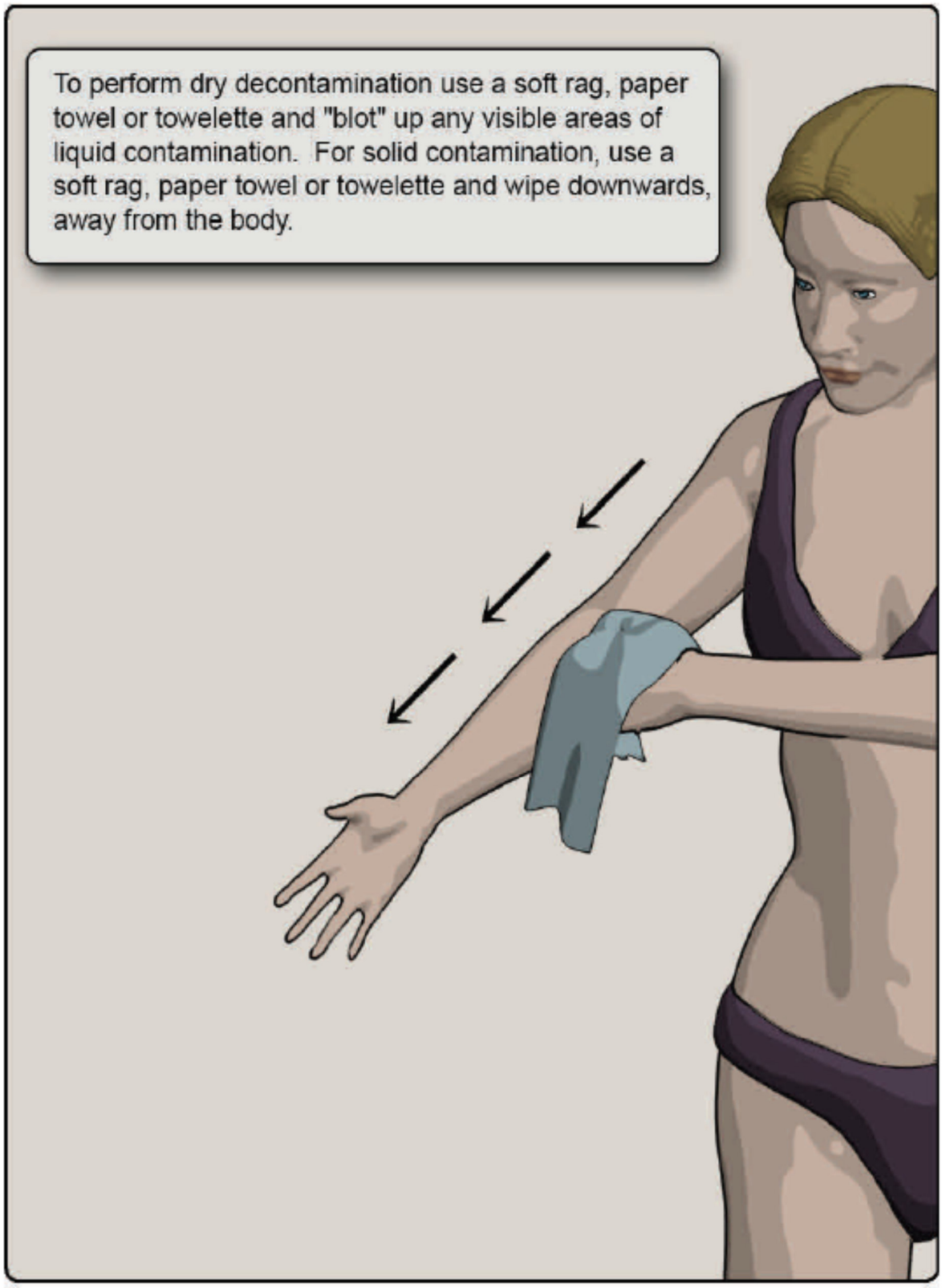


Figure 16 - Off Gassing Hazard