LEWIS COUNTY
— est. 1845 —

Lewis County
Fire Services & EMS Council

Mass Casualty Incident (MCI) Plan

January 31, 2020

Reformatted: 2001; Revised: July, 2006, 2019

Arbor Health MCI Exercise 2019 - Randle Fire District 14 EMD, Morton, WA.

Annex to:
Lewis County CEMP –
ESF # 8 Health, Medical and Mortuary Services

Prepared by: Division of Emergency Management
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Lewis County Mass Casualty Incident (MCI) Plan

Annex to:
Lewis County CEMP – ESF # 8 Health, Medical and Mortuary Services

Suggested Operating Procedures

For Responding EMS Units to Mass Casualty Incident

Using SALT Triage

January 31, 2020

(Replaces: Reformatted: 2001, Revised: July 2006)

Level I	**Up to 6** patients	Medically oriented incident that exceeds the capabilities of the initial responding agencies.
Level II	**7-12** patients	Medically oriented incident possibly requiring the activation of the Emergency Operations Center. May require out-of-county resources and the distribution of patients to multiple medical facilities.
Level III	**13 or more** patients	EOC personnel will be notified. Local EMS agencies and medical facilities may require out-of-county assistance.

Acknowledgements

The Lewis County Emergency Medical Services (EMS) providers that collaborated in the development of this plan include the following:

Medical Program Director	LC FD # 18 - Glenoma
LC FD # 1 - Onalaska	Cowlitz-Lewis FD # 20 -
LC FD # 2 - Toledo	Riverside Fire Authority
LC FD # 3 - Mossyrock	Chehalis Fire Department
LC FD # 4 - Morton	American Medical Response
LC FD # 5 - Napavine	Lewis County Medic One
LC FD # 6 - Chehalis	Providence Centralia Hospital
LC FD # 8 - Salkum	Morton General Hospital
LC FD # 9 - Mineral	Elected Official
LC FD # 10 - Packwood	Consumer
LC FD # 11 - PeEll	Law Enforcement
LC FD # 13 - Curtis	Government Agency
LC FD # 14 - Randle	Physician
LC FD # 15 - Winlock	Prevention Specialist
LC FD # 16 - Doty	Airlift NW
LC FD # 17 - Ashford	Life Flight Network

Promulgation

Lewis County Emergency Management Deputy Director:

Andy Caldwell — 2-6-2019 Date

Lewis County Medical Program Director:

Dr. Peter McCahill — 2/6/19 Date

Lewis County Fire Chief's Association:

Gregg Peterson, Chair — 2-6-2019 Date

Lewis County Emergency Medical Services (EMS) Council:

Doug Fosburg, Chair — 2-6-2019 Date

Lewis County Board of County Commissioners:

Gary Stamper, Chair — Date

Plan Distribution List

CD	Plan Agency	Staff Title	Date Issued
	BOCC	Clerk of the Board	
	Risk Management	Administrator	
X	E911	Director	
X	LC DEM	Manager	
X	Chehalis	EM Liaison	
X	Mossyrock	EM Liaison	
X	Morton	EM Liaison	
X	Napavine	EM Liaison	
X	Pe Ell	EM Liaison	
X	Toledo	EM Liaison	
X	Vader	EM Liaison	
X	Winlock	EM Liaison	
X	LC Coroner	Coroner	
X	LC Sheriff	Sheriff	
X	American Red Cross	Coordinator	
X	AMR	Supervisor	
X	Salvation Army	Administrator	
X	Providence Hospital	Asst. Admin. Patient	
X	Morton Hospital	Director	
X	Lewis County Medic One	Supervisor	
X	Riverside Fire Authority #1 (Centralia)	Chief	
X	Riverside Fire Authority #2 (Harrison)	Chief	
X	Chehalis Fire Department	Chief	
X	Lewis County FD # 1 - Onalaska	Chief	
X	Lewis County FD # 2 - Toledo	Chief	
X	Lewis County FD # 3 - Mossyrock	Chief	
X	Lewis County FD # 4 - Morton	Chief	
X	Lewis County FD # 5 - Napavine	Chief	
X	Lewis County FD # 6 - Chehalis	Chief	
X	Lewis County FD # 8 - Salkum	Chief	
X	Lewis County FD # 9 - Mineral	Chief	
X	Lewis County FD # 10 - Packwood	Chief	
X	Lewis County FD # 11 - Pe Ell	Chief	
X	Lewis County FD # 13 - Curtis	Chief	
X	Lewis County FD # 14 - Randle	Chief	
X	Lewis County FD # 15 - Winlock	Chief	
X	Lewis County FD # 16 - Doty	Chief	
X	Lewis County FD # 17 - Ashford	Chief	
X	Lewis County FD # 18 - Glenoma	Chief	
X	Lewis County FD # 20 - Cowlitz/Lewis	Chief	
X	Washington State Patrol	Sergeant	
X	Chehalis Police Department	Chief	
X	Morton Police Department	Chief	
X	Mossyrock Police Department	Chief	
X	Napavine Police Department	Officer in Charge	
X	Pe Ell Marshal's Office	Marshal	
X	Toledo Police Department	Chief	
X	Vader Police Department	Chief	
X	Winlock Police Department	Chief	
X	EMS Medical Program	Director	
X	Airlift NW	EMS Representative	
X	Life Flight Network	EMS Representative	
X	Washington State EMD	Plans Division Manager	

Record of Changes

NOTICE TO PLAN HOLDERS: In order to maintain a current ***Lewis County Mass Casualty (MCI) Plan****, changes* will be issued periodically by the Lewis County Division of Emergency Management. Please make those changes upon receipt, and record them on this page. **If a previous change number shows no entry, you may not have an up-to-date version of this plan.**

CHANGE	DATE	LOCATION/PAGES(S) CHANGED	INITIALS
1	July, 2006	Revision of 2001 plan, complete replacement	
2	Feb, 2020	Complete replacement, based on SALT	

Lewis County Mass Casualty Incident Plan (MCI)

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Field Checklists

ATTACHMENT SECTION

I. LEWIS COUNTY TRIAGE SYSTEM PHILOSOPHY

The intent (philosophy) of this plan is to treat and save the greatest number of patients possible under extreme conditions. Responders must remember that this is not a routine response; otherwise you would not be using the MCI Plan and triage system.

Key to the success of a multi casualty response is the standardization of response procedures for sorting, treating and transporting patients. Responders must learn to recognize when circumstances are present that warrant a shift from normal response procedures to the MCI procedures. Dependent upon the size and complexity of the MCI, the Incident Commander will be tasked with determining what elements of the plan need to be employed to bring the response to a satisfactory conclusion. Incident Commanders must remain situationally aware to stay ahead of the incident development curve while avoiding the pit fall of building too large an ICS structure that exhausts precious resources.

When responders are overwhelmed in an MCI, in-depth patient care does not typically occur until the patient arrives at a treatment area or they are placed inside a transport unit. Treating patients where they are found, like in a routine response, slows the system down for the other patients. When dealing with large numbers of victims, it is very likely that the standard of medical care will be less than what would normally be expected so adjustments in expectations must be made to match the situation.

Out of necessity, well intentioned civilians and the walking wounded may be used to assist with patient care. Other responders including Law Enforcement and Public Works with little formal medical training are encouraged to learn how they can fill a role in the MCI disaster response.

Proficiency comes with repeated exercise of these plans and procedures; therefore, response agencies expecting to use this system are encouraged to regularly review and train in its use and whenever possible involve their partner agencies and responders.

II. EXECUTIVE SUMMARY and PLANNING ASSUMPTIONS

When responders encounter overwhelming numbers of patients all at once they must quickly recognize that their treatment decisions for individual patients must be adjusted to the benefit of the many. While we always strive to provide the best medical care, we must recognize that certain circumstances will warrant changes in the standard of medical care. This predictably will occur when there are more patients in need than there are response resources on a scene.

The “Golden Hour” of emergency medicine is a well-accepted concept which states that patients of trauma need to have surgery within one hour of the insult or injury to

maximize survivability. In today's world we must recognize that the same principals will apply to non-trauma, medical emergencies involving mass respiratory distress and decontamination cases. Therefore, in all MCI's regardless of the cause, rapid transport to definitive care centers is the best way to increase survivability for as many patients as possible.

This plan seeks to reduce the number of unnecessary actions and to streamline efforts to reduce the time it takes to remove all patients from the scene. Important features of the plan include:

- Use of the SALT triage system to quickly sort patients.
- Use of color-coded flagging tape and triage tags to classify patients.
- Limiting initial care during triage to essential lifesaving intervention and expanding care as time, equipment, and resources allow.
- Providing scalable instructions for first arriving units depending on the level of the MCI encountered.
- Encouraging the establishment of geographic divisions at larger incidents to speed triage and removal;
- Scaling patient tracking and documentation with the size and complexity of an incident.

This plan differs from previous Lewis County MCI plans in several ways.

- A transportation corridor should now be established and secured early in the incident to facilitate rapid patient transport.

- The use of flagger tape and triage tags remains the preferred triage tool. Patients will be "Global Sorted" into three categories where found. Walking wounded patients, GREEN (minimal), will be removed from the impact area to be assessed last. Patients with "Purposeful Movement" will be assessed second, and those "Still/Obvious Life Threat" will be assessed first.

  In the "Initial" triage, the "Still/Obvious Life Threat" patients will be assessed (using flagger tape) either RED (Immediate)/YELLOW (Delayed), GREY (Expectant) or BLACK (Dead).

  RED (Immediate) and YELLOW (Delayed) patients will be moved to treatment areas as quickly as possible by members of the Removal Team and subsequent arriving responders. During the assessment, responders may perform the four Life Saving Interventions (LSIs) as needed. Each victim must be triaged as quickly as possible.

  Once this has been accomplished, Removal Teams should return to locate the GREY patients for movement to the CCP or appropriate Treatment area. BLACK/Dead patients will not be moved, unless it is necessary to access live patients or for responder safety reasons.

- Patients marked for decontamination that are not at the decontamination area may now be moved to the decontamination area and then triaged and taken to the corresponding treatment area once decontamination is complete.

Extrication priorities will be dynamic based on severity, access, and resources. It may be prudent to remove some YELLOW (Delayed) patients before RED (Immediate) patients. Situations such as extended extrication times, YELLOW (Delayed) patients blocking the access of RED (Immediate) patients, physical barriers, or a shortage of staffing may necessitate altering extrication priorities.

The Casualty Collection Point (CCP) to the treatment area may be used to upgrade or down grade triaged patients being transported to the RED/YELLOW treatment areas. The color-coded flagging tape should be left in place when the triage tag is applied to the extremity. When the CCP is no longer staffed, the triage tags may be applied in the Treatment area, or for sure at the Transport area. If a patient is being directly transported without going to a Treatment area, a tag will be placed on the patient by the Transport Group Supervisor prior to transport.

MCI's can be as small as a few patients or as large as hundreds and our responders must be trained to recognize the difference. Flexibility is integrated into this plan to accommodate all sizes of incidents. The extent of which the MCI plan, tools and procedures are used can and will be driven by the size of the MCI. Use as much of the plan as is needed to handle the incident and to stay ahead of the incident curve. Over commitment to the plan could place limited response resources in assignments that are unnecessary. Issues related to a fractured or geographically challenging incident are also addressed within the plan. Federal and regional disaster levels were used to help determine MCI incident sizes and the appropriate procedures for each level.

This plan is intended to be integrated with local, state, and federal governmental agencies and interagency cooperation shall be in accordance with the National Incident Management System (NIMS). In recognition of known resource limitations and the ingenuity of our responder's, dependent upon the size and complexity of an MCI, multiple ICS positions may be assigned to a single individual or not at all. MCI positions are named within the plan, but radio designators are left to be determined at the incident.

SALT / MCI OVERVIEW

1. **Tagging and Initial Triage**:

- Move as quickly as possible, but don't neglect the processes (triage, allocation of patients to hospitals, command etc.).
- Perform Global Sort and separate GREEN (Minimal) patients and move them out of the impact area. Appoint a GREEN / INC Area Manager, if necessary.
- Begin individual assessment with patients that are RED (Immediate) "Still, obvious life threat".
- Initial triage tagging (on the right wrist or uninjured arm) is done with flagger ribbons, placing a small piece in your pocket for later count matching. Perform LSI as necessary:
    - Control major hemorrhage
    - Open airway (if child 2 rescue breaths)
    - Chest decompression
- Indicate contaminated patients with ORANGE polka dot ribbons. (Always notify hospital of contaminated patients and – mark "DECON" has been performed on the Triage Tag placed after DECON is completed).
- Triage personnel should return to the CCP to reconcile their ribbon pieces with the Triage Group Manager. This number will be reported to the Medical Branch Director to determine the number of RED (Immediate), YELLOW (Delayed), and BLACK (Dead) patients. Triage personnel will then be available for reassignment duties such as removal or treatment teams.
- Depending on the incident size or the need, some GREENs (Minimal) and "Involved, Non-Casualties" (INC) could be assigned to stay with patients until EMS personnel are available.

2. **Patient Removal and Reconnaissance Teams:**

- If the incident is large enough, assign a team to conduct reconnaissance and report to the IC.
- Assemble patient removal teams from subsequent arriving units and personnel finishing triage.
- Setup the Casualty Collection Point (CCP) near the entrance to the RED and YELLOW Treatment Areas. Assign a responder to the CCP to Perform Secondary triage and apply triage tags - **care should be taken to not slow down patient distribution to treatment areas at the CCP**.
- Patient Removal Teams should remove RED (Immediate) patients first, then YELLOW (Delayed) patients. Once both RED (Immediate) and YELLOW (Delayed) patients have been removed, the Removal Teams should re-triage the GREY (Expectant) patients or transfer contaminated patients to Decon.

3. **Treatment**

- Set up treatment areas near the transportation corridor. Mark them with flagger tape: RED (Immediate) and YELLOW (Delayed).
- The Treatment Group Manager will coordinate patient evacuation with the Transport Group Manager.
- The Treatment Group Manager will report the number of patients no longer needing transport to the Medical Branch Director.
- The Transport Group Manager will report the number of patients transported to the Medical Branch Director.

III. DEFINITIONS & ACRONYMS:

A. DEFINITIONS:

Term	Definition
Alternative Care Facility (ACF)	Location, preexisting or created, that serves to expand the capacity of a hospital in order to accommodate or care for patients when an incident overwhelms local hospital capacity. In an MCI, patients will be triaged and transported to the hospital not the ACF for definitive care.
ALS: Advanced Life Support	Invasive emergency medical services requiring advanced medical treatment skills as defined in chapter 18.71 RCW.
ALS/BLS Transport Corridor	Designated parking area for patient transport vehicles. Operators and attendants will not leave their vehicles.
Apparatus Level I Staging:	Staging at incident address, a block away or otherwise in the immediate area. (Primarily a short term action).
Apparatus Level II Staging:	Staging away from incident, usually for larger events and at a set location with other apparatus.
Base Station (Hospital)	Hospital term for local Medical Control. See page 8.
Basic Life Support (BLS):	Non-invasive emergency medical services requiring basic medical treatment skills as defined in chapter 18.73 RCW.
Casualty Collection Point (CCP):	Also known as "Triage Funnel," or "Choke Point". An area designated by the Triage Group Supervisor that every patient filters through prior to movement into the Treatment area. The CCP is usually located at the entrance to the Treatment area. All patients will receive a triage tag at the CCP. .
Color Identifiers (Flagging Ribbons/Triage Tags/Tarps):	A color-coded identification system used to designate medical priority of patients during a mass casualty incident. • RED (immediate) • YELLOW (delayed) • GREEN (minimal) • GREY (expectant) • BLACK (zebra stripe) (dead) • ORANGE with polka dots (used in addition to the above ribbons to indicate potential hazardous material contamination)
Decon:	To decontaminate a person or persons. Decontamination resources: Joint Base Lewis McChord Fire and Emergency Services has a 300-person Decon Trailer. Regionally Decon resources are available on site at Capital Medical Center, Providence St. Peters and Centralia Hospitals.
Disaster Medical Control Center (DMCC): See Page 10 Also SEE: Pages 26-27	Disaster Medical Coordination Centers are designated hospitals where trained medical personnel gather to help coordinate patient movement during an incident that may overwhelm the healthcare community. DMCCs are responsible for supporting EMS and the healthcare

Term	Definition
Also See: Medical Control (local)	community by identifying available beds and placing patients at the most appropriate facility, based on their injuries or illness, as quickly as possible. For the purpose of the plan, Providence St. Peter Hospital will be the primary DMCC for Lewis County with Good Samaritan Hospital as backup. (See pages 53 & 54 attachments for Charge Nurse telephone numbers).
Emergency Medical Services (EMS):	Medical treatment and care which may be rendered at the scene of any medical emergency or while transporting any patient in an ambulance to an appropriate medical control, including ambulance transportation between medical facilities.
Patient Removal Team	Team that moves patients out of the impact area to the casualty collection point (CCP) and then to the treatment and transport areas.
Extrication	The process of removing a patient from an entrapment.
Field Treatment Site (FTS)	Area designated or created by emergency officials for the congregation, triage, medical treatment, holding, and/or evacuation of casualties following a multiple casualty incident.
Field Triage	The process of rapidly categorizing a large number of patients according to their severity of injury in order to prioritize their extrication and/or removal to the treatment area. Various forms of triage ***are*** used to determine the severity of a patient's injuries and condition. Lewis County uses the following SALT system: ▪ **Lewis County Mass Casualty Triage SALT**: Algorithm/System (Sort, Assess, Lifesaving Interventions, Treatment/Transport).
Funnel	Out-dated terminology, now called **"Casualty Collection Point (CCP)**, for the area all patients in a mass casualty incident pass through to ensure patient count, triage tagging, and entry into a Treatment Area to await transport based upon their level of injury.
GREEN Area	An area dedicated for congregation, treatment, and care of patients with minimal injuries. Designated as a separate area from Treatment due to the large number of potential patients and the special considerations they may need such as shelter, food and restroom facilities. Depending on the type of incident they may also be considered witness/suspects and require police presence.
GREEN Area Manager	A functional IMS position designed to manage the GREENs (Minimal) at an MCI. The GREEN Area Manager is responsible for assuring patients in this area are re-triaged to decrease the original numbers down to just those needing medication attention and transmit that number to Treatment Group Supervisor.

Term	Definition
Initial Triage	The SALT process of applying flagging ribbons to patients at the scene of a mass casualty incident to rapidly classify those injured and report preliminary patient counts to the IC and hospitals and prepare for transport to hospitals.
Intermediate Life Support (ILS)	A person certified to provide mobile intravenous therapy and advanced airway procedures as defined in RCW 18.71.200.
Involved, Non-Casualty (INC)	Involved, non-casualty (INC) are those from the incident who are not in need of medical attention. It is important to remove those not going to the hospital(s) from the patient count in order to provide receiving agencies with a more realistic number of patients that will be transported.
Levels of Life Support	ALS- Advanced Life Support; BLS-Basic Life Support; Intermediate Life Support.
Lewis County Search & Rescue (LCSAR):	Comprised of Lewis County Sheriff's Office deputies and volunteers. By statute, administered by the Sheriff's Office. Teams include the following: ATV Team of searchers with All Terrain Vehicles; Dog Team trained for scent tracking; Rope Rescue Team, trained in low and high angle rescues; and a Snow Mobile Team. Most members are also trained in ground searches for people as well as evidence searches. Activated by request through the 911 Communications Center.
Lewis County Technical Rescue Team (LC TRT):	The Lewis County Technical Rescue Team consists of Fire Service and Law Enforcement personnel. The team is trained and equipped for both water rescue (including swift water) and rope rescue (both low and high angle rescue). The TRT Team is activated via request through the 911 Communications Center.
MCI Bags:	There are two types of bags: the Command MCI bag and the First Responder MCI Bag. The Command MCI Bag contains ICS vests, materials for establishing a medical branch, limited protective supplies, various check lists and writing materials. The First Responder MCI Bag is limited to a belt with the triage-system colored flagging tapes to be used in Initial triage field tagging. See page 50 for MCI Bag contents list.
Mass Casualty Incident (MCI)	Any medically oriented incident that overwhelms the initial EMS response. An incident resulting from man-made or natural causes with associated illness or injury to a large number of people. The effect is that patient care cannot be provided immediately to all and resources must be managed. An MCI is categorized into three levels: ▪ **Level I** involving **Up to 6** patients: o Medically oriented incident that exceed the capabilities of the initial responding agencies. ▪ **Level II** involving **7-12** patients:

Term	Definition
	○ Medically oriented incident possibly requiring the activation of the Emergency Operations Center. May require out-of-county resources and the distribution of patients to multiple medical facilities. ▪ **Level III** involving **13 or more** patients: EOC personnel will be notified. Local EMS agencies and medical facilities may require out-of-county assistance.
MCI Response	Varied level of resources dispatched to an incident dependent upon the nature of the incident, the number of patients, and their severity of injury.
MCI Unit:	A mobile unit, which contains large quantities of medical supplies that can be dispatched to a scene of an MCI.
Medical Command Post	Medical command functions are executed at this location. The medical command post may be co-located or proximal to the Incident Command Post.
Medical Control See: Page 26 Also See: Disaster Medical Control Center (DMCC)	A term used in the local EMS community to identify the base station hospital that can be used as a resource or to gain concurrence with the action plan. The Medical Control can also provide the protocol to follow for patient care. East County uses Morton General Hospital as their Medical Control and West County uses Providence Centralia Hospital. NOTE: Hospital personnel continue to refer to this as “Base Station” hospital.
Medical Direction	Physician direction over pre-hospital activities. Also includes written policies, procedures, and protocols for pre-hospital emergency medical care and transportation.
Medical Program Director (MPD)	This position is certified by and appointed by the Washington State Department of Health, and operates under the direction and protection of the state. In this role, the MPD is responsible for the education, certification, and quality assurance for the care provided by all emergency medical services in Lewis County. Thus, all emergency medical services personnel in Lewis County work under his/her state license.
Medical Group/Branch	Ensures that Triage, Removal, Treatment, Transportation, GREEN Area, Medical Staging, and Morgue Team functions are performed; establish positions as necessary
Medical Supply Area	Medical supplies are cached at this location. The medical supply area should be located proximal to the treatment area to facilitate re-supply of the individual treatment areas.
Off-Site Communications	Radio, cell or data communications with contacts not at the emergency scene or command post. Off-Site Communications must be routed thorough the Incident Commander, except transportation (through the Transport Group Supervisor).

Term	Definition
Personal Protective Equipment (PPE)	Refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment include physical, electrical, heat, chemicals, biohazards, and airborne particulate matter.
Recon	The act of gathering information to support the operation or function being performed.
Rescue Group/Branch	In larger or more complex incidents Rescue Branch will oversee Groups/Teams for the removal and extrication of patients.
Run Cards	Pre-designated response plans filed with Communications.
SALT	Lewis County Mass Casualty Triage Algorithm/System (Sort, Assess, Lifesaving Interventions, Treatment/Transport)
Secondary Triage	A patient evaluation that occurs following the initial patient assessment and sorting. This activity may occur in the Casualty Collection Point (CCP), in the Treatment Areas or during the transportation phase.
Size-up	The initial evaluation phase of the emergency situation, to include description of what is seen, resources needed, initial actions, and safety considerations. The size-up shall be reported by the first arriving unit or Incident Commander and updated as need throughout the situation.
Staging Area	Locations where incident personnel and equipment are assigned on an immediately available status. There are two "Staging Levels" as follows: **Level I Staging**: Following the arrival of the first EMS/FIRE unit(s) – initial units will stage in their direction of travel, uncommitted, approximately one (1) block from the scene until assigned by Command. **Level II Staging**: Level II Staging is utilized for large events when Command desires to maintain a reserve of resources on-scene, and when the need to centralize resources is required. Level II Staging places all reserve resources in a central location and automatically requires the implementation of a Staging Manager.
Technical Rescue Team	A Lewis County Multi-Disciplinary Technical Rescue Team.
Transport Area	All patients are moved to this designated area following treatment to be loaded and transported to a medical facility.
Treatment Area	The designated area for the collection and treatment of patients. The same color flagging tape or flags that are found on the triage tags identify the treatment area.

Term	Definition
	▪ **RED (Immediate):** an area where patients require immediate assistance ▪ **YELLOW (Delayed):** an area where patient injuries are serious (delayed) but not immediately life-threatening ▪ **GREEN (Minimal):** an area where patients with minimal injuries are kept.
Triage	The sorting of patients into categories based upon their need for treatment and probability of survival.
Triage Tag	A tag that is affixed to each patient's extremity before entering the treatment area that is color-coded to indicate the patients triage level. The tag contains an area for basic patient information and unique identifying numbers for patient tracking purposes.
Secondary Triage	A patient evaluation that occurs following the initial patient sorting and assessment. This activity may occur in the Casualty Collection Point (CCP), in the Treatment Area or during the transportation phase.
Unified Command	Unified Command is a unified team effort which allows all agencies with jurisdictional responsibility for the incident, either geographical or functional, to manage an incident by establishing a common set of incident objectives and strategies.
Unique Identifier Number	Number preprinted on a band, tag (METTAG®) or bracelet to assist in tracking patient throughout the incident from initial entry to final disposition.
Zones (Hot, Warm, Cold, Exclusion)	Operating zones that define areas of an incident and provide for a safe working area for responders. These Zones are used in response to Fire/EMS Response to Hazardous Materials incidents or Large – Scale Violent Incidents involving threats or acts of violence in cooperation and coordination with responding Law Enforcement Agencies found in the Appendixes.

B. ACRONYMS:

Acronyms	Definition
ACF	Alternative Care Facility
ALS	Advanced Life Support
BLS	Basic Life Support
CAN	Conditions, Actions and Needs Report
CCP	Casualty Collection Point
DMCC	Disaster Medical Control Center See pages: 11, 26-27
EMS	Emergency Medical Services
FTS	Field Treatment Site (page 20)
GN	GREEN (Minimal)
GY	GREY (Expectant)

HM	Hazard Materials
ILS	Intermediate Life Support
LC SAR	Lewis County Search & Rescue
LC TRT	Lewis County Technical Rescue Team
MCI	Mass Casualty Incident
MIRFs	Medical Incident Report Forms
MPD	Medical Program Director
MSO	Medical Services Officer
PPE	Personal Protective Equipment
R	RED (Immediate)
RPM	Respirations, Pulse, Mentation
SALT	Sort, Assess, Lifesaving Interventions, Treatment/Transport
SORT	Special Operations Rescue Team
START	Simple Triage and Rapid Treatment
Y	YELLOW (Delayed)

IV. MCI CONCEPT OF OPERATIONS

A. Disaster Medical Coordination Center DMCC

(Also See Pages 26-27 for Medical Control duties / processes.)

A DMCC is activated following an incident that may overwhelm the healthcare system such as a Mass Casualty Incident (MCI) or hospital evacuation. An activation request typically comes from Fire/EMS at the scene. A DMCC is operated by trained emergency department staff that may consist of doctors, nurses, technicians, administrative personnel and/or EMS partners.

DMCCs are task with:

- Gathering information from the field
- Making initial notification to area hospitals; requesting bed availability and ability to receive patients
- Coordination or assistance with patient placement with hospitals, Fire/EMS and other DMCCs

When gathering information from the field, DMCCs seek five key points of information:

1. Location of incident
2. Number of patients (adults & pediatrics)
3. Types of injuries
4. Mechanism of injury
5. Any contamination or exposure concerns

In large events (greater than 10 patients), a DMCC will notify its partners to assist with other support needs such as family reunification, and/or any resource requests. Partners include: other healthcare facilities, the Northwest Healthcare Response Network, Department of Health, local and/or county public health, city and/or county emergency management. Incidents near county lines require

notification to neighboring regional DMCCs to potentially assist with patient placement.

The DMCC for Lewis County is Providence St. Peter Hospital, Olympia (West District).

B. Lewis County 911 Communications Center

Lewis County 911 Communications Center (911 Communications) is the answering point and dispatch center for all law enforcement, fire services, and emergency medical services in Lewis County. The 911 Communications Center has put in place a matrix and/or a run card to activate an MCI and dispatch the proper resources to the scene of the incident. All requests for MCI upgrades and Mutual Aid are coordinated through 911 Communications Center. Any EMS, Fire Service, Law Enforcement or other qualified individual en route to or on the scene of the emergency is authorized to declare the Level of MCI and request activation of the Emergency Operations Center (EOC) if necessary. If the dispatcher calls for one, they will notify the IC to let them know why. Following are the patient numbers/responders needed guidelines for calling an MCI:

C. MCI Run Card

Lewis County MCI Run Card MCI Resources Staffing Guidelines				
***MCI Level**	**# Patients**	**Responders Needed**	**Chiefs Needed**	**Comments**
Level I	**Up to 6**	**13**	**1**	**3 – 2** Person Engine Co. **2 – 2** Person Medic Units **3 – 2** Person *Aid Units *Aid Units staffed with 1 Driver and FF EMT
Level II	**7-12**	**26**	**2**	**6 – 2** Person Engine Co. **4 – 2** Person Medic Units, **6 – 2** Person *Aid Units *Aid Units staffed with 1 Driver and FF EMT
Level III	**13 or More**	**30+**	**3**	**9 – 2** Person Engine Co. **6 – 2** Person Medic Units, **All available** *Aid Units *Aid Units staffed with 1 Driver and FF EMT
Note: ***Staffing of the Aid Units would be by 1 Driver and 1 EMT pulled from the Engine Personnel for Transport.***				
***Level I – Consider notifying AMR-Seattle; Level II – Notify AMR – Seattle**				
For all MCI activations, the Lewis County Communications Center shall notify the Lewis County Fire Mobilization Coordinators (by Spillman Page).				

If you are the Incident Commander, Fire Chief, or designee; request 911 Communications to notify the County Fire Coordinator of the incident.

Coordinator	1ST Alternate	2nd Alternate
Jeff Jaques Fire Chief, Lewis Co FD 14 County Fire Coordinator **(360) 508-0133**	Doug Fosburg Fire Chief, Lewis CO FD 3 Alternate County Fire Coordinator **(360) 880-3262**	Kevin VanEngdom Lewis Co FD 5 Alternate County Fire Coordinator **(360) 304-0768**

D. Fire Coordinator Contact Process

1. All resources requests for either County, Regional, State or Federal response will be activated through the County Fire Coordinator.
2. The IC or Fire Chief contacts the County Coordinator via 911 Communications Center and requests activation of LC Mobilization Plan and leaves a contact number.

   It is highly recommended that, all agencies utilize the alarm levels in their response plans and that at a second alarm, 911 Communications Center is directed to notify the County Fire Coordinators, via "Spillman Paging," of the incident. The 911 Communications Center will strive to notify the County Fire Coordinator of any second alarm incident or any level MCI.

3. This notification will give the County Fire Coordinator an opportunity to contact county agencies to see what staffed apparatus would be available for response and/or move up to support the incident. It is advised that units be selected to ensure that no large holes in coverage are left in any area of the county.

E. First Arriving Units

The first responding unit will establish the Incident Commander, who will accomplish the Incident Commander Help Sheet.

Upon arrival the initial unit officer will broadcast the initial report over the radio, including the following in the report:

- Unit identifier
- The location, or corrected location
- Initial basic impression
- Initiate command with name
- Initiate command post location

As with any fire or rescue response, the initial unit is also responsible to give an initial CAN (Conditions, Actions and Needs) report. These reports give 911 Communications Center and all incoming units a "picture" of what the initial unit is seeing.

F. Incident Commander

If no Incident Commander is at the scene, the most qualified responder/officer will assume Incident command until relieved. The Incident Commander shall be responsible for the management of operations at the scene of the incident. The Incident Commander may appoint an aide to assist with the task list to prevent being overwhelmed.

G. Next Arriving Units

Initial units will stage in their direction of travel, approximately one block from the sign as directed by Command. In large incidents, additional responders will proceed directly to the Level II Staging Area and check in with the Staging Manager, unless directed to go to the scene. EMS personnel shall not leave the staging area or transport zone without the permission of the Staging Manager or Transport Group Supervisor.

NOTE: When responding to mass casualty incidents, responders shall keep radio communications to a minimum on 911 Communications Center and operations frequencies.

H. Size Up

As soon as possible, the Incident Commander will give a size-up report to the Lewis County 911 Communications Center including:

1. Initiate the Command Designator and Command Post location_____
2. Designate Command frequency.
3. Description of the scene.
4. Number of patients: _____
5. Determine and direct the initial actions
6. Identify dispatch and operations frequencies to be used.
7. Designate the Transportation Corridor
8. Determine Level I and Level II staging areas.
9. Identify safety concerns.

As the incident proceeds, the IC will provide additional reports to the Lewis County 911 Communications Center that will include the following:

1. Briefly describe an impression of the scene, including known hazards
2. Cause of the incident if known
3. Updates of the initial patient count
4. Initial actions and assignments
5. Determine and request any needed additional resources

I Initial Actions & Reports

The initial actions of the first arriving unit officer are critical to ensuring a successful outcome. Depending on the size and complexity of the incident, the initial unit may be able to fill many roles, or handle only a few assignments.

Critical Initial Unit Actions:

- Initial and size-up reports
- Establish and secure the transportation corridor
- Give assignments to incoming units (to include staging)

Assignments to be handled by initial units:

- Begin Recon and Triage according to SALT procedures, as soon as possible
- Perform a risk assessment and begin reducing the immediate danger to patients, rescuers, or the public
- Designate a GREEN area and have all GREENs moved to that location
- Begin removal and treatment of patients as able

J. Removal of Patients

To be completed with emphasis on the following:

- First move RED (Immediate)-YELLOW (Delayed)
- GREENS (Minimal) – designate responder or GREEN (Minimal) to move those able to a GREEN Area. Those going to the GREEN area are tagged there.
- BLACK (Dead) stays where found
- GREY (Expectant) moved only after REDS (Immediate)/YELLOWS (Delayed), if then
- Recon group and next arriving units help staff triage and removal teams

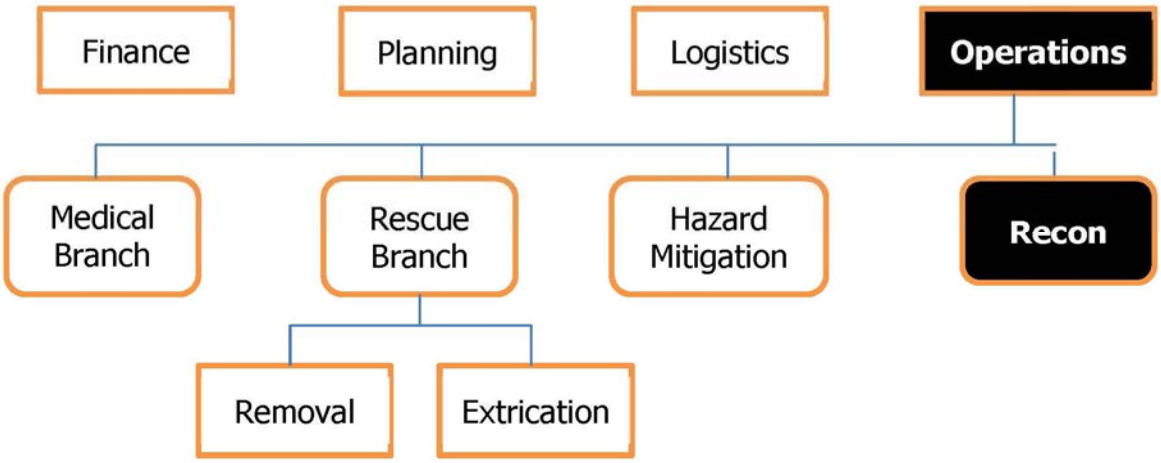
K. Recon Group, if needed

Depending on the size and complexity of the incident, a rapid reconnaissance of the entire MCI site is essential to establish the scope and scale of the incident. This may require a Recon Group consisting of multiple teams. The overriding factor should be speed as opposed to specificity to ensure that the information reaches the IC in a timely manner.

Recon should identify the following:

- Equipment needs
- Levels of PPE that will be required. (Note: Differing levels may be required in different areas.)
- Estimate the number and condition of patients involved so that the appropriate MCI response can be initiated through the IC
- Hazards
- Cause of the incident
- Any physical barriers preventing easy access between areas in the hazard zone. If so, identify areas for multiple treatment and transportation areas

Recon teams should consider using an elevated platform to help form an overall picture of the incident. This can include nearby buildings, aerial ladders, or geographical highpoints. Helicopters may also be considered for Recon. If MEDIVAC is being considered, Recon should evaluate any restrictions to landing zone locations. Additionally, consider the possibility of implementing temporary flight restrictions to news helicopters and other aircraft that may be operating over the emergency scene. Recon reports directly to Operations (example next page).



L. Progress Reports

Progress reports are required any time there is a change of the Incident Commander and every 10 minutes.

The progress reports should include the following:

- Current estimated total patient count
- Update transportation corridor location as needed
- Numbers of RED (Immediate), YELLOW (Delayed), GREEN (Minimal), and BLACK (Dead) patients when known
- Number of patients remaining to be removed
- Number of patients transported
- Progress of hazard mitigation
- Additional resources needed

M. Tactical Benchmarks

- All patients removed
- All RED (Immediate) and YELLOW (Delayed) patients transported
- All patients transported/clear of incident
- Any tactical benchmarks appropriate for hazard mitigation

N. Off-site Communications

Off-site communications is defined as radio, cell or data communications with contacts not at the emergency scene or command post. Off-Site Communications must be routed through the Incident Commander, except transportation (through the Transport Group Supervisor).

O. Scene Security

Scene security will be the responsibility of law enforcement, but Fire and EMS personnel must stay alert to potential security issues including but not limited to:

- Secondary Devices
- Crowd control
- Traffic control

The situation may cause the delay of certain operations while law enforcement clears the hazard area. Clear and consistent communication between Fire, EMS, and Law Enforcement is critical to maintain security.

1. Hazard Zones (Hazmat)

Initial units need to clearly establish appropriate operational zones for the incident. The zones must be clearly communicated to all on-scene responders, including law enforcement. The hazard zone locations should be broadcast over the all frequencies to inform all incoming units even if coordination with law enforcement is handled face to face. Fire scene tape should be used to clearly mark the exclusion zone (outer perimeter) of an incident when possible. Larger sites may need to be secured by law enforcement. See Hazardous Materials Appendix I for a list of the established zones

2. Crowd Control

Care must be given to crowd control, but total exclusion of bystanders may not be possible or practical as patients of the incident may have been separated from friends, or family members, and will experience even greater anxiety when dealing with the unknown.

If at all possible, reunification may help in this effort as needed or appropriate. If exclusion is impossible or impractical, attempts should be made to moderate the risk to both bystanders and rescue personnel with the help of law enforcement.

3. Bystanders

MCI incidents may draw bystanders with varying levels of skill and expertise. These bystanders can be helpful if utilized in a safe and

organized way, but if they are ignored, they can hinder efforts and increase the risk to both themselves and personnel.

It is recommended that bystanders may be assigned appropriate tasks according to their self-claimed knowledge, skills, and abilities as long as the risks associated with these tasks are minimized. It may be difficult or impossible to verify the claims of expertise by bystanders and care should be taken to place them in supervised roles. It is important to remove or replace bystanders as resources become available.

P. Staging

Two separate staging areas may be considered based on the size and complexity of the MCI. Level I staging area should be for personnel or equipment immediately available for use. A location providing a maximum of possible tactical options regarding access, direction of travel, water supply, etc., should be selected. At no time should units self-assign. Level I staging occurs in the initial operations of small events, and ends quickly as new resources are directed to the Level II Staging area with a larger capacity.

In large scale incidents, there may be a Level II Staging Area when warranted. **In the Level II Staging area, personnel are not to leave their vehicles**. The locations of various apparatus should be arranged to ensure ALS/BLS units can get out as needed.

Level II Staging should be considered for any declared MCI or other incidents in which Command desires to centralize resources, or simply to park apparatus in a central, designated location. Units which are already staged (Level I) or en-route to Level I Staging, will stay in Level I unless otherwise directed by Command. All other responding units will proceed to the Level II Staging Area. When activating Level II Staging, Command will give an approximate (named) location for the Staging Area and request a separate radio channel for the Staging area.

The Level II Staging Area should be some distance away from the Command Post and the emergency scene to reduce site congestion, but close enough for prompt response to the incident site. A Staging Manager should be appointed with a Level II incident.

Q. Transportation Corridor

The first arriving unit is responsible for defining and determining a transportation corridor. **The Corridor must be kept clear**. The corridor must be maintained until law enforcement takes over the security of the corridor. If the initial unit cannot commit a member, they will assign that task to another unit from the initial response.

The transportation corridor must be established early and clearly communicated by the first arriving unit during the initial size-up. The exact street, entry point, exit point, and direction of flow must all be determined and communicated. Law enforcement will clear and protect the designated corridor; all other apparatus should keep this location clear. Large incidents may require law enforcement to extend the protected corridor all the way to the hospitals.

The member controlling the corridor should anticipate requirements for treatment and decontamination areas, and a patient loading area adjacent to the designated corridor.

All apparatus operators must keep the transportation corridor clear.

R. Triage Area

It is understood that all patients should be triaged where found, with the exception of GREENs (Minimal). However, depending on the variables of the scene, triage may be accomplished by: a Triage Team, Removal Teams, or after safely leaving the area (this pertains to GREEN (Minimal) who are moved out of the area to be tagged separately or perhaps not at all if they self-release and are not be transported—local hospitals should be notified of possible influx of walk-ins).

Triage will be dynamic, but will be a collective and ongoing effort to constantly evaluate patients at every step in the MCI process. SALT triage standard will be used to evaluate patients.

S. Treatment Area

The patient treatment area will be established in conjunction with the transportation corridor. It should be adjacent to the transportation corridor to facilitate communication, tracking, and patient transfer. If the treatment area and transportation corridor are unable to be co-located, they should be located as close as possible with a clear path between the two.

The treatment area will be the responsibility of the Treatment Group Supervisor, typically, a senior ALS member appointed by the Medical Branch Director.

Removed patients will be delivered directly to the treatment area through the **CCP** (funnel) unless diverted to the transport corridor by the Treatment Group Supervisor.

Every effort should be made to only have one area for each treatment color. Large incidents may necessitate large treatment areas with separate areas and staff for RED (Immediate) and YELLOW (Delayed) patients. Multiple treatment

areas with corresponding transportation corridors may be needed. Treatment Group Supervisor needs to request enough staff to handle care for the expected number of patients that may be present.

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by the Treatment Group Supervisor in accordance with Lewis County EMS Protocols, Policies, Procedures, Guidelines and/or direction from DMCC / Medical Control.

1. Field Treatment Site

When circumstances dictate that EMS resources must continue to hold RED (Immediate) patients, the Medical Branch Director should consider establishing a Field Treatment Site (FTS). An FTS may be as simple as extended use of the treatment areas created at the incident or as complex as translocating patients to an Alternate Care Facility that has been opened to EMS. In some cases local agencies and jurisdictions will predetermine where EMS might naturally establish an FTS. Ad-hoc FTSs may be established wherever the IC can rally enough resources to effectively care for patients.

EMS may need to establish an FTS for any of the flowing reasons:

- Transport resources are inadequate
- Transport cannot keep pace with removal

T. GREEN Area

The Triage Team(s) at an MCI will direct those who can walk to a designated area of refuge, or GREEN Area. These patients will be initially classified as GREENs (Minimal). As soon as possible, a GREEN Area Manager should be designated.

Law enforcement is critical in establishing and maintaining the GREEN area. Law enforcement will likely want to interview and document GREENs (Minimal) for investigation purposes. Security in the GREEN Area may be necessary.

The GREEN Area Manager will liaison with law enforcement and is responsible for the following:

- Documentation. Triage and tag all patients (including GREENs [Minimal]). GREENs will be included in the overall patient count.
- Perform secondary triage as necessary. When necessary, upgrade patients to RED (Immediate) or YELLOW (Delayed) as needed and move those patients to the indicated treatment area(s).

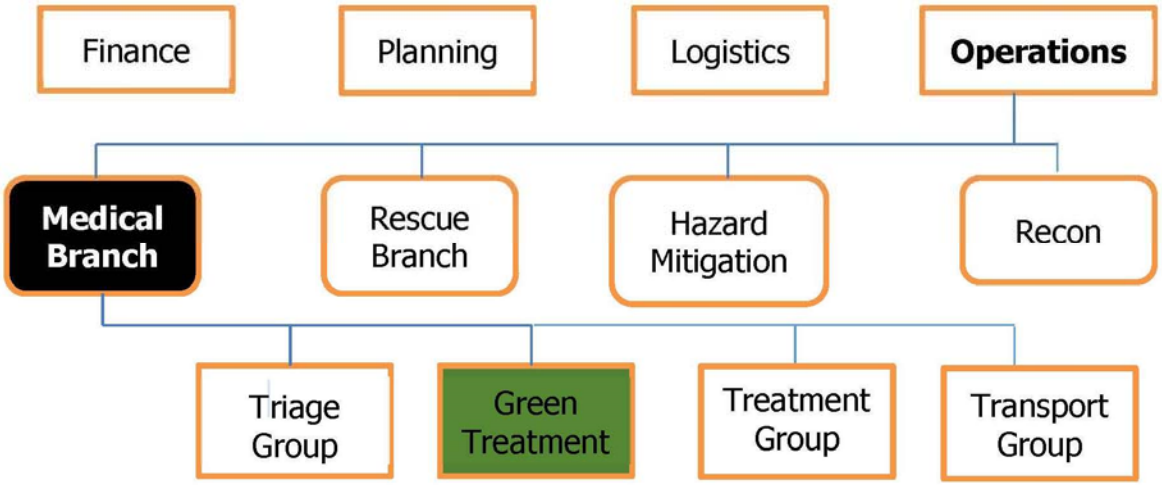
- Patient Tracking. Remove tags from GREENs (Minimal) as they are released from the scene. Deduct any GREEN (Minimal), "Injured, Non-Casualty" (INC) not needing transport to hospitals from the patient count. Verify remaining count with the Treatment Group Supervisor.

- Contain patients as needed (liaison with law enforcement for interviews)

- Provide basic medical care

- Provide information as it becomes available to the GREENs (Minimal)

- Victim Assistance and Family Reunification
  - Consider comfort needs such as restroom facilities, water, blanket, etc.
  - Consider the need for emotional support including the chaplains, family members, or outside counseling support. (Many of the GREENs (Minimal) may have been separated from friends, or family members, and will experience even greater anxiety when dealing with unknown factors.)
  - Coordinate transportation of the GREENs (Minimal) to the appropriate facility for treatment or family reunification center (Emergency responder should accompany GREENs (Minimal) during transport).



U. Communications

A single tactical radio channel may be adequate for a small MCI. Large or complex MCIs may quickly overwhelm a single radio channel, hampering critical communication. Therefore, maintain radio discipline as required. The Incident Commander should forecast incidents and with the assistance of the 911 Communications Center, may designate multiple radio channels for the incident. Possible radio channel assignments are:

- Command
- Fire
- Logistics
- Ground-Air Rescue (VTAC 11)
- Hazard Materials
- Medical
- Transportation
- Staging

Disaster Medical Control Center (Medical Control) to include:

- Establishing communications from scene to DMCC/Medical Control via cell phone
- Transportation

Radio communication may be further affected by many factors including:

- Areas of reduced radio signals
- Damage to radio/cell tower infrastructure
- System overload/outages

V. PATIENT DISPOSITION

A. Rescue

Patient removal from the hazard zone will be prioritized based on the patient's condition and difficulty of removal. In larger incidents, Rescue will supervise Removal as well as Extrication if needed.

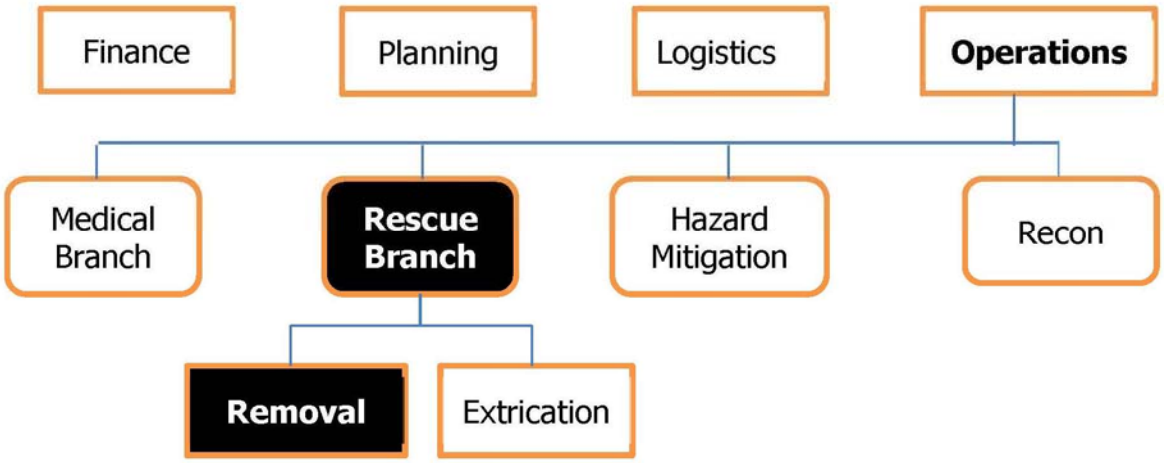
Large or complex incidents may require the hazard zone to be divided into geographical divisions. Supervisors should be alert to recon their assigned area.

Geographical recon includes:

- Number of patients in their area
- How many of those patients are RED (Immediate), YELLOW (Delayed), GREY (Expectant) and BLACK (Dead)
- Removal needs, including number of patients and complexity
- Hazards inside their area

1. **Removal**

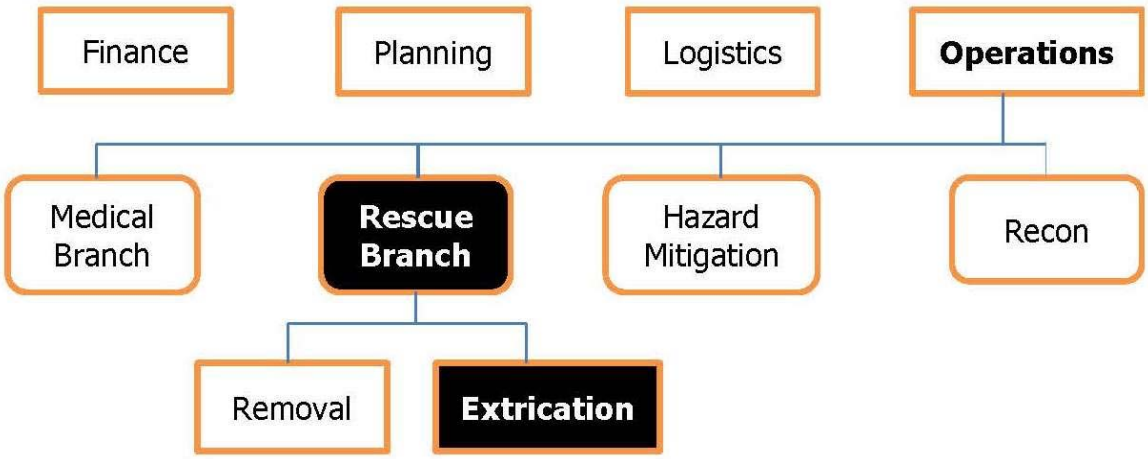
   Removal Teams will be composed of one or more pairs of personnel and will report to Medical or Rescue, depending on incident size, for the purpose of patient removal (harvesting) and delivery to the patient treatment area.



2. **Extrication**

   Disentanglement and technical rescue may be handled by extrication teams under direction of Rescue. When trapped patients are located, the extrication teams will be sent to assist with the technical removal of those patients. Extrication teams must prioritize their operations to remove as many viable patients as possible in the shortest amount of time.

   In smaller incidents it is appropriate for patient removal teams to be assigned to Medical versus their own group under Operations.



B. Decontamination

Any MCI, natural or intentional, may include the release of hazardous materials (hazmat). Rescuers will need to evaluate the potential need for a hazmat response and decontamination procedures. If a hazmat release is known or suspected, a hazmat response should be requested if not already dispatched. Primary tasks of the initial units include: wear the appropriate level of PPE, isolate the area and deny entry, consider a larger evacuation zone, and start emergency decontamination procedures.

Removal, treatment and/or transport of any patient cannot occur until the patient has gone through emergency decontamination.

It may be difficult to determine in the field if a patient is completely decontaminated, therefore patient contact should be limited to essential procedures in the field and during transport.

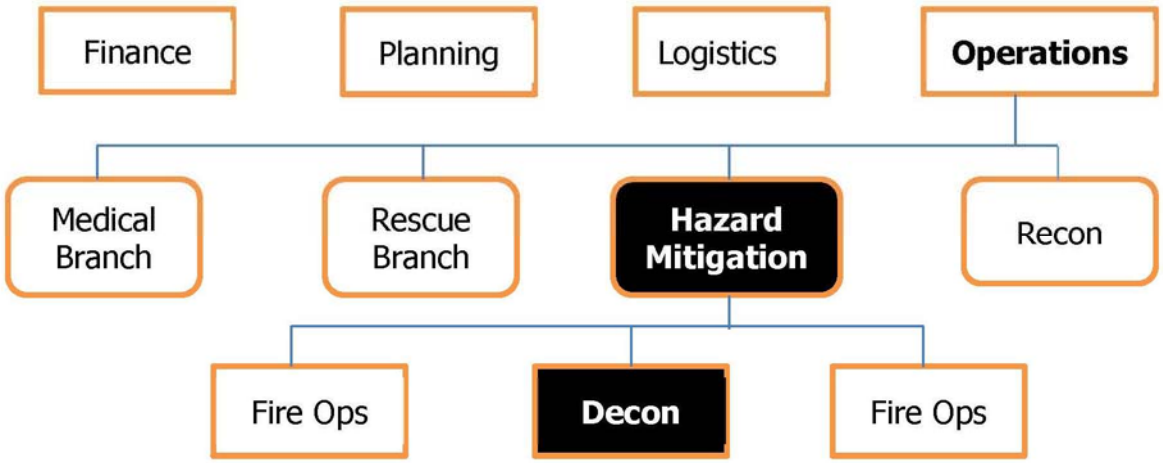
Tyvek suits should be used for patients after gross decon when their clothing has been discarded.

Decontamination procedures will occur in the warm zone.

If decontamination procedures are required, the IC must ensure that a large enough footprint has been established for both gross and technical Decon.

Patients in need of decontamination should have an ORANGE/POLKA DOT ribbon tied next to the initial triage ribbon and that tag and ribbon should not be removed. After Decon, mark the triage tag that decon has been completed, add a white ribbon to indicate Decon has been performed and move the patient to the treatment area.

Advise receiving hospitals that grossly decontaminated patients are being transported from the scene in time for them to initiate their own decontamination processes.



C. Patient Sheltering

Every attempt should be made to provide shelter for the patients in the patient treatment and GREEN areas. The shelter should provide protection from the hazards, weather, media, and the public.

Shelters of opportunity, or existing buildings, should be considered first. Priority will be given to structures with bathroom facilities, running water, and buildings with access that can be easily controlled. If no existing buildings are easily accessible or adjacent to the transportation corridor, then temporary shelters may be used.

Possible temporary shelters include:

- Tents from gross Decon Units
- Public / School transportation
- MCI Bus (if available)

When choosing a shelter, the possibility for an expanding incident needs to be considered, ensuring patients are not placed into an existing or future hazard zone.

D. Patient Care – Transport Coordination – Medical Control & DMCC

In general, personnel will treat RED (Immediate) patients first, YELLOW (Delayed) patients only as time allows, and GREY (Expectant) patients only after assuring that all patients from the RED (Immediate) and YELLOW (Delayed) categories are stabilized. Note: Deceased patients will not be moved, unless it is necessary to access a live patient. Depending on acuity and number of patients, it may be necessary to transport ALS patients in BLS units without the oversight of ALS personnel.

In a small incident, patient care protocols and transport may be managed by the local Medical Control. East County uses Morton General Hospital as their Medical Control and West County uses Providence Centralia Hospital. Once contact has been made with Medical Control the connection shall not be disconnected.

NOTE: Hospital personnel continue to refer to this as “Base Station” hospital.

In a large scale incident, notification of the local Medical Control is done first, then the region DMCC is notified. Providence St. Peter Hospital (page 53) shall serve as the primary DMCC for Lewis County. If less than 6 patients (Level I), consider not activating DMCC. Good Samaritan Hospital (page 54) shall serve as back up DMCC.

If neither primary nor back up DMCC is able to coordinate patient destination, Harborview Medical Center shall serve as the third option. Transport shall notify the receiving hospital of patient numbers and triage status prior to patient transport if possible. Individual transporting units will not routinely communicate to hospitals unless directed to do so. (Also See: Page 11 for DMCC Concepts of Operations.)

E. Patient Count and Tracking

Patient count and tracking are important aspects of an MCI, especially when the incident is large and complex. An attempt will be made to count and track every patient who is cared for at an incident. The level of tracking may have to be scaled to an individual incident. Factors such as environment, severity of injuries, hazards, number of patients, and available responders will dictate the level of tracking. At no time will these activities be priorities above patient care and transport.

Patient count and tracking will be the responsibility of Transportation in coordination with Treatment. An attempt will be made to attach a unique identifier to each individual patient. Transportation will attempt to keep track of the number of RED (Immediate), YELLOW (Delayed), and GREENs (Minimal) as they are transported.

Any first responder may be assigned to Transportation as an aide to assist in patient count and tracking.

F. Documentation

1. Medical Incident Report Forms (MIRFs)

Patient documentation is important; however, documentation should never delay patient care or transport. Individual MIRFs should be attempted at every incident, however, as an incident grows in size and complexity MIRFs may not be reasonable to complete. Incidents may have segments when MIRFs may be completed and other segments that circumstances prevent usage of MIRFs. At a minimum, a photograph of all command and control boards, MCI position sheets (Reference Guides, Job Aides) shall be taken and filed with the incident report or official record.

2. Unique Number with Transporting Agency

When a patient is received by a transporting unit, personnel will document the unique identifier that is attached to the patient onto their agency's MIRF. If a unique identifier has not been assigned to the patient, then the transporting

unit's personnel will do so. Every effort will be made to give a copy of the unique identifier to Transport.

G. Transportation

Transport will assign patients to transporting units as those resources arrive. Constant communication between Transport and Treatment is important to ensure that patients are ready to be transported. Constant communication between Transport and Staging is important to ensure transport units are available and move into position when needed. Transportation will communicate patient loads and receive transport unit destination assignments from the DMCC.

Larger incidents may require non-traditional assets. If non-traditional assets without emergency signal devices are used, consideration should be given to using law enforcement escorts to aid during travel. Containing bio-hazardous material in non-traditional assets may be difficult, but tarps, plastic, or other resources should be used to limit the spread of this material.

If a GREEN (Minimal) is not transported e.g. the patient has been reunified with friends or family, their name should be documented on the Transport Unit Patient Log.

VI. MEDICAL BRANCH - OVERVIEW

A. Medical Branch (Group)

One of the first arriving EMS members should assume the role of Medical Branch**,** until relieved by a more senior member. The role of Medical Branch, while initially filled by one of the first arriving EMS members, should be assumed by a senior EMS member, likely a Medical Services Officer (MSO), when possible. Intimate knowledge of the plan is necessary for the Medical Branch.

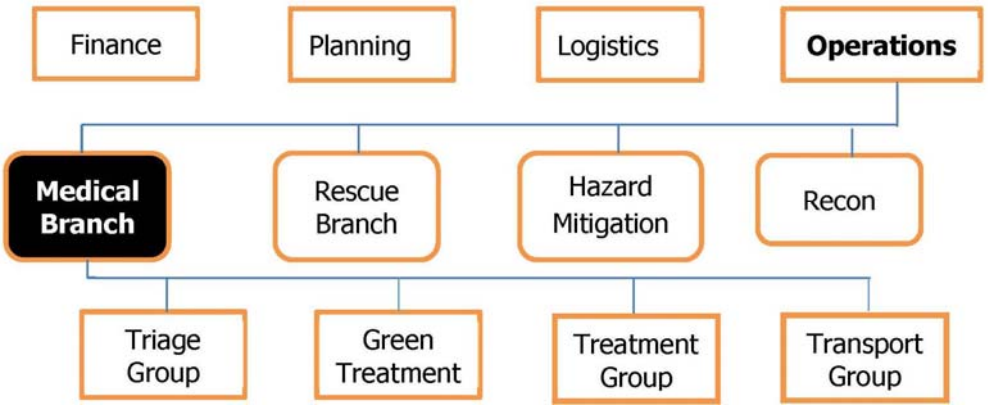
Medical Branch is responsible for the following tasks:

- Transportation
- Treatment
- Triage
- Extrication and patient removal in the absence of a Rescue Branch
- Consider activation of the DMCC (Medical Control)
- GREEN Area management

Medical Branch may handle most or all of the responsibilities in smaller incidents. Larger or complex incidents will require Medical Branch to be proactive in forecasting the incident and begin assigning roles as soon as possible. The use

of Aides or Assistants will be needed particularly in complex incidents. Circumstances may dictate a large number of ALS and BLS personnel where:

- ALS personnel need to be prioritized to treatment due to a high patient count;
- Patient removal from the hazard zone will require a large amount of BLS personnel and/or complex coordination.



1. Treatment

Medical Branch may designate ***a senior*** EMS member to be Treatment Group Supervisor. (Note: Smaller incidents may allow Medical Branch to retain this role). Treatment is responsible for the following:

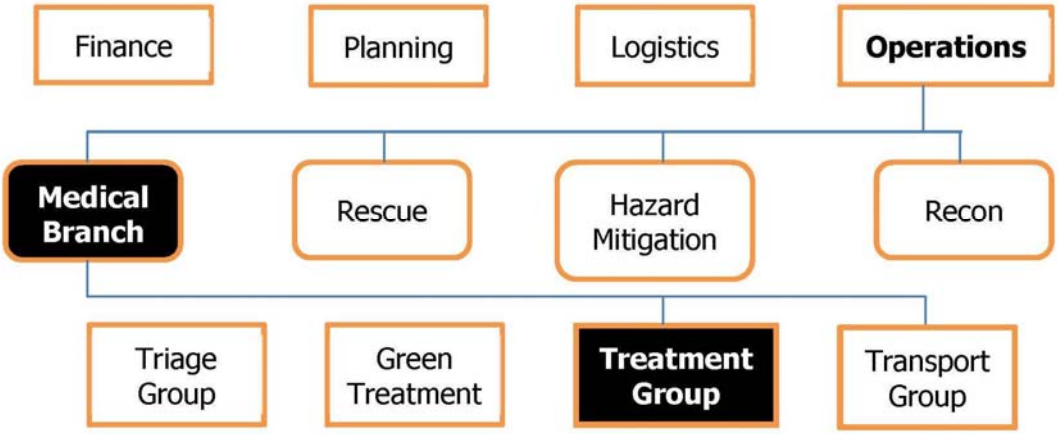
- Receiving patients from Removal
- Supervising treatment of patients
- Managing Treatment Personnel
- Coordinating with Transportation
- Prioritizing patients for transport

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by the Treatment Team Leader.

Treatment, with input from Transportation, may elect to have patients delivered directly to the transportation corridor for transport.

Treatment should request adequate personnel and resources to care for the expected number of patients.

The use of Aides or Assistants will be needed particularly in complex incidents.



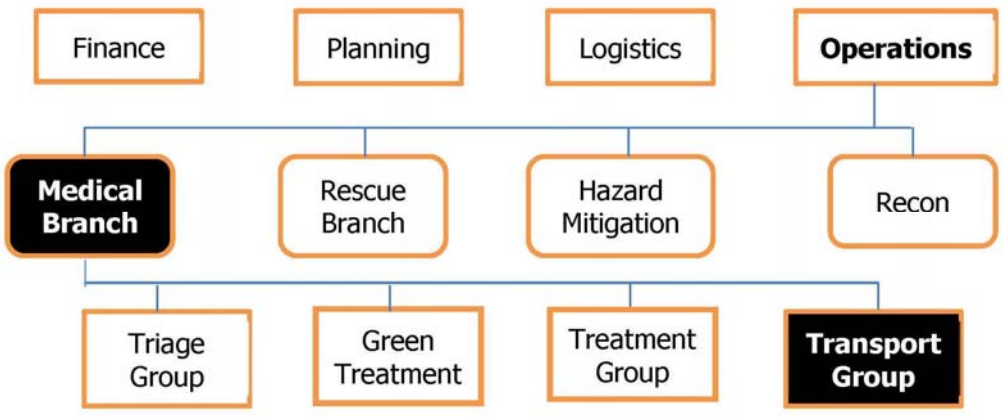
2. Transportation

Transportation should be designated early by Medical. Smaller incidents may allow Medical to retain this role. Transportation should be a senior EMS member capable of performing a wide range of duties including:

- Communication with DMCC (Medical Control)
- Keeping a total patient count of all transported patients (may be delegated to one or more Aides)
- Coordination with Treatment
- Coordination with law enforcement to clear the transportation corridor
- Liaison with transportation resources
- Liaison with Staging to maintain transportation resources
- Initiate tracking if unique identifier not already assigned

Incidents that require multiple transportation corridors must have multiple personnel assigned to Transport. They may act independently of each other. Transportation will contact the DMCC independently for patient destinations and be responsible for patient count and tracking.

The use of one or more Transportation Group Aides will be needed, particularly in complex incidents.



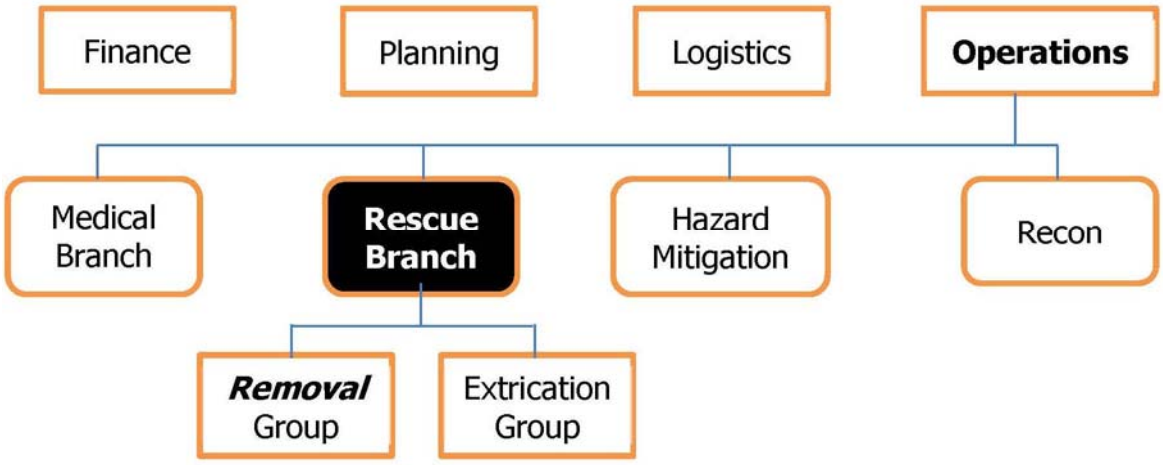
B. Rescue

Rescue should be considered when:

- ALS staffing needs to be prioritized to patient treatment and transport
- Any part of patient removal from the hazard zone will require a large amount of BLS resources

Rescue may be in charge of triage and removal of all patients from the hot zone into the patient treatment areas.

Technical Rescue Teams will report to Rescue to serve as technical advisors, and participate in extrication as needed.



INCIDENT COMMANDER FIELD CHECKLIST

First on-scene, unless passed: the most qualified responder/officer will assume Incident Command until relieved

Radio Frequency: ☐ **REDNET** ☐ **V-TAC (12-13)** ☐ **LERN** ☐ **Other** _____
V-TAC 11 Reserved for Air Opps

1. **Establish Command** Done ☐ _____

2. **Complete size-up, inform 911 Communications Center**: Done ☐ _____
   - ☐ a. Name Incident: _____ Location: _____
   - ☐ b. Describe the scene.
   - ☐ c. Estimate number of patients: _____
   - ☐ d. Determine and direct initial actions
   - ☐ e. Designate radio frequencies

Command:	Fire:	Transportation:	Rescue:
Logistics:	Medical:	Hazmat:	

   - ☐ f. Establish Personnel Accountability System
   - ☐ g. Determine Level 2 staging area location
   - ☐ h. Determine transportation corridor
   - ☐ i. Notify Emergency Management
   - ☐ j. Identify safety concerns
   - ☐ k. Consider additional resource needs

3. **Relay size-up information to E911 Communications**. Done ☐ _____

4. **Don "Incident Commander" vest, assign positions/checklists**: Done ☐ _____
   - ☐ a. Medical Branch Director
   - ☐ b. Triage Group Supervisor
   - ☐ c. Treatment Group Supervisor
   - ☐ d. Transport Group Supervisor
   - ☐ e. Staging Manager
   - ☐ f. Safety Officer

5. **Ensure Medical Control/DMCC are notified of situation**: Done ☐ _____
   - ☐ a. Type of incident
   - ☐ b. Estimated patient count
   - ☐ c. Special considerations (Hazardous Material)

6. **Determine MCI level from the Triage Group Supervisor tag count**: Done ☐ _____

   - ☐ **Level I**: Up to 6 patients
   - ☐ **Level II**: 7 to 12 patients
   - ☐ **Level III**: 13 or more patients

7. **Request 10-minute status updates from all officers** Done ☐ _____

8. **Consider other needs**: law enforcement, mass transportation, morgue, chaplains, rehabilitation, debriefings. Done ☐ _____

9. **Check patient and responder accountability**. Done ☐ _____

10. **Appoint Public Information Officer (PIO)** as media liaison. Done ☐ _____

11. **Coordinate officer demobilization actions**. Done ☐ _____

All duties remain the responsibility of the IC unless delegated to another!

Incident Commander Field Status Report

Patient Total: _____

Triage Breakdown:

RED (Immediate): _____ YELLOW (Delayed): _____ GREEN (Minimal): _____
GREY (Expectant): _____ BLACK (Dead): _____ HAZMAT: _____

Officers assigned/Areas established: Done ☐ _____

Medical Branch Director: _____ Transport Group Supervisor: _____

Triage Group Supervisor: _____ Staging Manager: _____

Treatment Group Supervisor: _____ Safety officer: _____

Morgue Established: ☐ Yes ☐ No Done ☐ _____

Total patients transported: _____

Reminder: Appoint an Aide before you are overwhelmed!

MEDICAL BRANCH DIRECTOR FIELD CHECKLIST

Radio Frequency: ☐ **REDNET** ☐ **V-TAC (12-13)** ☐ **LERN** ☐ **Other** _____
V-TAC 11 Reserved for Air Opps

Takes Direction from Incident commander and is responsible for directing all medical operations. Also responsible for accountability tracking of the medical group officers:

~Triage Group Supervisor ~ Treatment Group supervisor ~ Transport Group Supervisor ~ Staging Manager

If Medical Branch Director is not appointed, Incident Commander completes this.

1. If delegated by the Incident Commander, immediately conducts size-up including: Done ☐
   - ☐ Name the incident _____ ☐. Describe scene.
   - ☐ Estimate number of patients: _____ ☐ Determine/direct initial actions
   - ☐ Identify dispatch and operations frequencies ☐ Establish Command Post location
   - ☐ Establish staging area location. ☐ Establish Transportation Corridor
   - ☐ Identify safety concerns. ☐ Consider need for additional resources
2. Provide the size-up information to the Incident Commander Done ☐
3. **Don "**Medical Branch Director**" vest**. Done ☐
4. If designed by the Incident Commander, relay the following information to the Medical Control/DMCC Done ☐

☐Providence (360) 330-8515 ☐Morton General (360) 496-6866 ☐DMCC (360) 493-0202

   - ☐ a. Type of incident.
   - ☐ b. Estimated patient count.
   - ☐ c. Special considerations (Hazardous Material).

5. Ensure placement of Medical Supply Area(s), if needed: Done ☐ _____
6. If asked by the IC, appoint the following: Done ☐ _____
   - ☐ Triage Group Supervisor, Name: _____
   - ☐ Treatment Group Supervisor, Name: _____
   - ☐ Transport Group Supervisor, Name: _____
7. Obtain patient counts from Triage Group Supervisor/Green Area Manager Done ☐ _____
8. Relay patient count to Incident Commander. Done ☐ _____
9. Obtain additional resources needed, requesting them through the IC. Done ☐
10. Benchmarks: Done ☐
    - ☐ All Patients removed ☐ All RED (Immediate) patients transported
    - ☐ All patients transported/clear of incident ☐ Any hazard mitigation

SAFETY OFFICER FIELD CHECKLIST

Radio Frequency: ☐ **REDNET** ☐ **V-TAC (12-13)** ☐ **LERN** ☐ **Other** _____
V-TAC 11 Reserved for Air Opps

The Safety Officer takes directions from Incident Commander and is responsible for:

- Participating in planning meetings
- Identifies hazardous situation associated with the incident
- Reviews the Incident Action Plan for safety implications
- Exercises emergency authority to stop and prevent unsafe acts
- Investigates accidents that have occurred within the incident area.
- Assigns assistants as needed
- Reviews and approves the medical plan

☐ **Don "Safety Officer" vest. Receive briefing from IC**. _____

☐ **Obtain radio frequencies**: _____

Command:	Fire:	Transportation:	Rescue:
Logistics:	Medical:	Hazmat:	

☐ **Check Personnel Accountability System** _____

☐ **Yes**, a personnel accountability system is in place
☐ **No. Immediately recommend modifications to the IC**

☐ **Consider** the abandonment signal; if used, communicated to all teams _____

☐ **Complete a scene survey & report back to IC** _____
Check potential hazards including:
a. Utility status c. Collapse zones e. Hazardous materials
b. Traffic d. Citizens f. Other hazards

☐ **Yes**, team integrity (teams of two or more) is being maintained. _____

☐ **Yes**, proper PPE is in use. _____

☐ **Yes**, additional safety officers are needed. _____

☐ **Yes**, the Incident Action Plan needs to be revised. _____

☐ **Yes**, equipment is being used appropriately _____

☐ **Yes**, decontamination is being provided. _____

☐ **No**, decontamination is needed and hasn't been provided. _____

☐ **Yes**, a critical incident stress debriefing is needed. _____

Remember: Request Additional Safety Officers As Needed

STAGING MANAGER FIELD CHECKLIST

Radio Frequency: ☐ **REDNET** ☐ **V-TAC (12-13)** ☐ **LERN** ☐ **Other** _____
V-TAC 11 Reserved for Air Opps

The Staging Manager takes direction from the Medical Branch Director and is responsible for:

- Manages the Level II staging area in two sections, see Item # 2 below
- Groups apparatus/resources to accommodate easy facilitation to assignments
- Receives minimum resource numbers from the Medical Branch Director
- Directs transport units to loading area as requested by the Transport Group Supervisor
- Notifies the Medical Branch Director when transport vehicle numbers fall below the number set by the Medical Branch Director
- May communicate directly with the Transport Group Supervisor

1. **Don "Staging Manager" vest** and receive briefing from Medical Branch Director.
   Done ☐ _____
2. **Develop a two-part staging area**: Done ☐ _____

   ☐ Part One: **Consists of patient transport units**. (Stage one (1) block away)
   Transport Unit personnel will be advised to stay with their unit.

   ☐ Part Two: **Consists of single resources**. (Stage 3 to 5 minutes from scene)
   Extrication crews should stay together.

3. **Group apparatus/resources** to accommodate easy facilitation to assignments Done ☐ _____
4. **Direct transport units to transport area** as requested by the Transport Group Supervisor
   Done ☐ _____
5. **Notify the Medical Branch Director when transport vehicle numbers fall below set number** .
   Done ☐ _____

In-coming units report to a staging area so that resources are assembled in one place.

If possible, staging should be within eyesight of the transport zone.

STAGING MANAGER FIELD LOG SHEET

Reminder: Group apparatus/resources to accommodate easy facilitation to assignment.

List Responding Units: **Time:** _____	**Minimum Transport Vehicle #** **(Set by** Medical Branch Director**)**

STAGED APPARATUS:

Unit #	ALS/ILS/BLS Transport Capable Y/N	In Staging Area	Assigned To	Time

STAGED PERSONNEL:

UNIT #	CERTIFICATION LEVEL	ASSIGNED TO	TIME

TRANSPORT GROUP SUPERVISOR FIELD CHECKLIST

Radio Frequency: ☐ **REDNET** ☐ **V-TAC (12-13)** ☐ **LERN** ☐ **Other** _____
V-TAC 11 Reserved for Air Opps

Takes direction from the IC or Medical Branch Director and is responsible for:

- Reconcile patient count by removing INC (involved, non-casualty) number
- Obtain patient destinations from Medical Control/DMCC
- May communicate directly with the Staging Manager
- Receives patient injuries, needs information from Treatment Group supervisor and relays same to Medial Control/DMCC
- Supervise patient loading activities
- Maintain traffic flow routes
- Accountability tracking of transport group personnel

1. **Don "Transport Group Supervisor" vest, obtain briefing from Medical Branch Director** Done ☐ _____
2. **Develop patient loading zones**. Done ☐ _____
3. **Coordinate entrance/exit routes with Medical and Staging Managers** Done ☐ _____
4. **Contact Staging Manager to request transport units move into loading zone** Done ☐ _____
5. **Coordinate with law enforcement to maintain transportation corridor** Done ☐ _____

*6. **Work closely with Treatment Group Supervisor to provide Medical Control/DMCC with required patient counts, classifications of injuries, and patient routing information**. **(Removes INC from numbers and estimates of likely POV transports).** Done ☐ _____

7. **Direct loading of transport vehicles** Done ☐ _____
8. **Transport GREENs to Reunification Point** . Done ☐ _____
9. ☐ **Complete Transport Group Supervisor Log**. Done ☐ _____
   ☐ **Obtain destinations from Medical Control/DMCC**.
   ☐ **Relay destinations to waiting transport units**.
10. **Collect tag stubs**. Done ☐ _____
11. **Match tag stubs** Done ☐ _____
    ☐ **Match with Treatment Group Supervisor**
    ☐ **Report findings to Medical Branch Director**

*12**. Confirm number of patients and destinations with Medical Control/DMCC** Done ☐ _____

Communicates direct with Medical Control/DMCC
****If patients are diverted due to nature of their injuries,**
the Transport Group Supervisor must be notified.

TRANSPORT GROUP SUPERVISOR
LOG SHEET

The Transportation Group Supervisor will confer with the Treatment Group Supervisor to provide patient information to Medical Control/DMCC. Medical Control/DMCC will require:

- Reconcile patient count by removing INC (involved, non-casualty) number
- Patient counts
- Classifications of injury
- Routing information (destination recommendation from on-scene officer)
- Collect tag stubs and reconcile them with the Treatment Group Supervisor

DO NOT

- Overload ambulances
- Place too many serious patients in the same unit or direct too many patients to any single receiving facility
- Send local transport units on out-of-area transports. Direct these requests to out-of-area mutual aid units

TAG #	Triage Class	DESTINATION	Unit #	Time Out
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			

GREEN AREA MANAGER FIELD CHECKLIST

Radio Frequency: ☐ **REDNET** ☐ **V-TAC (12-13)** ☐ **LERN** ☐ **Other**
V-TAC 11 Reserved for Air Opps

The GREEN Area Manager takes direction from the Treatment Group Supervisor. The GREEN Area Manager is responsible for:

- Gathering all ambulatory or non-injured patients together and move away from the scene
- Tag GREENs (Minimal) use flagging tape.
- Perform an initial triage.
- Responsible for tracking non-injured who self-release (using Patient Release Form).
- Provides GREEN (Minimal) count (and any self-released) to the Treatment Group Supervisor.
- Performs periodic ongoing triage.
- Liaisons with Law Enforcement for interviews as necessary.
- Provides for GREEN group transportation to hospital or Reunification Center.
- If conditions deteriorate, re-tags patients and moves to YELLOW (Delayed) or RED (Immediate) Treatment Area.
- Considers comfort needs and provides available information to patients.

1. **Receives Treatment Group Supervisor briefing**. Done ☐ _____

2. **Gathers all GREENs/INCs** and moves away from initial scene to GREEN Area

Done ☐ _____

3. .**Documents Patients** Done ☐ _____

- ☐ Triage and tag patients (with flagging tape if triage tags are in short supply).
- ☐ Record patients' status on the GREEN Area Manager Log Sheet
- ☐ Liaison with Law Enforcement to arrange necessary interviews.
- ☐ Complete Patient Release Forms for those uninjured or refusing transport
- ☐ Coordinate transport to hospital or Family Reunification Center as appropriate.
- ☐ Provide patient counts/updates to Treatment Group Supervisor

4. **Periodically provide Secondary Triage**. Done ☐ _____

☐ If patient condition degrades, re-triage and escort to appropriate YELLOW or RED area

5. **Provide information updates** to GREENs as it becomes available. Done ☐ _____

GREEN AREA MANAGER FIELD LOG SHEET

The GREEN Area Manager takes direction from the Treatment Group Supervisor. The GREEN Area Manager is responsible to:

- Performs an initial triage and tags patients with flagger tape
- Documents all patients on a Log Sheet to account for INC (Involved, Non-Casualty) (for Law Enforcement interviews), group transportation to hospital or Reunification Center, and those who self-release
- Reconciles patient count by removing INC (Involved, non-casualty) number that are not injured or refuse transport (AMA) and forwarding number for transport to Treatment Group Supervisor.
- If patient conditions deteriorate, re-tag and move to YELLOW (Delayed) or RED (Immediate) Treatment Area and notify Treatment Group Supervisor of change in numbers.
- Arranges for transportation, and or comfort needs
- Provides available information to patients

	NAME / Tag #	Triage Class	DESTINATION	Law Interview	Self-Release AMA
1		Gn Red Y Hm			
2		Gn Red Y Hm			
3		Gn Red Y Hm			
4		Gn Red Y Hm			
5		Gn Red Y Hm			
6		Gn Red Y Hm			
7		Gn Red Y Hm			
8		Gn Red Y Hm			
9		Gn Red Y Hm			
10		Gn Red Y Hm			
11		Gn Red Y Hm			
12		Gn Red Y Hm			
13		Gn Red Y Hm			
14		Gn Red Y Hm			
15		Gn Red Y Hm			

TREATMENT GROUP SUPERVISOR FIELD CHECKLIST

Radio Frequency: ☐ **REDNET** ☐ **V-TAC (12-13)** ☒ **LERN** ☐ **Other** _____
V-TAC 11 Reserved for Air Opps

Takes direction from the Medical Branch Director **and is responsible for**:

- Supervises treatment areas: RED, YELLOW, GREEN
- Ensures patient care documented on the triage tags: vital signs, treatment done, time and patient name, if known
- Confers with Transport Group Supervisor regarding patient injuries, needs and destinations
- Responsible for tracking injured released at scene (not transported)
- Establishes Medical Supply, re-supply through Medical Branch Director
- Accountable for treatment group personnel
- Periodically conducts Secondary Triage

1. **Don "Treatment Group Supervisor" vest and receive** Medical Branch Director **briefing.**
   Done ☐ _____
2. **Develop treatment teams from available personnel** Done ☐ _____
3. **Develop treatment areas** (mark with flagger tape): Done ☐ _____

   ☐ **RED:** Immediate
   ☐ **YELLOW:** Delayed
   ☐ **GREEN:** Minimal
4. **Supervise patient care**: Done ☐ _____

   ☐ Chart patient vitals on triage tag
   ☐ Chart patient treatment in the RED and YELLOW (GREEN if not delegated) Areas
   ☐ **Periodically conduct Secondary Triage**
5. Confers with GREEN Manager regarding triaged patients upgraded to Treatment/Transport
   Done ☐ _____
6. Works with Transportation Group Supervisor to provide Medical Control/DMCC with the following information:
   Done ☐ _____

   ☐ Patient counts
   ☐ Classifications of injuries
   ☐ Patient routing information.
7. **Relay patient injuries to** Transport Group Supervisor for patient evacuations Done ☐ _____
8. **Maintain treatment area medical supply**. Works through Medical Branch Director for resupply.
   Done ☐ _____

NOTE: Periodically Conduct Secondary Triage ! !

Non-medical bystanders can be very useful in helping identify or track where patients are transported.
Limit treatment to: airway control, oxygen, severe bleeding control, and necessary fluid therapy.

TREATMENT GROUP SUPERVISOR FIELD LOG SHEET

Remember to conduct Secondary Triage regularly.

Non-medical bystanders can be very useful in helping identify or track where patients are transported.

Use triage tag to document the vital signs, treatment done, time, patient's name (if known).

TAG #	Triage Class	NAME	Chief Complaint	Released Y/N
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			
	Gn Red Bk Y Gy Hm			

Work closely with the Transport Group Supervisor to provide Medical Control/DMCC with required patient counts, classifications of injuries and patient routing information. Limited treatment to: airway control, oxygen, severe bleeding control, and necessary fluid therapy only.

TREATMENT GROUP SUPERVISOR – FIELD PATIENT RELEASE FORM

NOTE: Adults do not have to be released to another party.

Tag #	PATIENT NAME	Date of Birth M/D/Yr	TIME	IF MINOR, TO WHOM RELEASED (print: Name, Relationship	Signature of Receiving Party

TRIAGE GROUP SUPERVISOR FIELD CHECKLIST

Radio Frequency: ☐ **REDNET** ☐ **V-TAC (12-13)** ☐ **LERN** ☐ **Other** _____
V-TAC 11 Reserved for Air Opps

Takes direction from the Medical Branch Director.
The Triage Group Supervisor **is responsible for:**

- Development of triage tagging teams
- Development of patient removal teams
- Establishing triage Casualty Collection Point (CCP) [Funnel]
- Triaging patients
- Matching torn triage tag stubs with Transport Group Supervisor
- Accountability tracking of triage group personnel

1. **Don "Triage Group Supervisor" vest.** Done ☐ _____

2. **Assign triage tagging teams.** Place ribbons on uninjured arm of patients Done ☐ _____
   Tear piece and put in pocket for count and later matching.

3. If necessary, **assign a GREEN Manager and designate a GREEN location.** Done ☐

4. **Reassign taggers** and additional **crews to patient removal teams to move RED (Immediate) and YELLOW (Delayed)** patients to the CCP (Funnel) for secondary triage. Done ☐

5. **Establish the triage CCP (Funnel)**. Mark with flagging tape. Done ☐ _____

6. **Triage the patients** at the CCP (Funnel). Apply triage tag mark the correct color.
   Keep a tag stub for accountability. Done ☐ _____

7. **Direct patient removal teams to/through CCP and into treatment areas**. Done ☐ _____

8. **After tagging is complete, count the number of stubs and/or flagging pieces.**
   This is the total patient count. Done ☐ _____

9. **Report <u>total patient count</u>** to: Done ☐ _____

   a. Medical Branch Director, or Done ☐
   b. If no Medical Branch Director, to Incident Commander Done ☐

10. **<u>Match torn triage tag stubs</u> with Transport Group Supervisor**. Done ☐ _____

COMMUNICATIONS FIELD CHECKLIST

Keep radio communications to a **minimum** on dispatch and operations frequencies.

- If no Incident Commander is at the scene, the most qualified responder/officer will assume Incident Command until relieved and immediately accomplish the Incident Commander Help Sheet.

- Initial **dispatch and incident command communications** will be conducted on:

  - Fire-1: Chehalis/West, South and Central County areas…….. 154.190 rx / csq 154.190 tx / pl 123.0
  - Fire-2: Riverside Fire Authority/Cent…… 154.9725 rx / pl 123.0 159.0725 tx / pl 123.0
  - Fire-3: Randle area……..… 156.105 rx / csq 155.805 tx / pl 131.8
  - Fire-4: Packwood area…….. 156.105 rx / csq 155.805 tx / pl 88.5
  - Fire-5: Mineral area…… 154.190 rx / csq 159.315 tx / pl 118.8

- Dispatch will advise of staging area location. Respond directly to the Staging Area and check in with the Staging Manager, unless directed to go to the scene. ***Do not abandon your unit unless approved by command***.

- The Incident Commander will assign the event an operations frequency, either:
  ☐ (REDNET) 153.830 ☐ VTAC 12 154.4525 ☐ VTAC 13 158.7375 ☐ VTAC 14 159.4725
  - (VTAC 11 reserved for Air Ops)
- Dispatch will advise to switch to the operations frequency upon arrival at the scene or staging area.

- **Radio instructions given on scene should be repeated back to assure accurate message.**

- Medical Control/DMCC communications will be on:

  ☐ Cellular Phone or ☐ HEAR 155.340

Law Enforcement	Dispatch	(360) 740-1105	**24 Hr-Numbers**
	Lewis County Sheriff's Office	(360) 748-9286 or (360) 740-1266	(360) 740-1105
DEM	Division of Emergency Mgmt	(360) 740-1151	(360) 740-1105
Hospitals	Providence - Centralia ER	(360) 330-8515 / 8516	
	St. Peter - Olympia ER	(360) 493-0202	
	St. Johns/Peace Health - Longview ER	(360) 423-1530	
	Morton General ER	(360) 496-6866	
Clinics	Steck - Chehalis	(360) 748-0211	
	Woodland - Centralia	(360) 736-9822	
	Woodland - Chehalis	(360) 748-9822	
	Pe Ell Clinic - Pe Ell	(360) 291-3232	
	Napavine Medical Clinic	(360) 262-3990	
	Randle Clinic - Randle	(360) 497-3333	
	Shoestring Valley - Onalaska	(360) 978-6888	
	Valley View Hlth Ctr - Chehalis	(360) 330-9595	
	Valley View Hlth Ctr - Centralia	(360) 669-0335	
	Valley View Hlth Ctr - Morton	(360) 496-5101	
	Valley View Hlth Ctr - Onalaska	(360) 978-6600	
	Valley View Hlth Ctr - PeEll	(360) 291-3232	
	Valley View Hlth Ctr - Toledo	(360) 864-4400	
	Valley View Hlth Ctr - Winlock	(360) 785-9400	

Dispatch will only record en route time and available time. The Responder shall record all other times.

TRIAGE & TAGGING PROCESS HELP SHEET

TRIAGE PERSONNEL - Reports to the Triage Group Supervisor.

Triages patients and assigns them to appropriate treatment areas.

1. Obtain situation briefing from Triage Group Supervisor / check into personnel accountability system.
2. Don position identification vest (if available).
3. Report to designated on-scene triage location, generally at the CCP.
4. Secure adequate supplies of triage tags and flaggers tape.
5. Assess situation for safety concerns.
6. Triage and tag injured patients. Classify patients using SALT while noting injuries and vital signs if taken.
7. Direct movement of patients to proper Treatment Areas.
8. Provide appropriate medical treatment to patients prior to movement as incident conditions dictate.

PATIENT MOVEMENT / TRANSPORT PERSONNEL. - Reports to Triage Group Supervisor

1. Obtain situation briefing from Triage Group Supervisor / check into personnel accountability system.
2. GREENs (minimal) should be moved to the care of the GREEN Area as soon as possible.
3. Individual responders may be assigned to remove ambulatory patients from the scene.
4. Assemble teams of two or three personnel for non-ambulatory patient removal.
5. Locate the backboard and patient mover supply cache and pickup needed materials.
6. Locate “Casualty Collection Point (CCP)”” and try to locate and remove RED (Immediate) patients first, followed by Yellow (Delayed) patients by passing through the CCP.
7. When all RED (Immediate) / YELLOW (Delayed) patients have been removed, check with the Triage Group Supervisor to confirm next assignment that may involve GREY (Expectant) or DECON patients.

OFFICER RESPONSIBILITIES REFERENCE

Incident Commander	• Establish Command; Conducts Size-up, or delegates to Medical Branch Director • Provides Size-up information to 911 Communications • Appoints ICS officer positions. Assumes responsibilities for all duties for positions not filled • Notifies Medical Control/DMCC of MCI situation; Determines level of MCI incident • Notifies Lewis County Emergency Management as needed • Serves as or appoints PIO as media liaison • Requests status updates from officers every 10 minutes, adjusts response as necessary • Considers other needs: transportation, chaplains, rehabilitation, morgue, debrief, demobilization, EOC • Coordinates officer demobilization actions • Responsible for patient and responder accountability
Medical Branch Director	• Takes direction from Incident Commander; if delegated, provides Size-up information to IC • If asked by IC, appoints Triage, Treatment, and Transportation Group Supervisors • If needed, ensures placement of Medical Command Post and Medical Supply Area(s) • If delegated, obtains initial triage patient count from Triage Group Supervisor; relates count to IC/Medical Control/DMCC • Determines need for additional resources and requests from IC
Triage Group Supervisor	• Takes direction from Medical Branch Director • Assigns GREEN Area Manager and designates a GREEN location, if necessary • Develops triage tagging teams; Develops patient removal teams • Establishes Casualty Collection Point (CCP); Triages patients at the CCP • Reports total patient count to IC and/or Medical Branch Director • Match torn triage tag stubs with Transport Group Supervisor • Accountability tracking of triage group personnel
Treatment Group Supervisor	• Takes direction from Medical Branch Director; Develops treatment teams; Supervises treatment areas • Confers with GREEN Manager regarding triaged patients upgraded to Treatment/Transport • Ensures patient care is documented on triage tags; Periodically conducts Secondary Triage • Coordinates with the Transport Group Supervisor for patient counts and loading. • Responsible for tracking injured released at scene (not transported) • Establishes Medical Supply • Match tag stubs with Transport Group Supervisor; report findings to Medical Branch Director • Accountability tracking of personnel assigned to treatment group
GREEN / INC Area Manager	• Takes direction from the Treatment Group Supervisor. • Gathers all ambulatory patients and moves them to GREEN area. • Triage, tag, and record patients on Log sheet; Liaison with Law Enforcement for interviews. • Completes Release Forms for INCs or any refusing transport, updating patient count to Treatment Group Supervisor. • Coordinates, comfort needs, patient info, group transport to hospital or Family Reunifications Center.
Transport Group Supervisor	• Takes direction from IC or Medical Branch Director • Communicates directly to Medical Control/DMCC; may communicate directly to Staging Manager • Receives patient injury information from Treatment Group Supervisor • Obtains patient destinations from Medical Control/DMCC • Supervise patient loading activities, maintains traffic flow routes • Accountability tracking of transport personnel, matches tag stubs w/Treatment Group Supervisor.
Staging Manager	• Takes direction from the Medical Branch Director; Manages the two-part staging area • May communicate directly with the Transport Group Supervisor • Groups apparatus/resources to accommodate easy facilitation to assignments • Notifies Medical Branch Director when transport vehicle numbers fall below number set by the Medical Branch Director • Directs transport units to loading area as requested by the Transport Group Supervisor
Medical Control/DMCC	• Coordinate patient destinations based upon patient condition and hospital availability • Assist EMS with patient care protocols
Safety Officer	• Takes direction from the Incident Commander and participates in planning meetings • Identifies hazardous situation associated with the incident • Reviews the Incident Action Plan for safety implications • Exercises emergency authority to stop and prevent unsafe acts • Investigates accidents that have occurred within the incident area. • Assigns assistants as needed • Review and approves the medical plan

*CLIPBOARD DISTRIBUTION CHART

***All checklists remain the responsibility of the Incident Commander for any Officer positions not appointed.**

1. **Incident Commander** (8 sheets)

   Incident Commander Field Checklist
   Incident Commander Status Report
   Triage System Procedures
   Communications Field Checklist (2)
   Officer Responsibilities Reference (2)
   Hospital Contacts and Directions (2 pages back-to-back)

2. **Medical Branch Director (**2 sheets)

   Medical Branch Director Field Checklist
   Triage System Procedures

3. **Safety Officer** (2 sheets)

   Safety Officer Field Checklist (2)

4. **Staging Manager** (3 sheets)

   Staging Manager Field Checklist
   Staging Manager Field Log Sheet (2)

5. **Transport Group Supervisor (**5 sheets)

   Transport Group Supervisor Field Checklist
   Transport Group Supervisor Field Log (3)
   Hospital Contacts and Directions (2 pages back-to-back)

6. **Treatment Group Supervisor** (6 sheets)

   Treatment Group Supervisor Field Checklist
   Treatment Group Supervisor Field Log Sheet (3)
   Patient Release Form (2)

7. **Triage Group Supervisor** (2 sheets)

   Triage Group Supervisor Field Checklist
   Triage System Procedures

8. **GREEN Area Manager** (2 sheets)

   GREEN Area Manager Field Checklist
   GREEN Area Manager Log Sheet (4)

RECOMMENDED CONTENTS FOR MASS CASUALTY INCIDENT (MCI) BAGS

Any unit that has the potential to be dispatched to an MCI should consider having a MCI bag onboard. There are two recommended MCI bags, Command MCI Bag and First Responder MCI Bag.

Command MCI Bag

Each agency should have enough Command MCI Bags on hand to ensure at least one is available at the scene. Recommended items include:

- **Checklists**: MCI procedures/tasks and job descriptions.
- **Tags**: No less than three packages of 10.
- **Flagging Tape**:
  1 Roll GREEN
  1 Roll YELLOW
  1 Roll RED
  1 Roll GREY
  1 Roll BLACK (zebra stripe)
  1 Roll ORANGE with polka dots
  1 Roll WHITE
  1 Roll Fire Line-Do Not Cross
- **Vests Set (7)**:
  Incident Commander, Medical Branch Director, Staging, Triage, Treatment, Transport, and Safety
- **Clipboards**: 1 for each position and patient logs
- **Writing Utensils**: Pens, pencils, all-weather markers (such as grease pencil)
- **Face Masks**: (6) Barrier protection for any artificial respirations
- **Protective gloves**: 3 sets each S M L XL
- **Eye Protection**: At least six

First Responder MCI Bag

The First Responder MCI Bag should be available on every apparatus. Recommended items include:

- **Belt holding the following Flagging Tape**:
  1 Roll GREEN
  1 Roll YELLOW
  1 Roll RED
  1 Roll Grey
  1 Roll BLACK (zebra stripe)
  1 Roll ORANGE with polka dots

Attachment A:

MCI RUN CARDS

Lewis County Run Cards for MCI –

Suggested MCI resource needs to be considered by individual agencies to establish Communications Center Run Cards:

Lewis County MCI Run Card MCI Resources Staffing Guidelines				
***MCI Level**	**# Patients**	**Responders Needed**	**Chiefs Needed**	**Comments**
Level I	**Up to 6**	**13**	**1**	**3 – 2** Person Engine Co. **2 – 2** Person Medic Units **3 – 2** Person *Aid Units *Aid Units staffed with 1 Driver and FF EMT
Level II	**7-12**	**26**	**2**	**6 – 2** Person Engine Co. **4 – 2** Person Medic Units, **6 – 2** Person *Aid Units *Aid Units staffed with 1 Driver and FF EMT
Level III	**13 or More**	**30**	**3**	**9 – 2** Person Engine Co. **6 – 2** Person Medic Units, **All available** *Aid Units *Aid Units staffed with 1 Driver and FF EMT
Note:* *Staffing of the Aid Units would be by 1 Driver and 1 EMT pulled from the Engine Personnel for Transport.				
***Level I – Consider notifying AMR-Seattle Level II – Notify AMR – Seattle**				
For all MCI activations, the Lewis County Communications Center shall notify the Lewis County Fire Mobilization Coordinators (by Spillman Page).				

Attachment B:

Options for Consideration in Agency Run Cards

1. Notifications

Notified By	To Be Notified
Lewis County Communications Center	Medic/AID Units, Responders
Medical Branch, From the Scene	Disaster Medical Control Center (DMCC) (Medical Control): Providence St. Peter Hospital Good Samaritan is the backup
Responding Agency	Private Ambulance & BLS Transport Providers
Incident Commander Delegated	PIO
IC & Response Plan/Countywide Paging (Spillman)	Chief Officer Notification
Local, Regional, State Fire Coordinators	Predetermined Out of Area ALS Strike Team, EMS Task Force, Engine Strike Team, Structural Task Force
IC & Response Plan	Intercity Transport and School District Buses
IC & Response Plan	MCI Units, Trailers etc.
Lewis County Communications Center	Thurston County SORT
Lewis County Communications Center notification of WSP	HazMat
Lewis County Communications Center	Lewis County Coroner's Office
Lewis County Communications Center	Lewis County Emergency Management
Lewis County Communications Center	Lewis County Public Health
Lewis County Communications Center	Area Law Enforcement

2. Additional Resources Notifications

Consider the following if MCI is larger than MCI – III. The request for the resources below would be attained through ***the Lewis County Communications Center.***

Jurisdiction	Resource	Requesting Party
Regional Resources	Out of County Structural Task Forces	Regional Coordinator
	Out of County Engine Strike Teams	Regional Coordinator
	Out of County EMS Task Forces	Regional Coordinator
	Out of County ALS Strike Teams	Regional Coordinator
	Thurston County SORT Team	Regional Coordinator
State Resources	HazMat Team & Decon for up to 300 (JBLM F&ES)	State Coordinator
	Mass Casualty Unit (JBLM)	State Coordinator

Attachment C:

Area Hospital Contacts and Directions

Hospital	Address	City	Phone	Directions
Local				
Providence Centralia Hospital	1820 Cooks Hill Rd.	Centralia	360-330-8515	**Heading North on I-5**: **Take exit 81**. Follow (H) signs. **Turn Left** onto Mellen Street. **Keep Right .4 mi.** on Cooks Hill Rd. **turn Left** on Scheuber Rd. Go .02 mi to West parking lot Emergency Department on left. **Heading South on I-5**: **Take Exit 82** Harrison Ave. **Go straight** cross Harrison Ave. Follow frontage road signage (H) to Cooks Hill Rd. **Turn Right at Mellen Street**. Follow (H) signs over bridge. **Keep right on Cooks Hill rd .04 mi. Turn Left** on Scheuber Rd. **Go .02 mi** to West parking lot. Emergency Dept. will be on the left.
Morton General Hospital	521 Adams	Morton	360-496-6866	Take Exit 68 off I-5 Take Hwy 12 East to Morton Left on 7th Right on Adams St.
North				
St. Peters Hospital	413 N Lilly	Olympia	360-493-0202	Take I-5 N to exit 107 Turn Right on Pacific. Turn Left on Lilly, Left on Ensign, to Hospital
Capital Medical Center	3900 Capital Mall Dr.	Olympia	360-956-2590	Take I-5 to exit 104 Follow Hwy 101 to Black Lake Blvd Exit Right on Black Lk Blvd Left on Cooper Pt Rd. Left on Capital Mall Blvd to Hospital
Summit Pacific Medical Center	600 E. Main St.	Elma	360-495-3244	I-5 to exit 88. Left on Hwy 12 into Elma Left to stay on Main St. to Hospital**.**
Madigan Army Medical Center	9040A Jackson Ave JBLM, WA 98431	JBLM	253-968-1396	**Call ahead and give rig # so guard shack lets you in**. Take I-5 N to Jackson Ave, Turn Right, Right on Gardner Loop Rd.
St. Clare Hospital	11315 Bridgeport Wy	Lakewood	253-588-2255	Take I-5 to Exit 125 Turn North on Bridgeport to Hospital
St. Joseph's Hospital	1718 S "I" St	Tacoma	253-426-6769	Take I-5 to Exit 132 (Hwy 16) Take Sprague Exit North on Sprague Turn Right on 19th Avenue Left on "J" Street
Tacoma General Hospital	315 S "K" St	Tacoma	253-627-8500	Take I-5 to Exit 132 (Hwy 16) Take Sprague Exit (north) Angle to Right to Division Street Turn Right on "J" Street to Hospital

Area Hospital Contacts and Directions - (Continued)

Hospital	Address	City	Phone	Directions
North (Continued)				
Allenmore	S. 19th & Union	Tacoma	253-596-5114	Take I-5 to Exit 132 (Hwy 16) Take Sprague Exit N on Sprague Turn Left on 19th Avenue to Hospital
St. Anthony's Hospital	11567 Canterwood Blvd.	Gig Harbor	253-530-2000	I-5 North. Take exit 132 for Hwy 16 towards Bremerton/Gig Harbor. Take exit for Burnham Dr NW. Stay in left lane as you enter roundabout. Take 3rd exit onto Canterwood Blvd. Pass 1st hospital entrance, turn right at the 2nd hospital entrance.
Good Samaritan Hospital	407 14th SE	Puyallup	253-848-0465	Take I-5 to Exit 127 Go East on Hwy 512 to S. Meridian Turn Right onto Meridian Turn Left on 14th Ave SE
Mary Bridge Children's Hospital	311 S "K"	Tacoma	253-403-1476	Take I-5 to Exit 132 (Hwy 16) Take Sprague Exit, (North) Angle to Right to Division Street Turn Right on "J" Street to Hospital
St. Francis Hospital	34515 9th Ave S.	Federal Way	253-835-8100	I-5 North. Take exit 142B for S. 348th St toward WA-99. Merge onto WA-18. WA-18 becomes S. 348th St. Turn right onto 9th Ave. Turn left at the last hospital entrance.
Auburn Regional Medical Center	20 2nd NE	Auburn	253-735-7561	I-5 to Exit 142B (Hwy 18) East on Hwy 18 to Auburn Wy Go North on Auburn Wy Left on Main Right on Auburn Ave. Go Left on 2nd.
Harborview Medical Center	325 9th Ave	Seattle	206-731-3074	Take I-5 to Exit 164A Take the James St Exit Turn Right on James Street Right on 9th Street to Hospital
South				
St. John's Longview	1614 E Kessler Blvd	Longview	360-636-4818	Take I-5 to Exit 36 West on Hwy 432 Right on 15th then Left on Kessler.
Salmon Creek Medical Center	211 NE 139th St.	Vancouver	360-487-1400	Take I-5 to Exit 7. Merge onto I-205 S. Take NE 134th St exit. Keep left toward WSU. Left on 134th St. Left on 20th. Right on 139th to the hospital.
Southwest Washington Medical Center	400 NE Mother Joseph Place	Vancouver	360-514-2000	Take I-5 to Exit 7 Take I-205 to Exit 28 Right onto Mill Plain Right on Mother Joseph Place

Attachment D:

SALT TRIAGE SYSTEM OVERVIEW (MCI)

Taken from the Model Uniform Core Criteria for MCI Triage
Federal Interagency Committee (FICEMS) on EMS

The **SALT** (Sort, Assess, Life-Saving Intervention, Treatment/Transport) triage system was developed by the Centers for Disease Control and Prevention (CDC) to address limitations in START and other triage systems. It has been endorsed by numerous national EMS groups. It is designed to reduce triage time and has an additional triage category to better utilize resources, and CDC has proposed SALT as the national standard for MCI triage.

Use **SALT** triage to assess any significant number of victims rapidly. It can be used easily and effectively by all EMS personnel.

INITIAL AND SECONDARY TRIAGE PRIOR TO TRANSPORT

Initial Triage

- Use triage ribbons (color-coded strips), not triage tags, during initial triage. One should be tied to an upper extremity in a VISIBLE location (on the right wrist, if possible).

    - **RED** – Immediate
    - **YELLOW** – Delayed
    - **GREEN** – Minimal
    - **GREY** – Expectant
    - **BLACK** – Dead (both ribbons and triage tags use a black & white zebra stripe rather than black for easier visibility in low light).
    - **ORANGE and polka dot ribbon** - used in addition to one of the above ribbons to indicate victim has been contaminated with a hazardous material. The dots are to make the Orange easier to distinguish from Red.

- Move as quickly and safely as possible, making quick decisions. Remember that the victim may be re-triaged, probably multiple times, and the category will be revised, up or down, whenever needed.

- Over-triage can be as harmful as under-triage. If everyone is tagged red, those who are truly red will receive delayed treatment, delayed transport, and delayed definitive care.

    - **NOTE**: Expectant does NOT mean dead.

        - It means the patient is unlikely to survive given the current resources.

        - Treatment and transport should be delayed until more resources, field or hospital, are available. If there are delays in the field, consider

requesting orders for palliative care, e.g., pain medications if time and resources allow.

Secondary Triage

- Secondary Triage **must** be performed on all victims prior to transport.
- Treatment Area may also be the Casualty Collection Point (CCP), or the CCP may be separate.
    - Patients should be reassessed periodically, including when moved to a CCP, or when their condition or resources change.
- Utilize Triage Tags and complete pertinent and available information on the tag.
    - Affix the tag to the victim using **the triage ribbon**. This is not done at the initial triage site, but after patients enter the Treatment Area or by the Transport Group if patient is being directly moved without going to Treatment Area.
    - Tags are applied after patients enter the Treatment Area or CCP, or by Transport Group if the patient is being directly removed without going to the Treatment Area.
- Orange Ribbons (indicating contaminated patients) are **not** removed during Decon.
    - 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 triage category (Red, Yellow, Green, Gray, or Black (zebra), and the other an Orange polka-dot ribbon.
    - Move ribbons to Decon under them.
    - After patients are Deconned, add a white ribbon to the patient and be sure to note “Decon” on the Triage Tag Intervention and note the time. (That way the hospital know the patient has had field Decon, but may still be somewhat “dirty”.)
    - **Notify hospitals of an MCI involving victim contamination**
- Priority for transport is determined in the Treatment Area or by the Transport Group.
- Patient allocation, that is, distribution of patients among various hospitals, is one of EMS’ most crucial tasks.

SORT, ASSESS, LIFE-SAVING INTERVENTION, TREATMENT/TRANSPORT PROCESS

S – Sort

- **Global Sorting: Action 1**
    - Action: "Everyone who can hear me please move to [designated area] and we will help you" (use loudspeaker 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, a bystander) and notify Incident Command or Medical Branch Director of number of patients and their location. **Do not forget these victims**. Someone must re-triage them as soon as possible.
    - In smaller incidents, such as a motor vehicle crash with a few victims where you do not want any of them to move on their own, skip Action 1, and go to Global Sorting Action 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
- **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
- Begin assessing all non-ambulatory victims 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.
- Each victim must be triaged as quickly as possible.

Assess:

- **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.

- **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 (Immediate)**.
    - If the answer to **any** of those questions is no and the patient is **Not** likely to survive given current resources, tag them as **GREY (Expectant)**.
    - If the answer to **all** of those questions is yes but injuries are not minimal 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 (Minimal)**.

- **Two mnemonics for the four Assess Questions:**
  - **CRAP**:
    - **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., cannot follow commands, absent peripheral pulse, respiratory distress, or uncontrolled hemorrhage are all "bad"), then the patient is tagged either RED or GREY.

Life Saving Interventions:

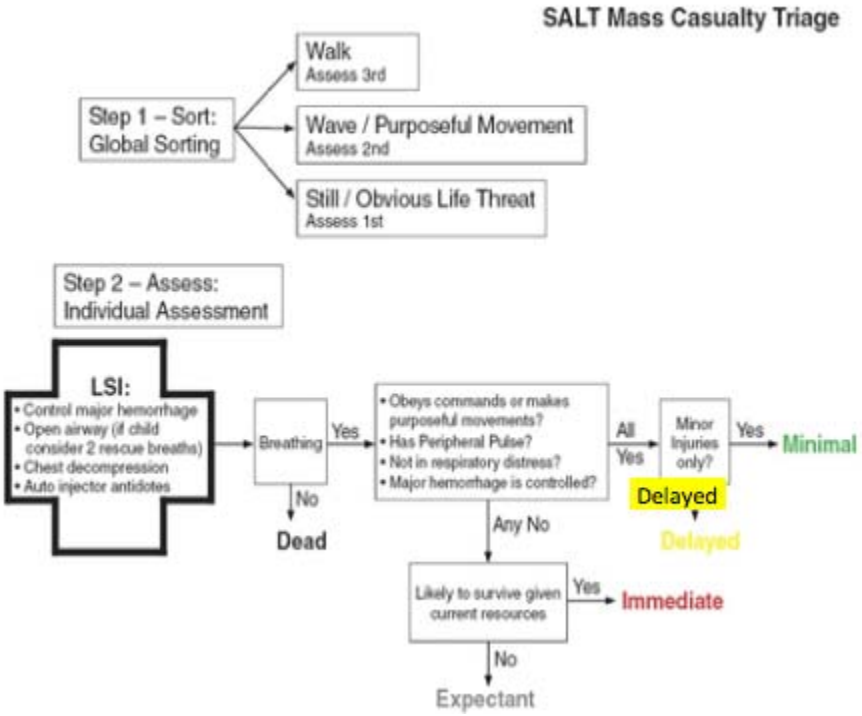
- **Only** correct life-threatening problems during triage.
    - Control major hemorrhage
    - Open airway (if child, consider giving two rescue breaths)
    - Needle chest decompression
    - Auto injector antidotes

Treatment/Transport:

- Transport/treatment priority is typically given to **RED** (**Immediate**), **YELLOW** (**Delayed**), then **GREEN** (**Minimal**).
- **GRAY** (Expectant) patients should be treated/transported as resources allow.
- Patients should be reassessed periodically, including when moved to the CCP, or when their condition or resources change.

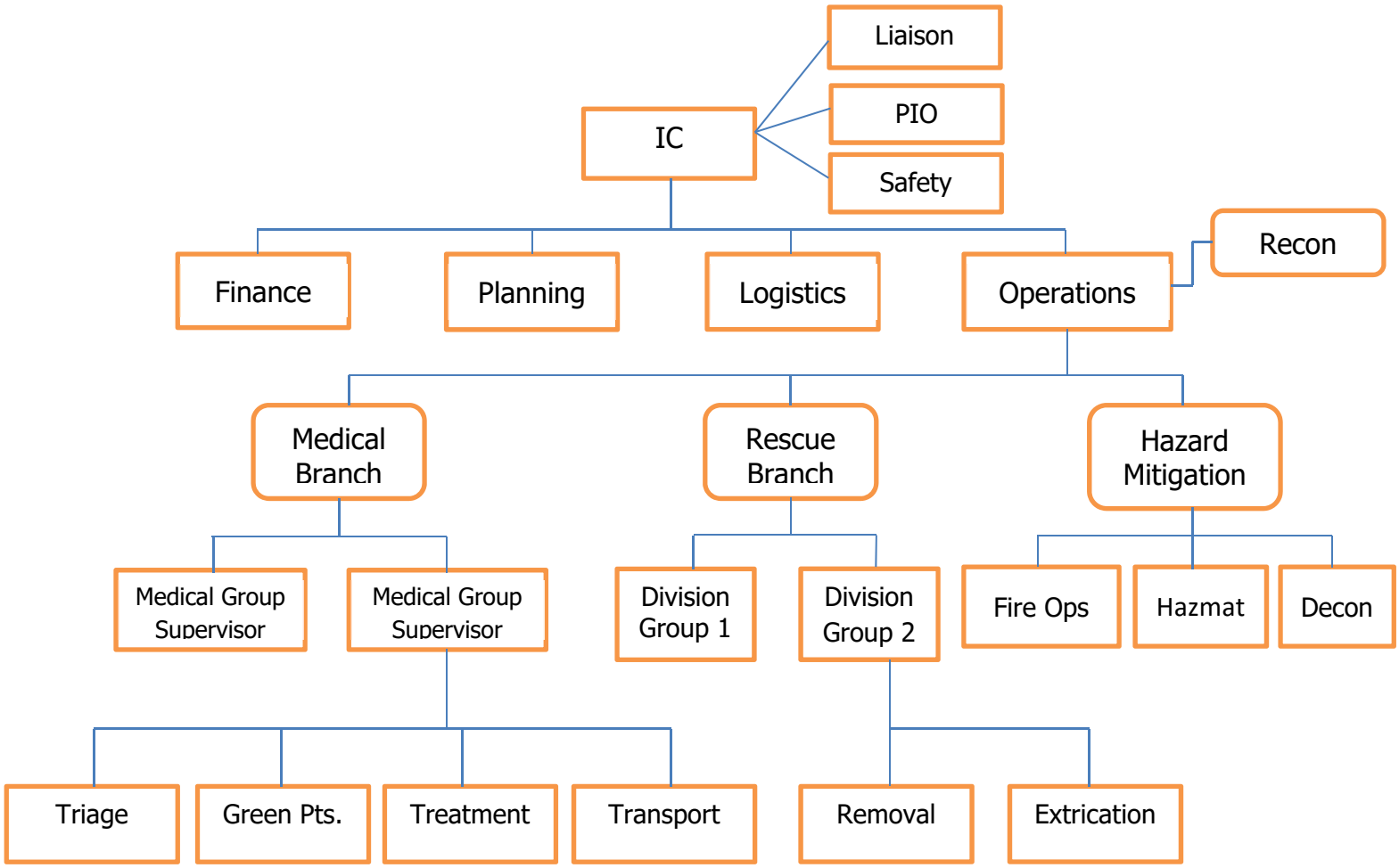
Special Considerations:

- When using Triage Tags, if the patient's condition or the triage priority changes, indicate that on the tag. If necessary, add a new tag to identify the new triage priority, and if time permits, the reason for the change.



Attachment E:

ICS Chart - Full

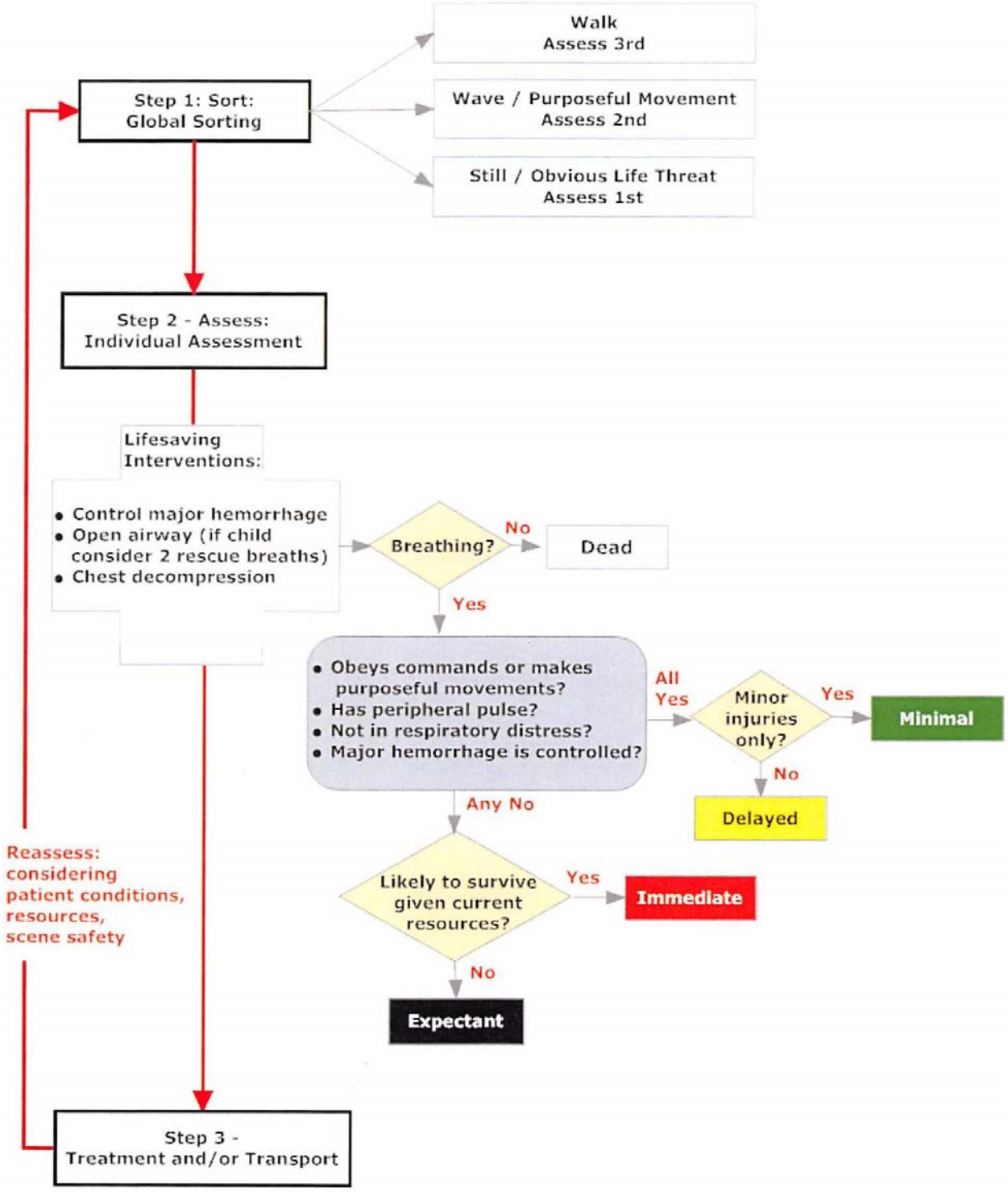


This is the org chart for a large scale incident. As with other incidents, multiple roles may be filled by one individual as span of control and need allow. (e.g. Medical Group Supervisor may fill the roles of GREEN Area Manager, Treatment and Transport Group Supervisor. Geography and work volume may alter this).

THIS CHART IS NOT INTENDED TO IDENTIFY ALL ASPECTS OF ICS AT A LARGE INCIDENT.

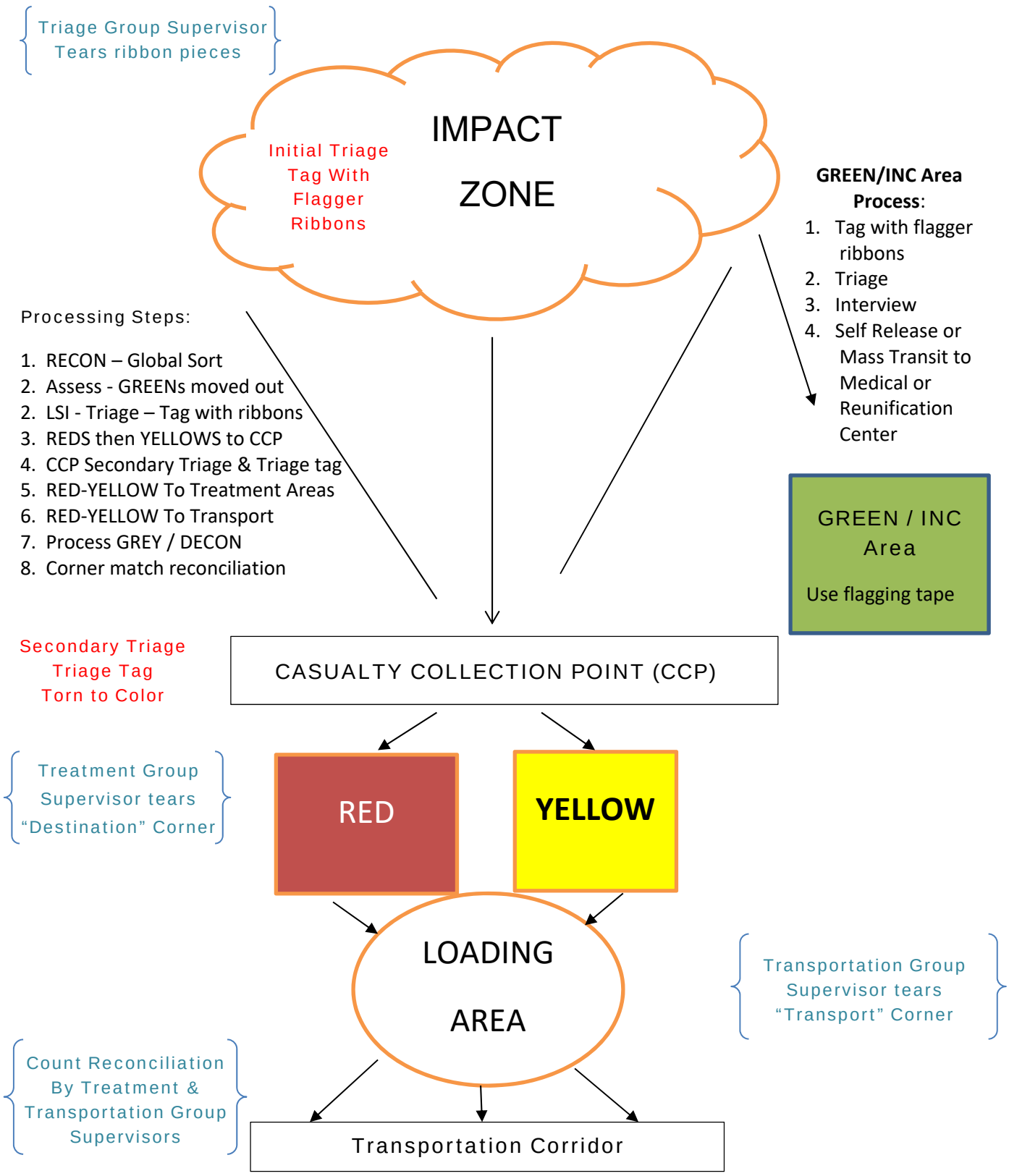
ATTACHMENT F

Mass Casualty Triage Diagram - *SALT



*Recommended SALT Triage, National Association of EMS Physicians (NAEMSP) & National Registry of EM Technicians (NREMT)

ATTACHMENT G
Tagging Chart

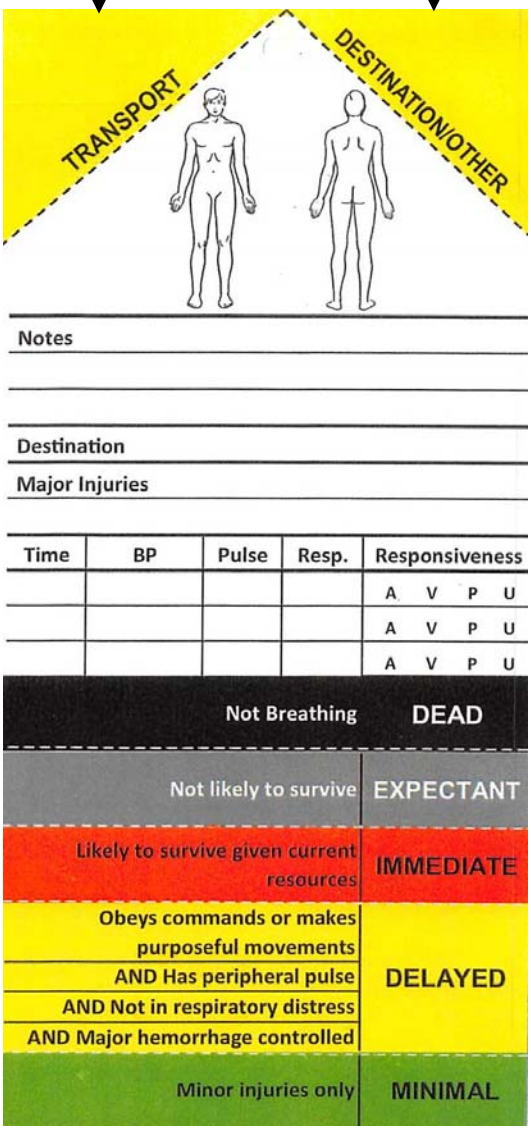


ATTACHMENT H

Triage Tag

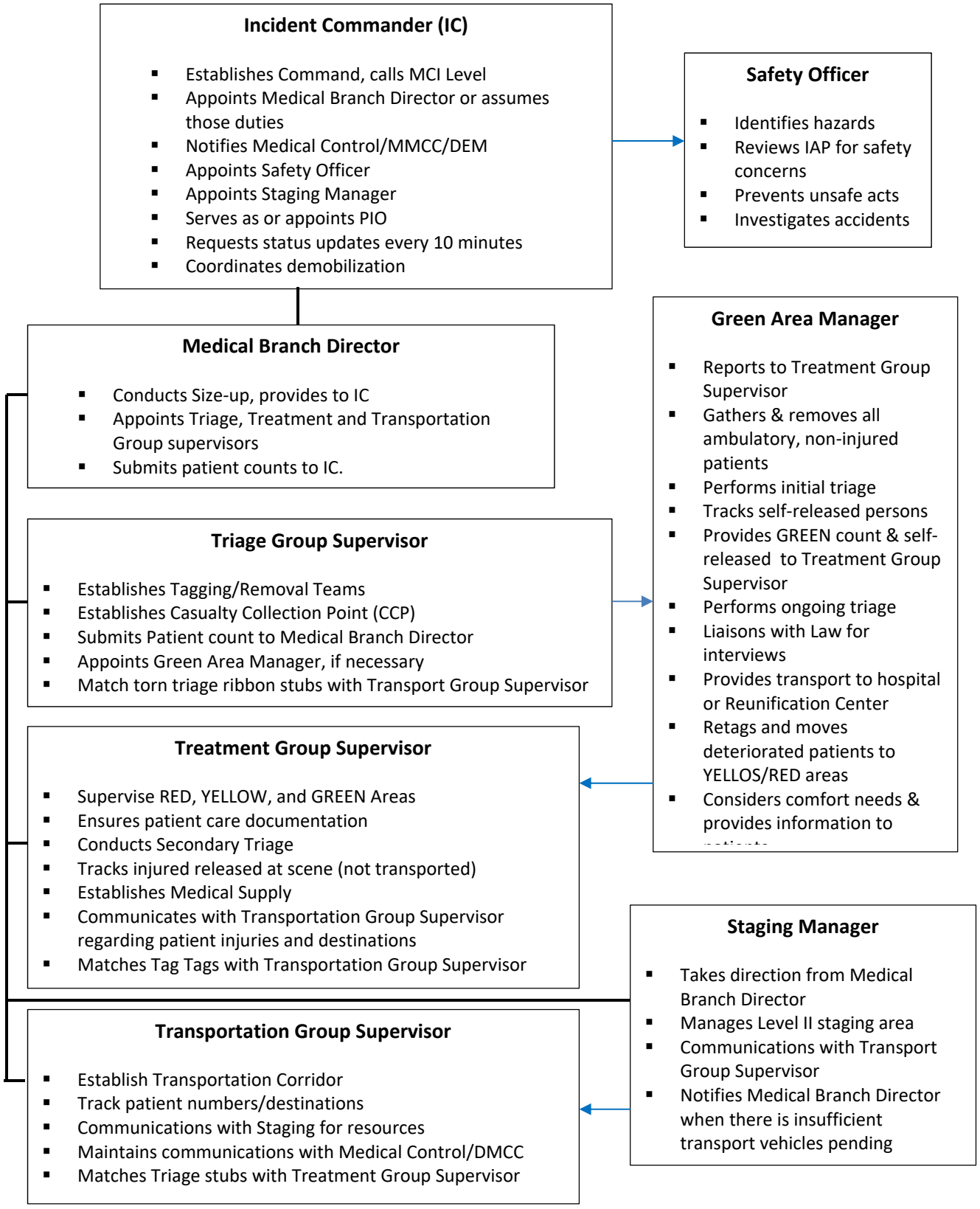
Transportation Group Supervisor corner

Treatment Group Supervisor corner



ATTACHMENT I

Primary Duties – Authorities Chart



ATTACHMENT J

MCI Triage Bag Inventory Recommendation

ATTACHMENT J

MCI Triage Bag Inventory Recommendation – Page 2

- SALT-triage algorithm inserts
- Survey ribbon:
  - Green
  - Yellow
  - Red
  - Grey
  - black and white striped
  - orange with polka dots
  - white
- Several pairs of large gloves (90% of EMS providers can function in this size)
- 3-4 of the most common sized NPA's and OPA's
- 3-4 hemostatic gauze pads or 4x4's
- 2-3 tourniquets
- A face mask or shield
- 2 occlusive dressings
- Heavy duty medical tape
- Flashlight or headlamp
- Trauma shears
- Grease pen and or permanent marker
- 10 triage tags with attached cordage
- 2- 10g-14g catheters for chest decompression