



# **Northeast Colorado RETAC Mass Casualty Emergency Operations Plan**

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## **EXECUTIVE SUMMARY:**

The purpose of this Emergency Operations Plan (EOP) is to provide the constituents of Northeast Colorado Emergency Medical/Trauma Advisory Council (NCRETAC) with an organized, expandable and practical operational plan to ensure victims of incidents are cared for appropriately.

Multi-casualty Incidents can include: motor vehicle accidents; aircraft accidents; floods; tornados; hazardous materials spills; nuclear incidents; fires; explosions; earthquakes; war-related disasters; acts of terrorism; etc. It is the goal of the NCRETAC to ensure the preparedness of our providers by providing the training and exercises necessary for competency. This document also functions as the Standard Operating Procedure (SOP), which will be made available to all EMS provider agencies within the NCRETAC.

It is the responsibility of the NCRETAC to describe, categorize, inventory and track the available resources within our region and to assist with prehospital care reimbursement and cost recovery in the event of a disaster. In all cases of cost recovery, availability of complete, accurate and timely documentation can help a response organization capture the compensation it is due.

Most incidents involving between 1 and 5 victims are usually handled by initial responding units with subsequent requests for additional assistance depending upon the number of victims involved and the severity of their injuries. Larger multi-casualty incidents will overwhelm the initial responding resources as well as area hospitals. For this reason it is important to have a common and useable EOP. A common MCI-EOP allows multiple agencies to function in an organized and coordinated manner, with all agencies understanding their roles and the hierarchal structure of the Incident Command System (ICS). Cooperating agencies should also have mutual aid agreements established not only to respond to the incident, but also to ensure that communities will have adequate response to other 911 calls.

This EOP conforms to the standards, terminology and procedures contained in the National Incident Management System (NIMS) document. This document uses the Incident Command System (ICS) which is designed to enable efficient and effective incident management by integrating a variety of responding agencies, communication centers and receiving hospitals.

In the ICS there can be a single Incident Commander (IC) or a Unified Command (UC). Both have advantages and disadvantages and depending upon the size and type of incident, the jurisdiction and the number and type of responding agencies. Regardless the type of command structure established it must be done early and cooperatively. The IC will then formulate an Incident Action Plan (IAP) which must take into account the number of victims, location, potential hazards and any specialized needs such as technical rescue, HAZMAT etc. It is possible that the first arriving unit may assume the initial IC role and conduct a size-up and formulate an IAP. It is imperative that Medical Branch personnel through their Medical Supervisor are aware of and allowed to provide input to the IAP. For large disasters with multiple staging areas, then it is possible to have an Area Commander (AC) with multiple IC under their control.

In the ICS there are 4 sections which include Operations, Planning, Logistics and Administration. Our duties will fall under the Operations Sections and specifically the Medical Branch. Other Operational Branches include Fire Suppression, Hazmat, Rescue, Investigative and Law/Military. Under the Medical Branch there may be up to 5 Medical Divisions with each Division capable of handling up to 16 patients depending on criticality, location etc.

The Incident Command Post (ICP) should be located in the immediate vicinity of the incident. If it is a small incident then the ICP may also function as the Emergency Operations Center (EOC). In larger incidents requiring multiple agencies and resources, the EOC may be based at another location.

Effective communications and information management is vital to efficient incident management. Common operating and communication format as well as data collection will follow standards as designated by the NIMS Integration Center (see appendix).

Physician Advisory Board

Northeast Colorado RETAC

## **INTRODUCTION:**

Large multi-casualty incidents will overwhelm the initial responding resources. The Medical Supervisor must have delineated and expandable operational procedures to assure that proper emergency pre-hospital care and the prevention of further injury to victims, the public and public safety personnel will be provided.

This pre-determined EMS Emergency Operations Plan must provide for the effective treatment and transportation of multiple casualties through the principles of "Triage" management.

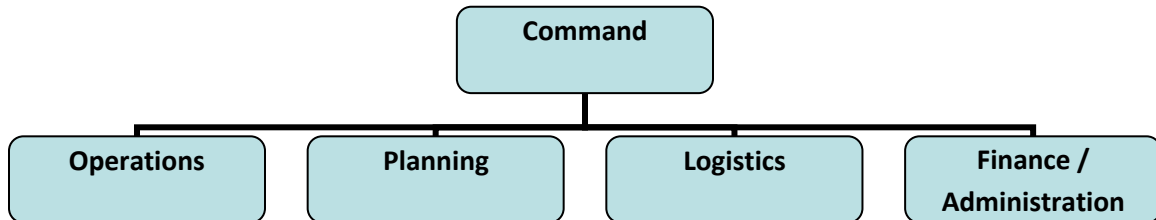
The medical functional group structure is designed to utilize all aspects of Emergency Medical Service response resources, including on-scene Physician medical direction, if applicable.

While most incidents are generally handled on a daily basis by a single jurisdiction at the local level, there are important instances in which successful domestic incident management operations depend on the involvement of multiple jurisdictions, functional agencies, and emergency responder disciplines. These instances require effective and efficient coordination across this broad spectrum of organization and activities.

The National Incident Management System (NIMS) uses a systems approach to integrate the best of existing processes and methods into a unified national framework for incident management. This framework forms the basis for interoperability and compatibility that will, in turn, enable a diverse set of public and private organizations to conduct well-integrated and effective incident management operations. It does this through a core set of concepts, principles, procedures, and organizational processes, terminology, and standards requirements applicable to a broad community of NIMS users.

## THE INCIDENT COMMAND SYSTEM:

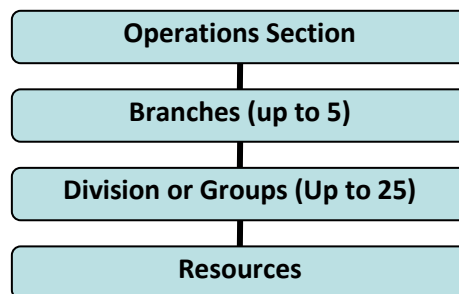
The Incident Command System (ICS) is the combination of facilities, equipment personnel, procedures, and communications operating within a common organizational structure, designed to aid in domestic incident management activities. It is used for a broad spectrum of emergencies, from small to complex incidents.



Incident Command System: Basic Functional Structure (adopted from NIMS)

## THE OPERATIONS SECTION:

The Operations Section is responsible for managing tactical operations at the incident site directed toward reducing the immediate hazard, saving lives and property, establishing situation control, and restoring normal conditions.



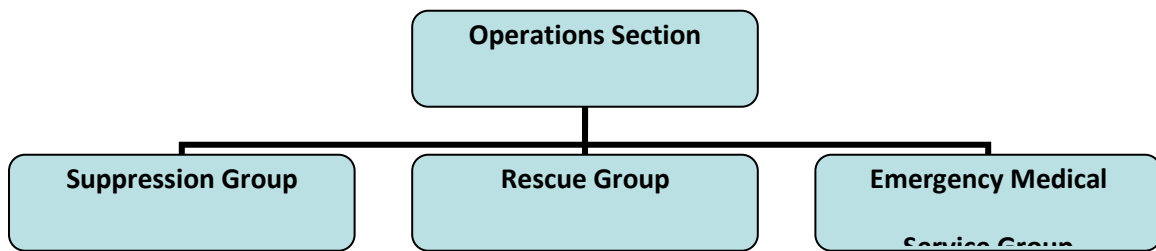
Major Organizational Elements of Incident Operations

## DIVISIONS AND GROUPS:

Divisions and groups are established when the number of resources exceeds the Operations Section Chief's manageable span of control. Divisions demarcate physical or geographical areas of operation within the incident area, while Groups demarcate functional areas of operation for the incident.

## FUNCTIONAL GROUPS:

Functional groups can best be used to describe areas of like activity (e.g., rescue, suppression, medical)



## RESOURCE ORGANIZATION:

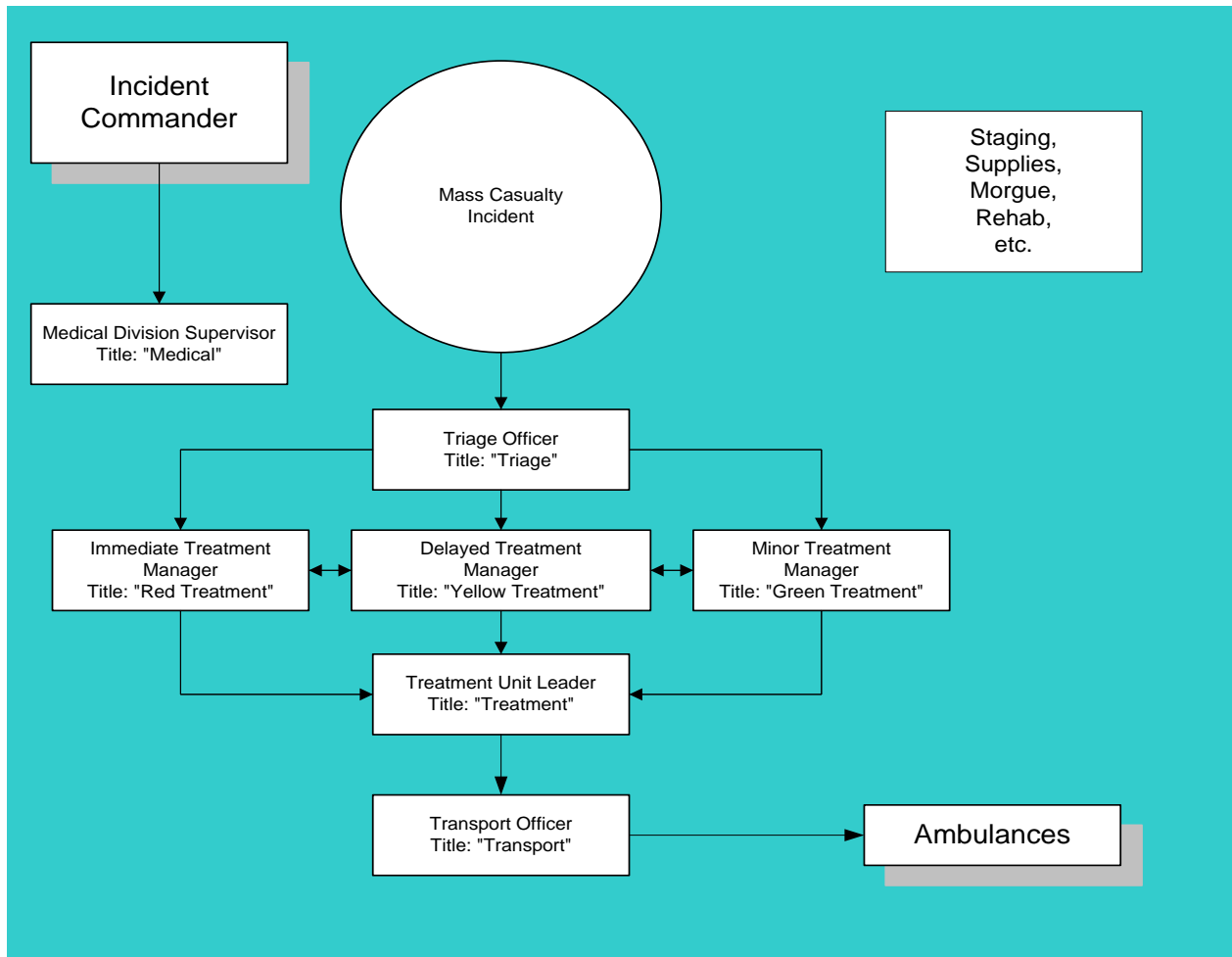
Initially, in any incident, individual resources that are assigned will report directly to the IC. As the incident grows in size or complexity, individual resources may be organized and employed in a number of ways to facilitate management.

**MEDICAL DIVISION:**

The Medical Division (or Group) organizational structure is designed to provide the Medical Group Supervisor with the basic expandable system for handling any number of patients in a multi-casualty incident. A second Medical Division may be established if geographical or incident conditions warrant.

A minimum structure is required whenever five or more critical patients are being cared for (see Expanded Medical page 6). When the number of victims reaches 16 or more, one or more Medical Divisions are required, however, the degree of implementation will depend upon the number of victims.

**MEDICAL DIVISION ORGANIZATION CHART:**





**MASS CASUALTY INCIDENT CATEGORIES**

MCI procedures are tiered into one of FOUR (4) categories:

- MCI-0.....Mini MCI (2-5 casualties; at least one critical)
- MCI-I.....Expanded Medical Emergency (6-15 casualties)
- MCI-II.....Major Medical Emergency (16-50 casualties)
- MCI-III.....Medical Disaster (51 or more casualties)

**TRANSPORT STRATEGY NOTES:**

- 1-2 critical patients = Split-first arriving crew
- 3-5 critical patients = First-in-last-out
- > 5 critical patients = Full EMS Division (Triage, Treatment and Transport,)

***MCI - 0: (Mini Mass Casualty Incident, aka Mini MCI)***

Mini-Mass Casualties (MCI-0) are classified as incidents with 2-5 injured patients with at least one critical. These occur with greater frequency than other MCI types and can serve as real-time incidents that utilize the same principles applicable to larger MCI events. Therefore the Mini-MCI event can be considered the basic Medical Division, which can be expanded to meet the demands of larger more complex MCI events.

**FIRST ARRIVING AMBULANCE:**

The first arriving ambulance will take charge of and coordinate patient care activities. All additional responding ambulances will coordinate their efforts with the first arriving fire, ambulance and law enforcement agencies. Overall Incident Command is typically assumed by Fire Officers.

*First Arriving Ambulance responsibilities are:*

1. Announce "Mini-MCI" over the Radio
2. Report to or establish command.
3. Most Qualified EMT immediately attends to the most serious patient.
4. EMT performs triage (scene survey; mechanism; number of victims; severity of injuries) then reports back to paramedic.
5. Triage and tag each patient and prioritize victims for transport.
6. Request additional resources as appropriate through incident command.
7. Rapidly package all patients and assemble them in a central collection point.
8. Most Qualified EMT sees all additional critical patients.

When operating in the Mini-MCI mode, all caregivers will provide the following standard exam and treatment:

1. All "walking wounded" are directed to wait in or near the ambulance.
2. Non-Walking Wounded Exam: Respiration / Perfusion / Mental Status
  - a) Airway (yes/no)
  - b) Breathing > 30
  - c) Pulse (carotid or radial);
  - d) Cap refill > 2 seconds
  - e) Skin Color (pale, normal, cyanotic);
  - f) LOC (follows commands)
  - g) Chest (look, listen, feel).
3. Treatment:
  - a) Establish airway.

- b) Seal chest wounds / treat tension pneumothorax.
  - c) Control Major Hemorrhage.
  - d) Package on Backboard.
4. Move to Collection Area.
- Do not waste time with unnecessary treatment or examinations. All patients should be rapidly examined and packaged, using a minimum of personnel... further examination and treatment may take place in the collection area (time permitting).
5. Radio Reports:
- Use the "command name" in the report.

***MCI - I: an MCI - I involves between 6 to 15 casualties, with at least five considered being in critical condition.***

The medical aspects of an incident may be handled by the Medical Division Supervisor and/or the Medical Division/Treatment Supervisor through direct requests for additional emergency medical and hospital personnel and equipment, depending upon the number of victims, severity of injuries and magnitude of the incident.

To determine the amount of additional emergency medical personnel required, the following is recommended:

1. One ALS EMT and one EMT or First Responder for each critical patient
2. One EMT for every 3-non-critical patient
3. One Senior EMT as Medical Communication, Transportation Leader
4. One Senior EMT as Triage Control Officer

*The Medical Incident Commander shall also assure that:*

1. Sufficient ambulance and/or appropriate transport vehicles have been requested
2. Sufficient fire suppression support personnel have been requested
3. Activation of Hospital and Mutual Aid Frequencies

*The following line positions are recommended minimums:*

1. A Triage Control Officer.
2. A Transportation Control Officer.

**NOTE: Local Mutual Aid will be needed**

***MCI - II: A MCI - II involves between 16 and 50 casualties.***

The Medical Division Supervisor shall establish a Medical Division, at a level of support/line personnel as determined by the number of victims and the magnitude of the incident.

To determine that amount of additional emergency medical personnel required, the following is recommended:

1. A complete Medical Division appropriately staffed pursuant to the number of casualties.
2. One ALS EMT per three critical victims.  
(Note: Patient ratio increased from MCI - I).
3. One EMT per seven minor injuries. (Note: Patient ratio increased from MCI - I).

NOTE: Regional Mutual Aid will be needed.

***MCI - III: MCI - III involves 51 or more casualties, and the magnitude of the incident can be handled by the resources available.***

The Incident Commander (typically assumed by a Fire Service Officer) shall establish one or more Medical Divisions at a level of support/line personnel as determined by the number of victims and the magnitude of the incident. To determine the amount of additional emergency personnel required, the following is recommended:

1. A minimum of one complete Medical Division.
2. One ALS EMT per three critical patients.
3. One EMT per seven minor injuries.

**NOTE: County, and/or State assistance will be needed.**

### **MULTI-CASUALTY INCIDENT RESOURCE MOBILIZATION:**

Protocols must be established in advance of Multi-Casualty Incidents with communications centers for the activation and mobilization of additional patient care and transport resources. The on scene challenges faced by EMS personnel at these events require the mobilization of resources be preplanned.

In addition it is an essential element of MCI medical response preparedness that Mutual Aid Agreements exist between neighboring EMS agencies. A sample EMS mutual aid agreement is available for review in the Northeast Colorado All-Hazards Region's "Regional Mass Casualty Incident Plan" (see Appendix).

#### ***MCI-I (6-15 patients)***

(All units report to staging)

1. Full first alarm fire response.
2. Request a total of 5 ambulances.
3. Request 1 helicopter to scene or appropriate Emergency Department (ED) (optional).
4. 1 bus
5. Notify: Appropriate emergency department via radio and/or telephone; landline or cell

#### ***MCI-II (16-51 patients)***

(All units report to staging)

1. Full second alarm fire response (ask incident commander).
2. Request an additional 5 ambulances (total of 10)
3. activate available search and rescue team
4. Request additional helicopter to scene or appropriate ED (total of 2)
5. Request additional bus (total of 2)

#### ***MCI-III (51 or more patients)***

(All units report to staging)

1. Full third alarm fire response
2. LCSO search and rescue
3. Request additional 10 ambulances (total of 20)
4. Request additional helicopter to scene or appropriate ED (total of 3 - optional)
5. Request additional bus (total of 3 - optional)

## PRINCIPLES OF TRIAGE:

"Triage" is a word, which originated on World War I battlefields, and comes from the French word "triage", meaning, "to pick out". Triage was originally applied to the process of sorting out which casualties could be returned to the front by concentrating the limited medical resources available to their injuries. Today triage has come to mean the process whereby patients are sorted according to medical need; the idea being that critical patients with reversible injuries or illnesses are treated first. Minor, terminal, or fatally injured patients are consigned to lower priorities for care. This system serves to obtain maximum salvage rates with medical resources available at the time. The critical feature of real triage is that it is field oriented. This prevents overloading of pre-hospital emergency medical providers and allows more efficient use of available resources to save lives.

Triage is most useful in disaster settings where medical facilities are truly overwhelmed; as in earthquake, aircraft disaster, high-rise fire, etc. In this setting, persons who would survive without help are virtually ignored during triage, as are patients who will probably die despite massive medical intervention. The middle group of patients who will benefit most are the patients who receive treatment after categorization by the triage teams at the scene.

There are several principles that must be learned by Paramedics and EMTs to effectively triage and deliver disaster style medicine.

1. In a large-scale disaster, total patient care is impossible. The slightly injured patient may receive very little, or no treatment. They may also have to wait considerable time. Also, the very critically ill patient, with little chance for survival, may receive little or no care since that would waste resources that could save many other lives if applied properly.
2. Triage sorts or classifies patients, providing no patient care because the institution of treatment would slow down the triage capability to an intolerable pace. The exception to this is airway management and the control of dangerous bleeding. All emergency medical personnel should deal with these exceptions as quickly as possible and then go on to the next patient. Routinely, in real disasters, triage can be effective at a rate of about 30 patients an hour, depending upon the scope of the disaster and the available resources
3. The Triage Teams must tag the patients, noting their initial assessment, vital signs if taken, treatment rendered, and the patient's triage classification. It is a time consuming and often-fatal mistake to triage in the field without tagging the patient, since he/she requires re-triaging at the medical facility to which he is transported.

By using a casualty sorting system, you are focusing your activities in the middle of a chaotic and confusing environment. You must identify and separate patients rapidly, according to the severity of their injuries and their need for treatment.

## En route

Even while you are responding to the scene of an incident, you should be preparing yourself mentally for what you may find. Perhaps you've been to the same location. Where will help come from? How long will it take to arrive?

## Initial Assessment - Stay Calm

The first thing you should do upon arriving at the scene of an incident is to try to stay calm, look around, and get an overview of the scene. These visual surveys give you an initial impression of the overall situation, including the potential number of patients involved, and possibly, even the severity of their injuries. The visual survey should enable you to estimate initially the amount and type of help needed to handle the situation.

## Your Initial Report - Creating a Verbal Image

The initial report is often the most important message of a disaster because it sets the emotional and operational stage for everything that follows. As you prepare to give the first vital report, use clear language (no signals or radio jargon), be concise, be calm, and do not shout. You are trying to give the communications center a concise verbal picture of the scene. The key points to communicate are:

- Location of the incident
- Type of incident
- Any hazards
- Approximate number of victims
- Type of assistance required

You might give the following report: "This is a major accident involving a truck and a commercial bus on Highway 305, about 2 miles east of Route 610. There are approximately 35 victims. There are people trapped. Repeat: This is a major accident. I am requesting the fire department, rescue squad, and seven ambulances at this time. Dispatch additional police units to assist."

### **S.T.A.R.T. TRIAGE:**

The Colorado Mass Casualty Medical Response System has established a common triage methodology using the Simple Triage And Rapid Treatment (START) module (see appendix). Patients will be triaged (or categorized) using the Airport Option METTAG.

### ***START TRIAGE IS USED TO FIND PATIENTS:***

This system is designed to assist rescuers to find the most seriously injured patients. As more rescue personnel arrive on the scene, the patients will be re-triaged for further evaluation, treatment, stabilization, and transportation. A patient may be re-triaged as many times and as often as time allows.

Remember that injured patients do not stay in the same condition. The process of shock may continue and some conditions will become more serious as time goes by. As time and resources permit, go back and recheck the condition of all patients to catch changes in condition that may require upgrading to attention.

### ***WORKING AT A MULTIPLE- OR MASS-CASUALTY INCIDENT:***

You may or may not be the first person to arrive on the scene of a multiple- or mass-casualty incident. If other rescuers are already at the scene when you arrive, be sure to report to the incident commander before going to work. Many events are happening at the same time and the incident commander will know where your help and skills can best be used. By virtue of training and local protocols, the incident commander is that person who is in charge of the rescue operation.

In addition to initially sizing up an incident, clearly and accurately reporting the situation, and conducting the initial START triage, the first responder will probably also be called on to participate in many other ways during multiple- and mass-casualty incidents.

As more highly trained rescue and emergency personnel arrive on the scene, accurately report your findings to the person in charge by using a format similar to that used in the initial arrival report. Note the following:

- Approximate number of patients.
- Numbers that you've triaged into the four levels.
- Additional assistance required.
- Other important information.

After you have reported this information, you may be assigned to use your skills and knowledge to provide patient care, traffic control, fire protection, or patient movement. You may also be assigned to provide emergency care to patients, to help move patients, or to assist with ambulance or helicopter transportation.

In every situation involving casualty sorting, the goal is to find, stabilize and move Priority One patients first.

**TRIAGE:**

Step 1 - Separation of the walking wounded from the mass casualty site.

- ◆ Direct all victims able to stand and walk without significant pain to a predetermined “GREEN” treatment area.
- ◆ Select a GREEN treatment area large enough for MCI size and appropriate for bus ingress and egress.
- ◆ Assign first aid personnel, EMTs or Medics, if available to this area.

Step 2 - Triage those remaining by the START Algorithm; respiration, perfusion and mental status, by using only simple gross intervention skills i.e. airway and bleeding control only, (please review the START ALGORITHM (adult) and Jump-Start ALGORITHM (pediatric) on following pages.

Step 3 - Appropriate category tagging of the victim and the victim’s site with the Triage Tag

- ◆ The tear off strip will be removed and retained by the Transportation Supervisor.
- ◆ The right corner of the tag is for personal belongings, tag tracking, etc..
- ◆ The primary tag (main portion) stays with the patient and both the tag and patient are delivered to the hospital.

***PATIENT TRIAGE CATEGORIES:***

***Category 0 – Non-salvageable/ dead***

COLOR – BLACK

Last to be transported and by coroner's vehicles.

Do not move bodies unless they are blocking rescuers access to other victims or there are extenuating circumstances (approaching fire, poss. building collapse, etc.), which may destroy the body.

***Category I - Immediate, Critical***

COLOR – RED

First to be transported, as soon as possible via ambulance. Help maintain airway, respiration greater than 30/minute, poor perfusion and/or abnormal mental status.

***Category II: Delayed, Serious***

COLOR - Yellow

Can wait a little longer for transport. Respiration's < 30/min., normal perfusion and mental status clear. Delayed does not mean no serious injury. Injuries may span a wide range and require frequent reassessment and further prioritization for transport while in the central treatment area.

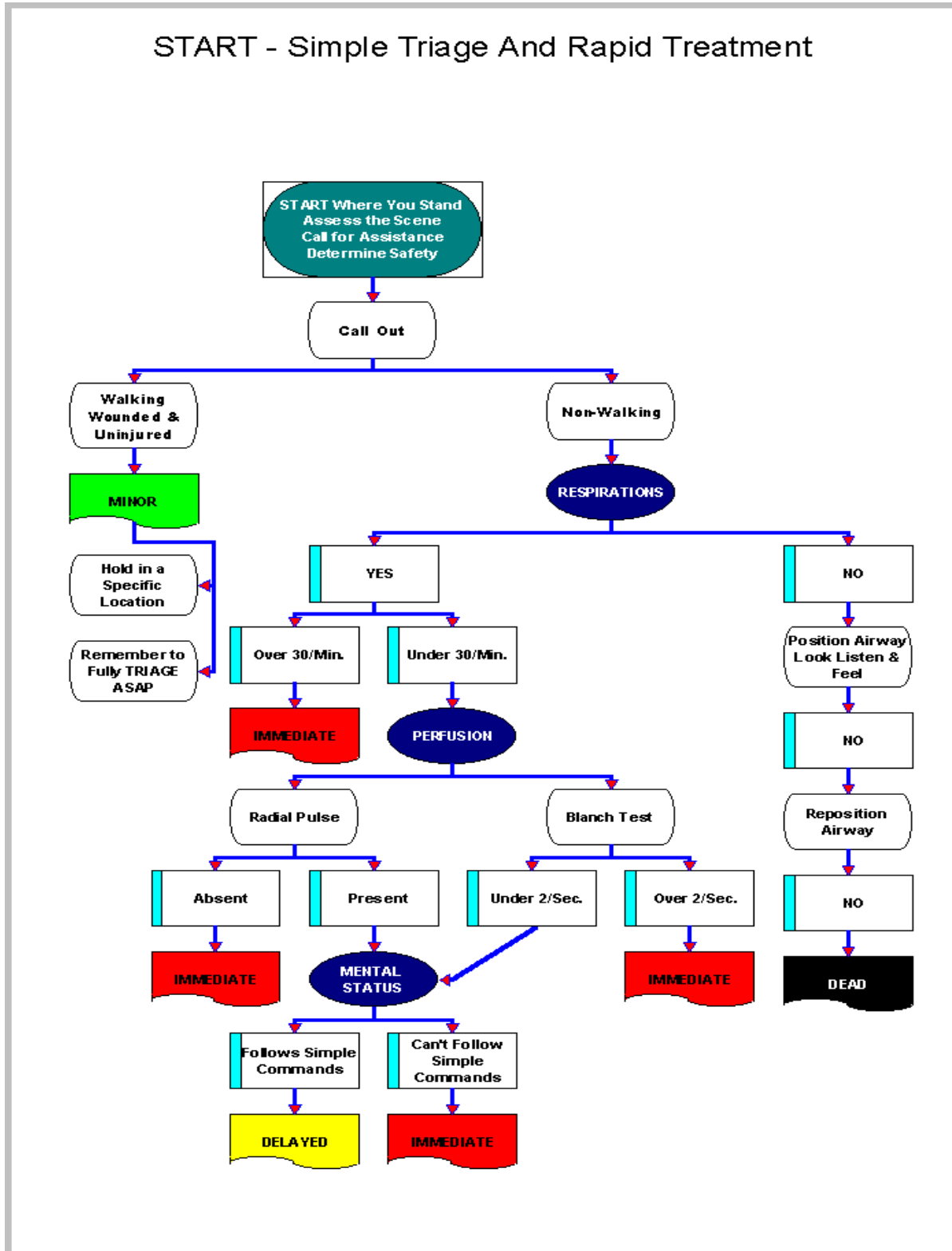
***Category III: Walking wounded***

COLOR - GREEN

Walking wounded, minor injuries: First to be separated and later to be transported by non-ambulance transport (first aid).

Remember that in a major disaster, it is unlikely that you can save all the victims. The important thing is to work together with the other rescuers to save as many patients as you can. START gives you the best chance of doing that.

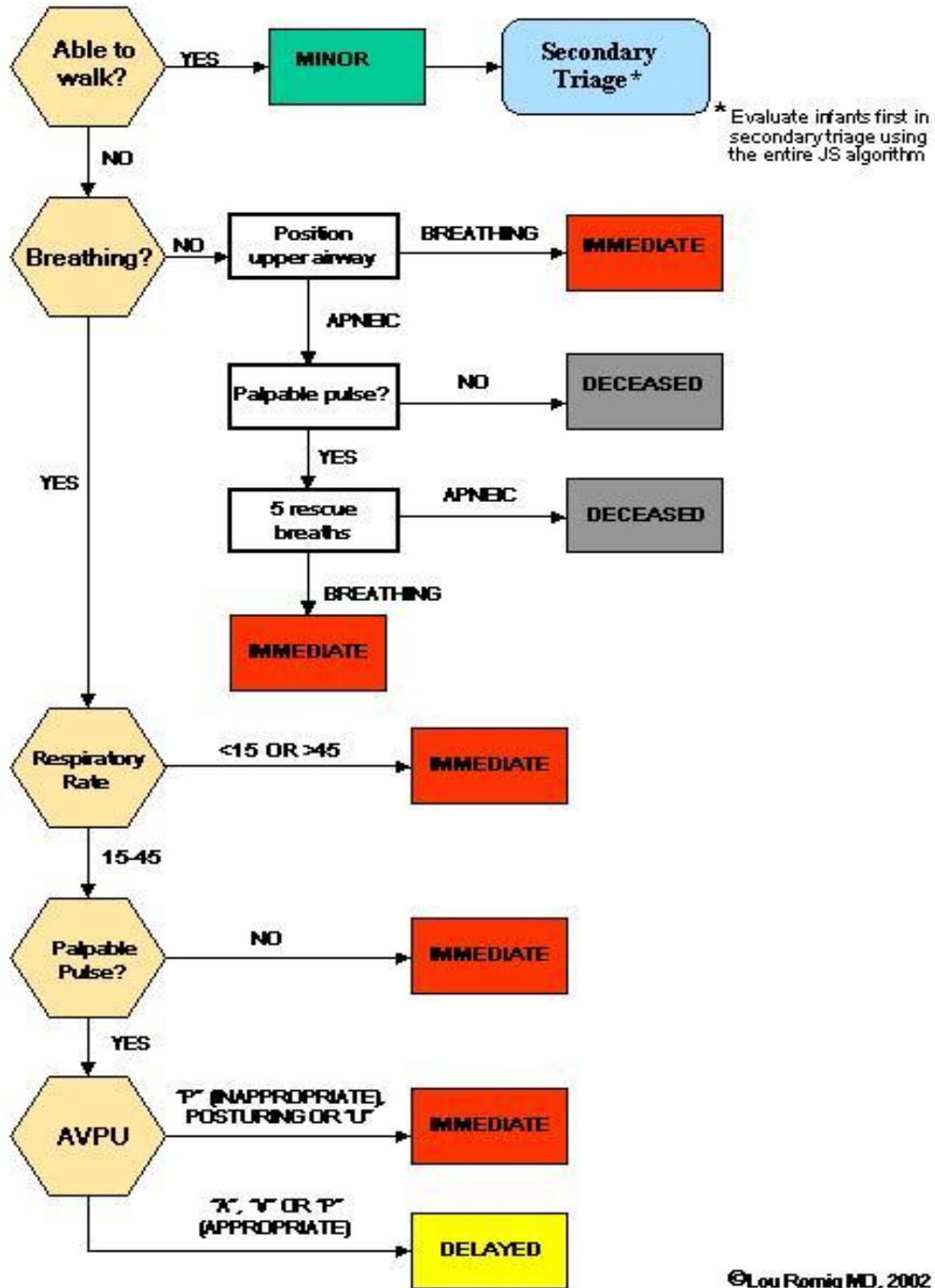
S.T.A.R.T Triage Flow Chart



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

Jump S.T.A.R.T Flow Chart

# JumpSTART Pediatric MCI Triage®



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

## **SAFETY CONSIDERATIONS AT MCI EVENTS:**

All emergency types are fraught with potential hazards. Safety during any rescue operation is paramount. Multi-casualty Incidents can include: motor vehicle and aircraft accidents; natural disasters; nuclear incidents; war-related disasters; acts of terrorism; etc. Many risks are associated with MCI events, which could involve hazardous materials, inclement weather, temperature extremes, fire and explosion, toxic gases, unstable structures and vehicles, heavy equipment, road hazards and sharp edges and fragments and the potential for hostile situations such as perpetrators and unruly crowds.

Recent terrorism events worldwide emphasize that such attacks, once thought of as only a remote possibility, are now real-world risks. First responders and emergency medical personnel cannot afford to be unprepared and all must seriously consider and plan for the possibility that they may be targets. In any EMS response, hazards that may endanger the rescuer and/or the patient must be assessed.

**IF THERE IS ANY SUSPICION OF HAZARDOUS MATERIALS:**

### **STAY AWAY!**

Unless you have received training in handling hazardous materials and can take the necessary precautions to protect yourself, you should keep far away from the contaminated area or "hot zone."

Because the potential for exposure to situations involving hazardous materials is so great, responders must protect themselves from injury and contamination. Hazardous materials (Hazmat) incidents involving chemicals occur every day, exposing many people to injury or contamination. During a hazardous materials incident, responders must protect themselves from injury and contamination

The single most important step when handling any hazardous materials incident is to identify the substance(s) involved. Federal law requires hazardous materials placards be displayed on all vehicles containing large quantities of hazardous materials. Manufacturers and transporters should display the appropriate placard, along with a four-digit identification number, for better identification of the hazardous substance.

The US Department of Transportation published the Emergency Response Guidebook, which lists the most common hazardous materials, their four-digit identification numbers, and proper emergency actions to control the scene. It also describes the emergency care of ill or injured patients.

### **REMEMBER: Contaminated patients will contaminate unprotected rescuers!**

These patients should be removed from the contaminated area, decontaminated by trained personnel (typically Fire Department HazMat Teams), given necessary emergency care, and transported to a hospital. Because most fatalities and serious injuries sustained in hazmat incidents result from breathing problems, constant reevaluation of all patients is necessary so that a patient whose condition worsens can be identified and moved to a higher triage level. Once patients are decontaminated triage in hazmat incidents has one major function; to identify victims who have sustained an acute injury as a result of exposure to hazardous materials.

## POSITION CHECKLISTS:

### MEDICAL BRANCH DIRECTOR:

Definition: Most Qualified ALS EMT  
Commanded by: Incident Commander; Operations Chief  
Subordinates: All Medical Groups; All Transportation Groups  
Radio Designation: Medical Command  
Function: Responsible for the implementation of the Incident Action Plan within the Medical Branch.

Duties:

1. Review Common Responsibilities (NIMS EMS MCI Plan page 2-3).
2. Review Group Assignments for effectiveness of current operations and modify as needed.
3. Provide input to Operations Section Chief for the Incident Action Plan.
4. Supervise Branch activities.
5. Report to Operations Section Chief on Branch activities.
6. Maintain Unit/Activity Log (ICS Form 214).

### MEDICAL GROUP/DIVISION SUPERVISOR:

Definition: Senior EMT, prefer ALS  
(First on scene and independent of jurisdiction.)  
Commanded by: Incident Commander, or Branch Director.  
Subordinates: Triage; Treatment; Transportation, Medical Supply and Morgue Supervisors.  
Radio Designation: Medical  
Function: Responsible for the overall management and delegation of all functions of the Medical Division.

Duties:

1. Establish and supervise a Medical Division. (See Medical Division Matrix)
2. Review Common Responsibilities (NIMS EMS MCI Plan page 2-3).
3. Participate in Medical Branch/Operations Section planning activities.
4. Establish Medical Group with assigned personnel, request additional personnel and resources sufficient to handle the magnitude of the incident.
5. Designate Unit Leaders and Treatment Area locations as appropriate.
6. Isolate Morgue and Minor Treatment Area from Immediate and Delayed Treatment Areas.
7. Request law enforcement/coroner involvement as needed.
8. Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, backboards, litters, and cots).
9. Ensure activation or notification of hospital alert system, local EMS/health agencies.
10. Direct and/or supervise on-scene personnel from agencies such as Coroner's Office, Red Cross, law enforcement, ambulance companies, county health agencies, and hospital volunteers.
11. Request proper security, traffic control, and access for the Medical Group work areas.
12. Direct medically trained personnel to the appropriate Unit Leader.
13. Maintain Unit/Activity Log (ICS Form 214).

### **TRIAGE UNIT LEADER:**

Definition: Paramedic, EMT-A, EMT-I or EMT  
Commanded by: Medical Division Supervisor  
Subordinates: Triage personnel  
Radio Designation: Triage Leader  
Function: Assure responsibility for providing triage.  
Duties:

1. Develop organization sufficient to handle assignment.
2. Inform Medical Group Supervisor of resource needs.
3. Implement triage process.
4. Coordinate movement of patients from the Triage Area to the appropriate Treatment Area. Give periodic status reports to Medical Group Supervisor.
5. Maintain security and control of the Triage Area.
6. Establish Morgue.
7. Maintain Unit/Activity Log (ICS Form 214).

### **TRIAGE PERSONNEL:**

Definition: Paramedic, EMT-A, EMT-I or EMT  
Commanded by: Triage Unit Leader  
Subordinates: None  
Radio Designation: Triage  
Function: Triage patients and assign them to appropriate treatment areas.

Duties:

1. Report to designated on-scene triage location.
2. Triage and tag injured patients. Classify patients while noting injuries and vital signs if taken.
3. Direct movement of patients to proper Treatment Areas.
4. Provide appropriate medical treatment to patients prior to movement as incident conditions dictate.

### **MORGUE MANAGER:**

Definition: Personnel designated by Incident Command  
Commanded by: Medical Division Supervisor (Coroner's Office)  
Subordinates: Aides as required  
Radio designation: Morgue  
Function: Manage all morgue activities.

Duties:

1. Establish a temporary morgue remote from the patient areas.
2. Secure the area.
3. Maintain records, including victims' identity, location where found.

**TREATMENT UNIT LEADER:**

Definition: Paramedic, EMT-A, EMT-I or EMT  
Commanded by: Medical Division Supervisor  
Subordinates: Treatment Groups  
Radio Designation: Treatment  
Functions: Responsible for supervision of treatment of  
Victims assigned to the Treatment Areas.

Duties:

1. Don identifying vest.
2. Establish the Treatment Area. Consider size, safety, space, weather, lighting, and ease of access and egress for transport vehicles. Arrange Treatment Area in parallel rows of separate patient groupings IMMEDIATE (RED) / DELAYED (YELLOW) / MINOR (GREEN). Report location to MEDICAL DIVISION SUPERVISOR.
3. Prioritize patients arriving in the Treatment Area for treatment.
4. Account for all personnel assigned to TREATMENT.
5. Establish Treatment Area Supervisors.
6. Determine the order of transport of patients and most appropriate transport based on recommendations from ALS treatment personnel.
7. Maintain communications with TRIAGE and TRANSPORTATION.
8. Provide essential and frequent progress reports to MEDICAL DIVISION SUPERVISOR.

**TREATMENT DISPATCH MANAGER:**

Definition: Paramedic, EMT-A, EMT-I or EMT  
Commanded by: Treatment Unit Leader  
Subordinates: Treatment Groups  
Radio Designation: ???  
Functions: Responsible for coordinating transportation of patients out of the Treatment  
Areas with the Patient Transportation Unit Leader

Duties:

1. Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
2. Establish communications with the Patient Transportation Unit Leader.
3. Verify that patients are prioritized for transportation.
4. Advise Medical Communications Coordinator of patient readiness and priority for transport.
5. Coordinate transportation of patients with Medical Communications Coordinator.
6. Assure that appropriate patient tracking information is recorded.
7. Coordinate ambulance loading with the Treatment Managers and ambulance personnel.
8. Maintain Unit/Activity Log (ICS Form 214)

**IMMEDIATE TREATMENT MANAGER:**

Definition: Most Qualified Highest Trained EMS Provider  
Commanded by: Treatment Supervisor  
Subordinates: Treatment Area Personnel  
Radio Designation: Red Treatment  
Function: Responsible for treatment of victims in the  
Minor Treatment Area

Duties:

1. Receive and treat victims assigned to your unit.
2. Assure standing orders for A.L.S. procedures have been obtained.
3. Assure patients are prioritized for transport.
4. Coordinate transportation of victims through "TRANSPORT" Supervisor.
5. Assure that appropriate medical and patient information is recorded.

**DELAYED TREATMENT MANAGER:**

Definition: *Paramedic, EMT-A, EMT-I or EMT*  
Commanded by: Treatment Supervisor  
Subordinates: Treatment Area Personnel  
Radio Designation: Yellow Treatment  
Function: Responsible for treatment of victims in the Delayed Treatment  
area

Duties:

1. Receive and treat victims assigned to your unit.
2. Assure standing orders for A.L.S. procedures have been obtained.
3. Assure patients are prioritized for transport.
4. Coordinate transportation of victims through "TRANSPORT" Supervisor.
5. Assure that appropriate medical and patient information is recorded.

**MINOR TREATMENT MANAGER:**

Definition: *Paramedic, EMT-A, EMT-I or EMT*  
Commanded by: Treatment Supervisor  
Subordinates: Treatment Area Personnel  
Radio Designation: Green Treatment  
Function: Responsible for treatment of victims in the Minor  
Treatment Area

Duties:

1. Receive and treat victims assigned to your unit.
2. Assure standing orders for A.L.S. procedures have been obtained.
3. Assure patients are prioritized for transport.
4. Coordinate transportation of victims through "TRANSPORT" Supervisor.
5. Assure that appropriate medical and patient information is recorded.

### **TRANSPORTATION SUPERVISOR:**

Definition: Senior Paramedic or Paramedic Supervisor  
Commanded by: Medical Division Supervisor  
Subordinates: Communications, staging, and records personnel.  
Radio Designation: Transport  
Function: Coordinate patient transportation. Communicate with receiving facilities. Maintain records.

Duties:

1. Designate a Vehicle Staging Area (within sight of the loading area).
2. Establish an ambulance loading area near the treatment area (within 25 feet).
3. Coordinate patient transportation with "RED, YELLOW, GREEN TREATMENT" Area Supervisors.
4. Supervise the loading of patients into ambulances.
5. Request additional ambulances through "MEDICAL" division commander.
6. Request additional helicopters through "AIR OPS" if activated.
7. Communicate with receiving hospitals to include: number of victims;
8. their severity and destination.
9. Obtain bed space information.
10. Assure patient information and destination is recorded.

### **MEDICAL COMMUNICATIONS COORDINATOR:**

Definition: Paramedic, EMT-A, EMT-I or EMT  
Commanded by: Transportation Unit Leader  
Subordinates: Treatment Groups  
Radio Designation: ???  
Functions: Responsible for continuous communications with the hospital alert system to maintain status of available hospital beds to assure proper patient transportation. The Medical Communication Coordinator assures proper patient transportation and destination.

Duties:

1. Establish communications with the hospital alert system.
2. Determine and maintain current status of hospital/medical facility availability and capability.
3. Receive basic patient information and condition from Treatment Dispatch Manager.
4. Coordinate patient destination with the hospital alert system.
5. Communicate patient transportation needs to Ambulance Coordinators based upon requests from Treatment Dispatch Manager.
6. Communicate patient air ambulance transportation needs to the Air Operations Branch Director based on requests from the treatment area managers or Treatment Dispatch Manager.
7. Maintain appropriate records and Unit/Activity Log (ICS Form 214)

### **GROUND AMBULANCE COORDINATOR:**

Definition: Paramedic, EMT-A, EMT-I or EMT  
Commanded by: Transportation Unit Leader  
Subordinates: Treatment Groups  
Radio Designation: ???  
Functions: Manages the Ambulance Staging Area(s), and dispatches ambulances as requested.

Duties:

1. Establish appropriate staging area for ambulances.
2. Establish routes of travel for ambulances for incident operations.
3. Establish and maintain communications with the Air Operations Branch Director regarding Air Ambulance Transportation assignments.
4. Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager.
5. Provide ambulances upon request from the Medical Communications Coordinator.
6. Assure that necessary equipment is available in the ambulance for patient needs during transportation.
7. Establish contact with ambulance providers at the scene.
8. Request additional transportation resources as appropriate.
9. Provide an inventory of medical supplies available at ambulance staging area for use at the scene.
10. Maintain records as required and Unit/Activity Log (ICS Form 214)

### **MEDICAL SUPPLY COORDINATOR:**

Definition: Qualified personnel  
Commanded by: Medical Division Supervisor  
Subordinates: Aides as required.  
Radio designation: Supply  
Function: Responsible for maintaining required medical supplies for the division.

Duties:

1. Acquires, distributes, and maintains status of medical equipment and supplies.
2. Requests additional medical equipment and supplies as needed, through "MEDICAL" division commander.

### **STRIKE TEAMS:**

Definition: Qualified Personnel / volunteers  
Commanded by: Triage or Transport Supervisors  
Subordinates: None  
Radio Designation: Strike Team1; Strike Team 2; etc.  
Function: Work at assigned tasks

Duties:

1. Evacuate victims to the triage and/or treatment areas.
2. Record and relay the location of all patients found.
3. Transport patients to and from the various patient areas.
4. Load victims into ambulances from the treatment areas.