

Multi-Casualty Incident Response Plan

**County of San Luis Obispo
Emergency Medical Services Agency
Policy # 210**

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SECTION 1.0: MCI PLAN ADMINISTRATIVE ELEMENT

1.1 SCOPE

This plan is limited to Multi-Casualty Incidents (MCI) within the County of San Luis Obispo (SLO) Operational Area.

1.2 OBJECTIVES and AUTHORITY

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

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

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

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

1.3 TRAINING and EXERCISES

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

1. First Receiver (Hospitals Only)

- a. Hospital Incident Command System (HICS)
- b. HICS Hazardous Materials Awareness
- c. ICS – minimum of ICS 100 and ICS 200 for Healthcare level
- d. National Incident Management System (NIMS) IS-700
- e. Working knowledge of EMS Agency Policies and Procedures
- f. EMS related communication tools (radios, ReddiNet, etc.) as required in EMS policy.

2. All Field First Responders

- a. Simple Triage and Rapid Treatment (START) and JumpSTART
- b. California Standardized Emergency Management System (SEMS)
- c. ICS - minimum of ICS 200 level
- d. Appropriate Hazardous Materials level for agency/role
- e. Working knowledge of FIRESCOPE Field Operations Guide, MCI
- f. Working knowledge of EMS Agency Policies and Procedures (All EMS providers)
- g. EMS related communication tools (radios, ReddiNet, etc.) as required in EMS policy.

3. Ambulance Provider Field Supervisor

- a. ICS 300 level
- b. EMS related communication tools (radios, ReddiNet, etc.) as required in EMS policy.

4. On-Scene Command Staff

- a. ICS 400 level
- b. EMS related communication tools (radios, ReddiNet, etc.) as required in EMS policy.

5. Assigned EOC or DOC Command Staff

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

1.4 MCI LEVELS IN the County of SLO

MCI LEVEL I 5-10 patients

A suddenly occurring event that has the potential to overwhelm any part of the EMS system and/or the number of patients is greater than can be handled by the usual initial response. Depending on the severity of the injuries the system may have adequate resources to respond and transport the patients. Duration of the incident is expected to be less than 1 hour. Examples: Motor vehicle accident, active shooter.

MCI LEVEL II \geq 11 patients

A suddenly occurring event that has the potential to overwhelm any part of the EMS system and/or has the need for additional resources requested within the Operational Area from neighboring counties. Regional medical mutual aid system is activated. An adequate number of additional ambulances are not likely to be immediately available, creating a delay in transporting patients. The duration of incident is expected to be greater than 1 hour.

SECTION 2.0: OPERATIONAL ELEMENT

2.1 PRE-ARRIVAL ACTIVATION OF MCI PLAN:

The report of a multi-casualty incident will typically be made to a Public Safety Answering Point (PSAP) in one or more of the following manners:

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

Role of Dispatch Centers

In situations where Sheriff's Dispatch Center personnel suspects there is a potential for multiple patients, the dispatcher will relay that information to the responding resources. The dispatch center in the Area Having Jurisdiction (AHJ) will continue to operate as the lead dispatch for the incident.

Dispatch of Ambulances

All ambulances will be dispatched from the County of SLO Sheriff's Medical Communications (MedCom) dispatch center.

Dispatch Notification of Agencies

The AHJ dispatch agency will notify all lead agencies according to dispatch protocols and will give notification of a possible MCI along with an estimate of casualties (if available) to all responding

personnel. The dispatch center in the AHJ will continue to operate as the lead dispatch for the incident.

Designated MCI Dispatch Center

The AHJ dispatch agency will continue to operate as the lead dispatch agency for the incident.

2.2 ON-SCENE MCI ACTIVATION:

Activation Authority

The following have the authority to activate the MCI plan:

- The agency vested with IC responsibility

Activation Guidelines for Personnel on Scene

The initial arriving first responder shall:

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

SECTION 3.0: MCI ACTIVATION RESPONSE LEVEL I or II

3.1 COMMUNICATION AND NOTIFICATIONS:

AHJ Dispatch Centers' Responsibilities:

- Dispatch appropriate resources from your jurisdiction.
- Request Mutual Aid fire resources under any preplanned response matrix or at the request of the IC.
- Request all ambulance resources from MedCom.
- Coordinate communication between response agencies if requested.

MedCom Responsibilities:

- Dispatch requested resources from your jurisdiction.
- Inform all responding personnel of a possible MCI and, if known, the potential number of patients.
- Notify the ambulance provider Field Supervisor.
- Inform all ambulance responders of radio fire channel(s) designated by IC.
- Notify all ambulances of MCI Level – I or II.
- Inform all hospitals of the MCI with the potential number of patients.

- Poll all hospitals by radio, ReddiNet, etc. to determine the number and triage category of patients that each hospital can take from the scene by number of red, yellow and green tags. MedCom shall communicate the information back to the IC/Transportation Unit Leader.
- Notify Public Health Department (PHD) for Level II MCI.
- Dispatch additional ambulances as requested by the IC.
- Coordinate communication between response agencies if requested.

3.2 FIELD OPERATIONS

Incident Command

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

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

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

MCI ALS Roles

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

Transportation Staging

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

Additional Personnel

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

Triage and Treatment

- Simple Triage and Rapid Treatment (START/JumpSTART) system will be used by initial on-scene responders (Triage Unit) in order to assess ill or injured patients involved in the incident (Attachment D).
- JumpSTART will be used for children 8 years old or less (Attachment D).
- Patients will be placed in red, yellow and green categories.
- Re-triage all tagged patients every fifteen minutes if possible. If staffing allows, begin a more detailed assessment of patients.
- After initial triage, ALS personnel will use criteria specified in the County of SLO EMS Agency Trauma Triage Criteria, Patient Destination Policy and the MCI Destination Decision Algorithm to identify all trauma patients who will require transport to a designated trauma center (Attachment E).
- Treatment Unit Leader is an ALS provider when possible. Treatment Unit personnel will include ALS providers.
- A treatment area will be established when necessary for the incident and patient care needs. In some scenarios, patients may not be moved to the treatment area due to need for extrication, access to medical transport from their location, or other circumstance.
- Patients are managed in the field by EMS personnel; with patient care focused upon life stabilizing treatments and expeditious transport of victims to appropriate hospitals and trauma centers (Attachment E).
- The County of SLO EMS Agency's currently approved patient triage tags will be used in an MCI of 3 or more patients. All patients will be tagged!
- Prehospital care personnel shall ensure that adequate supplies of tags are available during their shift. Engine Companies should carry at least ten (10) tags per vehicle and ambulances should carry at least fifteen (15) tags per unit.

- Level I MCI: Triage Tag and Patient Care Report (PCR). The triage tag number shall be included in the documentation for each PCR.
- Level II MCI: Triage tags may be used in lieu of a patient care report (PCR) if necessary due to a large number of patients. Any care provided will be documented on triage tag.
- Patients who are re-triaged to a lower priority than their initial assessment, shall be re-tagged with a new triage tag, noting the time, and initials of the person making the assessment. The initial triage tag should be destroyed. Care should be taken that the new triage tag number is recorded and used on all communication.
- Receiving Hospitals shall monitor and retrieve all triage tags utilized to identify patients transported from the MCI. The triage tag will be saved as the medical record of prehospital care.

Patient Destinations

- Transportation Unit Leader and Medical Communications Coordinator positions will be filled with qualified and trained personnel, who may be ambulance provider staff or fire agency staff, as designated by the IC.
- Treatment Unit personnel will use the SLO EMS Agency's Trauma Triage Criteria and Patient Destination Policy to identify trauma patients meeting trauma step criteria. The MCI Destination Decision Algorithm will be used for Level I and II MCIs to assist in determining destination.
 - **Every effort shall be made to transport trauma patients to a designated trauma center. In a Level II MCI transport to a designated trauma center may not always be possible.**
 - **Every effort will be made to distribute patients appropriately, so as not to overwhelm hospital resources. Even though a hospital's pre-determined patient acceptance numbers may meet the requirement of the incident, this does not mean that all of the patients should be transported to that facility!**
- The Transportation Unit Leader, in coordination with Medical Communications Coordinator, will determine transportation methods and destinations and advise receiving hospitals via radio and/or ReddiNet.
- Where possible, and secondary to patient care requirements, attempt shall be made to transport family members to the same hospital.

3.3 PUBLIC HEALTH DEPARTMENT ROLES

In Level II MCIs:

- Assess hospitals, ambulance providers, and other healthcare providers to establish their degree of functionality.

- The Public Health Department (PHD) will activate the MHOAC role to assist needed resources from outside the Operational Area via the regional medical mutual aid plan of the Regional Disaster Medical Health System (RDMHS) and report situation status to medical and health regional and state agencies if necessary.
- Overwhelming numbers of victims may require non-traditional medical resources such as Field Treatment Sites (FTS), local clinics and urgent care centers in order to provide initial emergency medical assistance. PHEP/CHADOC may activate FTS for treating non-critical patients.

3.4 HOSPITAL ROLES

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

3.5 LAW ENFORCEMENT ROLES

Law enforcement responsibilities may include:

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

3.6 TERMINATION OF THE MCI ACTIVATION

- 3.6.1 As soon as the condition has been mitigated and/or is under control, the IC should terminate the MCI activation via a declaration by radio to the AHJ dispatch center.
- 3.6.2 If during an initial activation for a MCI the IC determines that the MCI declaration is not necessary the IC may cancel the activation. Communication of the termination of the MCI or the cancellation of the MCI activation is identical.
- 3.6.3 AHJ and MedCom will broadcast the termination of the MCI operation or the cancellation of the MCI declaration and notify all previously notified agencies.
- 3.6.3 Upon notification MedCom will issue a radio message stating that the MCI is cancelled or ended to all affected hospitals in and out of the county area.

SECTION 4.0: COMMUNICATION

4.1 FIELD/HOSPITAL COMMUNICATION

- Upon notification of a MCI, and prior to arrival at the scene, the ambulance provider Field Supervisor will initiate radio communication with the IC on scene to report, "This is the ambulance Field Supervisor en route to the scene from _____ location."
- The IC, Transportation Unit Leader or designee will contact MedCom to determine receiving facility bed availability. MedCom will poll receiving facilities to determine the number of red, yellow and green tagged patients that each facility can receive. This information will be communicated back to the IC, Transportation Unit Leader or designee by MedCom.
- The Transportation Unit Leader will activate the MCI via ReddiNet.

4.2 TRANSPORT/HOSPITAL COMMUNICATION

4.2.1 During Transport

The Transportation Unit Leader shall provide a brief radio report to the receiving hospital, as early as possible, to include the number of patients being transported and the triage tag colors.

4.2.2 Notification of Hospitals

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

4.2.3 Base Station Contact

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

SECTION 5.0: TRANSPORTATION OF THE INJURED

5.1 REQUESTING AMBULANCE AND TRANSPORTATION RESOURCES

- All requests for ambulance and transportation resources must originate from the IC or designee. The MHOAC may request additional ambulances via the medical mutual aid system at the request of the IC or designee if additional resources from outside of the County are required.
- The IC will determine if an Air Operations' position will need to be activated and resources required to manage landing zone(s).
- Medical Group Supervisor or Patient Transport Unit Leader will communicate with the IC any recommendations for resource requests for air and ground medical transport resources.

EMS resource requests shall include at a minimum:

- Number of ambulances required.
- Service types and mode (BLS, ALS, air, bus, etc.).
- Staging area location.
- Radio frequency/channel (to be used for coordination with the incident's Transportation Group Supervisor).
- Numbers and types of patients/casualties (red, yellow and green).
- Factors (Trauma/HazMat/Medical) that may affect transport decisions.

Use of appropriate EMS Air Response Units is recommended to transport patients.

5.2 AMBULANCE REQUEST GUIDELINES:

- During a MCI, care must be taken to balance the required number of ambulances to manage the MCI with the consideration for the need to maintain ambulance coverage in the County.
- When ambulances respond into the County of SLO from other counties for mutual aid purposes, these out-of-county ambulances will be assigned to the MCI incident or county coverage as appropriate to the incident.
- The IC should work with the SLO ambulance provider(s) and/or the MHOAC when a Level II MCI is declared to request additional ambulance resources such as Ambulance Strike Teams.
- Medical Mutual Aid System: The PHD will activate the MHOAC role to request needed medical resources (such as Ambulance Strike Teams) from outside the Operational

- Area via the regional medical mutual aid plan of Regional Disaster Medical Health System (RDMHS).

5.3 INITIAL CALCULATION OF THE REQUIRED NUMBER OF AMBULANCES

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

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

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

$$\text{REQUIRED AMBULANCES} = \frac{\text{NUMBER OF IMMEDIATE PATIENTS}}{\text{DIVIDED BY TWO (2)}} + \text{Plus One (1)}$$

Example: $\frac{\text{Ten (10) immediate patients}}{2} + 1 = \text{Six (6) ALS units/ambulances}$

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

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

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

5.3.3 Identifying and Assigning EMS Resources

- MedCom will identify and assign local EMS resources.
- If needed, MedCom will coordinate resource requests under established medical mutual aid agreements with the MHOAC and the ambulance provider(s).

5.4 PROVISIONS FOR EQUIPMENT

5.4.1 Treatment Areas

In certain MCIs, it will be necessary to establish treatment areas. The primary function of treatment areas is to provide an area where patients can be accounted for and stabilized/treated with available resources until transport is available. In events when

patients will be not be able to be transported for an extended period of time it will be necessary to establish a cache of equipment on site to treat these patients.

5.4.2 Equipment and Supply Resources

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

- Fire units may be equipped with both ALS and BLS supplies.
- All County of SLO fire agencies maintain back-up medical supplies at their respective stations or logistics warehouse.
- All County of SLO ambulances are equipped with both ALS and BLS supplies.
- All County of SLO ambulance agencies maintain back-up medical supplies at their respective stations and/or logistics warehouse.
- Out of county ambulances may have only BLS supplies.
- Ambulance Field Supervisor units carry BLS and ALS supplies.
- Equipment cache trailers/trucks.

5.4.3 Ambulance Medical Equipment

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

SECTION 6.0: HANDLING THE DECEASED

Sheriff-Coroner should direct on-site morgue operations.

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

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

SECTION 7.0: POST INCIDENT REVIEW

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

The operational debrief will be facilitated by the agency vested with IC responsibility and a designated representative of the EMS Agency, and will follow the County of SLO EMS Agency's QI Program Guidelines to ensure confidentiality, to promote positive and frank feedback and identify lessons learned for training improvements.

This debrief shall be conducted following an established debriefing format to facilitate such a review. The elapsed time between the incident and the operational debrief is at the discretion of the host agency, however, it is recommended that the operational debrief be held as soon as practical after the incident, ideally within one week following the termination of the MCI.

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

At their discretion the County of SLO Trauma Advisory Group will review trauma related MCIs.

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

SECTION 8.0: MCI PLAN REVISIONS

As needed, and in consultation with first responder agencies, the MCI Plan may be revised and/or updated by the EMS Agency; based upon current medical knowledge, technology, procedure, and trends in prehospital care.

OPERATIONAL CONSIDERATIONS

- 1) The Patient Transportation Unit Leader is responsible for managing patient transportation and may be the first ambulance paramedic arriving on scene.
- 2) All incoming personnel shall assume support roles based upon assignment/mission designated by the IC. All personnel shall report to staging for direction unless instructed otherwise.
- 3) All personnel with an assigned ICS position should be easily identified through the use of ICS position vests.
- 4) All personnel should have MCI position checklists/job action sheets for their assigned position (Attachment C).
- 5) Complete ICS forms as appropriate to the scope or complexity of the incident. (i.e.: 201,202,203, 214, etc.)
- 6) During the MCI, all onsite agencies shall request additional resources through the IC or his/her designee. The IC shall communicate with the Medical Group Supervisor or Transportation Unit Leader regarding patient transportation resource needs.
- 7) The IC should consider personnel needs to manage triage, patient movement, and patient management in the treatment areas when requesting resources.
- 8) Personnel shall continue to follow County of SLO EMS Agency policies and protocols
- 9) Triage and use of triage tags will be performed according to Section 3.2 of the County of SLO MCI Plan.
 - Criteria specified in the County of SLO EMS Agency's Trauma Triage Criteria and Patient Destination policy and the Patient Destination Algorithm will be used to ensure that all appropriate trauma patients are identified for transport to a designated trauma hospital. Both in and out of county designated trauma hospitals will be utilized.
 - i. Every effort will be made to transport trauma patients to a trauma center. In a Level II MCI transport to a designated trauma center may not always be possible.
 - Transportation Unit Leader/Medical Communications Coordinator will determine transportation methods and destinations and advise receiving hospitals via radio and/or ReddiNet.
 - Patient destination considerations may include: destination of patients from another MCI, MCI patients who self-report to the hospital(s), distance, number of transport vehicles, etc.
- 10) Use of air ambulance is encouraged to transport patients with an emphasis on patients that meet criteria for trauma center destinations.
- 11) Consideration should be made to reallocate personnel from the extrication and triage areas to the treatment areas as patients are triaged and moved into the treatment areas.
- 12) It is important to reassess patients in the treatment area and during transport.
- 13) The IC or designee, when requested by the Incident's Medical Branch Director, orders all EMS aircraft, assigns the Heli-Spot Manager and Safety Officer, and designates the landing zone(s).
- 14) The IC or designee should request Critical Incident Stress Debriefing (CISD) as soon as a need is identified.
- 15) Receiving hospital notifications should be brief and include the following information:
 - Number of patients being transported.
 - Triage tag number and color. If possible, denote the County of SLO Step Criteria.
 - Chief complaint/mechanism of injury.
 - Code of transport and estimated time of arrival (ETA).

COMMAND STRUCTURE AND AUTHORITY

SINGLE JURISDICTION

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

MULTI-AGENCY/JURISDICTION

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

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

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

COMMAND AUTHORITY PRINCIPLES

- The IC will be a designated representative from a law enforcement, fire, or public health agency having jurisdictional, investigative, or legal authority for the incident.
- The first arriving personnel of any agency may function as the IC implementing the necessary actions until the role can be relinquished to the appropriate agency.
- Agencies that are assisting or providing mutual aid in support of an incident will function under the direction of the designated IC or Unified Command.
- In multi-agency and/or multi-jurisdictional incidents, a Unified Command may be established at a single (site) command post (location).
- MCI ICS positions: Only those ICS positions required, due to the size and nature of the incident need be filled.

- Any large incident may need to have several divisions and/or branches under one director. Use the FIRESCOPE organizational chart as the guide to establish appropriate ICS structure and positions for the incident size.

FIRESCOPE MCI Position Checklists

MEDICAL BRANCH

DEFINITION

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

MODULAR DEVELOPMENT

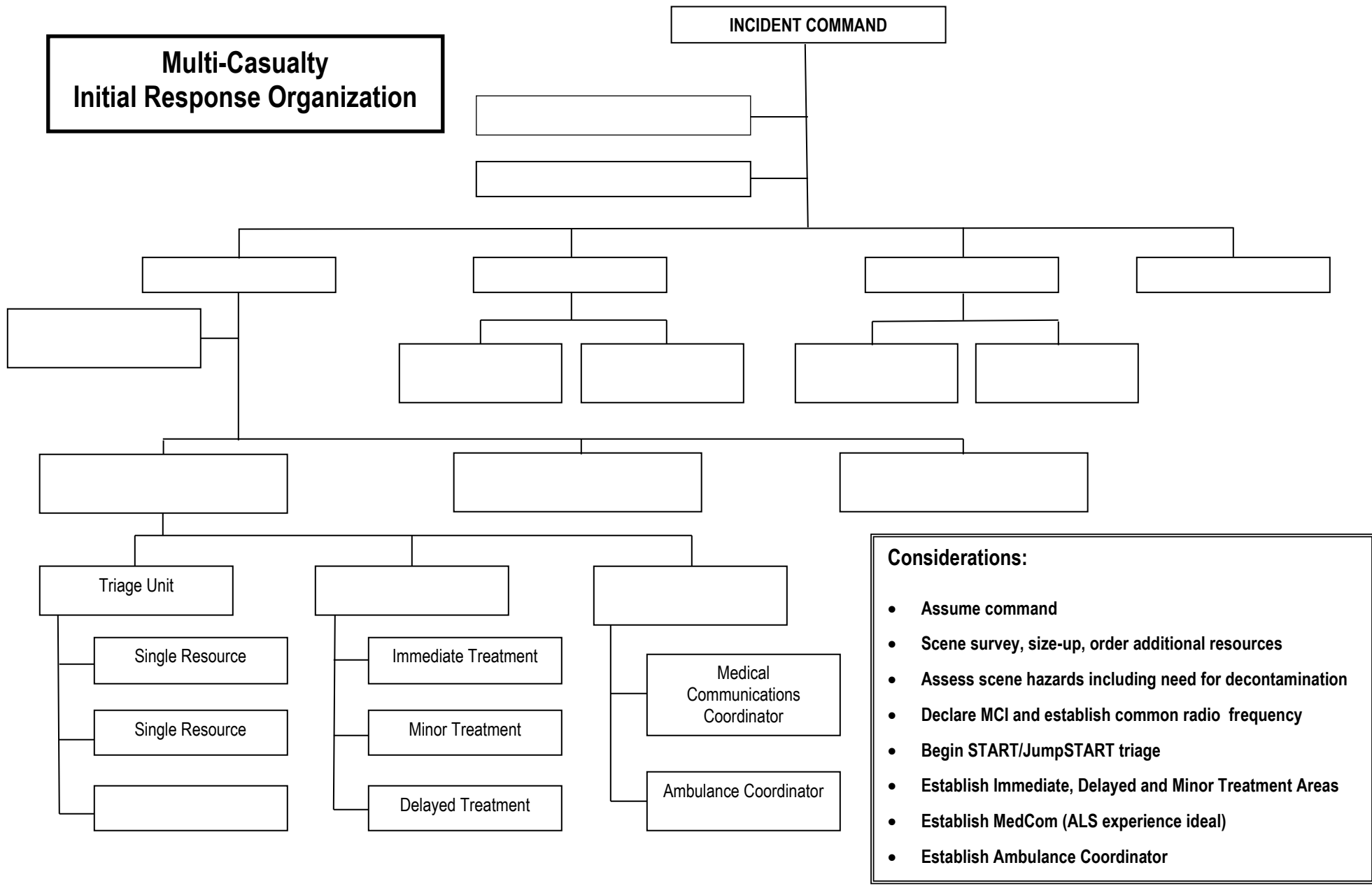
A series of examples for the modular development of the Medical Branch within an incident involving mass casualties are included to illustrate one possible method of expanding the incident organization.

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

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

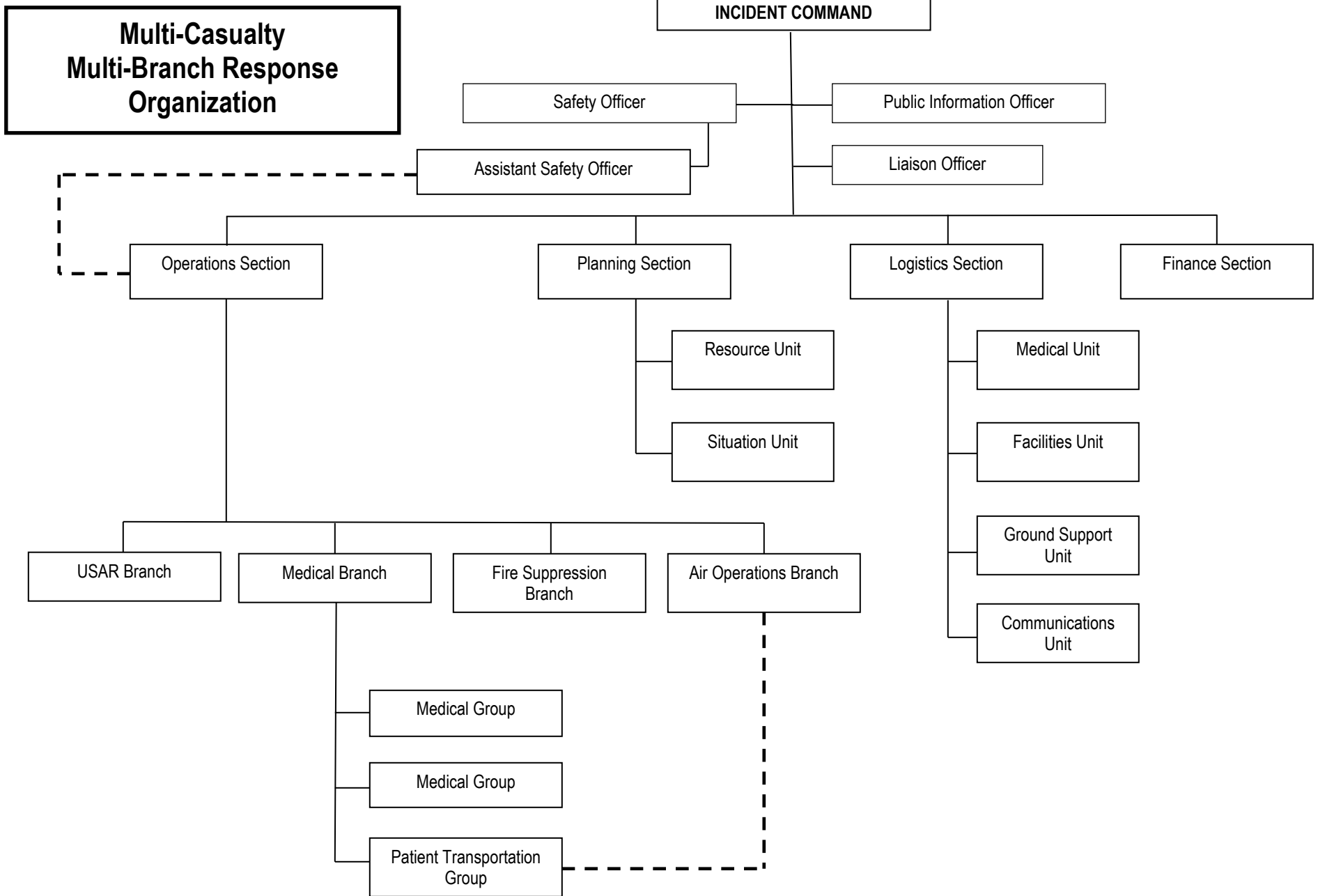
Multi-Group Response: All positions within the Medical Group are now filled. The Air Operations Branch is shown to illustrate the coordination between the Patient Transportation Unit and the Air Operations Branch. A Rescue Group is established to free entrapped victims. May consult with MHOAC for additional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

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

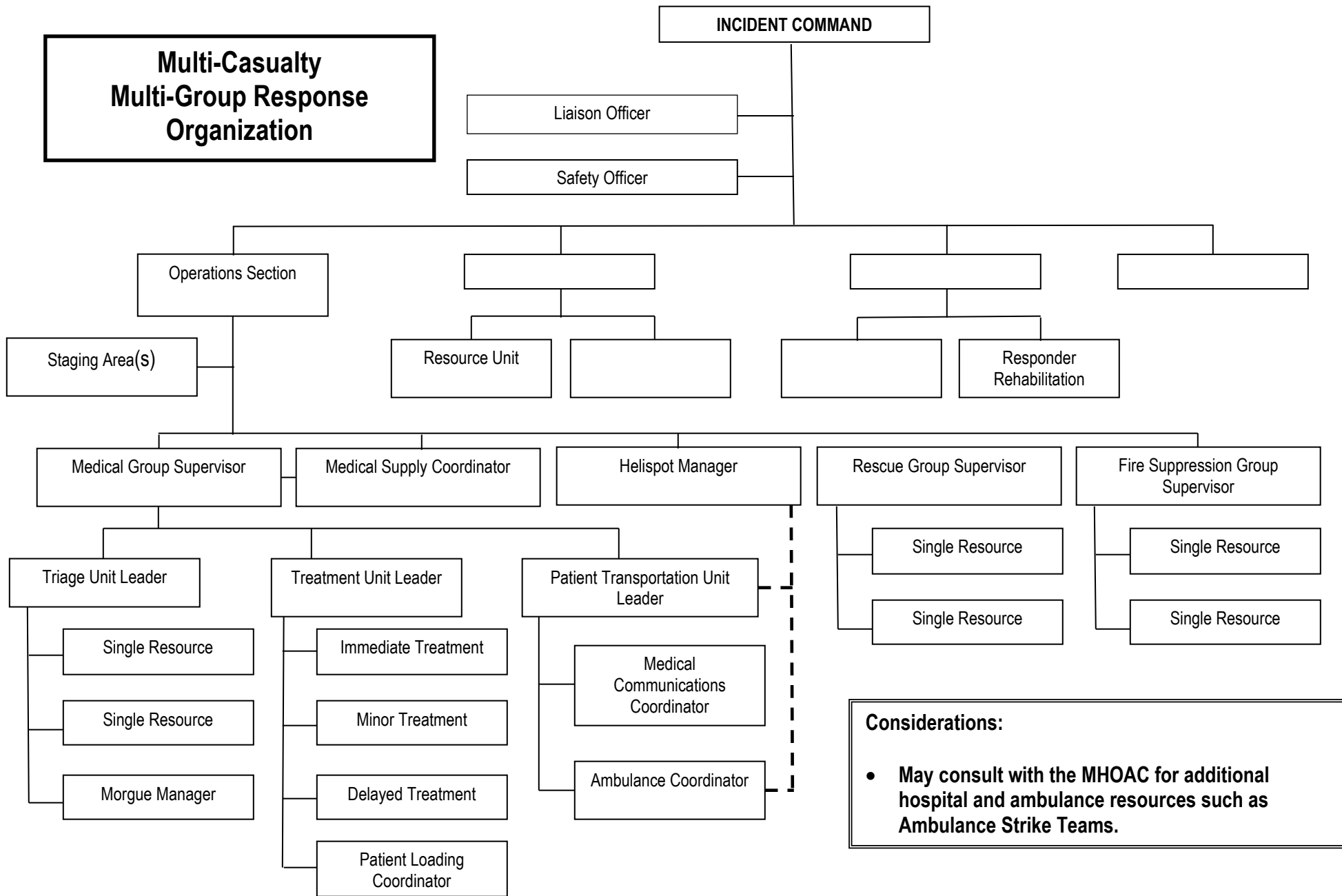


Initial Response Organization: The Incident Commander manages initial response resources as well as all Command and General Staff responsibilities. The Incident Commander assigns the resource with the appropriate communications capability to the Medical Communications Coordinator to establish communications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

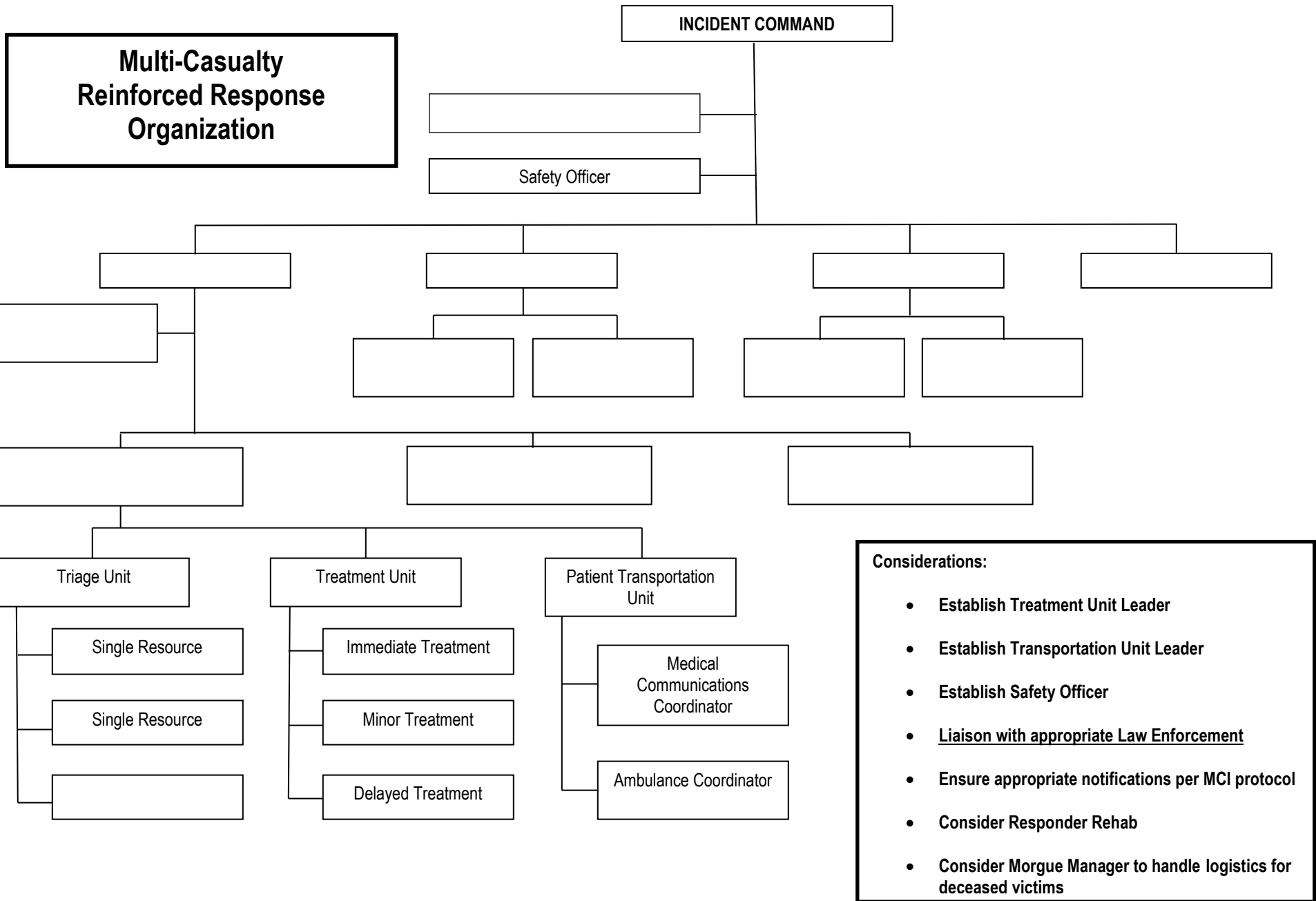
County of San Luis Obispo MCI Plan



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



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



Reinforced Response Organization: In addition to the initial response, the Incident Commander establishes a Safety Officer, Treatment Unit Leader, Patient Transport Unit Leader and Ambulance Coordinator. Patient treatment areas are established and staffed.

INCIDENT COMMANDER
Job Action Sheet

Refer to FIREScope Field Operation Guide, Common Responsibilities and Incident Commander Checklist of major responsibilities.

- Refer as needed to the County of SLO EMS Agency MCI Plan
- Assume incident command and establish or participate in Unified Command with other responding agencies (law, fire, EMS, other agency).
- Size up the situation by determining the nature and magnitude of the incident, the estimated number of injured, and severity of the injuries.
- Confirm and communicate a declaration of the MCI status and MCI level (I or II) to dispatch and activate the MCI plan.
- Assign appropriate ICS roles to responding personnel using MCI job action sheets, vests (if available and warranted) and appropriate documentation forms located in MCI kits. MCI kits are on all fire battalion chief vehicles and ambulance supervisor vehicles.
- Establish the ambulance staging area, triage and treatment areas and morgue area as appropriate.
- Establish initial priorities and immediate resource requirements.
- Coordinate with the appropriate position (i.e. Medical Group Supervisor, Transportation Unit) regarding patient transportation resource needs.
- Determine if an Air Operations position will need to be activated and the resources that will be required to operate landing zone(s).
- Order appropriate medical management resources.
- Work with the MHOAC when a Level II MCI is declared, to request additional needed ambulance resources such as Ambulance Strike Teams, via medical mutual aid from RDHMS Region 1.
- In Level II events consider establishment of an agency representative from the ambulance provider to coordinate ambulance resources through a liaison officer.
- Complete the 201 and other ICS forms as appropriate to the scope or complexity of incident.

MEDICAL BRANCH DIRECTOR
Job Action Sheet

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

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

MEDICAL GROUP SUPERVISOR
Job Action Sheet

The Medical Group Supervisor reports to the Medical Branch Director and supervises the Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader and Medical Supply Coordinator. The Medical Group Supervisor establishes command and controls the activities within a Medical Group:

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

TRIAGE UNIT LEADER
Job Action Sheet

The Triage Unit Leader reports to the Medical Group Supervisor and supervises Triage Personnel/Litter Bearers and the Morgue Manager. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the triage area. When triage has been completed and all the patients have been moved to the treatment areas, the Unit Leader may be reassigned as needed:

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

TRIAGE PERSONNEL
Job Action Sheet

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

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

LITTER BEARER PERSONNEL
Job Action Sheet

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

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

MORGUE MANAGER
Job Action Sheet

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

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

TREATMENT UNIT LEADER
Job Action Sheet

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

- Review Common and Unit Leader Responsibilities (FIRESCOPE).
- Develop organization sufficient to handle assignment.
- Direct and supervise Patient Loading Coordinator, Immediate (red), Delayed (yellow), and Minor (green) Treatment Areas.
- Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
- Ensure adequate patient decontamination and proper notifications are made (if applicable).
- Maintain record of all patients' status.
- Receives triage tag stubs from Triage Unit Leader and inserts these in the Triage Tag Receipt Holder.
- Maintains Treatment Unit Leader Count Worksheet and notes trauma patients.
- Establish communications and coordination with Patient Transportation Unit Leader.
- Ensure that MedCom receives basic patient information and condition from Treatment Area Managers and/or Patient Loading Coordinator.
- Coordinate with Immediate (red) Treatment Area Manager to communicate patient air transportation needs to MedCom.
- Ensure continued assessment of patients and re-assess/re-locate as necessary throughout Treatment Areas.
- Ensure that ALS Treatment Unit personnel will use criteria specified in the SLO EMS Agency Trauma Triage Criteria and Patient Destination policy to ensure that all appropriate trauma patients are identified for transport to a designated trauma center.
- Every effort will be made to transport trauma patients to a trauma center. In a Level II MCI transport to a designated trauma center may not always be possible.
- Assign incident personnel to be litter bearers/treatment personnel.
- Responsible for the movement of patients to ambulance loading areas.
- Request sufficient medical caches and supplies including DMSU or support trailers.
- Give periodic status reports to Medical Group Supervisor.
- Request specialized medical resources through the MHOAC. (ex. DMAT, DMORT, MRC)
- Maintain Unit/Activity Log (ICS Form 214).

PATIENT LOADING COORDINATOR
Job Action Sheet

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

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

IMMEDIATE (RED) TREATMENT AREA MANAGER
Job Action Sheet

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

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

Delayed (YELLOW) TREATMENT AREA MANAGER
Job Action Sheet

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

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

MINOR (GREEN) TREATMENT AREA MANAGER
Job Action Sheet

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

- Review Common Responsibilities (FIREScope).
- Assign treatment personnel to patients.
- Provide assessment of patients and re-assess/relocate as necessary.
- Report patient status to Treatment Unit Leader.
- Ensure appropriate level of treatment is provided to patients.
- Ensure that patients are prioritized for transportation.
- Coordinate with Unit Leader to ensure that MedCom receives basic patient information and condition.
- Coordinate transportation of patients with Patient Loading Coordinator.
- Notify Patient Loading Coordinator of patient readiness and priority for transportation.
- Ensure that appropriate patient information is recorded.
- Maintain Unit/Activity Log (ICS Form 214).

PATIENT TRANSPORTATION UNIT LEADER
Job Action Sheet

Reports to the Medical Group Supervisor.

Supervises: Medical Communications Coordinator, Ambulance Coordinator.

Responsible for the coordination of patient transportation and maintenance of records relating to the patient's identification, condition, and destination.

May be initially established as a Unit and upgraded to a Group based on incident size or complexity:

- Review Common Responsibilities and Unit Leader Responsibilities in FIRESCOPE
- Designate Ambulance Staging Area(s).
 - Ensure that ambulance staging area is away from ingress and egress pathways for ground/air resources for the operation.
- Ensure the establishment of communications with the appropriate hospitals or other coordinating facility/agency via radio and/or ReddiNet.
- Ensure that bed availability from hospitals is communicated to MedCom including trauma bed availability from designated trauma centers.
- Tracks available beds in and out of county for victims of incident using Hospital Availability Worksheet.
- Every effort will be made to transport trauma patients to a trauma center. In a Level II MCI transport to a designated trauma center may not always be possible.
- Direct the off-incident transportation of patients as determined by the Medical Communications Coordinator.
- Maintain or ensure that Ambulance Coordinator maintains Transportation Receipt Holder with receipts from triage tags for patients that have been transported from the scene.
- Establish communications with the Ambulance Coordinator and the Helispot Manager.
- Coordinate the establishment of the Helispot(s) with the Medical Group Supervisor and the Helispot Manager
- Request additional medical transportation resources (air/ground) as required.
- Notify the Ambulance Coordinator of ambulance requests.
- Maintain Unit/Activity Log (ICS Form 214).

MEDICAL COMMUNICATIONS COORDINATOR
Job Action Sheet

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

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

AMBULANCE COORDINATOR
Job Action Sheet

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

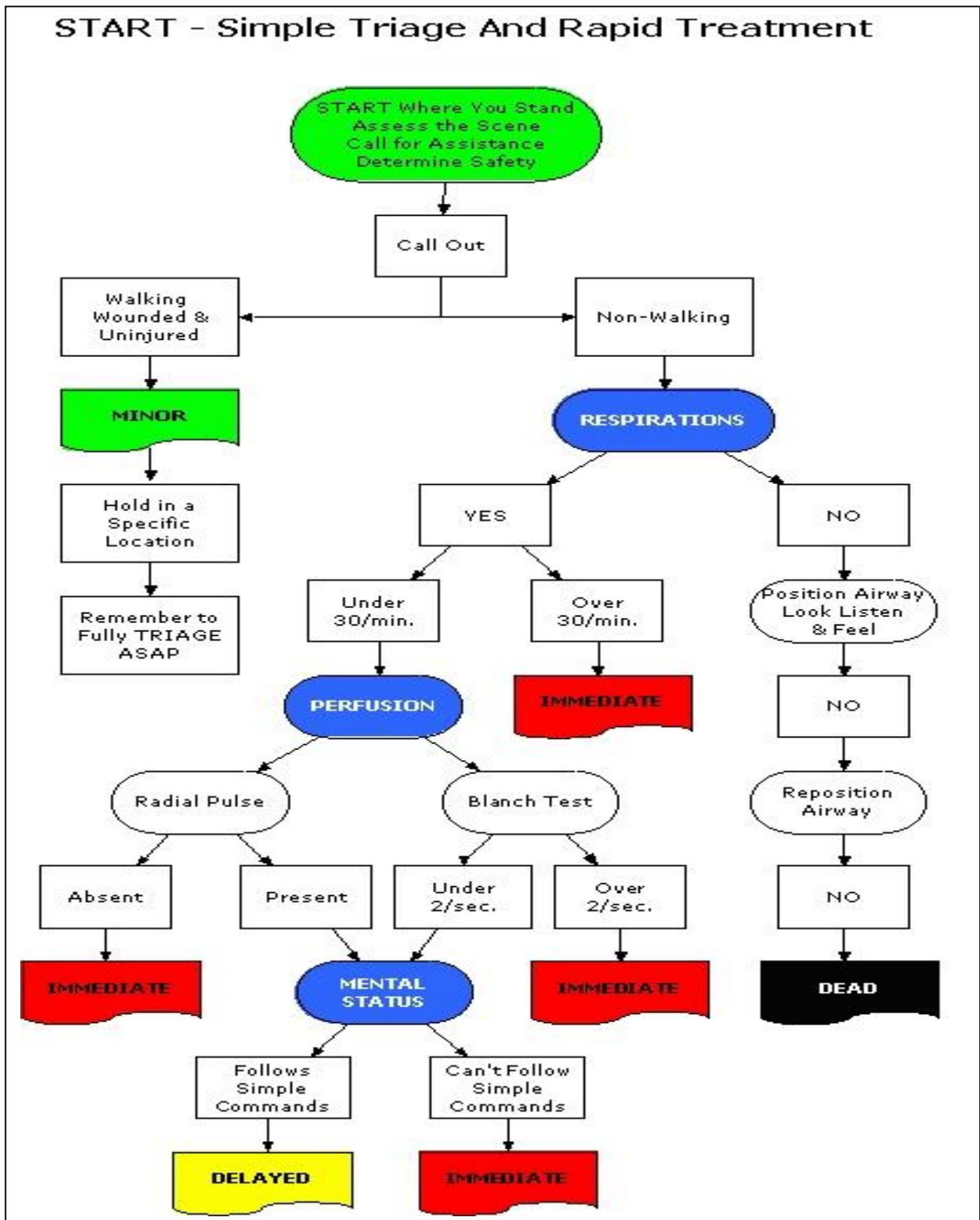
- Review Common Responsibilities (FIREScope).
- Establish appropriate Staging Area for ambulances.
- Establish routes of travel for ambulances for incident operations.
 - Ensures that ambulance Staging Area is away from ingress and egress pathways for ground/air resources for the operation.
- Requests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

MEDICAL SUPPLY COORDINATOR
Job Action Sheet

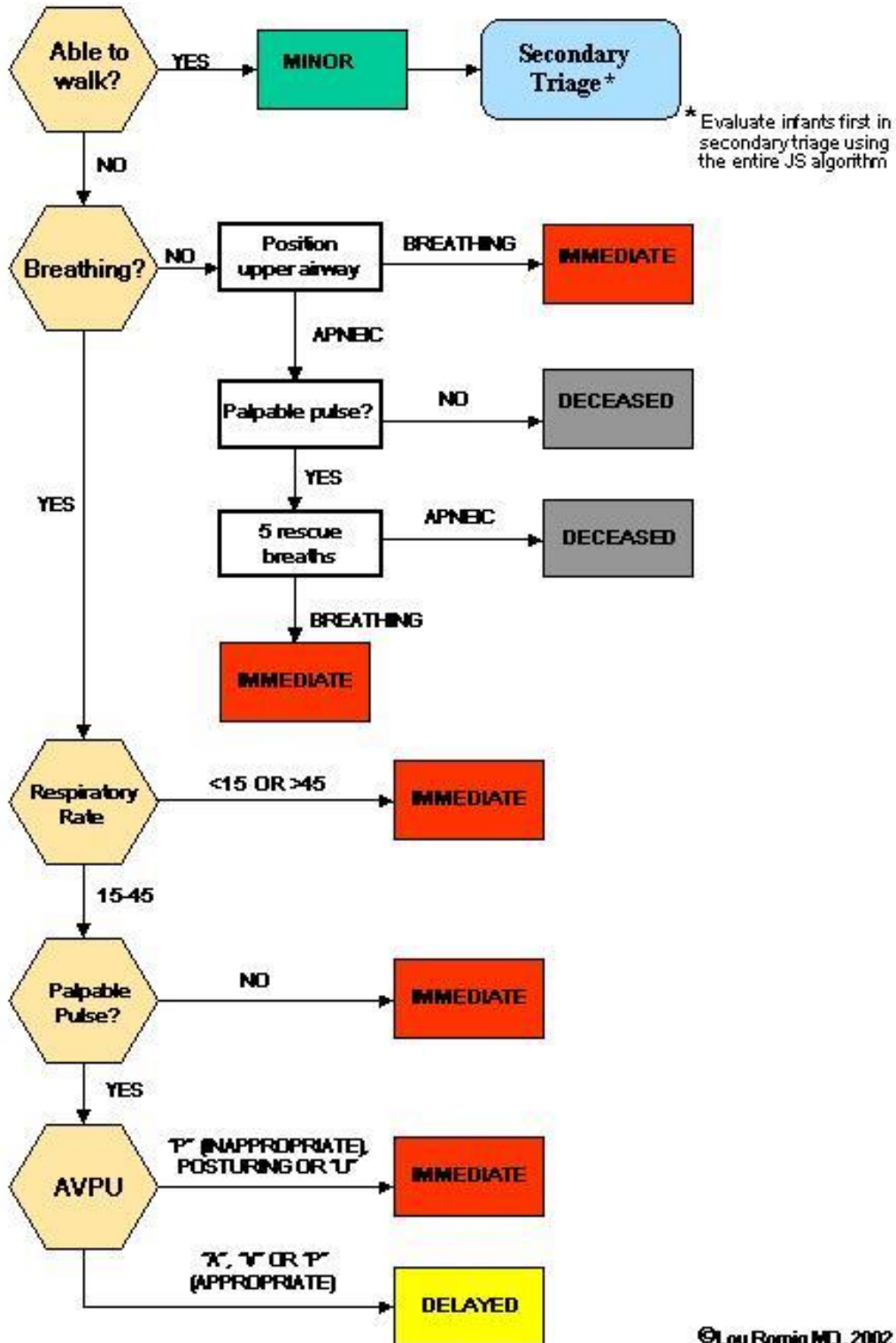
The Medical Supply Coordinator reports to the Medical Group Supervisor and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group:

- Review Common Responsibilities (FIREScope).
- Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group.*
- Request additional medical supplies.*
- Distribute medical supplies to Treatment and Triage Units.
- Maintain Unit/Activity Log (ICS Form 214).

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



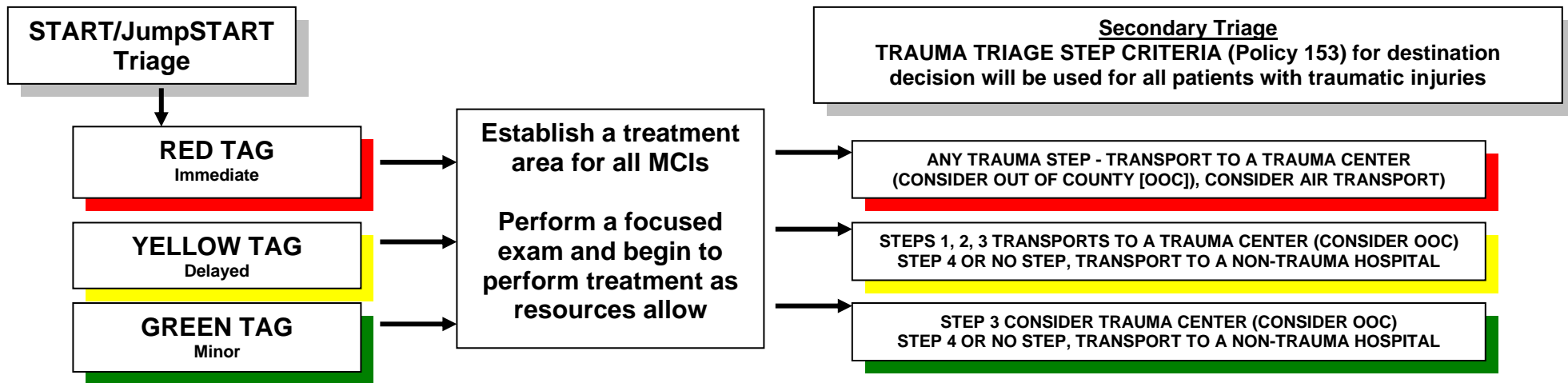
JumpSTART Pediatric MCI Triage[®]



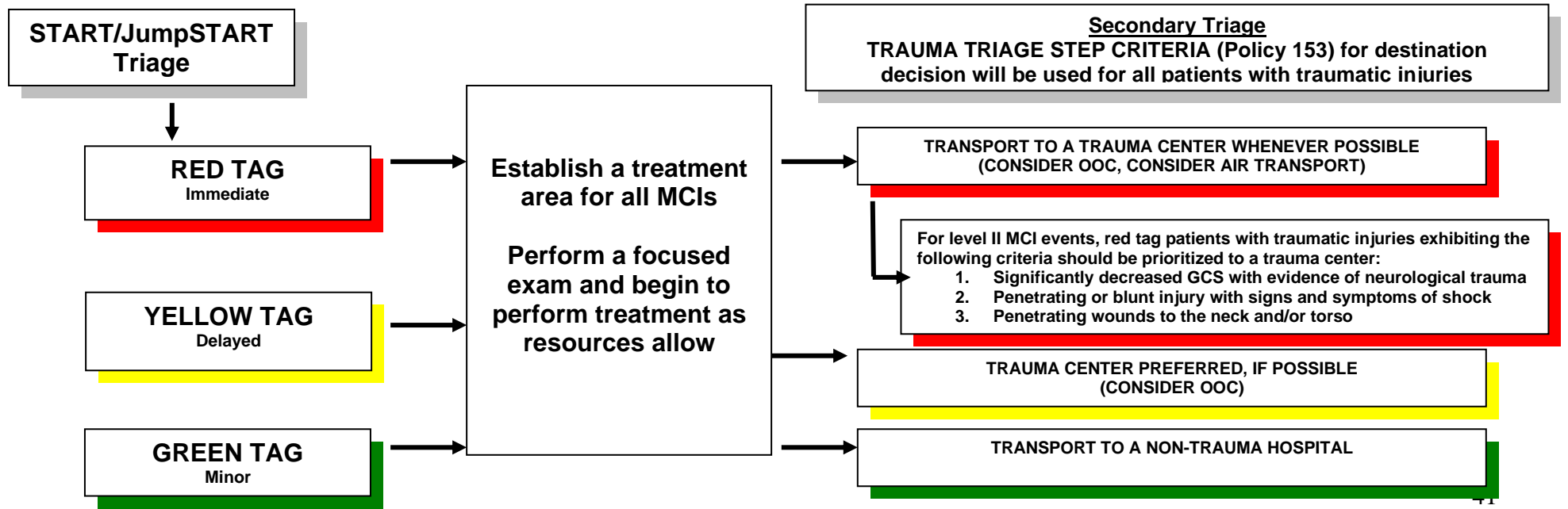
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MCI DESTINATION DECISION ALGORITHM including TRAUMA TRIAGE

LEVEL I MCI FULL ePCR & TRIAGE TAGS




LEVEL II MCI Patient documentation on triage tag



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

TRIAGE COUNT WORKSHEET



Triage Count Worksheet

Incident Comm Plan Tac#

Recorder Name Agency Date / / Time :

Triage Unit Members

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

Initial Count

Location Time

ADULTS

Tally from Triage Teams		Total
I	IMMEDIATE	<input style="width: 40px;" type="text"/>
D	DELAYED	<input style="width: 40px;" type="text"/>
M	MINOR	<input style="width: 40px;" type="text"/>
	MORGUE	<input style="width: 40px;" type="text"/>

PEDIATRICS

Tally from Triage Teams		Total
I	IMMEDIATE	<input style="width: 40px;" type="text"/>
D	DELAYED	<input style="width: 40px;" type="text"/>
M	MINOR	<input style="width: 40px;" type="text"/>
	MORGUE	<input style="width: 40px;" type="text"/>

MedCom Advised PT Total

Secondary Count

Location Time

ADULTS


Tally from Triage Teams		Total
I	IMMEDIATE	<input style="width: 40px;" type="text"/>
D	DELAYED	<input style="width: 40px;" type="text"/>
M	MINOR	<input style="width: 40px;" type="text"/>
	MORGUE	<input style="width: 40px;" type="text"/>

PEDIATRICS

Tally from Triage Teams		Total
I	IMMEDIATE	<input style="width: 40px;" type="text"/>
D	DELAYED	<input style="width: 40px;" type="text"/>
M	MINOR	<input style="width: 40px;" type="text"/>
	MORGUE	<input style="width: 40px;" type="text"/>

MedCom Advised PT Total

Treatment Unit Leader Count Worksheet


Treatment Unit Leader Count Worksheet

Incident Comm Plan Tac#

Recorder Name Agency Date / / Time

IMMEDIATE	Count	Time	Count	Time	Count	Time	Count	Time
Area Manager		:		:		:		:
Wants/Needs	Traumas <input style="width: 40px;" type="text"/>	Notes	Traumas <input style="width: 40px;" type="text"/>	Notes	Traumas <input style="width: 40px;" type="text"/>	Notes	Traumas <input style="width: 40px;" type="text"/>	Notes

DELAYED	Count	Time	Count	Time	Count	Time	Count	Time
Area Manager		:		:		:		:
Wants/Needs	Traumas <input style="width: 40px;" type="text"/>	Notes	Traumas <input style="width: 40px;" type="text"/>	Notes	Traumas <input style="width: 40px;" type="text"/>	Notes	Traumas <input style="width: 40px;" type="text"/>	Notes

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

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

Treatment Unit Leader Triage Tag Receipt Holder

Triage Tag Receipt Holder

Indicate Treatment Area(s) Incident Page of

Area Mgr Agency Date / / Time : : Comm Plan Tech

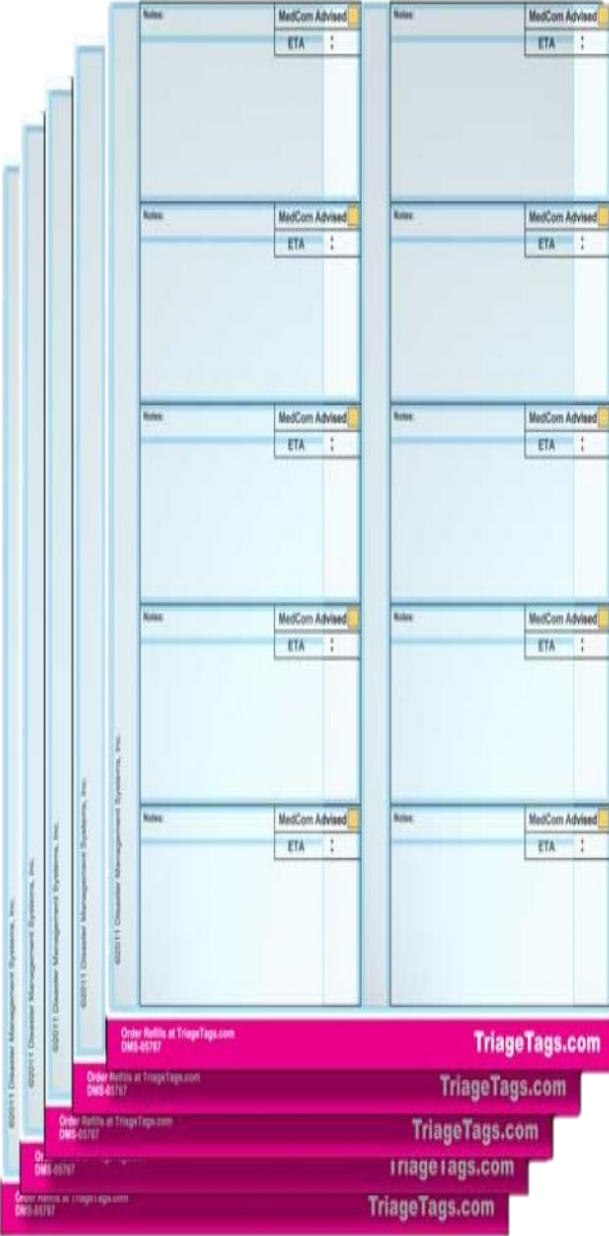
1	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	11	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	21	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	31	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
2	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	12	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	22	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	32	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
3	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	13	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	23	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	33	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
4	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	14	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	24	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	34	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
5	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	15	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	25	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	35	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
6	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	16	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	26	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	36	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
7	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	17	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	27	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	37	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
8	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	18	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	28	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	38	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
9	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	19	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	29	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	39	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>
10	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	20	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	30	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>	40	Trauma Patient Notes: Transported / Transferred <input type="checkbox"/>

Order Refill at TriageTags.com

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TriageTags.com

Triage Tag TRANSPORTATION RECEIPT HOLDER



MCI Patient Tracking Form

The initial estimated capacity of each facility is listed below. Regardless of a receiving facilities capability, the appropriate **DISTRIBUTION** of patients is imperative to ensure that one facility is not overloaded.

Capacity of Facilities	Total Patients Sent by Color			
	Facility	Red Tag/ Immediate	Yellow Tag/ Delayed	Green Tag/ Minor
	Arroyo Grande	1	1	2 or more
	French	1	2	2 or more
	Sierra Vista - TC	4	3	10
	Twin Cities	3	4	12
	Marian - TC	3	6	12

The number will be reconfirmed and updated by Transportation Unit Leader or MedCom with the initiation of a MCI. The updated numbers will then be transmitted to either the IC or Transportation Leader upon request.

County of San Luis Obispo MCI Medical Cache Resources

Cache Type	Unit Designation	Estimated Patients:	Requesting Via:	Owner: Location

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

Organization	ACS	Vent	Pallets	Location

County of San Luis Obispo EMS Agency MCI AFTER ACTION CHECKLIST

Date of MCI: _____ Incident Commander: _____

Location of Incident: _____

Level of MCI declared: _____ # of patients: _____

- | | YES | NO |
|---------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. The IC declared a MCI and the AHJ dispatch center notified MedCom. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The PHD MHOAC was notified by MedCom of a Level II MCI/potential MCI. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ambulance staff checked in with the IC for assignment to a MCI position. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. All resources were ordered through the IC. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Triage & treatment areas were set up. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. All patients were triaged and triage tags were applied. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. On scene patient care and transport destinations were reviewed for appropriateness. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. MCI positions were assigned in a timely manner to responding personnel, while following the ICS, and were appropriate. | <input type="checkbox"/> | <input type="checkbox"/> |

Was the operational response different than that described in the SLO EMS Agency MCI Plan? If so, describe any resource limitation(s) or other reason(s) that the plan could not be followed.

Fax or email this form to the County of SLO EMS Agency within 24 hours of the MCI to 805-788-2517