

# Snohomish County

## Multiple Casualty Incident Plan



January 1, 2012

## ACKNOWLEDGEMENTS

---

Dr. Ron Brown  
Snohomish County Medical Program Director

Greg Macke, Chair  
Snohomish County EMS Council

Mark Correia, Assistant Chief  
Snohomish County Fire District #1

Eric Andrews, Assistant Chief  
Snohomish County Fire District #7

Shaughn Maxwell, Captain-MSO  
Snohomish County Fire District #1

Larry Hadland, Captain-MSO  
Lynnwood Fire Department

Roger Vares, FF/PM  
Everett Fire Department

Kristina Forbes, FF/PM  
Lynnwood Fire Department

Tony Mace, FF-EMT  
Snohomish County Airport Fire Department

Snohomish County EMS Council

King County EMS

Snohomish County Fire Chiefs Association

## TABLE OF CONTENTS

I.	EXECUTIVE SUMMARY.....	3
II.	PLANNING ASSUMPTIONS.....	4
III.	DEFINITIONS.....	5
IV.	MCI CONEPTS OF OPERATIONS.....	8
	A. Dispatch.....	8
	B. Initial Report and Size Up.....	8
	1. Progress Reports.....	8
	2. Tactical Benchmarks.....	8
	C. Initial Actions.....	9
	D. Recon.....	9
	E. Scene Security.....	10
	1. Operational Zones.....	11
	2. Crowd Control.....	11
	3. Volunteers.....	12
	F. Staging.....	12
	G. Transportation Corridor.....	12
	H. Treatment Area.....	13
	1. Field Treatment Site.....	13
	I. Triage.....	13
	J. Green patient Area.....	14
	K. Communications.....	15
V.	PATIENT DISPOSITION.....	16
	L. Rescue.....	16
	1. Extraction.....	16
	M. Extrication.....	16
	N. Decontamination.....	17
	O. Patient Sheltering.....	18
	P. Field Treatment.....	19
	Q. Patient Count and Tracking.....	19
	R. Documentation.....	20
	1. MIRFS/Epcr.....	20
	2. Unique Number with Transporting Agency.....	20
	S. Transportation.....	20
VI.	JOB ASSIGNMENT.....	21
	A. Medical.....	22
	1. Treatment .....	22
	2. Transportation.....	22
	B. Rescue.....	23

Appendix A: MCI Dispatch RUN CARDS.....24  
Appendix B: MCI Duty Cards.....26  
Appendix C: Good Samaritan Form.....28

DRAFT

Snohomish County fire, EMS, and police departments define a Multiple Casualty Incident (MCI) as any time the presence of multiple patients at an incident affects the treatment decisions of individual patients.

Snohomish County strives to always provide the best care possible to any patient. However, when there are more patients than the resources on scene can adequately take care of, the goal must be to provide the best treatment possible for as many patients as possible. This means that operations must be adjusted to maximize the efficient use of available resources.

The goal with this plan is to effectively manage an incident with an overwhelming number of patients while effectively, efficiently, and safely delivering patients to definitive care.

This plan seeks to reduce chokepoints, unnecessary actions, and streamline efforts to reduce the time it takes to remove all patients from the scene. This includes:

- using the Sick/Not Sick triage standard to reduce time spent triaging;

- having the first arriving company establish a transportation corridor to ensure a smooth flow of transportation resources;

- establishing geographic divisions in larger incidents to speed triage and extraction;

- scaling patient tracking and documentation with the size and complexity of an incident.

With the emphasis on rapid transport and efficient use of resources, Snohomish County Fire, EMS, and police agencies will be ready to handle a Multiple Casualty Incident.



The traditional definition of an MCI is: any incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at that incident. A more specific working definition is any time the presence of multiple patients at an incident affects the treatment of individual patients.

The priority of an MCI response is to streamline efforts to speed patient transition to definitive care centers.

This plan is scalable to all sizes and complexity levels of MCI responses. Any action that delays the treatment or transport of patients should be modified or eliminated as long as it does not increase the risk to responders.

It is preferred that Snohomish County emergency responders will use the Sick/Not sick model for MCI triage. "Sick" patients will be classified as red. "Not Sick" patients will be classified as yellow or green. Other triage types may be used if approved by the Snohomish County MPD and EMS Council.

All triage systems produce similar results, resulting in red, yellow, green and black patients. Therefore, when working with other agencies, it does not matter if different triage systems are used.

It is believed a triage funnel point creates an unnecessary choke point, impeding patient care. The use of a triage funnel point is optional.

Deceased patients will not be moved, unless it is necessary to extract a live patient.

The mental stress to the responders during an MCI can cause dramatic adverse effects. Individual agencies are encouraged to develop a program to help care for the emotional and mental health of their staff.

**Alternate Care Facility (ACF):** Location, preexisting or created, that serves to expand the capacity of a hospital in order to accommodate or care for patients when an incident overwhelms local hospital capacity. In an MCI, patients will be triaged and transported to the hospital not the ACF for definitive care.

**Base:** Designated parking area for apparatus that are assigned a task or function during an incident.

**Colored Flagging:** A color coded identification system used to designate medical priority of patients during a Multiple Casualty Incident.

Red Flagging (immediate)

Yellow Flagging (delayed)

Green Flagging (minor)

Black (black/white) Flagging (deceased)

White Flagging (decontaminated/clean patient)

**Decon:** To decontaminate a person or persons in accordance with the Snohomish County Hazardous Materials/Weapons of Mass Destruction Operating Guidelines.

**Disaster Medical Control Center (DMCC) (formerly known as Hospital Control):** The DMCC (also known as Hospital Control) is the Hospital responsible for providing Transport with a coordinated distribution of patients to area hospitals based on patient needs and the hospitals capabilities. For the purpose of this plan, Providence Hospital will be the primary DMCC for Snohomish County with Harborview Medical Center as the backup.

**Extraction:** The process of moving patients out of the hot zone to the treatment and transport areas.

**Extrication:** The process of removing a patient from an entrapment.

**Field Treatment Site:** Area designated or created by emergency officials for the congregation, triage, medical treatment, holding, and/or evacuation of casualties following a multiple casualty incident.

**Field Triage:** The process of rapidly categorizing a large number of patients according to their severity of injury in order to prioritize their extrication and/or extraction to the treatment area.

**Sick/Not Sick:** The Sick/Not Sick approach to triage utilizes the EMT's knowledge and experience to rapidly evaluate a patient's physiological status. The sick patient is categorized as Red. The not sick patient is considered Green if they are able to get up and walk on their own, and Yellow if they have injuries preventing moving themselves. (Snohomish County 2010 EMT Patient Care Guidelines) It is understood that the Sick/Not Sick model encompasses the ABC, START, RPM, and other triage systems used to determine the patient's severity and transport priority.

**Israeli Triage:** Ambulatory patients are automatically triaged for delayed care. For others, categorization is based on vital signs. A quick look will determine if the patient can verbally respond and if the airway is open. Otherwise, the physician performs a simple chin lift or jaw thrust maneuver, or attempts removal of oral debris. If there is no respiration after the airway is opened, the patient is declared dead. After respiration, the pulse and capillary refill are checked, and if there is no peripheral pulse or capillary refill is delayed, the patient is triaged for immediate care. If a good peripheral pulse exists and capillary refill is normal, the patient is triaged for urgent care. Any ongoing bleeding should be stopped.

**Green Patient Area:** An area dedicated for congregation, treatment, and care of patients with minor injuries. Designated as a separate area from Treatment due to the large number of potential patients and the special considerations they may need such as shelter, food and restroom facilities. Depending on the type of incident they may also be considered witness/suspects and require police presence.

**Green Patient Manager:** A functional IMS position designed to manage the green patients at an MCI.

**Multiple Casualty Incident (MCI):** An incident resulting from man-made or natural causes with associated illness or injury to a large number of people. The effect is that patient care cannot be provided immediately to all and resources must be managed.

**MCI Response:** Varied level of resources dispatched to an incident dependent upon the nature of the incident, the number of patients, and their severity of injury.

**MCI Unit:** A mobile unit, which contains large quantities of medical supplies that can be dispatched to a scene of an MCI. MCI units typically treat 50 or more patients.

**Medical:** Ensures that Triage, Extraction, Treatment, Transportation, Green Patient Area, Medical Staging, and Morgue Team functions are performed; establishing positions as necessary.

**Medical Staging:** An area established to maintain medical supplies, personnel and equipment. The Medical Staging Area will not be necessary at all incidents. When it is indicated, Medical will assign a Medical Staging Manager.

**Recon:** The act of gathering information to support the operation or function being performed.

**Rescue:** In larger or more complex incidents Rescue will oversee the extraction and extrication of patients.

**Staging:** Location where incident personnel and equipment are assigned on an immediately available status.

**Transportation Staging:** Designated parking area for patient transport vehicles. Operators and attendants will not leave their vehicles.

**Treatment Area:** The designated area for the collection and treatment of patients.

- Red: an area where patients require immediate assistance
- Yellow: an area where patient injuries are serious (delayed) but not life-threatening
- Green: an area where patients with minor injuries are kept

**Unique Identifier:** Number preprinted on a band or bracelet to assist in tracking patient throughout the incident from initial entry to final disposition

**Zones (Hot, Warm, Cold, exclusion):** Operating zones that define areas of an incident and provide for a safe working area for responders.

**A. Dispatch**

There are two dispatch centers in Snohomish County: Snocom and Snopac. Each individual dispatch center has put in place a matrix and/or a run card to activate an MCI and dispatch the proper resources to the scene of the incident. All requests for Mutual Aid are coordinated through the dispatch centers.

**B. Initial Report and Size Up**

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

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

Unit identifier

The location, or corrected location

Initial basic impression

As soon as possible, the officer will give a size-up report including:

Briefly describe an impression of the scene, including known hazards

Cause of the incident if known

Estimate total number of patients

Establish the Command Designator and Command Post location

Designate the Transportation Corridor (see Transportation Corridor )

Initial actions and assignments

Base and Staging locations

Additional resource requests

## 1. Progress Reports

Progress reports are required any time there is a change of the Incident Commander and every 20 minutes. ICs may request a ten-minute timer to facilitate progress reports.

The progress reports should include the following:

Current estimated total patient count

Update transportation corridor location as needed

Numbers of red, yellow, green, and black patients when known

Number of patients remaining to be extracted

Number of patients transported

Progress of hazard mitigation

Additional Resources needed.

## 2. Tactical Benchmarks (broadcast dispatch agency for time stamps)

All patients extracted.

All red patients transported

All patients transported/clear of incident

Any tactical benchmarks appropriate for hazard mitigation

## C. Initial Actions

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

Critical Initial Company Actions:

Initial and size-up reports

Establish and secure the transportation corridor

Give assignments to incoming units (to include staging and base).

Assignments to be handled by initial companies:

## Begin Recon and Triage

Perform a risk assessment and begin hazard mitigation for the purpose of reducing the immediate danger to patients, rescuers, or the public

Designate a green patient area and have all green patients move to that location

Begin extraction and treatment of patients as able.

### D. Recon

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

Recon should identify the following:

Equipment needs

Levels of PPE that will be required. (Note: Differing levels may be required in different areas.)

Estimate of the number and condition of patients involved.

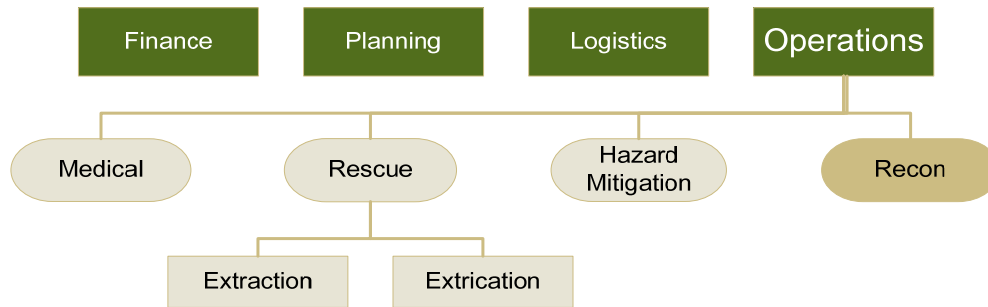
Hazards

Cause of the incident

Any physical barriers preventing easy access between areas in the hazard zone. If so, identify areas for multiple treatment and transportation areas.

Recon teams should consider using an elevated platform to help form an overall picture of the incident. This can include nearby buildings, aerial ladders, or geographical highpoints. Helicopters may be considered.

Recon reports directly to Operations (example below).



## E. Scene Security

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

Secondary threats

Crowd control

Traffic control

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

### 1. Operational Zones

Initial companies need to clearly establish hot, warm, and cold zones. The zones must be clearly communicated to all on-scene responders, including law enforcement. The operational zone locations should be broadcast over the main tactical channel to inform all incoming units even if coordination with law enforcement is handled face to face. Fire scene tape should be used to clearly mark the exclusion zone (outer perimeter) of an incident when possible. Larger sites may need to be secured by law enforcement.

The following list outlines the zones that should be established:

**The Hot Zone:** will include the area of any non-ambulatory patients that have not been removed as well as ongoing hazards. The Hot Zone will be considered a higher risk area, and should be restricted

to personnel who have donned appropriate PPE and have an assigned task within the Hot Zone.

The Warm Zone: is the transition area between the Hot and Cold Zones and will contain any decontamination procedures.

The Cold Zone: will contain all Emergency services activities not involved in the Hot or Warm Zones. This includes the Treatment area, Transportation Corridor, Command Post and Staging areas.

The Exclusion Zone: will be the outside limit of the Cold Zone. The public and media will be located outside the Exclusion Zone. Small incidents will allow scene tape to be used to physically designate the Exclusion Zone. Law enforcement should be used in larger incidents to secure the Exclusion Zone.

## 2. Crowd Control

Care must be given to crowd control, but total exclusion of bystanders and volunteers may not be possible or practical. If exclusion is impossible or impractical, attempts should be made to moderate the risk to both bystanders and rescue personnel with the help of law enforcement.

## 3. Volunteers

MCI incidents may draw civilian and professional volunteers with varying levels of skill and expertise. These volunteers can be helpful if utilized in a safe and organized way, but if they are ignored, they can hinder efforts and increase the risk to both themselves and personnel. Volunteers may be assigned appropriate tasks according to their self-claimed knowledge, skills, and abilities as long as the risks associated with these tasks are minimized. It may be difficult or impossible to verify the claims of expertise by volunteers and care should be taken to place them in supervised roles. It is important to remove or replace volunteers as resources become available. Attempts shall be made to collect name and contact information of such volunteers.

## **F. Staging**

Two separate staging areas should be considered based on the size and complexity of the MCI. The first staging area should be for personnel or equipment immediately available for use.

There should be a separate Transportation Staging area that is established for apparatus that will be used to transport patients from the scene to a facility. The Transportation Staging area may be managed by a private ambulance supervisor with capabilities of communicating to both Transport as well as the staged units. In the Transportation Staging area, personnel are not to leave their vehicles.

## **G. Transportation Corridor**

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

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

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

All apparatus operators must keep the transportation corridor clear.

## **H. Treatment Area**

The patient treatment area will be established in conjunction with the transportation corridor. It should be adjacent to the transportation corridor to facilitate communication, tracking, and patient transfer. If the

treatment area and transportation corridor are unable to be co-located, they should be located as close as possible with a clear path between the two and their locations broadcast over the primary tactical radio channel.

The treatment area will be the responsibility of TREATMENT, typically, a senior ALS member appointed by MEDICAL.

Extracted patients will be delivered directly to the treatment area unless diverted to the transport corridor by Treatment. A funnel point will be optional.

Large incidents may necessitate large treatment areas with separate areas and staff for red and yellow patients. Multiple treatment areas with corresponding transportation corridors may be needed.

TREATMENT needs to request enough staff to handle care for the expected number of patients.

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by TREATMENT in accordance with Snohomish County EMS Policies, Procedures, and Guidelines.

#### **1. Field Treatment Site**

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

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

Transport resources are inadequate

Transport cannot keep pace with Extraction

Number of patients at the incident cannot be handled at hospitals

### **I. Triage**

Triage will be dynamic, but will be a collective and ongoing effort to constantly evaluate patients at every step in the MCI process. The Sick/Not Sick triage standard will be used to evaluate patients, unless the Israeli Triage System is being used.

It is understood that all patients should be triaged. However, depending on the variables of the scene, triage may be accomplished by a Triage team, Extraction teams, or after safely leaving the area.

Geographic triage allows a member to triage patients in their assigned area and prioritize those patients for extraction.

### **J. Green Patient Area**

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

The Green Patient Area Manager is responsible for the following:

Re-triage the patients to affirm their green status

Liaison with law enforcement

Provide basic medical care

Contain patients as needed (share responsibility with law enforcement).

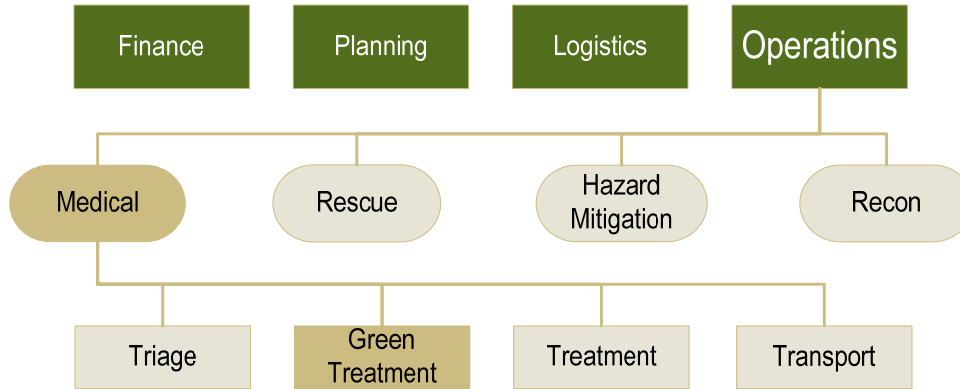
Consider comfort needs such as restroom facilities, water, blankets, etc.

Documentation

Patient Tracking

Coordinate transportation of the green patients to the appropriate facility for treatment or family reunification (emergency responder should accompany green patients during transport)

Victim Assistance and Family Reunification



### K. Communications

A single tactical radio talk-group may be adequate for a small MCI. Large or complex MCIs may quickly overwhelm a single radio talk-group, hampering critical communication. Possible radio talk-group assignments shall be employed and assigned as needed.

## L. Rescue

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

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

Geographical recon includes:

Number of patients in their area.

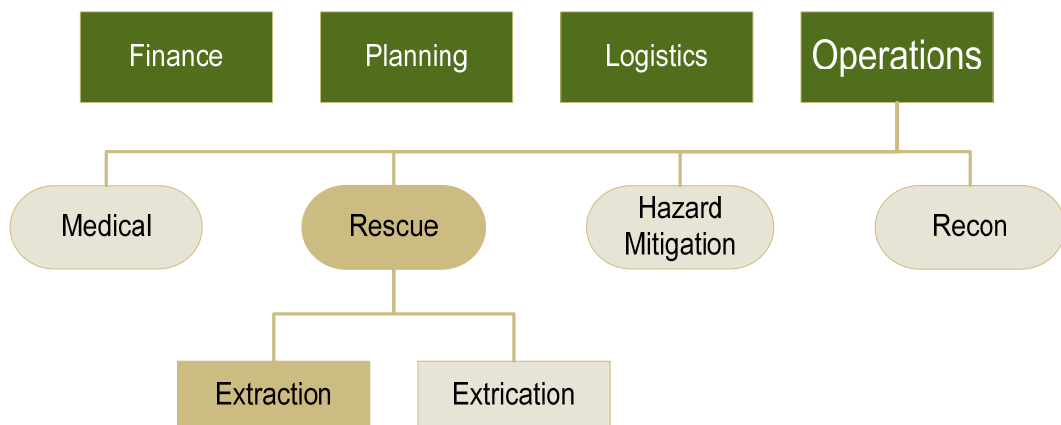
How many of those patients are Red, Yellow, and Black.

Extraction needs, including number of patients and complexity.

Hazards inside their area.

### 1. Extraction

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

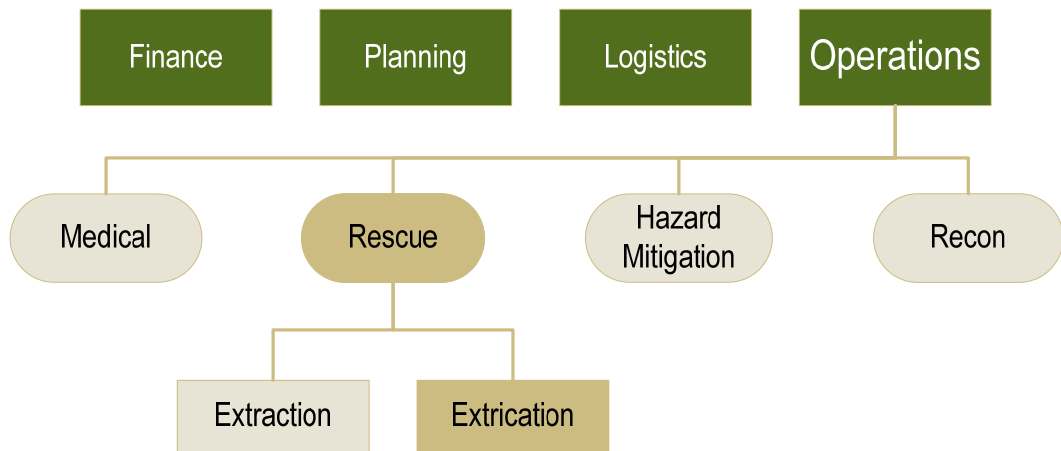


## M. Extrication

Disentanglement and technical rescue may be handled by extrication teams under direction of Rescue. When trapped patients are located,

the extrication teams will be sent to assist with the technical removal of those patients. Extrication teams must prioritize their operations to remove as many viable patients as possible in the shortest amount of time.

In smaller incidents it is appropriate for litter-bearers to be assigned to Medical versus their own group under Operations.



#### N. Decontamination

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

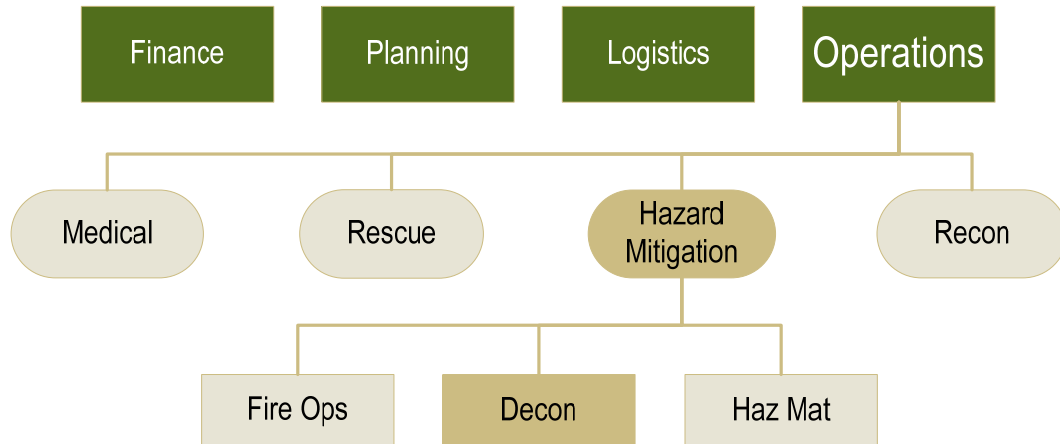
Treatment and/or transport of any patient cannot occur until the patient has gone through emergency decontamination and tagged with white flagging tape.

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

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

Decontamination procedures will occur in the warm zone.

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



#### O. Patient Sheltering

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

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

Possible temporary shelters include:

Tents from Decon Units

Public transportation buses

MCI bus

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

## P. Field Treatment

In general, personnel will treat “Red” patients first, “Yellow” patients only as time allows, and “Black” patients only after assuring that all patients from the red and yellow categories are stabilized. Depending on acuity and number of patients, it may be necessary to transport ALS patients in BLS units without the oversight of ALS personnel.

Providence Hospital shall serve as the primary DMCC. Harborview Medical Center shall serve as back up DMCC, and Overlake Hospital shall serve as the tertiary DMCC. Once contact has been made with the DMCC the connection shall not be disconnected.

If neither primary nor back up DMCC is able to coordinate patient destination, Transport shall notify the receiving hospital of patient numbers and triage status prior to patient transport if possible. Individual transporting units will not routinely communicate to hospitals unless directed to do so.

## Q. Patient Count and Tracking

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

Patient count and tracking will be the responsibility of Transportation in coordination with Green Patient Manager and Treatment. An attempt will be made to attach a unique identifier to each individual patient. Transportation will attempt to keep track of the number of red, yellow, and green patients as they are transported.

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

## R. Documentation

### 1. MIRFS/ePCR

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

### 2. Unique number with transporting agency

When a patient is received by a transporting unit, personnel will document the unique identifier that is attached to the patient onto their agency's MIRF/ePCR. If a unique identifier has not been assigned to the patient, then the transporting unit's personnel will do so. Every effort will be made to give a copy of the unique identifier to Transport.

## S. Transportation

TRANSPORTATION will assign patients to transporting units as those resources arrive. Constant communication between TRANSPORTATION and TREATMENT is important to ensure that patients are ready to be transported.

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

## T. Medical

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

MEDICAL is responsible for the following tasks:

Transportation

Treatment

Triage

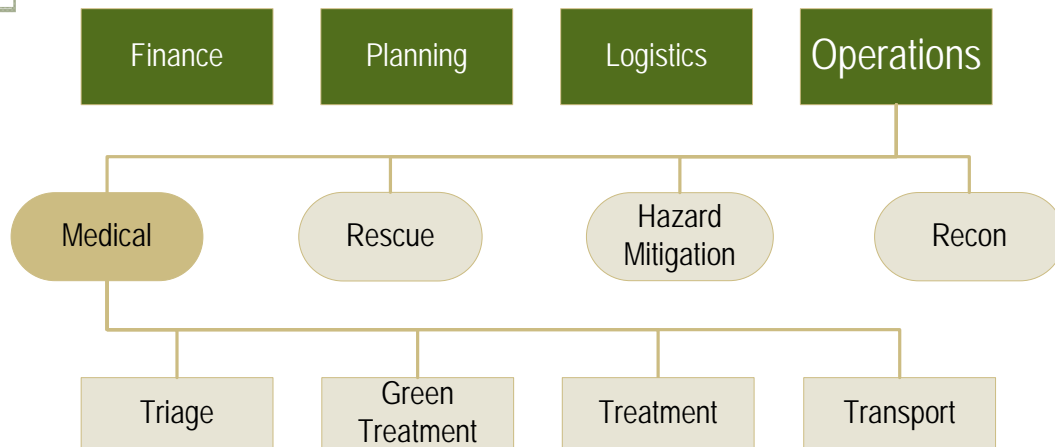
Ensure activation of the DMCC (Hospital Control)

Green Patient management

MEDICAL may handle most or all of the responsibilities in smaller incidents. Larger or complex incidents will require Medical to be proactive in forecasting the incident and begin assigning roles as soon as possible. The use of Aides or Assistants is highly encouraged in complex incidents or as needed. Circumstances may dictate a large number of ALS and BLS personnel where:

ALS personnel need to be prioritized to treatment due to a high patient count;

Patient removal from the hazard zone will require a large amount of BLS personnel and/or complex coordination.



### 1. Treatment

Medical may designate an ALS member to be TREATMENT. (Note: Smaller incidents may allow Medical to retain this role). Treatment is responsible for the following:

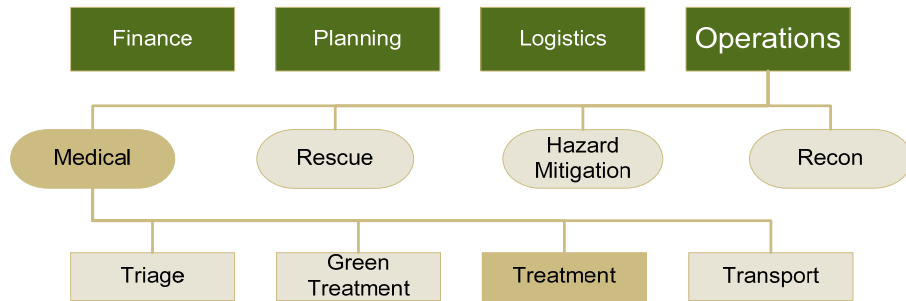
- Receiving patients from Extraction
- Supervising treatment of patients
- Managing Treatment Personnel
- Coordinating with Transportation
- Prioritizing patients for transport

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

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

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

The use of Aides or Assistants is highly encouraged in complex incidents or as needed.



## 2. Transportation

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

Communication with the DMCC (hospital control)

Keeping a total patient count of all transported patients (may be delegated to one or more Aides)

Coordination with Treatment

Coordination with law enforcement to clear the transportation corridor

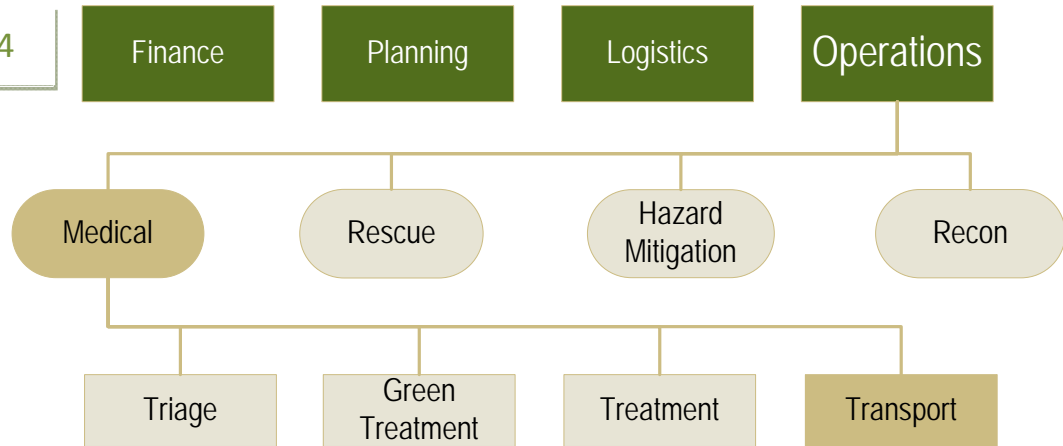
Liaison with transportation resources

Maintain adequate transportation resources

Initiate tracking if unique identifier not already assigned

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

The use of Aides or Assistants is highly encouraged in complex incidents or as needed.



## U. Rescue

Rescue shall be considered when:

ALS staffing needs to be prioritized to patient treatment and transport.

Any part of patient removal from the hazard zone will require a large amount of BLS resources or skills.

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

## Appendix A: MCI RUN CARDS

### Snohomish County Recommended Run Cards for MCI

CAD Alarm Level	Patients	Other units Add (Total)	ALS Units Add (Total)	BLS Units (Pub and/or Private) Add (Total)
1	5-9	2 Eng or Lad	2 (2)	3 (3)
2	10-19	Add 2 Eng or Lad (4) Add MCI Trailer (1)	1 (3)	4 (7)
3	20-29	Add 2 Eng or Lad (6) MCI Trailer (1) CT Bus (1)	1 (4)	5 (12) Consider Strike Tm
4	30-39	Add 2 Eng or Lad (8) MCI Trailer (1) CT Bus (1)	1 (5)	5 (17) Consider 2 <sup>nd</sup> Strike Tm
5 (NW Only)	40-49	Add 2 Eng or Lad (10) Add 1 CT Bus (2) Add 1 MCI Trailer (2)	2 (7) Consider Strike Tm.	5 (22) Consider 3 <sup>rd</sup> Strike Tm.
6 (NW Only)	50-100	Add 2 Eng or Lad (12) CT Bus (2) MCI Trailer (2)	3 (11) Consider 2 <sup>nd</sup> Strike Tm.	10 (32) Consider 4 <sup>th</sup> Strike Tm.
7 (NW Only)	100+	Add 4 Eng or Lad (16) Add 1 CT Bus (3) MCI Trailer (2)	5 (16) Consider 3 <sup>rd</sup> Strike Tm.	50 or more Consider 5 <sup>th</sup> , 6 <sup>th</sup> & 7 <sup>th</sup> Strike Tm.

*NOTE 1: The current CAD system only allows 4 alarms to be entered. The new CAD system (New World CAD) will allow for entering of higher alarm levels. Another limitation of current CAD is the amount of units that can be recommended at one time. The current limitation is 20 (three character) units per dispatch. Therefore depending on the amount of units, it is recommended that you request a balance of each alarm level separately. Moving directly to the fourth alarm level will likely miss quantity and types of units. Therefore during the interim period the matrix is recommended for the first four alarms. Greater alarms of the matrix shall be the responsibility of command to request resources as recommended or modified. Each agency shall assure that its FRL lists the resources authorized by the agency for the first four alarms. It is recognized that this list is a recommendation and that each agency may vary in its preferred resources sent to each alarm level.*

*NOTE 2: Due to the extensive resources required for an MCI, the command post must monitor and assure resources have been requested as desired. CAD system deficiencies can cause non dispatch of expected resources.*

*NOTE 3: When faced with incidents involving terrorism and weapons of mass destruction within the Snohomish County jurisdiction, the management of these incidents should follow the "Terrorism Response Coordination Plan".*

### **MEDICAL GROUP - Quick Start Card**

**\*\*\*Take 1 minute to read this card, it may save hours in the long run\*\*\***

#### **Responsibilities**

1. Oversee the Medical Group aspect of an MCI
2. Assign - Triage, Treatment, Transport Leaders
3. Declare and MCI to Charge RN - Colby (Primary) - HMC (Second) - Overlake (Tertiary)
4. Maintain Safety, Staffing & Equipment of the Medical Group.
5. Request additional resources through Incident Command.
6. Assure smooth and efficient Flow of patients through Triage, Treatment & Transport areas.

#### **Instructions**

1. Medical Group Reports to Command
2. Don Medical Group Vest and Radio
3. Request separate Radio Frequency for Medical Group Early if Scene Size indicates.
4. Obtain Snohomish County MCI Reference Book from MCI Kit
5. Contacts Hospital ER/Charge Nurse to Declare Open Protocol / MCI
6. Maintain Passport Accountability for all crews assigned to "Medical"
  7. Assigns Triage Team Leader (Usually First EMT On Scene).
  8. Assign Treatment Team Leader - (Usually 2nd Medic on Scene)
  9. Assign Transport Team Leader - (Usually 3rd Medic On Scene)
  10. Keep track of patient count and triage color
11. Obtain all Staffing and Equipment Needs requested by Triage and Treatment.
12. Insure Transport Team Leader has a defined AMB/Transport staging area and proper # of Transport Units

#### **Triage**

Funnel

#### **Treatment**

#### **Transport**

AMB Stag-

Medical

#### **Incident Flow Diagram**

**\*\*\*MEDICAL GROUP - Important Reminders\*\*\***

1. (Recommended) - Draw Diagram of MCI Scene on Medical Group board to assist incoming crews with seeing the Triage, Treatment, Transport Flow.
  2. Assure Leaders have proper Vests.
3. Create the shortest yet safest distance between Triage, Treatment and Transport areas to decrease time wasted with patient movement.
4. Request all on scene units assigned to MEDICAL to bring EMS Equipment to Treatment area.
  5. Maintain Efficient Flow between Triage, Treatment and Transport
6. Initial goal should focus on patient movement from triage to treatment,
7. Secondary goal should focus on patient treatment while awaiting transport units.
  8. Add resources where bottle necks occur.
9. Toward the end of the event you may reassign on scene units to transport if needed.
10. Assure Transport leader or their designee has contacted Colby ER / Charge RN and is working with the Charge RN for patient Transport Destination.
  11. Additional Requests if needed
  12. Paine Field, Everett, or King County MCI Units
  13. Request a Bus for Green patients.
  14. Request Airlift for Delayed extrication patients
  15. Request SCSO and ME for Morgue area.
  16. Request Chaplin
  17. AMB Transports
  18. Minimum of 2 patients per unit
  19. Try to limit each AMB to one Red if possible
20. Requests that AMB Return directly to Scene if large event

**First On Scene**

- First Officer - IC
- First FF/EMT or (2nd Medic) - Triage
- First Medic - Medical Group

**Additional Units Assigned to MEDICAL**

- 2nd Medic - Treatment Leader
- 3rd Medic - Transport Leader
- 2nd Officer - Funnel Point

**Additional Staffing**

- BLS Providers - Litter Carriers for Triage
- Medics - Assigned to Treatment

**\*\*\*Example of First Alarm Assignment\*\*\***

## Appendix C: Good Samaritan Card

Date:	Time:	Inc. #:
EMS Contact:		
PH:	PGR:	Cell:
Pt. Name:		
TX To:		
Good Sam Name:		
Address:		
Phone:	Wk Phone:	Other:
Email:		
Language:	Card:	Of:

### Good Samaritan Follow-up Card

Thank you for assisting out emergency service personnel in the care of an injured or ill person. The willingness of Snohomish County citizens to provide aid in an emergency can make a real difference in the patient's outcome.

Sometimes assisting with patient care results in direct contact with blood and body fluids. Contact with such fluids can occur through broken skin, cuts, scrapes, open sores or puncture wound – or through the eyes, nose, or mouth. **Not all exposures are significant**, yet exposures to blood or body fluids containing infectious agents can affect your health.

If you have had direct contact with blood or body fluids, please contact **Public Health – Snohomish County at 425-339-5200** within 24 hours. Say that you are a Good Samaritan seeking an assessment of an exposure to blood or body fluids. After business hours or weekends, you will be asked to leave a message. Public Health staff will promptly return your call.