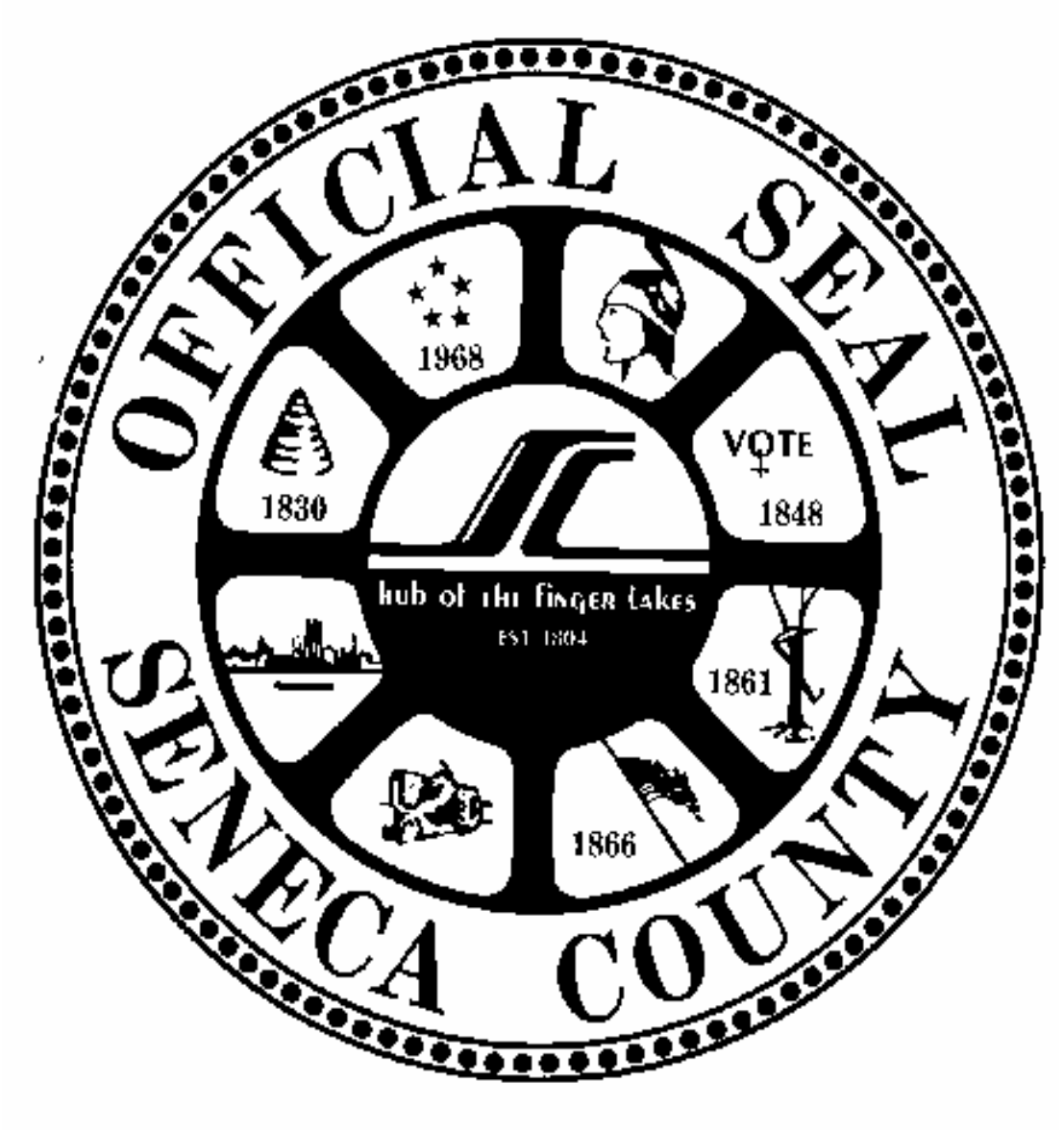
SENECA COUNTY
OFFICE OF EMERGENCY SERVICES



MASS CASUALTY INCIDENT RESPONSE PLAN

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Mass Casualty Incident Response Plan Updated April, 2011

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I. Scope and Purpose

A. This Mass Casualty Response Guide is intended as a guide for Emergency Medical Services personnel when addressing the functional responsibilities and scene management techniques, which must be employed at the scene of mass casualty incidents. It provides a quick and easy procedure to follow during multiple / mass casualty incidents so as to standardize the method of operation which, if necessary can be modified given the number of patients, severity of injuries and special circumstances involved in the incident.

B. The primary EMS agency responding to the incident is responsible for establishing the EMS / Medical functions. This is to ensure that extrication, triage, treatment, and transportation are implemented as needed. The manner in which each of these functions is implemented may differ according to the complexity of the situation. In multiple victim incidents, one or two individuals may be assigned the responsibility for the entire EMS / Medical functions. In mass casualty incidents, each function may need to be the responsibility of a separate individual.

C. These guidelines are not designed to delay patient care, but to make that care more efficient.

D. It is important that every member, of each agency, familiarize themselves with these guidelines and procedures in order to be prepared in the event of a multiple / mass casualty incident.

II. Plan Definition:

A multi casualty incident (MCI) is defined as any incident in which the number of injured persons fully engages the medical capabilities of the jurisdictional resources

III. Mass Casualty Incident Management Goals

A. Mass Casualty Patient Flow

1. The Incident Scene
    a) All victims are accounted for; trapped victims are rescued / extricated.
    b) Patients are counted and quickly triaged (S.T.A.R.T.) **(See Section V)**
    c) Triage tags are applied.
    d) Ambulatory patients are directed to a medically supervised area.
    e) These patients shall be moved from the scene to a Treatment Area as soon as that area is identified.
    f) move non-ambulatory patients from the scene to the Treatment Area.
    g) Patients are decontaminated (as needed) prior to leaving the incident scene.

B. The Treatment Area

1. Patients arriving from the incident scene are prioritized for treatment using a more in-depth assessment method (Secondary Triage)
2. Patients are placed in the Treatment Area and definitive / stabilizing emergency medical care is provided on the basis of triage priority.
3. Separate areas are created in the Treatment Area for Immediate (Red), Delayed (Yellow)and Minor (Green) injured patients.
4. A separate isolated area (Temporary Morgue) is created for casualties/ victims who die in the Treatment Area.

5. Personnel and equipment resources are allocated to patients on the basis of triage priority.
6. Patients are continuously reevaluated (re-triage).

C. Mass Casualty Patient Flow – continued

1. The Transportation Area
   a. Hospitals are contacted to obtain information to assist with the most appropriate patient distribution to medical facilities.
   b. Transportation resources are assigned on the basis of triage priority.
   c. Porters will move patients from the Transportation Area to the appropriate transport vehicle.
   d. Patients are transported to the most appropriate medical facility by the most appropriate means available.
   e. Emergency medical care and continuous reassessment is provided en-route to the medical facility.

IV. SCENE COMMAND

A. EMS will be part of a unified command at a mass casualty incident and will function to support a response designed to mitigate the incident-producing casualties (i.e., riot, natural disaster, fire, hazardous materials incident, terrorism etc.).

B. Position Function: To coordinate and manage the incident response so as to ensure life safety, stabilize the incident, conserve property, and provide for personnel safety, accountability, and welfare.

1. First unit (EMS, FIRE, LAW ENFORCEMENT) on scene assumes and establishes UNIFIED COMMAND.
   a) SURVEY the Scene (How Many & How Bad):
   (1) Type and / or Cause of Incident
   (2) Approximate Number of Patients
   (3) Severity of Injuries (Major or Minor)
   (4) Contact dispatch with survey information
   (5) **Declare Multiple Victim Incident or MCI**
   (6) Request resources and mutual-aid assistance as needed
   (7) Set-up scene to handle patients
   (8) S.T.A.R.T. – Simple Triage And Rapid Treatment

2. Evaluate and provide Size-up. Gather information on: potentially hazardous situations, current situation, current resources committed, and number of injuries.
3. Develop strategy for incident and revise plans on the basis of new information. Take whatever actions are necessary to stabilize incident.
4. Request additional resources as needed, assign resources and monitor work progress.
5. Account for all personnel assigned to the incident.
6. Appoint and assign additional functions as needed. Appoint a STAGING OFFICER early to handle the many responding resources:
   - EMS/MEDICAL:_____
   - FIRE: _____
   - STAGING OFFICER: _____
   - OPERATIONS: _____
   - SAFETY: _____
   - PIO: _____
7. Initiate, maintain, and control the communications process. Use a mobile radio.
8. Helpful Hints: ***Remember to delegate tasks***!

V. EMS COMMAND

SCENE MANAGEMENT/MASS CASUALTY INCIDENT (MCI) GUIDELINES

Pursuant to Article 3004-A of the Public Health Law, (see below) the Finger Lakes REMAC has developed this policy for mass casualty incident management. A mass casualty incident is any situation that requires more service or services than may be immediately available. When faced with an MCI, coordination of efforts becomes vital. Several different circumstances may exist at an MCI or disaster that will tax the skills of the advanced technicians. For this reason, several parameters have been set to augment the activities of the technicians. Those areas not covered are assumed to be handled per the protocols within this document without deviation.

The National Incident Management System (NIMS) will serve as the standard command and control system for emergency operations.

ORDER OF RESPONSIBILITY

On a multiple agency response involving the fire service and law enforcement, it is understood that responsibility for overall scene command may lie with an individual who is not an emergency care provider. This individual has overall responsibility for the safety of all responders at a scene. In some cases it may be appropriate for certified EMS personnel to provide medical direction to others engaged in technical activities such as extrication or rescue.

The highest level EMT/AEMT of the first toned agency on the scene becomes the ALS/Scene Coordinator and will coordinate the activities of all other EMS personnel arriving at the scene. He/she is also responsible for maintaining accurate records of these activities.

The highest level of EMT/AEMT directly caring for a patient bears direct responsibility for decisions made concerning the care of a specific patient, including treatment given and transport destination.

SPECIFIC POLICIES

1) All patients will be treated per the New York Statewide BLS Protocols and Finger Lakes Regional BLS/ALS protocols unless otherwise stipulated here.
2) Additional specialized resources may be requested by EMS providers by utilizing appropriate channels through the established scene commander.
3) In an MCI situation, transport destination will be determined by the EMS Scene Coordinator or designated Transport Officer by consulting the Transport and Destination Protocol as well as direct coordination with receiving hospitals.
4) If an IV has been established by an ALS provider, a BLS unit may transport patients with saline or heparin lock in place. **(SEE ATTACHED ALS IV PROTOCOL)**
5) A medical control physician may authorize a patient who has been administered medication to be transported with an EMT-Basic in attendance along with a list of medications and dosages given.
6) An AEMT, when treating more than one patient, should treat those patients in close proximity to each other so that they may monitor each patient. Patients should be brought to a holding area or staging area where they may receive treatment.
7) All individual responders should display visual identification at an emergency scene.
8) Patient care and transport will be documented.

ARTICLE 3004-A

Section 3004-A. Regional Emergency Medical Advisory Committees.

1. Regional emergency medical advisory committees shall develop policies, procedures, and triage, treatment, and transportation protocols which are consistent with the standards of the state emergency medical advisory committee and which address specific local conditions. Regional emergency medical advisory committees may also approve physicians to provide on line medical control, coordinate the development of regional medical control systems, and participate in quality improvement activities addressing system-wide concerns. Hospitals and pre-hospital medical care services shall be authorized to release patient outcome information to regional emergency medical advisory committees for purposes of assessing pre-hospital care concerns. Regional quality improvement programs shall be presumed to be an extension of the quality improvement program set forth in section three thousand six of this article, and the provisions of subdivisions two and three of such section three thousand six shall apply to such programs.

2. The committee shall nominate to the commissioner a physician with demonstrated knowledge and experience in emergency medical services to serve on the state emergency medical advisory committee.

3. No civil action shall be brought in any court against any member, officer or employee of the committee for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer, or employee of the committee, without leave from a justice of the Supreme Court, first had and obtained. In no event shall such member, officer, or employee be liable for damages in any such action if he or she shall have acted in good faith, with reasonable care and upon probable cause.

4. Any decision of a regional emergency medical advisory committee regarding provision of a level of care, including staffing requirements, may be appealed to the state emergency medical advisory committee by any regional EMS council, ambulance service, advanced life support service, certified first responder, emergency medical technician, or advanced emergency medical technician adversely affected. No action shall be taken to implement a decision regarding existing levels of care or staffing while an appeal of such decision is pending. Any decision of the state emergency medical advisory committee may be appealed pursuant to subdivision two-a of section three thousand two-a of this article.

VI. PATIENT DOCUMENTATION

The documentation of patients takes place on the SMART triage tags and the SMART command board. In a true MCI there will be no PCRs for each patient.

VII. MASS CASUALTY INCIDENT TRAILER STAGING

A. Position Function: To establish support for EMS/MEDICAL functions with equipment/supplies during an MCI

1. The MCI trailer will be transported to the incident scene by any available resource

2. The MCI Trailer will be established near the EMS/MEDICAL triage area once on scene.
3. Personnel will be assigned to the trailer to track equipment and supplies

VIII. AMBULANCE STAGING (Ground Transportation)

**********COMMAND SHOULD CONSIDER APPOINTING A STAGING OFFICER**********

A. To maintain resources of EMS manpower and EMS transport vehicles at a separate location away from the incident (may be included as part of incident STAGING).

1. Don identifying vest
2. Establish AMBULANCE STAGING in coordination with OPERATIONS and / or COMMAND.
3. Establish the Ambulance Staging Area at a site away from the scene. The Ambulance Staging Area should:
    a) Be large enough to handle the expected number of units
    b) Have easy access and egress
    c) Be close to major transportation routes
    d) Have easy access to the Transportation Area
    e) Provide appropriate vehicles, equipment and resources as requested.
4. Order all personnel to remain with unit.
5. Maintain and document the status of number and types of resources in AMBULANCE STAGING.

B. Helpful Hints
1. Maintain communications with EMS / MEDICAL and TRANSPORTATION.
2. Consider options for alternate transportation vehicles (Buses, etc.).
3. Consider options for removing medical supplies from ambulances for relocation to the TRIAGE and / or Medical Supply areas:
    a) Backboards / Straps Splints / Bandages
    b) Portable Oxygen Equipment / Supplies Blankets
    c) Airway Equipment / Supplies IV's, etc.
    d) ENSURE AMBULANCE COTS ARE NOT REMOVED FROM UNITS
4. Consider need for logistical supplies, food, drinks, etc.

IX. EXTRICATION

WILL BE HANDLED BY THE FIRE SERVICE

X. SIMPLE TRIAGE AND RAPID TREATMENT S.T.A.R.T.

I. Purpose

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

II. En route

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

A. **Initial Assessment - Stay Calm**

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

B. **Your Initial Report - Creating a Verbal Image**

1. The initial report is often the most important message of a disaster because it sets the emotional and operational stage for everything that follows. As you prepare to give the first vital report, use clear language (no signals or radio jargon), be concise, be calm, and do not shout. You are trying to give the communications center a concise verbal picture of the scene.
2. The key points to communicate are:
    a. Location of the incident
    b. Type of incident
    c. Any hazards
    d. Approximate number of victims
    e. Type of assistance required
3. Note: Be as specific with your requests as possible.

4. Before starting, take several deep breaths to give your mind time to catch up with your eyes and to try to calm your voice. You might give the following report: "This is a major accident involving a truck and a commercial bus on Highway 305, about 2 miles east of Route 610. There are approximately 35 victims. There are people trapped. Repeat: This is a major accident. I am requesting the fire department, rescue squad, and seven ambulances at this time. Dispatch additional police units to assist."

C. **Sorting the Patients**

1. It is important not to become involved with the treatment of the first or second patient with whom you come in contact. Remember that your job is to get to each patient as quickly as possible, conduct a rapid assessment, and assign patients to broad categories based on their need for treatment.
2. You cannot stop during this survey, except to correct airway and severe bleeding problems quickly. Your job is to sort (triage) the patients. Other rescuers will provide follow-up treatment.

The *START* System: It really works!

A. **The Simple Triage And Rapid Treatment** (***START***) system was developed to allow first responders to triage multiple victims in 30 seconds or less, based on three primary observations: Respiration, Perfusion, and Mental Status (RPM).
The ***START*** system is designed to assist rescuers to find the most seriously injured patients. As more rescue personnel arrive on the scene, the patients will be re-triaged for further evaluation, treatment, stabilization, and transportation. This system allows first responders to open blocked airways and stop severe bleeding quickly.

B. **Triage Tagging**: To Tell Others What You've Found
Patients are tagged for easy recognition by other rescuers arriving on the scene. Tagging is done using a variety of methods determined by your local Emergency Services System. Colored surveyors' tape or colored paper tags may be used.

1. The Four Colors of Triage
    a. Delayed care / can delay up to three hours
    b. Urgent care / can delay up to one hour
    c. Immediate care / life-threatening
    d. Victim is dead / no care required

2. The First Step in ***START***: Get up and Walk!
    a. The first step in ***START*** is to tell all the people who can get up and walk to move to a specific area. If patients can get up and walk, they are probably not at risk of immediate death.
    b. In order to make the situation more manageable, those victims who can walk are asked to move away from the immediate rescue scene to a specific designated safe area. These patients are now designated as MINOR.
    c. If a patient complains of pain on attempting to walk or move, do not force him or her to move.
    d. The patients who are left in place are the ones on whom you must now concentrate.

3. The Second Step in ***START***: Begin Where You Stand
    a. Begin the second step of ***START*** by moving from where you stand. Move in an orderly and systematic manner through the remaining victims, stopping at each person for a quick assessment and tagging. The stop at each patient should never take more than one minute.
    b. REMEMBER: Your job is to find and tag the IMMEDIATE patients --those who require immediate attention. Examine each patient, correct life threatening airway and breathing problems, tag the patient with a red tag and MOVE ON!

4. How To Evaluate Patients Using RPM
    a. The ***START*** system is based on three observations: RPM--Respiration, Perfusion and Mental Status. Each patient must be evaluated quickly, in a systematic manner, starting with Respiration (breathing).
    b. Breathing: It all ***START***S Here
        1) If the patient is breathing, you then need to determine the breathing rate. Patients with breathing rates **greater than 30 per minute** are tagged **IMMEDIATE**. These patients are showing one of the primary signs of shock and need immediate care.

2) If the patient is breathing and the breathing rate is less than 30 per minute, move on to the circulation and mental status observations in order to complete your 30-second survey.

3) If the patient is not breathing, quickly clear the mouth of foreign matter. Use a head-tilt maneuver to open the airway. In this type of multiple- or mass-casualty situation, you may have to ignore the usual cervical spine guidelines when you are opening airways during the triage process.

4) **SPECIAL NOTE:** The treatment of cervical spine injuries in multiple or mass casualty situations is different from anything that you've been taught before. This is the only time in emergency care when there may not be time to properly stabilize every injured patient's spine.

5) Open the airway, position the patient to maintain the airway *and* -
- if the patient breathes -- tag the patient **IMMEDIATE**. Patients who need help maintaining an open airway are **IMMEDIATE**.

6) If you are in doubt as to the patient's ability to breathe, tag the patient as **IMMEDIATE**. If the patient is not breathing and does not start to breathe with simple airway maneuvers, the patient should be tagged **DEAD**.

C. **Circulation:** Is Oxygen Getting Around?

1) The second step of the R**P**M series of triage tests is circulation of the patient. The best field method for checking circulation (to see if the heart is able to circulate blood adequately) is to check the radial pulse.

2) It is not large and may not be easily felt in the wrist. The radial pulse is located on the palm side of the wrist, between the midline and the radius bone (forearm bone on the thumb side). To check the radial pulse, place your index and middle fingers on the bump in the wrist at the base of the thumb. Then slide it into the notch on the palm side of the wrist. You must keep your fingers there for five to ten seconds, to check for a pulse. If the radial pulse is absent or irregular the patient is tagged **IMMEDIATE**. If the radial pulse is present, move to the final observation of the RPM series: mental status.

D. **Mental Status:** Open Your Eyes:

1) The last part of the RP**M** series of triage tests is the mental status of the patient. This observation is done on patients who have adequate breathing and adequate circulation.

2) Test the patient's mental status by having the patient to follow a simple command.

"Open your eyes." "Close your eyes," "Squeeze my hand." Patients who can follow these simple commands and have adequate breathing and adequate circulation are tagged **DELAYED**. A patient who is unresponsive or cannot follow this type of simple command is tagged **IMMEDIATE**. (These patients are "unresponsive" to verbal stimuli.)

***START* is Used to Find IMMEDIATE Patients**

This system is designed to assist rescuers to find the most seriously injured patients. As more rescue personnel arrive on the scene, the patients will be re-triaged for further evaluation, treatment, stabilization, and transportation. A patient may be re-triaged as many times and as often as time allows.
Remember that injured patients do not stay in the same condition. The process of shock may continue and some conditions will become more serious as time goes by. As time and resources permit, go back and recheck the condition of all patients to catch changes in condition that may require upgrading to **IMMEDIATE** attention.

A. Working at a Multiple- or Mass-Casualty Incident

1. You may or may not be the first person to arrive on the scene of a multiple- or mass-casualty incident. If other rescuers are already at the scene when you arrive, be sure to report to the incident commander before going to work. Many events are happening at the same time and the incident commander will know where your help and skills can best be used. By virtue of training and local protocols, the incident commander is that person who is in charge of the rescue operation.
2. In addition to initially sizing up an incident, clearly and accurately reporting the situation, and conducting the initial ***START*** triage, the first responder will probably also be called on to participate in many other ways during multiple- and mass-casualty incidents.
3. As more highly trained rescue and emergency personnel arrive on the scene, accurately report your findings to the person in charge by using a format similar to that used in the initial arrival report. Note the following:
    - Approximate number of patients.
    - Numbers that you've triaged into the four levels.
    - Additional assistance required.
    - Other important information.
4. After you have reported this information, you may be assigned to use your skills and knowledge to provide patient care, traffic control, fire protection, or patient movement. You may also be assigned to provide emergency care to patients, to help move patients, or to assist with ambulance or helicopter transportation.
5. In every situation-involving casualty sorting, the goal is to find, stabilize and move Priority One patients first.

IF THERE IS ANY SUSPICION OF A HAZARDOUS MATERIALS SPILL - STAY AWAY!

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

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

3. Once the appropriate protection of the rescuers has been accomplished, triage in hazardous materials incidents has one major function--to identify victims who have sustained an acute injury as a result of exposure to hazardous materials. These patients should be removed from the contaminated area, decontaminated

by trained personnel, given any necessary emergency care, and transported to a hospital.

4. **REMEMBER: Contaminated patients will contaminate unprotected rescuers!**

a. Emergency treatment of patients who have been exposed to hazardous materials is usually aimed at supportive care, since there are very few specific antidotes or treatments for most hazardous materials injuries. Because most fatalities and serious injuries sustained in hazardous materials incidents result from breathing problems, constant reevaluation of the patients in Priorities Two and Three is necessary so that a patient whose condition worsens can be moved to a higher triage level.

XI. TRANSPORTATION

A. Check List

1. Position Function: To coordinate all patient transportation and maintain all records related to patient and unit movement.
    a) Don identifying vest
    b) Establish the Transportation Area. Locate the area adjacent to the exit of the Treatment Area
    c) Establish transport vehicle flow pattern from Ambulance Staging Area to Treatment Area and from the Treatment Area to Hospitals.
    d) Contact the Coordinating Hospital to determine the capability of receiving facilities to receive patients, how many, and what triage priority.
        (1) Arrange transport for the patients that TREATMENT has selected for transport. TREATMENT should be sending patients to TRANSPORT in order with IMMEDIATE (RED) patients first, then DELAYED (YELLOW) patients and then MINOR (GREEN) patients.
        (2) Use appropriate mode of transportation based on patient needs and transportation resources at the Ambulance Staging Area and Landing Zone Area.
    e) Establish Porter Teams to move patients from the Treatment Area to the Transportation Area and Landing Zone Area and load patients on transportation
        (1) Inform transport crews of their destination and document patient and unit movements.
    f) Maintain communications with TREATMENT, AMBULANCE STAGING, and MEDICAL COMMUNICATIONS. Provide essential and frequent progress reports to EMS / MEDICAL as appropriate.

2. Helpful Hints
    a) Suggest alternative modes of transportation to EMS / MEDICAL (e.g. busses, helicopter, etc.).
    b) Ensure that transport units are backed in parallel to each other, not end-to-end.
    c) Consider appointing TRANSPORT RECORDER(S), TRANSPORT LOADER(S), and LANDING ZONE.
    d) Patient Transport worksheet
    e) Clinic Triage Levels
    f) Hospital Triage Levels

XII. MEDICAL COMMUNICATIONS

A COMMUNICATIONS OFFICER SHOULD BE DESIGNATED AND MUST COME THROUGH THE UNIFIED COMMAND STAFF

A. Check List

1. To maintain and coordinate all medical communications at the incident scene between TRANSPORTATION, dispatch, the Coordinating Resource Hospital and EMS / MEDICAL
   a) Don identifying vest
   b) Locate in close physical proximity to TRANSPORTATION
   c) Establish initial communications with the Coordinating Hospital or closest receiving hospital on Radio, Cellular telephone or Telephone and report:
      (1) MCI
      (2) CAUSE of incident
      (3) NUMBER of patients
      (4) SEVERITY of injuries
      (5) Obtain Hospital Emergency Capacity Information (Triage Levels).
      (6) Provide Transport Reports to Coordinating Hospital, to include:
         (a) UNIT Transporting
         (b) DESTINATION Hospital
         (c) NUMBER of Patients
         (d) PATIENT INFORMATION (Age, Triage Category, Major Injury/lllness)
         (e) ETA
      (7) Document all victim / patient and unit movements.

B. Helpful Hints

1. Maintain contact with the COORDINATING HOSPITAL.
2. Maintain communications with TRANSPORTATION and EMS / MEDICAL.
3. Use tactical Worksheets.

FOR ALL AMBULANCE, AIR AMBULANCES AND HOSPITAL CONTACT INFORMATION: CONTACT THE 911 DISPATCH CENTER.

XIV. TRANSPORT RECORDER

A. Check List

1. Position Function: To assist in ensuring proper documentation of victim / patient and unit movements.
   a) Don identifying Vest
   b) Locate at assigned patient egress point in the Transportation Area.
   c) Ensure that MEDICAL COMMUNICATIONS has the following information on each patient leaving the Treatment Area:
      (1) UNIT Transporting
      (2) DESTINATION Hospital
      (3) NUMBER of Patients
      (4) PATIENT INFORMATION (Age, Triage Category, Major Injury / illness)
      (5) ETA

d) Relay information to MEDICAL COMMUNICATIONS for reporting to the COORDINATING HOSPITAL.

e) Document the following information on each patient:

(1) UNIT Transporting

(2) DESTINATION Hospital

(3) NUMBER of Patients

(4) PATIENT INFORMATION (Identification Number, Age, Triage Category, Major Injury / illness)

(5) TIME of Departure