Central Oregon

Mass Casualty Incident Plan

Area Trauma Advisory Board Region 7

East Cascades Emergency Medical Services Council

Central Oregon Fire Operations Group

Purpose

The purpose of the ATAB 7/ECEMS/COFOG Mass Casualty Incident Plan is to provide guidance and structure during a Mass Casualty Incident. This plan is designed to provide a coordinated and unified response by multiple agencies and facilities in order to avoid overwhelming any single agency or facility during an MCI. Proper use of the plan should ensure the adequate care and orderly distribution of patients to appropriate hospitals. The plan should be implemented as early as possible in incidents that have the potential to overwhelm the first responding agency.

TABLE OF CONTENTS

Section 1

DEFINITIONS

ATAB 7 Mass Casualty Incident Plan

Definitions

AIR AMBULANCE LANDING ZONE (LZ): Area where air ambulances are loaded with patients from the treatment area. The Transport Group Supervisor and EMS Branch Director should work together on designating the location for the LZ. If possible the LZ should be close enough to the treatment area to carry patients to awaiting air craft. If not possible a ground ambulance may be necessary to shuttle patients from the treatment area to the LZ.

AMBULANCE LOADING ZONE: Area where patients are transferred from the Treatment Area into ambulances for transport. When possible, it should be arranged so ambulances can drive through, without backing up. The Staging Area Manager should direct incoming ambulances to the Ambulance Loading Zone and advise them to contact the Transportation Group Supervisor when they reach the zone.

ASSIGNED: Performing an active assignment.

AVAILABLE: Ready for assignment.

BRANCH: A grouping of divisions and/or groups to limit span of control in larger operations.

CASUALTY COLLECTION POINT: A facility or location of convenience where victims may be transported for initial evaluation and treatment.

COMMAND POST (CP): The physical location from which the Incident Commander exercises direction over the entire incident.

DIVISION: A division of an incident into geographical areas of operation.

EMS BRANCH DIRECTOR: The individual responsible for managing all the activities in the EMS Branch. The EMS Branch Director functions as a member of the Operations Section and may have three direct subordinates: Triage Group Supervisor, Treatment Group Supervisor, and Transport Group Supervisor. They should formulate a plan of action for the triage, treatment and transport of all patients.

EXTRACTION: Removing patients from the scene to the Treatment Area by porter teams.

EXTRACTION GROUP SUPERVISOR: Individual responsible for managing all the activities in the Extraction Group. Functions as a member of the Rescue Branch. They should formulate a plan of action for the immobilization and removal of all patients from the scene to the Treatment Area.

EXTRICATION: Removing patients from entanglements that hinder their extraction.

EXTRICATION GROUP SUPERVISOR: Individual responsible for managing all the activities in the Extrication Group. Functions as a member of the Rescue Branch. They should formulate a plan of action to extricate all victims on the scene.

FATALITY MANAGER: The individual responsible for the morgue area until relieved by the medical examiner or designee. Reports to the EMS Branch Director.

FIRE SUPPRESSION GROUP: Group responsible for the suppression of fires and the mitigation of fire hazards on the scene. Reports to the Operations Section Chief.

GROSS DECONTAMINATION: The process of removing potential contaminants through the use of water, a combination of soap and water, or other decontamination solutions.

HAINES (High Arm IN Endangered Spine) MODIFIED RECOVERY POSITION: A variant of the lateral recumbent position designed to minimize movement of the cervical spine. It is characterized by one arm being raised above the head (in full abduction) and used to support the patient's own head and neck.

IMMOBILIZATION: Securing patients to a backboard in the HAINES modified recovery position or using standard spinal immobilization precautions.

IMMOBILIZATION TEAM: Team of two rescuers that carry back boards to patients and immobilize them. Supervised by the Extraction Group Supervisor.

INCIDENT: An occurrence or event, either human-caused or natural phenomena, that requires action by emergency service personnel to prevent or minimize loss of life or damage to property and/or natural resources.

INCIDENT COMMANDER: The individual responsible for the overall management of all incident operations.

JUMPSTART TRIAGE: An objective system of triage which reduces both the over triage and under triage of pediatrics during an MCI. JumpSTART recognizes key differences between adult and pediatric physiology and uses appropriate pediatric physiologic parameters at decision points.

MASS CASUALTY INCIDENT (MCI): Any incident in which the emergency medical services personnel and equipment at that scene are overwhelmed by the number and severity of casualties at that incident.

MEDICAL TASK FORCE: A preplanned group of resources including 3 ambulances and two staff vehicles with 3 or 4 personnel (may not be EMT's) that responds to MCI's.

MEDICAL SUPPLY CACHE: A storage location in the treatment area for medical supplies that are acquired from MCI vehicles, ambulances, disaster kits or deliveries from resource hospitals.

MEDICAL SUPPLY MANAGER: The individual responsible for acquiring and maintaining appropriate medical equipment and supplies in the Medical Supply Cache. Supervised by the Treatment Group Supervisor.

MASS CASUALTY INCIDENT PLAN (MCIP): A plan which coordinates the response of multiple agencies in order to assure the delivery of adequate care and orderly distribution of patients to appropriate hospitals. The MCI plan may be implemented for any incident in which the emergency medical services personnel and equipment at that scene are overwhelmed by the number and severity of casualties at that incident.

OPERATIONS SECTION: The section responsible for all tactical action and all resources on scene.

OPERATIONS SECTION CHIEF: Individual responsible for the Operations Section. Reports directly to the Incident Commander. Responsible for directing all tactical resources to accomplish the goals and objectives developed by the Incident Commander.

OUT-OF-SERVICE: Not ready or available for assigned status.

PORTER TEAM: Team of four rescuers that move immobilized patients from the scene to the Secondary Triage Corridor via stretcher. Supervised by the Extraction Group Supervisor.

PRIMARY TRIAGE: A rapid initial treatment and triage of patients where they are found. Using the Simple Triage and Rapid Treatment (START) or JumpSTART (for pediatrics) algorithms, first responders provide for the correction of simple airway and circulation problems, and the initial classification of the severity of patient injuries. During Primary Triage patients are tagged with surveyors flagging tape.

RECEIVING HOSPITAL: Any hospital that will be receiving patients from the incident.

RESCUE BRANCH: The branch responsible for the extrication, immobilization, and extraction of all patients from the scene to treatment area.

RESCUE BRANCH DIRECTOR: The individual responsible for managing all the activities in the Rescue Branch. The Rescue Group Supervisor functions as a member of the Operations Section and may have two direct subordinates: Extraction Group Supervisor and Extrication Group Supervisor. They should formulate a plan of action for the extrication, immobilization, and extraction of all patients from the scene to the treatment area.

SAFETY OFFICER: Individual responsible for assessing hazardous and unsafe situations and develop measures for assuring personnel safety.

SECONDARY TRIAGE: Performed in the Secondary Triage Corridor. Patients will be re-triaged using START or JumpSTART and given a numbered triage tag.

SECONDARY TRIAGE CORRIDOR: Corridor leading to treatment area. Secondary Triage is performed in the corridor prior to entering the treatment area. After secondary triage is performed patients are then carried to the appropriate section of the treatment area, according to the triage priority they are assigned.

STAGING AREA MANAGER: The individual assigned the various tasks related to the arrival of emergency vehicles and personnel. Works directly with the Incident Commander or Operations Chief.

STRETCHER: Army style stretcher made of canvas stretched between two poles with handles. Designed for four rescuers to carry injured patients on.

TRANSFER CENTER: (541)-706-4844.The transfer center is the central contact point for the EMS Branch Director or Transport Group Supervisor. They are to be contacted via phone line to determine the receiving capabilities of area hospitals. The transfer center is also responsible for relaying patient information to receiving hospitals.

TRANSPORT GROUP SUPERVISOR: The individual responsible for the coordination of patient transportation and maintaining records related to patients, injuries, mode of transportation, and destination. Reports to the EMS Branch Director.

TRANSPORTATION RECORDER: The individual responsible for recording patients, injuries, mode of transportation and patient status. Coordinates patient information and movement.

TREATMENT GROUP SUPERVISOR: The individual responsible for proper secondary triage management, treatment, and coordination of all casualties in the Treatment Area. Reports to the EMS Branch Director.

TRIAGE GROUP SUPERVISOR: The individual responsible for supervising triage teams and ensuring patients are properly triaged and tagged. Reports to the EMS Branch Director.

TRIAGE TAGGING: ATAB 7 will use surveyor's flagging tape for identifying priorities of patients during primary triage. Upon secondary triage patients will receive a numbered triage tag. Patients will be prioritized based on START or JumpSTART during primary triage and ATAB 7 trauma criteria during secondary triage.

UNIFIED COMMAND: When there is an overlap of jurisdiction for the incident or there is more than one agency sharing the management responsibility, officials from EMS, Fire, Police, and other agencies may serve in a Unified Command. A Unified Command structure should consist of all the involved agency officials contributing to the command process, but there should be one key official that is recognized as the Incident Commander for communications purposes.

Section 2

GENERAL GUIDELINES

ATAB 7 Mass Casualty Incident Plan

GENERAL GUIDELINES

The Mass Casualty Incident Plan should be implemented on any incident that cannot be normally handled by the first responding ambulance service. The following guidelines are designed to give responders and facilities an action plan for mitigating a Mass Casualty Incident.

MASS CASUALTY INCIDENT MANAGEMENT GOALS

1. Do the greatest good for the greatest number
2. Make the best use of personnel, equipment, and facility resources
3. Do not relocate the disaster

FIRST ARRIVING UNIT

Upon arrival at a scene involving multiple patients the first unit on scene gives a visual size-up, establishes and announces command, confirms location and performs:

1. **Safety Assessment.** Assess the scene for:
    - Traffic hazards
    - Electrical hazards
    - Flammable liquids
    - Hazardous materials
    - Other life threatening situations
    - Be aware of potential secondary explosive devices

2. **Size Up.** Survey the incident scene for:
    - Type and/or cause of incident
    - Approximate number of patients
    - Severity level of injuries
    - Area involved, including problems with scene access

3. **Send Information:**
    - Contact dispatch with your size-up information:
        - Establish Command
        - Declare an MCI
        - Description of the incident including the number of patients
        - Report any critical hazards of the scene
        - Identify access and egress routes
        - Identify main radio frequency and tactical frequencies
        - Identify staging area
    - Request additional resources
        - Medical Task Forces
        - Structural Task Forces
        - Redmond Fire MCI Vehicle

- Haz-mat Team
- Law Enforcement
- Oregon Department of Transportation
- Search and Rescue

4. **Setup** the scene for management of the casualties:
    - Establish a command post
    - Implement the MCI plan
    - Secure the scene with law enforcement
    - Identify adequate work areas for Triage, Treatment, and Transport
    - Assign Triage and EMS Branch to the next arriving units

RESPONDING UNITS

Upon arrival, the second and third arriving units should report to the Incident Commander for briefing and assignment. Assignments should include:

1. **Establish** Triage Group
    - Use START and JumpSTART
    - Begin where you are
    - Ask anyone who can walk to move to a designated area
    - Use surveyor's tape to mark patients
    - Move quickly from patient to patient
    - Maintain patient count
    - Provide only minimal treatment
    - Consult Field Guide for further responsibilities, worksheets, and checklist

2. **Establish** EMS Branch
    - Contact SCMC transfer center at (541-706-4844)
        - Obtain receiving capabilities for area hospitals
        - Consider the activation of alternative care sites
    - Consult Field Guide for further responsibilities, worksheets, and checklist

3. **Establish** Treatment Group
    - Consult Field Guide for responsibilities and checklist

4. **Establish** Transport Group
    - Obtain receiving capabilities for area hospitals from EMS Branch
    - Consult Field Guide for further responsibilities, worksheets, and checklist

5. **Establish** Staging Area
    - Assign Staging Area Manager
    - Consult Field Guide for further responsibilities, worksheets and checklist

MUTUAL AID RESPONDING UNITS

Mutual aid units responding to the scene should get general directions from their dispatch. The dispatching agency will notify responding units as to the correct radio frequency to use. Units responding should contact the Staging Area Manager for the location and/or directions to the staging area. Responding units should review the MCI Field Guide while responding.

INCIDENT SCENE

- Locate all victims
- Direct ambulatory patients (Green) to a safe place
    - Assign an EMT to manage the Green Treatment Area
    - Self treatment supplies should be distributed
- Quickly triage patients using START and JumpSTART and apply triage ribbons
- Start extricating trapped patients
- Patients are decontaminated (as needed) prior to arrival in the treatment area
- Start moving non-ambulatory patients by porter from scene to treatment area
- Deceased victims are left where they lie, unless movement is required to access live patients

DECONTAMINATION

- Set up the decontamination corridor before the secondary triage corridor and before contaminated patients are moved
- Contaminated patients must be decontaminated before entry into the treatment area
- Gross decontamination with rapid clothing removal is the best option
- Request Haz-mat team if further decontamination is necessary

TREATMENT AREA

- Patients arriving from the scene are re-triaged at the entrance to the treatment area (secondary triage corridor) and tagged with a numbered triage tag
- Separate areas should be created in the treatment area for Immediate (Red), Delayed (Yellow), and Minor (Green). A separate isolated area (Temporary Morgue) should be created for victims who die in the treatment area
- Give stabilizing or definitive care based on triage priority (Red, then Yellow, then Green)
- Assign providers, equipment, and supplies to patients based on triage priority
- Consider use of special procedures teams to perform common treatments (airway, IV, splinting, etc.)
- Continuously reevaluate (re-triage) patients and move to other treatment areas as necessary
- Move patients who die to the temporary morgue

- Establish a Medical Supply Cache and stock with supplies from MCI vehicles, ambulances, and supplies received from hospitals
- Do not delay transport for treatment except for ABCs
- Select patients to transport based on severity (Red, then Yellow)

TRANSPORT AREA

- Setup a one-way in / one-way out "round robin" ambulance loading zone at the exit of the Treatment area
- EMS Branch Director and Transport Group Supervisor are the only personnel allowed to talk with the Resource Hospital
    - All communications should be via cell phone, use the HEAR frequency if cell reception is unavailable or unreliable.
- Notify the resource hospital as soon as possible
    - Request receiving capabilities of all receiving hospitals
    - Activate alternative care sites if necessary
- Assign patients to ambulances and helicopters based on severity and most appropriate vehicles available
- Move Minors (Greens) as soon as possible to vehicles such as buses
- Have porter teams move patients from treatment to the ambulance loading zone
- Load patients and direct ambulance to the appropriate hospital

TRANSPORTING AMBULANCES

- Ambulances will report to the Staging Area. Any unit arriving on scene prior to the establishment of a staging area must receive assignment from the IC or their designee.
- The driver of the vehicle MUST STAY WITH THE VEHICLE AT ALL TIMES. None of the crew should get involved in the Treatment Area during their patient loading.
- Ambulances may need to leave equipment at the scene for use in the treatment area.
- Transporting ambulances will receive patients from the transport area. The Transport Group Supervisor or designee will assign each ambulance a receiving hospital.
- **AMBULANCES ARE NOT TO COMMUNICATE DIRECTLY WITH RECEIVING HOSPITAL UNLESS ABSOLUTLEY NECESSARY**
- The patients Triage Tag is considered a sufficient pre-hospital care report form until a follow up report can be written
- Ambulances may need to restock from hospital supplies as well as be shuttles for equipment from the hospital to the treatment area
- After delivering the patient(s), the ambulance should return to the MCI staging area in serviceable condition until released from the scene by the IC or designee

TRANSFER CENTER

- Should designate a single person to be in constant contact via cell phone with the Transport Group Supervisor or EMS Branch Director
- The transfer center will contact all area hospitals to determine their receiving capabilities for Immediate (Red) and Delayed (Yellow) patients
- Alternative care sites should be contacted to begin setup and to determine their receiving capabilities for Minor (Green) patients.
- Information collected is to be relayed to the Transport Group Supervisor or EMS Branch Director
- Will relay patient information from the Transport Group Supervisor to receiving hospital
- May need to relay medical supply needs to receiving hospitals

RECEIVING HOSPITALS

- Should quickly collect their receiving capability for Immediate (Red) and Delayed (Yellow) patients and report to the Resource hospital
- Will receive the following information on ambulances en-route to their facility:
    - Unit #
    - Triage tag # and triage level
    - Estimated time of arrival

TERMINATION

An MCI may not be terminated for several hours to days after all patients have been treated and transported. As the incident winds down all resources committed to the incident will no longer be needed. At the discretion of the Incident Commander in coordination with the Operations Section Chief, units should be demobilized based on the following considerations:

- Units which have been on scene longest
- Units traveling the furthest

During the termination phase, also consider the following:

- At least one ambulance should remain on scene until all emergency operations have ceased
- Notifying the resource hospital when the transportation of the last patient is complete
- Attempt to return equipment to the agency it belongs to
- Consider the need for an immediate critical incident stress defusing followed by a debriefing a few days after the incident

Section 3

COMMUNICATIONS

ATAB 7 Mass Casualty Incident Plan

COMMUNICATIONS

GENERAL GUIDELINES

- The first responding agency's main operational frequency will be the primary command channel
- The primary command channel should be kept clear for operational radio traffic
- Requests for mutual aid should be made on the primary command channel to the primary agencies dispatch center
- Responding mutual aid units will be given the appropriate incident radio frequency when responding
- Units responding should contact the Staging Area Manager on the primary command channel unless otherwise directed
- Units without the primary command channel may be directed to use the Oregon State Fire Marshall Mutual Aid frequency
- Tactical Frequencies should be assigned to Branches and Groups as necessary to minimize radio traffic

MCI DISPATCHING

- The primary responding agency's dispatch center will be the dispatch center having jurisdiction
- The primary dispatch center will be responsible for notifying mutual aid agencies and other dispatch centers of the need for a mutual aid response
- COFOG has a preplanned air and ground medical unit response matrix to support efficient notification.
- Structural Task Forces are available for activation to an MCI
- These resources should be requested by the Incident Commander as needed through the primary command channel
- Dispatch should attempt to activate the closest resources
- Dispatch will relay the location of the incident, general directions to the scene if necessary, and the frequency which all units should contact the staging area manger
- If an agency is unable to fulfill their task force obligation, dispatch should request additional resources from another agency to insure a complete task force response

RADIO CALL NAMES:

INCIDENT COMMANDER	Command
OPERATIONS CHIEF	Operations
STAGING AREA MANAGER	Staging
EMS BRANCH DIRECTOR	EMS
TRIAGE GROUP SUPERVISOR	Triage
TREATMENT GROUP SUPERVISOR	Treatment
TRANSPORT GROUP SUPERVISOR	Transport
RESCUE BRANCH DIRECTOR	Rescue
EXTRACTION GROUP SUPERVISOR	Extraction
EXTRICATION GROUP SUPERVISOR	Extrication
FIRE SUPPRESSION GROUP	Suppression

CENTRAL OREGON

MUTUAL AID COMMON FREQUENCY PLAN

Structural Fire Zone				
CH	**Band**	**DESCRIPTION**	**RX** (Tone)	**TX** (Tone)
1		Individual Agency Dispatch		
2		Individual Agency Open		
3	W	HEAR	155.340	155.340
4	W	OSFM Mutual Aid	154.280	154.280
5	W	Tac 5 (Bend)	154.385	154.385
6	W	Tac 6 (Redmond)	155.520	155.520
7	W	Tac 7 (Crook Co)	155.550	155.550
8	W	Tac 8 (NW, Lapine)	153.830	153.830
9	N	Tac 9 (ODF NICS)	159.2400 (156.7)	159.2400 (156.7)
10		Individual Agency Open		
11		Individual Agency Open		
12		Individual Agency Open		
13		Individual Agency Open		
14		Individual Agency Open		
15	W	ODOT Tac	151.085 (131.8)	151.085 (131.8)
16	W	MAYDAY	155.220	155.220

Section 4

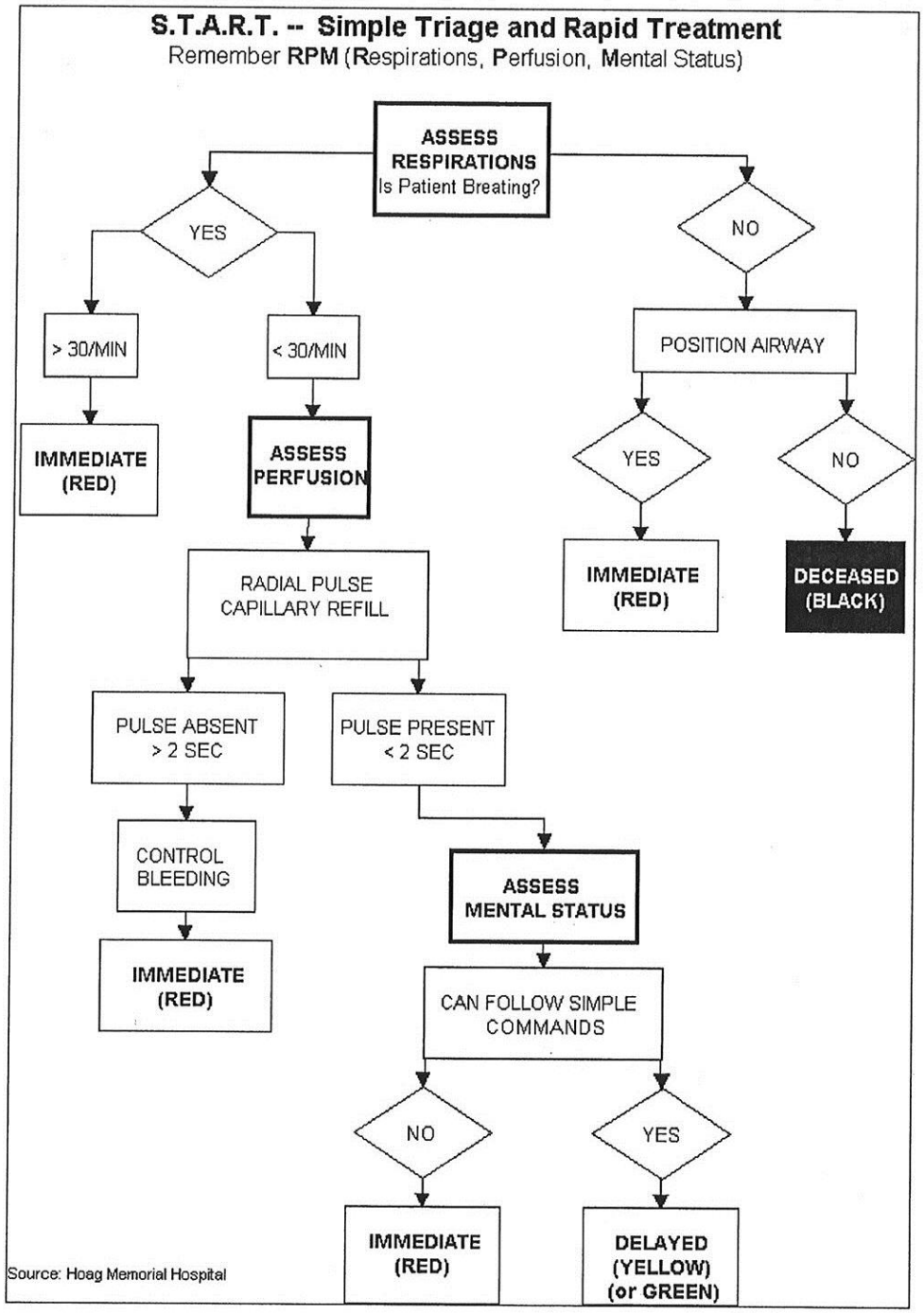
TRIAGE SYSTEM

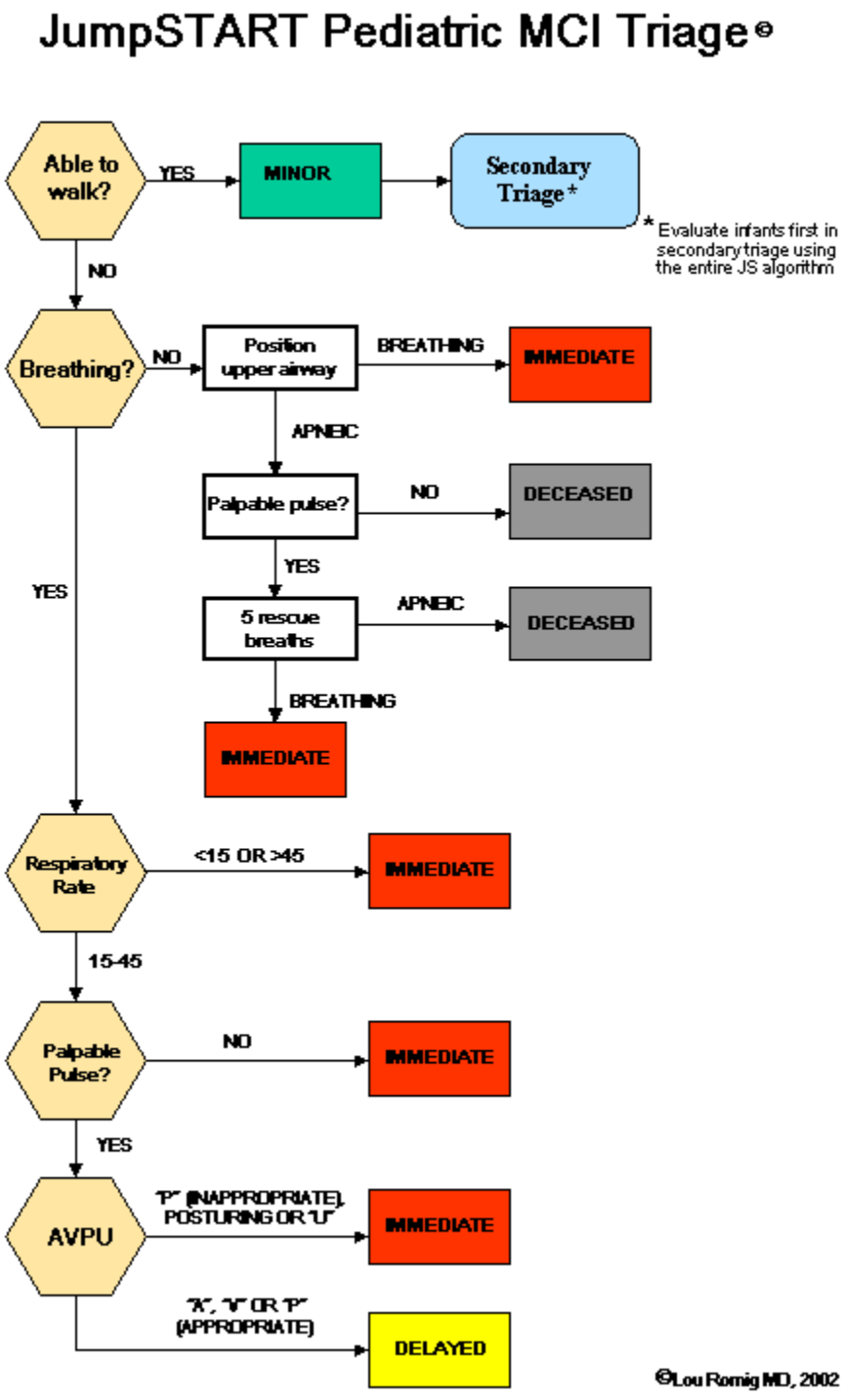
ATAB 7 Mass Casualty Incident Plan

TRIAGE SYSTEM

Triage should consist of:

1. **Primary Triage**
    - Patients are triaged where they are found using START or JumpStart and marked using surveyors flagging tape. Patients should be placed in High Arm IN Endangered Spine (HAINES) positioning when necessary.
2. **Secondary Triage**
    - Patients are triaged in the Secondary Triage Corridor at the entrance to the Treatment Area. Patients are triaged again using START or JumpSTART. Patients will receive a numbered triage tag indicating their color. The triage tag will serve as the record of patient care.


S.T.A.R.T. -- Simple Triage and Rapid Treatment
Remember RPM (Respirations, Perfusion, Mental Status)
ASSESS RESPIRATIONS
Is Patient Breating?
YES
NO
> 30/MIN
< 30/MIN
POSITION AIRWAY
IMMEDIATE (RED)
ASSESS PERFUSION
YES
NO
IMMEDIATE (RED)
DECEASED (BLACK)
RADIAL PULSE CAPILLARY REFILL
PULSE ABSENT > 2 SEC
PULSE PRESENT < 2 SEC
CONTROL BLEEDING
ASSESS MENTAL STATUS
IMMEDIATE (RED)
CAN FOLLOW SIMPLE COMMANDS
NO
YES
IMMEDIATE (RED)
DELAYED (YELLOW) (or GREEN)
Source: Hoag Memorial Hospital


JumpSTART Pediatric MCI Triage©
Able to walk?
YES
MINOR
Secondary Triage*
* Evaluate infants first in secondary triage using the entire JS algorithm
NO
Breathing?
NO
Position upper airway
BREATHING
IMMEDIATE
APNEIC
Palpable pulse?
NO
DECEASED
YES
YES
5 rescue breaths
APNEIC
DECEASED
BREATHING
IMMEDIATE
Respiratory Rate
<15 OR >45
IMMEDIATE
15-45
Palpable Pulse?
NO
IMMEDIATE
YES
AVPU
"P" (INAPPROPRIATE), POSTURING OR "U"
IMMEDIATE
"A", "V" OR "P" (APPROPRIATE)
DELAYED
©Lou Romig MD, 2002

Section 5

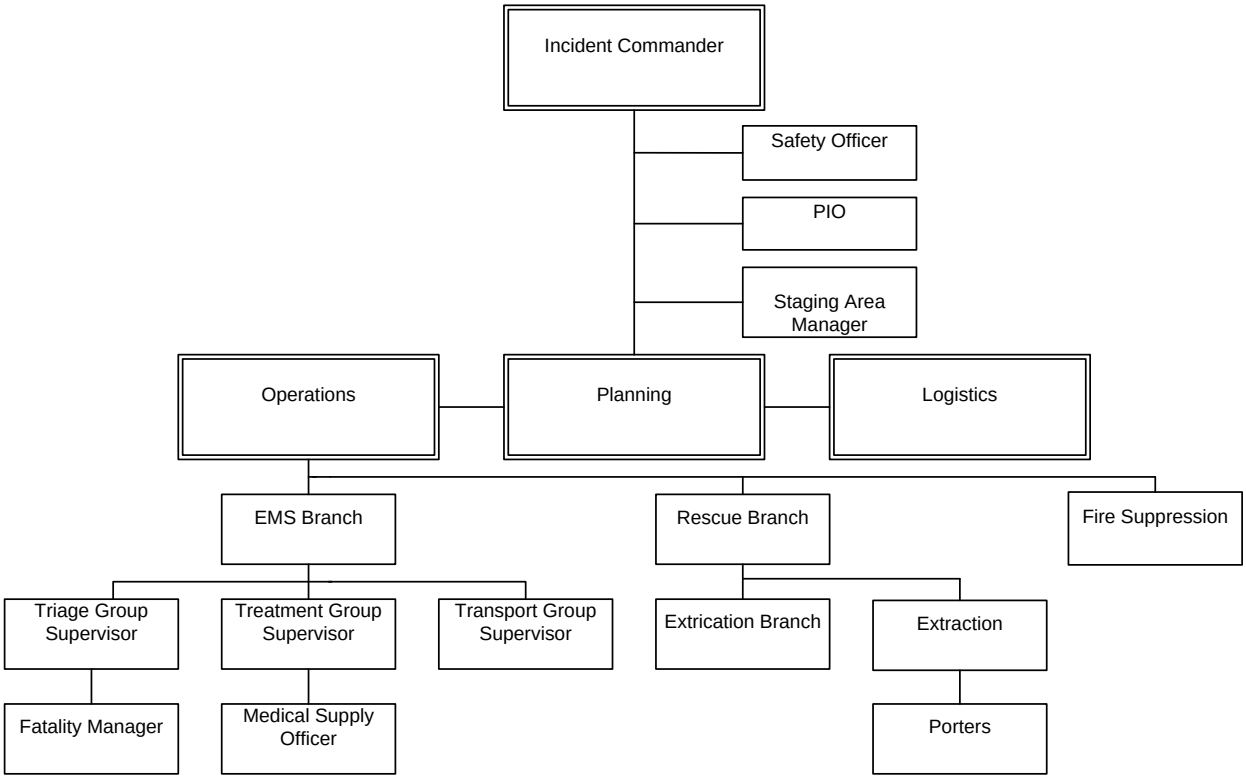
COMMAND STRUCTURE

ATAB 7 Mass Casualty Incident Plan

COMMAND STRUCTURE

The following command structure is intended to assist the Incident Commander in setting up an appropriate structure for the mitigation of an MCI. It is not the intent of this section to limit the structure being set up, or the number of personnel to involve, but merely to serve as a model when pre-planning and training. It is strongly advised however, that sound ICS principles of unity of command and span of control be observed when designing the command structure for an incident.

MCI Organizational Chart



Section 7

MCI RESOURCES

ATAB 7 Mass Casualty Incident Plan

Central Oregon Mutual Aid Resources

The Central Oregon Fire Operations Group (COFOG) has developed a complete matrix for efficient dispatching of air and ground ambulances. Regional task force resources are also organized through COFOG.
Locate the necessary information at:
www.centraloregonfireservices.org
Navigate to the COFOG tab.

Additional EMS/Fire Resources:

In addition to the above available resources the following agencies may be available for dispatch to an MCI:

- Redmond Fire MCI Vehicle
- Deschutes County Search and Rescue
- Oregon National Guard
- Oregon State Fire Marshal's Hazardous Material Team
- Klamath County Fire District
- Crescent Fire Department
- Chemult Fire Department
- Harney County Ambulance
- Rager Ambulance
- John Day Fire Department
- Mitchell Ambulance
- Dufur Fire Department
- Fossil Fire Department
- Sherman County Fire Department
- Maupin Fire Department

The above agencies must be contacted through their respective dispatch centers.

Alternative Care Sites:

The below clinics should be contacted early in the incident to begin preparation for receiving minor (Green) patients.

- Bend:
  - Bend Surgery Center – 75 patients
  - Cascade Surgery Center – 75 patients
- Redmond:
  - SCMC Family Care – 50 patients
  - Advanced Surgical Specialty – 10 patients

Casualty Collection Points:

The following sites are available to be set up as field treatment sites in the event all hospitals and medical clinics are at capacity and unable to handle any additional patients. Patients will be transported to these sites to receive field treatment until they can be transported to a receiving hospital. These sites require the deployment of SCMC-Bend MCI trailers or Redmond Fire's MCI Vehicle. Sufficient personnel must be assigned to these sites to care for patients and oversee the flow of patients into and out of the site.

- Deschutes County Fairgrounds – Requires SCMC-Bend MCI trailers or Redmond Fire MCI Vehicle

Additional Resources:

These resources should be contacted in order to setup shelters and provide support services at the incident.

- American Red Cross
- Norco
- Sanitation Services

Section 8

EMS RESOURCES STATE OF OREGON

ATAB 7 Mass Casualty Incident Plan

STATE OF OREGON EMS PREPAREDNESS PLAN

- http://www.oregon.gov/DHS/ph/ems/docs/2009/EMS_Plan_FINAL_w_radio.pdf