Foothills Regional Emergency Medical & Trauma Advisory Council

Serving Boulder, Clear Creek, Gilpin, Grand, & Jefferson Counties

Regional Multiple Casualty Incident Plan

(MCI)

Updated
December 2014

Table of Contents Page

1. FRETAC MESSAGE

The Foothills Regional Emergency Medical & Trauma Advisory Council (FRETAC) provides this plan to the agencies, facilities, counties, and state agencies within the boundaries of our RETAC with the understanding that it is considered a “living document”. Revisions of this plan are always on-going, and the plan will change as new information and data is obtained. Appendices to this plan are continually “in process” as events and data inspired standards are set.

The concept of this FRETAC Regional MCI Plan is that it is a document that unifies the efforts throughout the FRETAC to better prepare for multiple patient (mass casualty and mass evacuation) incidents. These efforts will ultimately enhance the entire EMS system. This plan has been developed by pre-hospital, hospital-based, emergency management and public health professionals. This design ensures a plan that is a “top-down – bottoms-up” approach.

This plan is meant as a "systems" plan only, and should NOT be interpreted as an Operational plan. This plan, along with the FRETAC Field Guide, should be used as templates to develop individual agency plans that work within our regional system.

The Foothills RETAC also acknowledges that resources around our state are changing very quickly, so the resource lists and other appendices will change.

A. The RETAC as an Agency Resource

Colorado Legislature mandated the development of regional medical systems. Under Senate Bill 00-180, which updated Colorado Revised Statute (CRS) 25-3.5-101 et seq., the “Colorado Emergency Medical and Trauma Services Act” (the Act) further defines the creation of the Regional Emergency Medical & Trauma Advisory Councils (RETACs).

Based on direction provided under the Act, the Foothills FRETAC was created through the Boards of County Commissioners in Boulder, Clear Creek, Gilpin, Grand and Jefferson Counties. The Commissioners from each county appoint regular members and possibly an alternate member to represent their interests on the FRETAC Board of Directors

This Plan has been approved by the Foothills Regional Emergency Medical and Trauma Advisory Council Board of Directors, but will be continually updated as a living document.

B. Purpose

The Foothills Regional Emergency Medical and Trauma Advisory Council (FRETAC) was created to develop a comprehensive and regional, emergency medical and trauma care system.

Each Board of County Commissioners and Office of Emergency Management within our five counties will be given a copy of this plan for their review and use as appropriate for their county.

This FRETAC Regional MCI Plan establishes a basis for unified response to a Multiple Casualty or Mass Evacuation incident in our region. The region covers Boulder, Clear Creek, Gilpin, Grand, and Jefferson Counties. The FRETAC Board of Directors encourages all pre hospital agencies, facilities, and county emergency managers to develop inter-operable MCI plans that include working agreements with neighboring agencies and facilities.

Pre-hospital, hospital and County MCI Plans may be tiered to this plan, and agency MCI standard operating guidelines may be tiered to respective county plans.

Successful management of any Mass Casualty or Mass Evacuation (with the use of the Regional MCI Plan) heavily depends upon cooperation and shared organization and planning among County Emergency Managers, healthcare professionals, administrators in facilities, prehospital agencies, and disaster related support agencies and government entities at all levels in the counties that comprise the FRETAC.

C. Administration and Support

The FRETAC MCI Committee is a standing committee of the Foothills RETAC. This committee shall work cooperatively with each county's Emergency Manager to link Local Emergency Planning with this Regional Plan

D. Plan Development and Maintenance:

This Regional MCI Plan, along with the FRETAC MCI Field Guide (appendix E) was originally written in 2004 through the FRETAC MCI Committee. The current plan of 2014 will be distributed via a wide-range of media.

The FRETAC MCI Committee is responsible for biannual reviews of the MCI Plan and MCI Field Guide. Other revisions can be made at any time that national, state, and federal standards change, upon approval of the committee and the FRETAC Board of Directors.

E. **Implementation:**

i. Revisions and/or amendments shall be acted upon by the FRETAC no longer than 60 days after all members have been notified of the proposed changes and have had an opportunity to respond through their representatives or in writing to the committee chair

2. Definition of Terms and Abbreviations

AHJ	Authority Having Jurisdiction
CISM	Critical Incident Stress Management
Communications Center	Dispatch Center
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Team
DOT	Department of Transportation
EMS	Emergency Medical Services
EMResource	Web-based Hospital Divert and Capability Reporting System
EMTS	Emergency Medical and Trauma Services
ETA	Estimated Time of Arrival
FRETAC	Foothills Regional Emergency Medical and Trauma Advisory Council
HazMat	Hazardous Material
IAP	Incident Action Plan
IC	Incident Commander
ICS	Incident Command System
IMT	Incident Management Team
MCI	Multiple Casualty Incident
MOU	Memorandum of Understanding
MGS	Medical Group Supervisor
NIMS	National Incident Management System

3. SITUATIONS AND ASSUMPTIONS

Each Agency will define what constitutes a Multiple Casualty Incident for their jurisdiction.

Situations

Potential MCIs in the FRETAC could include, but are not limited to:

- Major vehicular accidents with multiple victims.
- Urban, residential and wildland fires.
- Severe winter storms or other severe weather or natural disaster related situations.
- Public transportation accidents (aircraft, train, bus, chairlift).
- Construction and/or industrial and farm accidents including hazardous materials, or building collapses with multiple victims.
- River and/or localized flooding, dam failures, impassable highways, roads and bridges.
- Acts of terrorism, bio-terrorism and/or civil disobedience
- Military/Federally related incidents
- Any other incident that overwhelms the capabilities of local emergency response agencies.

Assumptions

- When considering activation of the Regional MCI Plan, all emergency response agencies are expected to maintain their own capabilities at predetermined levels to continue meeting local needs.
- Personnel, agencies and/or jurisdictions shall operate during an incident or evacuation under the National Incident Management System (NIMS).
- Facilities and prehospital agencies shall participate in periodic training exercises for their MCI Plan.
- Each prehospital agency will have an MCI Operational Plan in coordination with the Foothills RETAC Regional MCI plan.
- Each prehospital agency will be provided a template for their MCI Plan upon request.

4. CONCEPTS OF OPERATIONS

A. General Scope of the MCI Plan

i. Upon activation of this plan, the Communications Center, utilizing the Medical Resource Guide (Appendix D), contained in this plan, shall dispatch resources at the request of the Incident Commander at the incident

ii. The Communications Center will post the incident on the EMSystems website.

iii. Emergency operations on scene shall be conducted as outlined in the MCI Operational Plan of the AHJ or in the FRETAC Field Guide (Appendix E), and in accordance with legislation, local plans, medical protocol and mutual aid agreements.

iv. The Plan assumes and includes mutual aid agreements/MOUs between regional EMS, hospital/healthcare facilities and other prehospital agencies.

v. All MCIs within the FRETAC shall be handled in cooperation with, and under direction of, the agency or individual having jurisdiction (AHJ).

B. FRETAC MCI Field Guide (Appendix E)

i. Provides a standardized guide to assist in coordination and/or management of any response to an MCI within the FRETAC.

ii. Effectively utilizes various resources for MCI management in the FRETAC.

iii. Can assist in evacuation and care for a significant number of patients from any health care facility when the care and transportation of those patients exceeds the capabilities of the locality, facility, or jurisdiction.

iv. Will help ensure the largest number of survivors in mass casualty situations or healthcare facility evacuations.

C. Types of Multiple Casualty Events

The classification of the incident shall be determined by the IC based upon the needs of the scene and available resources.

- Resources for care and transportation of patients/victims may be requested and posted on the EMSystems website.
- Other (usually non-medical) resources may be requested on WebEOC or through the State OEM.

i. **LOCAL:** Required resources available to the agency or immediately available through normal mutual aid.

ii. **REGIONAL:** Required resources exceed those immediately available locally.

iii. **STATEWIDE:** When regional resources are overwhelmed, a statewide incident may be declared. Statewide mutual aid or a county disaster

declaration must be activated through the County Emergency Management System.

iv. **FEDERAL:** Activation of Federal resources requires a State declaration by the Colorado Office of Emergency Management and the Governor's office.

D. Management Goals

i. Do the greatest good for the greatest number of people.
ii. Make the best use of manpower, equipment and facility resources.
iii. Whenever possible, avoid relocating the MCI to the receiving facilities.
iv. Comply with any local, state, federal rules and regulations regarding patient care and transport.

E. Incident Priorities

i. Facility or agency provider safety, accountability and welfare
ii. Life Safety
iii. Incident Stabilization
iv. Conservation of Property and Evidence

F. Critical Incident Stress Management

i. CISM team can be activated through the local Communications Centers.

5. Organization and Assignment of Responsibilities

A. Participants: The regional response to an MCI or evacuation may involve the following:

I. EMS providers with Emergency Response agencies
II. Healthcare facilities
III. Trained First Responders
IV. Local, State, and Federal government agencies
V. Non-transport support such as Fire organizations, CISM teams, American Red Cross, public utilities, amateur radio and any local volunteer organizations involved in disaster recovery.

B. Local Emergency Plans

I. It is recognized that some localities and each county have a local emergency operations plan.
II. This Regional MCI Plan shall be transparent to, and support any local jurisdictional plan.
III. The FRETAC MCI Committee will provide assistance (upon request) to Counties/Agencies/Emergency Managers in preparation and maintenance of their MCI plan.

C. Initial Response to an Incident

i. The MCI Plan uses NIMS nomenclature and a standardized ICS approach to all incidents. Requests for additional resources shall originate from the IC and be routed through the appropriate Communications Center.

D. Activating the Operational MCI Plan

I. The agency, which is the Authority Having Jurisdiction (AHJ) can activate their MCI Plan from the scene.

II. Once the MCI Plan is activated, the Communications Center will make appropriate notifications via EMSystems.

III. The person activating the Plan will first identify him or herself, and give a report on the incident with type, location, number of patients and a callback number.

E. Responsibilities:

i. **<u>Hospitals and Healthcare Facilities</u>**

a. Facilities that are activated or alerted under the MCI Plan shall provide, through EMSystems, confirmation or adjusted information on the numbers of patients they can accommodate in the three START Triage categories:

Red: Immediate
Yellow: Delayed
Green: Walking Wounded
Black: Deceased/Not revivable

b. Facilities shall activate their own MCI plans for additional staffing based on anticipated patient counts from the scene

ii. **<u>Prehospital</u>**

a. Responding providers, including those responding in privately owned vehicles, shall communicate with their respective agencies, and then report to staging and SHALL NOT self-dispatch to scene of the incident.

b. To maintain security, all personnel responding to a MCI or facility evacuation shall be required to carry self-identification and proof of affiliation with their agency.

c. At the discretion of the IC, responding units may be directed to the staging area or to the Ambulance Loading Zone.

d. All prehospital providers responding to a MCI in the Foothills region agree to operate under the ICS utilizing the START triage system.

e. Localities affected by an MCI shall be responsible for activating local or regional mutual aid through their own Communications Centers. Use of the available statewide mutual aid resources shall be activated by a County Emergency Manager's request to the State of Colorado.

f. Personnel from responding agencies shall be responsible for all of their medical and incident documentation.

g. Prehospital agencies shall encourage their providers to participate in on-going training in ICS, START triage system, EMSystem Training, hazard awareness programs and other related MCI skills, along with periodic training exercises.

iii. **Office of Emergency Management**

a. Emergency Managers should be notified of an MCI event through their dispatch centers.
b. Emergency Management will activate their Emergency Operations Center (EOC) if deemed necessary to support the Incident Commanders in the field.
c. Acquisition of resources that are needed by the incident beyond the capability of the local response agency and the communications center will fall to the Office of Emergency Management (OEM) and/or the EOC.
d. A County to County resource request will be coordinated by the EOC.
e. Additional requests will funnel through the State Office of Emergency Management.
f. There may also be a coordinated request made through the local health department to the State Health Department for additional resources.
g. Typically a designated individual will respond to the EOC help coordinate those requests as a representative for ESF8.
h. Along with the direct coordination between agencies, the use of EMSystems and WebEOC in an MCI event is critical and is used by many OEMs to help with resource coordination.
i. Lastly, many OEMs will request a hospital liaison to the EOC to assist with resource and patient tracking.

iv. **Public Health**

a. Public Health representatives are typically the lead for Emergency Support Function (ESF) 8 to provide a coordinated response to health and medical care needs during and following an emergency or disaster incident.
b. ESF 8 supports the overall health and medical response through the EOC.
c. For emergency and disaster incidents requiring mutual-aid and local, state or federal assistance, public health will work with counterparts from such entities to seek, plan, and direct use of those assets.
d. When an incident is focused in scope to a specific type of a response, such as a mass casualty, the position and functions of ESF 8 will be assumed by appropriate personnel with expertise pertinent to the incident.

F. Medical Direction/Protocols

i. Established medical direction will be maintained by each agency's provider, even outside of the local agency's jurisdiction.
ii. Patient care shall be rendered in accordance with the established prehospital care protocols of each responding agency.

G. Fatalities and Mass Fatalities Incidents

i. It is critical that the Coroner's Office be notified as early as possible in any mass fatality situation.
ii. Fatalities and any incident debris need to be left in place to assist the Coroner in identifying victims.
iii. The Coroner and Law Enforcement shall be responsible for scene and evidence security.

H. Standard Precautions

i. All personnel involved in a response to any MCI or evacuation shall comply with standard precautions, to include universal precautions/body substance isolation, and all equipment and resources (PPE) for their own personal protection.

6. Direction and Control

A. Emergency Communications

i. The Communications Center shall be responsible for posting the incident on EMSystems and WebEOC (if available), which should be used during the incident to monitor hospital capabilities and to assign patient destinations to available healthcare facilities.
ii. The IC assures that a Communications Plan is developed for primary communication during the event.
iii. The Transportation Group Supervisor/Unit Leader shall report to their supervisor when all patients have been transported from the scene. This is a benchmark to be communicated to the Communications Center and posted to EMSystems.
iv. Only in cases of imminent life threats, shall ambulances make enroute changes to hospital destination. Notification must be made to both the receiving facility and to the Communications Center.
v. Clear language shall be used in all MCI responses as per ICS standards.
vi. Facilities that have 800 MHz radios available should utilize them as a redundant source of communications. A list of the available channels can be obtained from the Communications Office of the local jurisdiction.

B. Technical Rescue Operations/Specialized Resources

i. When needs exceed local capabilities or resources, utilize the Medical Resource Guide to locate specialized resources. Several local teams exist which have technical rescue capabilities.
ii. When needs exceed regional resources, additional assistance is available through the local EOC.

C. Hazardous Materials

I. A Hazmat activation and notification plan should exist locally for incidents involving hazardous materials.

II. Patients exposed to hazardous materials shall not be transported unless decontaminated.
III. All healthcare facilities are encouraged to have basic decontamination capabilities to treat patients exposed to hazardous materials.
IV. Patient self-transport should be anticipated by the facilities. Isolation and decontamination should be set up and available.
V. Decontamination shall be conducted according to accepted national guidelines established by DOT, OSHA, EPA, NFPA and any local hazardous material response plans.

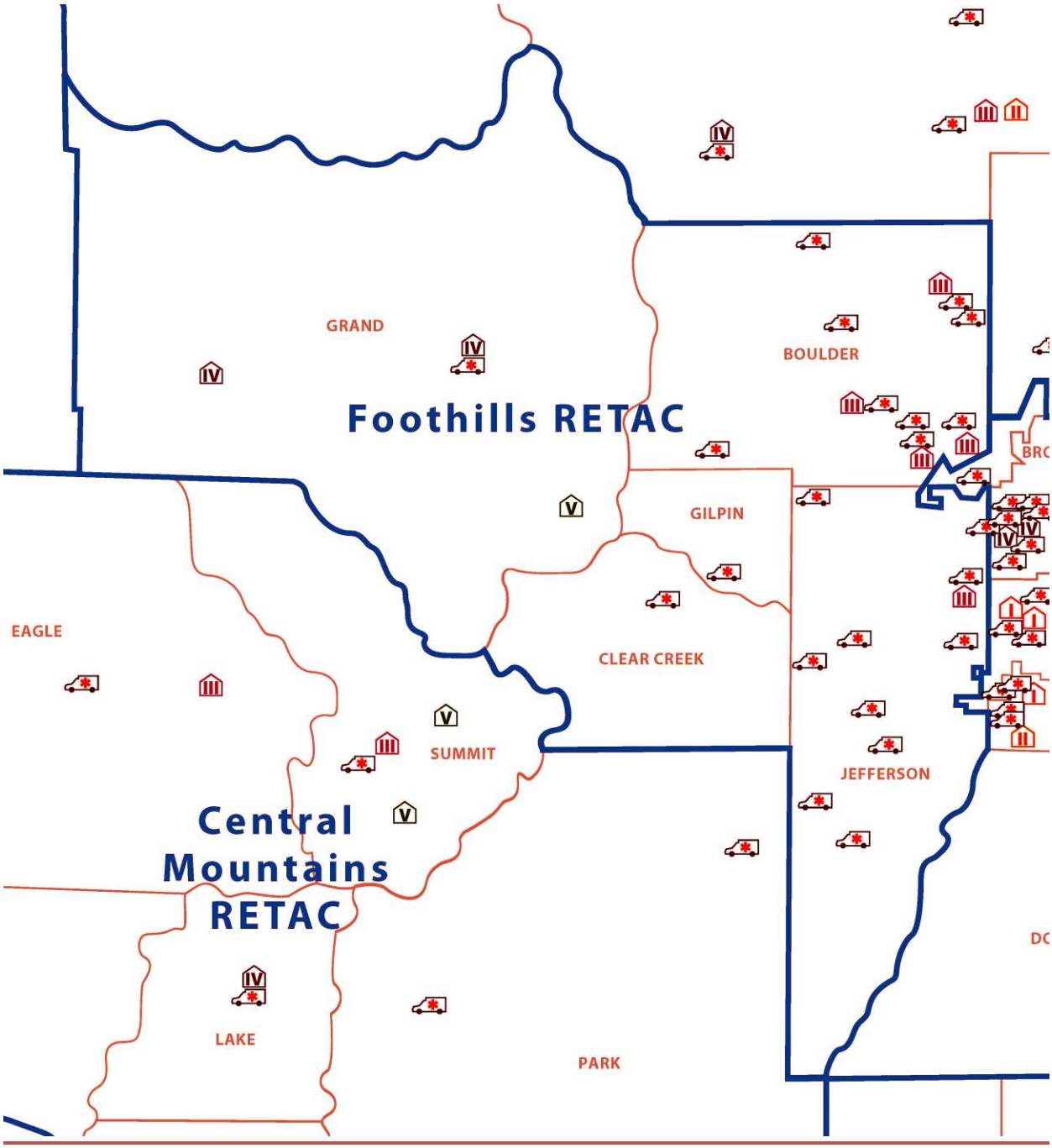
D. Air Operations

I. The Federal Aviation Administration (FAA) regulates airspace over an MCI.
II. Requests for restriction of airspace over a MCI should be made by the IC to the FAA Air Traffic Control Center (ARTCC) in Washington D.C. ARTCC Operations Manager available 24 hours/7 days – 303.651.4248.
III. County Sheriffs are able to request military air assistance for Search and Rescue Operations from the Air Force Rescue Coordination Center (AFRCC).
IV. In large-scale emergencies the CDEM is available. They can assist with larger scale air resource needs.

APPENDICES

APPENDIX A

FOOTHILLS RETAC MAP


GRAND
Foothills RETAC
BOULDER
GILPIN
CLEAR CREEK
EAGLE
SUMMIT
JEFFERSON
Central
Mountains
RETAC
LAKE
PARK

APPENDIX B

MCI TRANSPORT FORM FOR AGENCIES

Foothills RETAC Fire/EMS Agency

MCI Transportation Form

# Victims Reported by Triage Category				
I	II	III	IV	Totals

Date:_____

Incident Location:_____

Emergency Units Responding			

Hospitals						
Can Handle						
# Sent						

Tag Number	Category	Patient Name	Primary Injuries	Emergency Unit Transporting	Time of Departure	Hospital

Notes:

MCI Transport Form for PSAPs/Coms

Foothills RETAC Communications Office

MCI Transportation Form

# Victims Reported by Triage Category				
I	II	III	IV	Totals

Date:_____

Incident Location:_____

Emergency Units Responding			

Hospitals						
Can Handle						
# Sent						

Emergency Unit Transporting	Arrival at Scene	# Of Patients with Triage Categories	Time of Departure	Hospital	Arrival Time at Hospital
Notes:					

APPENDIX C

PREHOSPITAL AGENCY MCI POLICY TEMPLATES #1 & 2

STANDARD OPERATING PROCEDURES

EMERGENCY MEDICAL SERVICE

SOP #:

Category: Mass Casualty Incidents

Date:

I. Purpose:

Rapidly establish triage, treatment and transportation of multiple field casualties.

II. Procedure:

These procedures shall be implemented when personnel on the first arriving unit determine that **three or more ambulances** will be required to transport all victims from the scene to area hospitals. Due to the potential for HazMat or WMD in mass casualty incidents, extreme care should be taken to minimize risk to respondents. Other protocols may need to be integrated.

A. First Arriving Officer Duties:

The Officer on the first arriving EMS or fire unit shall be responsible for the initial scene assessment and coordination of the MCI response. He/she shall then assume Incident Command (IC) per Department Policy and Procedure and notify the Communications Office, designating the incident as an "MCI." The size-up report should also include the nature of the incident and an approximation of the number of victims, allowing the Communications Office to anticipate the resources required to meet the immediate needs.

1. The IC shall direct and coordinate all scene operations.

2. The IC shall designate routes of ingress and egress of ambulances and will notify the Communications Office of those routes on the radio.

3. The IC shall assign personnel to fill the roles of Triage Unit Leader and Transportation Unit Leader. The needs of the scene will help the IC decide the most appropriate personnel to fill these roles. Typically, these assignments will be given to the crew of the first arriving ambulance, to allow those individuals to maintain supervision of medical operations from their arrival until the last patient is transported from the scene ("First in, last out."). In some cases, the assignments may be given to other adequately trained personnel when they are not occupied with other duties, thus allowing ambulance personnel to remain with their ambulances and be available to treat and transport patients. Another factor that may enter into the assignment of personnel would be the presence of a new ambulance crewmember that is being trained and evaluated and is not yet ready to solely assume one of these assignments.

4. The IC shall determine the need and make requests for resources or personnel that may be necessary for scene operations and management.

B. Triage Unit Leader:

The attendant on the first arriving ambulance assumes the role of Triage Unit Leader until the IC makes the official assignment. Once assigned, the Triage Unit Leader shall don the appropriate vest, so as to be easily recognizable to all incoming ambulance crews.

1. The Triage Unit Leader's first responsibility is to provide rapid triage using the Simple Triage and Rapid Treatment (START) system for all victims of the incident. Triage Tags with the START system color coding should be utilized for patient tracking. Other methods with the START system color coding may be used by triage team members on scene to quickly identify triage categories for victims (e.g. tape, ribbons), providing that Triage Tags will be placed on victims prior to transport. When all victims are located within a small perimeter, the Triage Unit Leader can effectively perform triage for all victims and assign sufficient personnel to provide patient care while they await transportation. When several victims are scattered over a larger area, it may be necessary for the Triage Unit Leader to organize a team of rescue personnel to evacuate victims to a common location (Triage Funnel). The transfer of victims can be facilitated with the use of traffic cones, signs, or lengths of fire hoses deployed in a "cattle-chute" format (positioned from a wide area to a narrow end point). In this instance, the Triage Unit Leader may position himself at the Triage Funnel point to ensure that all victims are evaluated and triaged (or re-triaged).

2. When the transportation of several victims will be delayed, the Triage Unit Leader (in conjunction with the Transportation Unit Leader) may establish Patient Collection and Treatment Areas for each triage category. The location of these areas shall be in a safe area as close as possible to the Ambulance Loading Zone.

3. The Triage Unit Leader is responsible for designating (and communicating to the Transportation Unit Leader) the order of patients to be transported and which patients may require helicopter transportation.

4. When the Triage Unit Leader is the attendant on the first arriving ambulance, he/she resumes his/her original assignment when the last patients are prepared for transport. In most cases, the first ambulance to arrive on scene will be the last transporting ambulance.

C. Transportation Unit Leader:

The driver of the first arriving ambulance will assume the role of Transportation Unit Leader until IC makes the official assignment. Once assigned, the Transportation Unit Leader shall don the appropriate vest, so as to be easily recognizable to all incoming ambulance crews. The Transportation Unit Leader shall:

1. Be responsible for requesting the response of any additional EMS transportation resources (either to the Communications Office or to the IC/MGS). This may include the use of public transportation resources (i.e. buses), for numerous "walking wounded" patients.

2. Determine the divert status of potential receiving hospitals and instruct the Communications Office to contact specific hospitals to alert them of the scope of the incident and to request a report of the number of patients (per triage category) that they are capable of receiving. **Remember:** A non-Trauma Center can often step up their capabilities and become a temporary "Trauma Center" if they are notified early into the incident and given enough time to mobilize staff, operating rooms, etc.

3. Designate the Ambulance Loading Zone and inform the IC or MGS.

4. Be responsible for establishing and ensuring proper placement and staging of all EMS ground and air units.

5. Work with the IC, the Triage Unit Leader, and the Communications Office to ensure that all incoming EMS crews are clearly aware of the following:

   a) Routes for vehicle ingress and egress

   b) Incident conditions and possible hazards

   c) Vehicle staging site (if necessary)

   d) Ambulance Loading Zone, located as close as possible to the Patient Collection and Treatment Area

   e) Location of Equipment Stockpile Area

   f) Key equipment needed from EMS units upon their arrival

   g) The need for drivers to stay with (or near) their vehicles

6. Assign patients to EMS transport units and maintains MCI Transportation Form. The Transportation Unit Leader must "patrol" the Transportation area and be concerned with removing patients from the scene expeditiously, with critical patients transported first, whenever possible. The Transportation Unit Leader should (when possible) avoid assigning more than one critical patient to each transport unit. Assigning one "Red" and one "Yellow" patient to each transport unit generally results in more effective patient care when there is only one attendant. It is important that the Transportation Unit Leader stay out of the Patient Collection and Treatment Areas to avoid being "trapped." To this end, to the Transportation Unit Leader may establish a well-defined "on-deck" area near the Ambulance Loading Zone, where the next patients to be transported will be temporarily placed.

7. Assign hospital destinations to the first "wave" of EMS transport units and communicate it to Communication Center. After the first "wave" of transports from the scene, the Transportation Unit Leader will assign hospital destinations with advice from the Communications Office.

8. In large scale MCIs, the Transportation Unit Leader may assign the responsibility for making hospital notifications to the Communications Office.

9. Be responsible for implementing a system for tracking patients with their transporting vehicles and hospital destinations. The Transportation Unit Leader must ensure that the Triage Tag Tracer Stub is retained for each patient and that a corresponding log is maintained. The Transportation Unit Leader or the MGS is well-advised to appoint an Aide or Scribe to maintain the log.

10. When the Transportation Unit Leader is the driver on the first arriving ambulance, he resumes his original assignment when the last patients are prepared for transport. In most cases, the first ambulance to arrive on scene will be the last transporting ambulance.

The IC may appoint a Medical Group Supervisor (MGS), to whom the Triage and Transportation Unit Leaders will report. In smaller incidents, the MGS may assume the role of Transportation Unit Leader.

D. Transport Unit Crews:

1. Responding Transport Units will obtain information from the Communications Office such as staging location, routes of ingress and egress, and (if available) the identity and location of the Transportation Unit Leader. Transport Units that respond to an MCI after the initial ambulance are responsible for reporting as assigned to the Ambulance Loading Zone or designated staging area.

2. When reporting to the Ambulance Loading Zone, transport unit crews will park their ambulances and then immediately contact the Transportation Unit Leader.

3. The crews should anticipate the rapid assignment of patients for transport, along with a hospital destination, from the Transportation Unit Leader. Transport unit crews must avoid becoming separated from their ambulances so they can load and leave the scene expeditiously.

4. In consideration of the potentially large amount of telephone or radio traffic, hospital notifications should be as concise as possible. In very large scale MCIs, the Transportation Unit Leader may decide to assign hospital notifications to the Communications Office or the Incident Dispatcher if assigned by Command.

5. Freelancing by transport units shall be avoided and may result in release from the incident as determined by IC or MGS.

E. The Communications Office:

1. When personnel at the scene designate an "MCI," the Communications Office is responsible for entering the incident on the EMSystems website and WebEOC.

2. Dispatch available resources to meet the initial needs of the scene per procedure.

3. Contact other transport agencies to inform them of the incident and to determine available resources as necessary.

4. Dispatch additional resources as requested by IC or MGS.

5. Communicate to all responding ambulances designated routes for ingress and egress.

6. Monitor EMSystems website or contact area hospitals as necessary to determine capabilities for receiving patients (number per triage category) and relay information to Transportation Unit Leader.

7. Inform Command and on-scene resources as appropriate.

8. Maintain MCI Transportation Form and record number and type of patients, transport units, hospital destinations and appropriate times (especially arrival times at hospitals). Make recommendations for hospital destinations to the Transportation Unit Leader based upon information from the MCI Transportation Form.

9. When assigned by the Transportation Unit Leader, personnel in the Communications Office will make hospital notifications that should be concise and include:

a) Identification of the transport unit

b) Number of patients with their triage category designation

c) ETA for each transport unit

III. Reference:

Denver Metro EMS Protocols

PREHOSPITAL AGENCY MCI POLICY TEMPLATE #2

MULTIPLE CASUALTY INCIDENT (MCI) OPERATIONAL POLICY

These procedures shall be implemented when personnel on the first arriving unit determine that **three or more ambulances** will be required to transport all victims from the scene to area hospitals. Due to the potential for HazMat or WMD in mass casualty incidents, extreme care should be taken to minimize risk to respondents. Other protocols may need to be integrated.

A. First Arriving Officer

The Officer on the first arriving fire unit shall be responsible for the initial scene assessment and coordination of the MCI response (When arriving first on scene, EMS personnel will initiate these tasks until relieved by fire personnel.). The Officer shall then assume Incident Command (IC) per Interagency Policy and Procedure and notify Dispatch, designating the incident as an "MCI." (The Officer will maintain Incident Command until relieved.) The size-up report should also include the nature of the incident and an approximation of the number of victims, allowing Dispatch to anticipate the resources required to meet the immediate needs.

First Arriving Officer Checklist

- Scene assessment
- Coordination of the MCI response
- Assume Incident Command
- Notify Dispatch, designating the incident as an "MCI."
- The size-up report should also include the nature of the incident and an approximation of the number of victims.

B. Incident Command

1. The first person to assume Incident Command must immediately communicate with Dispatch and designate themselves to this role. Every time IC is passed on to other personnel, the new IC must clearly communicate this to Dispatch.
2. The IC shall direct and coordinate all scene operations.
3. The IC shall designate a dedicated radio frequency for local scene communication (preferably two, one specifically for patient transportation).
4. The IC shall designate routes of ingress and egress of ambulances and will notify Dispatch on the radio.
5. The IC shall assign personnel to fill the roles of Triage Unit Leader and Transportation Unit Leader. The needs of the scene will help the Officer decide the most appropriate personnel to fill these roles. Typically, these assignments will be given to the crew of the first arriving ambulance, to allow those individuals to maintain supervision of medical operations from their arrival until the last patient is transported from the scene ("First in, last out."). In some cases, the assignments may be given to personnel from a fire unit when they are not occupied with other duties and are adequately trained, thus allowing ambulance personnel to remain with the ambulance and available to treat and transport patients. The Officer should make these assignments after consulting with the senior member of the ambulance crew.
6. Once made, the IC will communicate the assignments to Dispatch.

a. When a Command Post is established with Unified Command, the IC should participate as the representative of Fire/EMS.
b. Establish site
c. Green Light or Flag
d. Representation by Law Enforcement, Fire, and EMS
e. Dialogue, consultation, mutual planning and decision-making

Incident Command Checklist

- The IC shall direct and coordinate all scene operations.

- The IC shall designate routes of ingress and egress of ambulances and will notify Dispatch of it on the radio.

- The IC shall determine the need and make requests for resources or personnel that may be necessary for scene operations and management.

- After consulting with the Transportation Unit Leader, the IC shall designate the Helicopter Landing Zone (as necessary) and assign personnel for ground contact.

- When Unified Command is established, represent Fire/EMS.

C. Medical Group Supervisor

The Medical Group Supervisor role may be assumed by the IC in small scenes. When the IC is supervising multiple operations (i.e. suppression, HazMat, etc.), he/she may assign a Medical Group Supervisor.

MISSION of Medical Group Supervisor**:** *To ensure that supervision and coordination is provided for triage, treatment and transportation of all patients.*

Medical Group Supervisor Checklist

- Report and provide frequent updates to the IC.
- The Medical Group Supervisor role may be assumed by the Incident Commander on small incidents
- Dress in identifying vest
- Locate in a visible position
- Assign radio TAC channel for MEDICAL
- Coordinate all medical operations
- Account for all personnel assigned to this group
- Monitor safety and welfare of group personnel
- Appoint and assign UNIT LEADERS and support staff

D. Triage Unit Leader

The attendant on the first arriving ambulance assumes the role of Triage Unit Leader until the IC makes the official assignment. Once assigned, the Triage Unit Leader shall don the appropriate vest, so as to be easily recognizable to all incoming ambulance crews.

1. The Triage Unit Leader's first responsibility is to provide rapid triage using the Simple Triage and Rapid Treatment (START) system. Triage Tags with the START system color coding should be utilized for patient tracking. Other methods with the START system color coding may be used by triage team members on scene to quickly identify triage categories for victims (e.g. tape, ribbons), providing that Triage Tags will be placed on victims prior to transport. When all victims are located within a small perimeter, the Triage Unit Leader can effectively perform triage for all victims and assign sufficient personnel to provide patient care while they await transportation. When several victims are scattered over a larger area, it may be necessary for the Triage Unit Leader to organize a team of rescue personnel to evacuate victims to a common location (Triage Funnel). The transfer of victims can be facilitated with the use of traffic cones, signs or lengths of fire hoses deployed in a "cattle-chute" format (positioned from a wide area to a narrow end point). In this instance, the Triage Unit Leader may position himself at the point of the Triage Funnel to ensure that all victims are evaluated and triaged (or re-triaged).
2. When the transportation of several victims will be delayed, the Triage Unit Leader (in conjunction with the Transportation Unit Leader) may establish Patient Collection and Treatment Areas for each triage category. The location of these areas shall be in a safe area as close as possible to the Ambulance Loading Zone.
3. Assigns personnel to provide patient care and re-triage to victims while they await transportation.
4. The Triage Unit Leader is responsible for designating (and communicating to the Transportation Unit Leader) the order of patients to be transported and which patients may require helicopter transportation.
5. When the Triage Unit Leader is the attendant on the first arriving ambulance, he/she resumes his/her original assignment when the last patients are prepared for transport. In most cases, the first ambulance to arrive on scene will be the last transporting ambulance.

<u>Triage Unit Leader Checklist</u>

- Provide rapid triage using the Simple Triage and Rapid Treatment (START) system for all victims of the incident.
- Perform triage for all victims and assign sufficient personnel to provide patient care while they await transportation if victims are located in a small area.
- Request a team of rescue personnel to evacuate victims to a common location if victims are scattered.
- When the transportation of several victims will be delayed, establish Patient Collection/Treatment Areas for each triage category. The location of these areas shall be in a safe area as close as possible to the Ambulance Loading Zone. The Triage Unit Leader will assign personnel to provide patient care and re-triage while victims are awaiting transportation.
- Designate (and communicate to the Transportation Unit Leader) the order of patients to be transported and which patients may require helicopter transportation.
- Resume original assignment when the last patients are prepared for transport.

E. Transportation Unit Leader

The driver of the first arriving ambulance will assume the role of Transportation Unit Leader until the IC makes the official assignment. Once assigned, the Transportation Unit Leader shall don the appropriate vest, so as to be easily recognizable to all incoming ambulance crews.

1. The Transportation Unit Leader is responsible for requesting the response of any additional EMS transportation resources (either through Dispatch or through the IC). This may include the use of public transportation resources, i.e. buses, for numerous "walking wounded" patients.
2. The Transportation Unit Leader must determine divert status of potential receiving hospitals and instruct Dispatch to contact specific hospitals to alert them of the scope of the incident and to request a report of the number of patients (per triage category) that they are capable of receiving. **Remember:** A non-Trauma Center can often step up their capabilities and become a temporary "Trauma Center" if they are notified early into the incident and given enough time to mobilize staff, operating rooms, etc.
3. The Transportation Unit Leader must designate the Ambulance Loading Zone and inform the IC and ensure proper placement and staging of all EMS ground and air units. Consult with IC to determine best location for a Helicopter Landing Zone when necessary.
4. Requests the response of the MCI Trailer as necessary.
5. Works with the IC, the Triage Unit Leader and Dispatch to ensure that all incoming EMS crews are clearly aware of the following:
    - Routes for vehicle ingress and egress
    - Incident conditions and possible hazards
    - Vehicle staging site (if necessary)
    - Ambulance Loading Zone, located as close as possible to the Patient Collection and Treatment Area
    - Location of Equipment Stockpile Area
    - Key equipment needed from EMS units upon their arrival
    - The need for drivers to stay with (or near) their vehicles
6. Assigns patients to EMS transport units and maintains MCI Transportation Form. The Transportation Unit Leader must "patrol" the Transportation area and be concerned with removing patients from the scene expeditiously, with critical patients transported first, whenever possible. The Transportation Unit Leader should (when possible) avoid assigning more than one critical patient to each transport unit. Assigning one Category Red and one Category Yellow patient to each transport unit generally results in more effective patient care when there is only one paramedic attending. It is important that the Transportation Unit Leader stay out of the Patient Collection/Treatment Areas to avoid being "trapped."
7. To this end, it is often advisable to establish a well-defined "on-deck" area near the Ambulance Loading Zone, where the next patients to be transported will be temporarily placed.
8. Assigns hospital destinations to the first "wave" of EMS transport units and communicates it to Dispatch. After the first "wave" of transports from the scene, the Transportation Unit Leader will assign hospital destinations with advice from Dispatch.
9. In very large scale MCIs, the Transportation Unit Leader may assign the responsibility for making hospital notifications to Dispatch.
10. Responsible for implementing a system for tracking patients with their transporting vehicles and hospital destinations. The Transportation Unit Leader must ensure that the Triage Tag Tracer Stub is retained for each patient and that a corresponding log is maintained.
11. When the Transportation Unit Leader is the driver on the first arriving ambulance, he/she resumes his/her original assignment when the last patients are prepared for transport. In most cases, the first ambulance to arrive on scene will be the last transporting ambulance.

<u>Transportation Unit Leader Checklist</u>

- Assume the role of Transportation Unit Leader until IC makes the official assignment.
- Responsible for requesting the response of any additional EMS transportation resources.

- Determine status of potential receiving hospitals and instruct Dispatch to contact specific hospitals to alert them of the scope of the incident and to request a report of the number of patients (per triage category) that they are capable of receiving.
- Designate the Ambulance Loading Zone and inform the IC.
- Requests the response of the MCI Trailer as necessary.
- Works with the IC, the Triage Unit Leader and Dispatch to ensure that all incoming EMS crews are clearly aware of the following:
    - Routes for vehicle ingress and egress
    - Incident conditions and possible hazards
    - Vehicle staging site (if necessary)
    - Ambulance Loading Zone, located as close as possible to the Patient Collection and Treatment Area
    - Location of Equipment Stockpile Area
    - Key equipment needed from EMS units upon their arrival
    - The need for drivers to stay with (or near) their vehicles
- Assign patients to EMS transport units and maintain MCI Transportation Form.
- Establish a well-defined "on-deck" area near the Ambulance Loading Zone, where the next patients to be transported will be temporarily placed.
- Assign hospital destinations to the first "wave" of EMS transport units and communicate them to Dispatch.
- After the first "wave" of transports from the scene, the Transportation Unit Leader will assign hospital destinations with advice from Dispatch.
- In very large scale MCIs, the Transportation Unit Leader may assign the responsibility for making hospital notifications to Dispatch.

F. Transport Unit Crews

1. Transport Unit Crews will obtain information from Dispatch such as staging location, routes of ingress and egress, and (if available) the identity and location of the Transportation Unit Leader. They are to report as assigned to the designated staging area or directly to the scene if ordered.
2. When reporting to the scene, transport unit crews will park their ambulances at the designated loading zone or ambulance staging area (if designated) and immediately contact the Transportation Unit Leader (or Staging Officer).
3. The crews should anticipate the rapid assignment of patients along with a hospital destination from the Transportation Unit Leader. Transport unit crews must avoid becoming separated so they can load and leave the scene expeditiously.
4. Hospital notifications should be made and as concise as possible. In very large scale MCIs, the Transportation Unit Leader may assign hospital notifications to Dispatch.
5. Freelancing by transport units shall be avoided and may result in release from the incident as determined by IC.

<u>Transport Unit Crews Checklist</u>

- Obtain information from Dispatch such as staging location, routes of ingress and egress, and (if available) the identity and location of the Transportation Unit Leader.
- Park ambulances at the designated loading zone or ambulance staging area (if designated) and then immediately contact the Transportation Unit Leader.
- Anticipate the rapid assignment of patients for transport and hospital destination.

- Hospital notifications should be as concise as possible.

G. Dispatch

1. When personnel at the scene designate an "MCI," Dispatch is responsible for entering the incident on the EMSystems website.
2. Dispatch available resources to meet the initial needs of the scene per established procedure.
3. At the direction of the IC, designate a dedicated radio frequency for local scene communication and inform all responding apparatus/agencies.
4. Contact other transport agencies to inform them of the incident and to determine available resources as necessary.
5. Communicate to all responding ambulances designated routes for ingress and egress.
6. Monitor the EMSystems website and contact area hospitals as necessary to determine capabilities for receiving patients (number per triage category) and relay information to the Transportation Unit Leader.
7. Maintain the MCI Transportation Form to record number and type of patients, transport units, hospital destinations and appropriate times. Dispatch may make recommendations for hospital destinations to the Transportation Unit Leader upon information from the MCI Transportation Form and EMSystems. When requested by the Transportation Unit Leader, personnel in Dispatch will make hospital notifications that should be concise and include:
    - Identification of the transport unit
    - Number of patients with their triage category designation
    - ETA for each transport unit

<u>Dispatch Checklist</u>

- Enter the incident on the EMSystems website.
- Dispatch available resources to meet the initial needs of the scene per procedure.
- Contact other transport agencies to inform them of the incident and to determine available resources as necessary.
- Dispatch additional resources as requested by IC or designee.
- At the direction of the IC, designate a dedicated radio frequency for local scene communication and inform all responding apparatus/agencies.
- Communicate to all responding ambulances designated routes for ingress and egress.
- Monitor EMSystems website and contact area hospitals as necessary to determine capabilities for receiving patients (number per triage category) and relay information to Transportation Unit Leader.
- Inform IC and on-scene resources as appropriate.
- Maintain MCI Transportation Form to record number and type of patients, transport units, and hospital destinations.
- Make recommendations for hospital destinations to the Transportation Unit Leader based upon information from the MCI Transportation Form and hospital capability reports on the EMSystems website.
- When assigned by the Transportation Unit Leader, Dispatch will make hospital notifications that should be concise and include:
    - Identification of the transport unit
    - Number of patients with their triage category designation
    - ETA for each transport unit

APPENDIX D

MOU FOR MCI CACHES

(FRETAC)

Foothills Regional Emergency Medical & Trauma Advisory Council

Serving Boulder, Clear Creek, Gilpin, Grand, & Jefferson Counties

Memorandum of Understanding
Regarding
MCI Caches

The Foothills Regional Emergency Medical & Trauma Advisory Council (FRETAC) partnered with "Sponsoring Agencies" in our region to provide EMS caches for the five-county region of the FRETAC. Our region includes Boulder, Clear Creek, Gilpin, Grand, and Jefferson Counties. The caches are standardized to a Minimum Inventory List approved by the FRETAC, but may contain additions to that list specific to the agencies holding the caches. They are intended to enhance the existing MCI response in that jurisdiction, but follow an overall regional MCI Response system. This MOU is intended to be used in conjunction with the FRETAC Cache Activation Policy and the Access Policy. The cache storage site and equipment upkeep and replacement may vary.

In general, the following policies will be in place across the region:

- This MOU will be in effect for two years after signatures are complete.
- A responsible person (i.e. Director, Chief, Manager, etc.), should sign the MOU every two years. There are multiple signature lines, to be used when there are no revisions to the MOU. If there are revisions, we will execute a new MOU.
- Access to inspect and replace equipment will be limited to only those personnel selected by the Sponsoring Agency, or a representative of the FRETAC. Each Sponsoring Agency will provide a location for the storage of the equipment with security and maintenance as deemed appropriate by the Sponsoring Agency and provide updated access information to the FRETAC.
- Equipment/supplies within the cache may be used when the Sponsoring Agency believes there is a "mass casualty incident" or other such emergency. Equipment/supplies should not be used for routine emergency response except by agreement between the Sponsoring Agency and the Requesting Agency for special events.
- Equipment within the cache may be used for other large or special events, but the Minimum Inventory List must be maintained.
- Activation of the cache will be the responsibility of the Incident Commander, County Emergency Manager, or other responsible party as the Requesting Agency deems necessary to enhance emergency response.
- The FRETAC will provide each Sponsoring Agency with a Minimum Inventory List to be maintained for the cache. This will be used to complete periodic inventory inspections. Each Sponsoring Agency receiving the caches will provide a letter signed by the Department Head/Director to the FRETAC with annual documents indicating the following:
    a. Current Minimum Inventory List with expiration dates of supplies; The letter should also document any request for replacement of damaged, expiring equipment if the agency feels they cannot afford the cost of the replacement supplies
    b. Inventory List of non-required items/equipment
    c. Location of cache and mechanism for deployment
    d. Size of ball/hitch and type of electrical connection
- Each Sponsoring Agency and the FRETAC will make biannual determinations on replacement of damaged, expiring equipment, as necessary. The FRETAC is not held to, or required to, replace this cache. Determination of replacement will be a biannual decision. The FRETAC would encourage each Sponsoring Agency to be responsible for the upkeep and replacement of supplies and equipment within their cache possibly using a standard "stock" rotation within their regular supplies.

- Each Sponsoring Agency will keep documentation regarding the status of the cache in an accessible location near the storage site. Any Sponsoring Agency policies and other documentation regarding the cache will be provided to the FRETAC upon request. The current FRETAC/Sponsoring Agency MOU will be kept at the cache site to be available to agency when Requesting Agency arrives.

- Any agency that has requested/used supplies within any of the caches will be responsible for replacement of used or damaged supplies from the cache as soon as possible after the event. Please refer to the current MOU at site.

- During transit and while deployed, the transporting agency shall be responsible for any damage or injury related to the cache or trailer used to transport the cache.

- The Sponsoring Agency that houses the cache should assure that the trailers are kept mechanically sound at all times for transport.

Sponsoring Agency Representative Signature: Date:

_____ _____

FRETAC Representative Signature: Date:

_____ _____

FRETAC: 7335 Grant Ranch Blvd #411 Phone: 970-724-3870 Cell: 303-594-9740 E-Mail: linda.u@msn.com

APPENDIX E

MINIMUM INVENTORY LIST FOR MCI CACHES

MCI Cache Minimum Inventory List

Foothills RETAC

2014

Category and Items	Boundtree Item # if using	Minimum Quantity	Count	Expiration Date
Wound/Burn Care:				
Trauma Pads	150062	25 ct		
4"x4" sponges	87705	4 cases		
Gauze roll - Kerlix 4"		4 cases		
Band-Aids (box)	85716	10 boxes		
Burn Sheet	150300	20 ct		
Coban 3" Self-adhering Wrap		48 rolls		
Tape- 2" Silk		4 boxes		
1" Silk		4 boxes		
Tourniquets - CAT or SOF-T		6 count		
IV/Syringes & Needles:				
0.9% Sodium Chloride 1000ml bag		12 cases		
IV Administration Set - Macrodrip	351160	3 cases		
Blood Pumps		24 count		
IV Catheters -16ga x 1 1/2"	602586	2 box/50 ct		
IV Catheters - 18ga x 1 1/2"	602560	2 box/50ct		
IV Catheters - 20ga x 1 1/4"	602535	1 box/50 ct		
Intraosseaous Kit w/18 gauge Jamshidi	62241518s	5 ct		
Tourniquets - Latex Free	350425	200 ct		
Alcohol Prep Pads (box)	606818	4 boxes		
Syringe 1cc TB with needle		1 box		
Syringe 3cc with needle		1 box		
Syringe 60cc		1 box		
Sharps Container	605488	2 ct		
Respiratory:				
50 psi Regulator	380020B	2 ct		
Oxygen ("M") Cylinder		2 ct		
Oxygen Hose - 25' (for multi-outlet manifold supply)	spiracle	2 ct		
Multi-Outlet Manifold (10 lpm, 5 ports)	389030	2 ct		
NRB Masks- Adult		50 ct		
Simple Masks- Pediatrics		12 ct		
Ambu Bags: Adult	530200	6 ct		

Ambu Bags: Child	533002	6 ct		
Oropharyngeal Airways	21008	6 kits		
Nasopharyngeal Airways		6 kits		

Personnel PPE:				
Exam gloves - Small -Latex Free- Midnight	295201	5 boxes		
Exam gloves - Medium -Latex Free- Midnight	295202	5 boxes		
Exam gloves -Large -Latex Free- Midnight	295203	10 boxes		
Exam gloves - X-Large -Latex Free- Midnight	295204	5 boxes		
Gowns	291576	20 ct		
Face Mask	291552	20 ct		
Sani-Cloth H Germicide Disposable Wipes	208472	2 cases		
Hand gel - sanitizing	201000	4 boxes		

Stabilization & Immobilization:				
Cervical Collars: Adult	L980010	20 ct		
Pediatric	264002	10 ct		
Backboard	35850Y	25 ct		
Headbeds		25 ct		
Duct Tape 2" x60 yds		10 rolls		
SAM Splints	661121	20 ct		
Towels (NOT on old list)				
Medical & Diagnostic Equipment:				
Blood Pressure Kit	54768641bk	5 ct		
Stethoscope	5402214	4 ct		
Penlights		12 ct		

Medical Other:				
Blankets - Emergency	666090	50 ct		
Sheets - Disposable	114550	2 boxes		
Bio-Hazard Bags	290590	50 ct		
Trauma Shears	4000058	20 ct		
Ring Cutter	400010	1 ct		
Ring Cutter replacement blades	400011	1 ct		

MCI Management:				
Triage Tags (METTAGS)	600001	200 ct		
Conterra Triage Kits		5 ct		
MCI Triage Flagging Rolls (Black/Red/Yellow/Green)		5/10/10/10		
Clipboards	488516	4 ct		
Sharpie Pens		3 boxes		
Vests - EMS Command	7304mci	included		
Tarp Set - Triage	605123	1 ct		
Headlamps- LED	1729E7	10 ct		

AA Batteries		1 large box		

Storage:				
Rubbermaid 16 Gallon Totes		6 ct		

Agency/County Specific List NOT listed above				

APPENDIX F

COMMUNICATIONS

MCI Communications

(General Guidelines)

By definition, an MCI overwhelms the local agency's ability to deploy adequate resources for the management of injured victims. By virtue of the need to call in outside resources and to adequately manage their response, effective communications between these outside agencies are paramount for successful resolution of the incident.

It is incumbent upon the local Dispatch/Communications Center (DISPATCH) to have operational mastery of radio spectrum (VHF, UHF, 800 trunked) and local topographical issues within their respective jurisdictions and effectively mitigate these concerns with requests for outside assistance. Dispatch must be intimately familiar with local, county, regional, and state communication channels/frequencies/talk groups (channels) available to meet the ever critical communication needs.

Knowledge of Tactical Interoperability Communications Field Operations Guides (TICFOGs) is essential to guide DISPATCH in assigning workable communications to field personnel. In addition, DISPATCH should advocate for the inclusion of as many interoperable channels into agency radios as possible. Pre-planned communication plans (ICS-205s) are highly suggested with those likely response agencies and associated disciplines (law, fire, EMS, etc).

APPENDIX G

STATE BOARD OF HEALTH RULES AND REGULATIONS PERTAINING TO PREPARATIONS FOR A BIOTERRORIST EVENT, PANDEMIC INFLUENZA, OR AN OUTBREAK BY A NOVEL AND HIGHLY FATAL INFECTIOUS AGENT OR BIOLOGICAL TOXIN
6 CCR 1009-5

THIS RULE IS IN THE REVISION PROCESS.
WHEN COMPLETE, IT WILL BE PLACED IN THIS APPENDIX

APPENDIX H

FOOTHILLS/MILE-HIGH RETAC MEDICAL RESOURCE GUIDE

SEPARATE DOCUMENT

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APPENDIX I

FRETAC MCI FIELD GUIDE

SEPARATE DOCUMENT