This document contains information relative to the Incident Command System (ICS) component of the National Incident Management System (NIMS). This is the same Incident Command System developed by FIRESCOPE.

Additional information and documentation can be obtained from the following sources:

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INTRODUCTION

The Multi-Casualty organizational module is designed to provide an organizational structure that will provide the necessary supervision and control for the essential functions required at virtually all Multi-Casualty incidents. This is based on the premise that controlling the operations and movement of personnel and equipment will increase patient care and provide a greater degree of safety. The primary functions will be directed by the Medical Group/Division Supervisor and the Patient Transportation Group Supervisor who report to the Multi-Casualty Branch Director. Resources that have direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators.

The functional positions under the Medical Group/Division Supervisor are Triage Unit Leader, Treatment Unit Leader, and Medical Supply Coordinator.

The Triage Unit Leader supervises triage personnel, who perform the actual triage of patients. Once triaged, patients are moved to the Treatment Unit, usually via backboard or litters carried by litter bearers. Triage personnel may work closely with personnel from other Groups or Branches in order to access patients. For example, a Rescue or Extrication Group may need to remove a trapped patient in order for Triage personnel to evaluate the patient. Likewise in order to control contamination, the Hazardous Materials Group may have to decontaminate patients prior to turning them over to Triage Personnel. The Morgue Manager establishes morgue operations; this responsibility ultimately rests with law enforcement or the coroner but may be staffed by others until their arrival. The Morgue Manager also reports to the Triage Unit Leader.

The Treatment Unit Leader supervises personnel assigned to treat patients. They may be divided into three physically separated areas, one each for Immediate Patients, Delayed Patients, and Minor Patients. Each of these areas may be managed by a Treatment Manager. The Treatment Unit Leader and Treatment Managers may not be the most medically qualified personnel at the incident; the most medically qualified should be working in the Immediate Patient treatment area performing patient care. The Treatment Dispatch Manager coordinates movement of patients from treatment areas to ambulances for transport to medical facilities and records information pertinent to the transport; this position also reports to the Treatment Unit Leader.

The Medical Supply Coordinator ensures that medical supplies and equipment on scene arrive where most needed. Such supplies usually come from fire service vehicles, law enforcement vehicles, and ambulances. Most of such work is done prior to the establishment of a Logistics Section and/or Supply Unit. After the establishment of a supply function, this position will work with supply or may be dropped from the organization altogether.
The Patient Transportation Group Supervisor supervises the Medical Communications Coordinator, the Ground Ambulance Coordinator, and the Air Ambulance Coordinator. Collectively they are responsible for movement of patients from the scene of the incident to medical facilities in close coordination with the Treatment Dispatch Manager(s) in the Medical Group/Division(s) and the medical facilities.

The Medical Communications Coordinator is responsible for establishing communications with a medical or other facility to determine the most appropriate facilities to which patients may be transported. The Ground Ambulance Coordinator is responsible for the flow of ambulances into and from the loading area(s) near the treatment areas. Close coordination and cooperation must occur between the Medical Communications Coordinator, the Ground Ambulance Coordinator and the Treatment Dispatch Manager in order to move patients efficiently. The Air Ambulance Coordinator is responsible for coordinating movement of patients from ground ambulances that have transported patients to the helispot to the helicopters. This person needs some familiarity with helicopter operations and must coordinate closely with the Helispot Manager or the helicopter personnel.

The Patient Transportation Group is separate from the Medical Group/Division because in large incidents multiple Medical Divisions may be necessary. However, through experience it is widely recognized that all patient transportation from an incident must be coordinated through one point. To do otherwise will most likely move the disaster to the medical facilities as lack of coordination will result in overloading some facilities. As an example a train wreck may require a Medical Division on each side of the train, i.e., the train is a physical barrier between groups of patients; only one Patient Transportation Group should exist to coordinate transportation.

The Multi-Casualty Branch may be part of a Multi-Branch organization. Rarely will an incident have only a Multi-Casualty component as the mechanism of injury, transportation accident, hazardous material exposure, etc., will dictate other operations such as fire suppression, extrication/rescue, and/or hazardous materials. Similarly, Unified Command may be in place as for hazardous materials or if the mechanism of injury was criminal, e.g., shooting or civil disturbance.
MODULAR DEVELOPMENT

A series of examples of modular development are included to illustrate one possible method of expanding the incident organization:

**Initial Response Organization**  Initial response resources are managed by the Incident Commander who will handle all Command and General Staff responsibilities. The first arriving resource with the appropriate communications capability should establish communications with the appropriate hospital or other coordinating facility and become the Medical Communications Coordinator. Other first arriving resources would become Triage Personnel.

**Reinforced Response Organization**  In addition to the initial response, the Incident Commander designates a Triage Unit Leader, a Treatment Unit Leader, Treatment Teams, and a Ground Ambulance Coordinator.

**Multi-Leader Response Organization**  The Incident Commander has now established an Operations Section Chief who has in turn established a Medical Supply Coordinator, a Manager for each treatment category, and a Patient Transportation Group Supervisor. The Patient Transportation Group Supervisor was needed in order for the Operations Section Chief to maintain a manageable span of control, based on the assumption that other operations are concurrently happening in the Operations Section.

**Multi-Group Response**  All positions within the Medical Group and Patient Transportation Group are now filled. Air Operations Branch is shown to illustrate the coordination between the Air Ambulance Coordinator and the Air Operations Branch. An Extrication Group is freeing trapped victims.

**Complete Incident Organization**  The complete incident organization shows the Multi-Casualty Branch and other Branches with which there might be interaction. The Multi-Casualty Branch now has three (3) Medical Divisions (geographically separate) but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals or other medical facilities.
Multi-Branch Organization

Incident Command

Safety
Liaison
Information

Operations Section  Plans Section  Logistics Section  Admin/Finance Section

Fire Suppression Branch  Rescue Branch  Multi-Casualty Branch

Medical Division A  Medical Division B  Medical Division C

Patient Transportation Group

Rescue Division A  Rescue Division B  Rescue Division C
MULTI-CASUALTY BRANCH

Definition:

The Multi-Casualty Branch Structure is designed to provide the Incident Commander with a basic expandable system for handling any number of patients in a multi-casualty incident.

One or more additional Medical Group/Division may be established under the Multi-Casualty Branch Director, if geographical or incident conditions warrant. The degree of implementation will depend upon the complexity of the incident.

See Multi-Casualty Organizational Chart Page 10.
MULTI-CASUALTY BRANCH DIRECTOR

Definition: Qualified Multi-Casualty Branch Director

Supervised By: Operations Section Chief

Subordinates: Group/Division Supervisors

Function: The Multi-Casualty Branch Director is responsible for the implementation of the Incident Action Plan within the Branch. This includes the direction and execution of branch planning for the assignment of resources within the Branch.

Duties:

1. Check-in and obtain briefing from Operations Section Chief.

2. Review Group/Division Assignments for effectiveness of current operations and modify as needed.

3. Provide input to Operations Section Chief for the Incident Action Plan.

4. Supervise Branch activities.

5. Report to Operations Section Chief on Branch activities.

6. Maintain Unit Log (ICS Form 214).
MEDICAL GROUP/DIVISION SUPERVISOR

Definition: Qualified Group/Division Supervisor

Supervised By: Branch Director

Subordinates: Triage Unit Leader, Treatment Unit Leader, Medical Supply Coordinator

Function: Establish command and control the activities within a Medical Group/Division, in order to assure the best possible emergency medical care to patients during a multi-casualty incident.

Duties:
1. Check-in and obtain briefing from Multi-Casualty Branch Director or Operations Section Chief.
2. Participate in Multi-Casualty Branch/Operations Section Planning activities.
3. Establish Medical Group/Division with assigned personnel; request additional personnel and resources sufficient to handle the magnitude of the incident.
4. Designate Unit Leaders and Treatment Area locations as appropriate.
5. Isolate Morgue and Minor Treatment Area from Immediate and Delayed Treatment Areas.
6. Request law enforcement/coroner involvement as needed.
7. Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, backboards, litters, cots).
8. Establish communications and coordination with Patient Transportation Group Supervisor.
9. Ensure activation of hospital alert system, local EMS/health agencies.
10. Direct and/or supervise on-scene personnel from agencies such as Coroner's Office, Red Cross, law enforcement, ambulance companies, county health agencies, and hospital volunteers.

11. Ensure proper security, traffic control, and access for the Medical Group/Division area.

12. Direct medically trained personnel to the appropriate Unit Leader.

MEDICAL GROUP/DIVISION SUPERVISOR

RESPONSIBILITIES

1. Manage all Medical Group/Division activities.

2. Establish security for treatment area.

3. Control resources; maintain records.

4. Develop a group/division organization to handle the medical emergency.

OPERATIONAL CONSIDERATIONS

1. Group/Division Command Location
   a. Safe area remote from Triage/Treatment areas with law enforcement perimeter control.
   b. Adjacent to Patient Transportation Group Supervisor's location when possible.

2. Ambulance traffic pattern and patient loading areas.

3. Treatment Areas - Consider isolating from each other.
   a. Immediate
   b. Delayed
   c. Minor

TRIAGE UNIT LEADER

Definition: Qualified Unit Leader

Supervised By: Medical Group/Division Supervisor

Subordinates: Triage Personnel/Litter Bearers and Morgue Manager

Function: Assume responsibility for providing triage management and movement of patients from the triage area. When triage has been completed, the Unit Leader may be reassigned as needed.

Duties:
1. Check-in and obtain briefing from Medical Group/Division Supervisor.
2. Develop organization sufficient to handle assignment.
3. Inform Medical Group/Division Supervisor of resource needs.
4. Implement triage process.
5. Coordinate movement of patients from the Triage Area to the appropriate Treatment Area.
6. Give periodic status reports to Medical Group/Division Supervisor.
7. Maintain security and control of the Triage Area.
8. Establish Morgue.
9. Maintain Unit Log. (ICS-214)
TRIAGE UNIT LEADER

RESPONSIBILITIES

1. Manage all Triage activities at incident scene.
2. Develop organization sufficient to handle assignment.
3. Direct the triage and movement of injured from the triage area.
4. Provide direction and guidance to personnel working on scene.
5. Establish a safe triage area.

OPERATIONAL CONSIDERATIONS

1. Assess Resource Needs
   a. Command, Communications
   b. Personnel
   c. Equipment and Supplies
   d. Relief Units
2. Inform Medical Group/Division Supervisor of minimum needs.
3. Consult with Triage Personnel.
4. Give Job Assignments
   a. Safety
   b. Records
   c. First-Aiders
   d. Transporters
5. Establish Morgue Location

*Note: Do not allow deceased patients to be moved from their original locations unless absolutely necessary. If possible, take pictures and mark location of deceased. This information is essential to the Coroner. Upon arrival of the Coroner's Office, the Coroner will take charge of Coroner related functions in the Morgue Area.

6. SAFETY SHALL BE OF PARAMOUNT CONSIDERATION
TRIAGE PERSONNEL

Definition: Medically qualified personnel.

Supervised By: Triage Unit Leader

Function: To triage patients on-scene and assign them to appropriate treatment areas.

Duties: 1. Check-in and obtain briefing from Triage Unit Leader.

2. Report to designated on-scene triage location.

3. Triage and tag injured patients. Classify patients while noting injuries and vital signs if taken.

4. Direct movement of patients to proper Treatment areas.

5. Provide appropriate medical treatment (ABC's) to patients prior to movement as incident conditions dictate.
TREATMENT UNIT LEADER

Definition: Qualified Unit Leader

Supervised By: Medical Group/Division Supervisor

Subordinates: 1. Treatment Dispatch Manager
2. Immediate Treatment Manager
3. Delayed Treatment Manager
4. Minor Treatment Manager

Functions: Assume responsibility for treatment, preparation for transport, and coordination of patient treatment in the Treatment Areas. Direct movement of patients to loading location(s).

Duties: 1. Check-in and obtain briefing from Medical Group/Division Supervisor.
2. Develop organization sufficient to handle assignment.
3. Direct and supervise Treatment Dispatch, Immediate, Delayed, and Minor Treatment Areas.
4. Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
5. Request sufficient medical caches and supplies as necessary.
7. Ensure continual triage of patients throughout Treatment Areas.
8. Direct movement of patients to ambulance loading area(s).
9. Give periodic status reports to Medical Group/Division Supervisor.
TREATMENT UNIT LEADER RESPONSIBILITIES

RESPONSIBILITIES

1. Manage all activities within Treatment Unit.

2. Develop organization sufficient to handle assignment.


4. Provide direction and guidance to subordinates.

5. Keep Areas off limits to all personnel except those needed. Acquire law enforcement assistance, when available.

6. Coordinate transportation needs with Patient Transportation. THE MOST CRITICAL PATIENTS SHOULD BE TRANSPORTED FIRST.

7. Assign hospital emergency response teams to treatment areas through their team leader.

OPERATIONAL CONSIDERATIONS

1. Assess Resource Needs
   a. Command, Communications
   b. Equipment, Supplies
   c. Medical Teams
   d. Relief Personnel
   e. Hospital emergency response teams

2. Give Job Assignments
   a. Treatment Managers
   b. Treatment Area Dispatcher
   c. Records
   d. Security

3. Standing Orders
TREATMENT DISPATCH MANAGER

Definition: Qualified Person

Supervised By: Treatment Unit Leader

Subordinates: As needed

Functions: Responsible for coordinating with Patient Transportation Group, the transportation of patients out of the Treatment Area.

Duties:
1. Check-in and obtain briefing from Treatment Unit Leader.
2. Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
3. Establish communications with Patient Transportation Group.
4. Verify that patients are prioritized for transportation.
5. Advise Medical Communications Coordinator of patient readiness and priority for dispatch.
6. Coordinate transportation of patients with Medical Communications Coordinator.
7. Assure that appropriate patient tracking information is recorded.
8. Coordinate ambulance loading with Treatment Manager and ambulance personnel.
TREATMENT DISPATCH MANAGER RESPONSIBILITIES

RESPONSIBILITIES

1. Organize Treatment Dispatch function. Request recorders and other resources as necessary.

2. Establish and maintain communication with Treatment Managers.

3. Verify patient transportation priority.

4. Establish and maintain communication with Ground and Air Ambulance Coordinators to request appropriate mode of transportation.

5. Establish and maintain communication with Medical Communications Coordinator.

6. Notify Medical Communications Coordinator of ambulance departure and destination.

7. Maintain appropriate records.

OPERATIONAL CONSIDERATIONS

   a. Communications
   b. Equipment and Supplies
   c. Recorders and Other Personnel

2. Cause the most critical patients who are ready for transport, to be transported first.

3. Give Job Assignments.
IMMEDIATE TREATMENT MANAGER

Definition: Qualified Manager

Supervised By: Treatment Unit Leader

Subordinates: Medical Teams

Functions: Responsible for treatment and re-triage of patients assigned to Immediate Treatment Area.

Duties:
1. Check-in and obtain briefing from Treatment Unit Leader and brief subordinates.
2. Request or establish Medical Teams as necessary.
3. Assign treatment personnel to patients received in the Immediate Treatment Area.
4. Ensure treatment of patients triaged to the Immediate Treatment Area.
5. Assure that patients are prioritized for transportation.
6. Coordinate transportation of patients with Treatment Dispatch Manager.
7. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
8. Assure that appropriate patient information is recorded.
DELAYED TREATMENT MANAGER

Definition: Qualified Manager

Supervised By: Treatment Unit Leader

Subordinates: Medical Teams

Functions: Responsible for treatment and re-triage of patients assigned to Delayed Treatment Area.

Duties:

1. Check-in and obtain briefing from Treatment Unit Leader and brief subordinates.

2. Request or establish Medical Teams as necessary.

3. Assign treatment personnel to patients received in the Delayed Treatment Area.

4. Ensure treatment of patients triaged to the Delayed Treatment Area.

5. Assure that patients are prioritized for transportation.

6. Coordinate transportation of patients with Treatment Dispatch Manager.

7. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.

8. Assure that appropriate patient information is recorded.
MINOR TREATMENT MANAGER

Definition: Qualified Manager

Supervised By: Treatment Unit Leader

Subordinates: Treatment Teams

Functions: Responsible for treatment re-triage of patients assigned to Minor Treatment Area.

Duties:
1. Check-in and obtain briefing from Treatment Unit Leader and brief subordinates.
2. Request or establish Medical Teams as necessary.
3. Assign treatment personnel to patients received in the Minor Treatment Area.
4. Ensure treatment of patients triaged to the Minor Treatment Area.
5. Assure that patients are prioritized for transportation.
6. Coordinate transportation of patients with Treatment Dispatch Manager.
7. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
8. Assure that appropriate patient information is recorded.
9. Coordinate volunteer personnel/organizations through Agency Representatives and Treatment Unit Leader.
TREATMENT MANAGERS
IMMEDIATE
DELAYED
MINOR

RESPONSIBILITIES

1. Manage all activities within Treatment Area

2. Develop organization sufficient to handle assignment.


4. Provide direction and guidance to subordinates.

5. Keep areas off limits to all personnel except those needed. Acquire law enforcement assistance, when available.

6. Coordinate transportation needs with Treatment Unit Leader. THE MOST CRITICAL PATIENTS SHOULD BE TRANSPORTED FIRST.

OPERATIONAL CONSIDERATIONS

1. Assess Resource Needs
   a. Command, Communications
   b. Equipment, Supplies
   c. Medical Teams
   d. Relief Personnel
   e. Hospital emergency response teams

2. Cause the most critical patients to be transported first.

3. Give Job Assignments
   a. Patient Care
   b. Transporters: ambulance loading
   c. Records
   d. Security (coordinate with Logistics Section)

4. Standing Orders
MEDICAL TEAMS

Definition: Qualified Personnel with supervision.

Composition: Medical Teams

Type I: 2 ALS plus 3 BLS Responders
Type II: 2 ALS Responders
Type III: 3 BLS Responders

* Note: Medical Team Type refers to qualification of personnel only. It does not refer to means of transportation, equipment or ability to transport patients. "ALS Company" or "BLS Company" includes qualified personnel and appropriate equipment to qualify as an ALS or BLS Company.

Supervised by: Assigned Manager/Unit Leader

Duties:
1. Receive briefing.
2. Perform triage and treatment as assigned.
3. Record patient information on triage tags.
4. Report changes in patient status to appropriate assigned Manager/Unit Leader.
PATIENT TRANSPORTATION GROUP SUPERVISOR

Definition: Qualified Manager

Supervised By: Multi-Casualty Branch Director

Subordinates: Medical Communications Coordinator, Air Ambulance Coordinator, Ground Ambulance Coordinator.

Function: Coordination of patient transportation and maintenance of records relating to patient identification, injuries, mode of off-incident transportation and destination.

Duties:

1. Check-in and obtain briefing from the Multi-Casualty Branch Director (if activated) or Operations Section Chief.

2. Establish communications with hospital(s).

3. Designate ambulance staging area(s).

4. Direct the transportation of patients as determined by Treatment Unit Leader(s).

5. Assure that patient information and destination is recorded.

6. Establish communications with Ambulance Coordinator(s).

7. Request additional ambulances, as required.

8. Notify Ambulance Coordinator(s) of ambulance requests.

9. Coordinate requests for air ambulance transportation through the Air Operations Director.

10. Establish Air Ambulance Helispot with the Multi-Casualty Branch Director and Air Operations Director.

11. Maintain Unit Log. (ICS-214)
PATIENT TRANSPORTATION GROUP SUPERVISOR

RESPONSIBILITIES

A. Develop organization sufficient to handle assignments.

B. Maintain record of all hospitals being utilized and their handling capabilities for proper dispatching.

C. Control all ambulance loading activities and movement. Maintain an accurate count of injured sent to hospitals and their classification (immediate, delayed).

D. Coordinate with Air Operations Director regarding transportation of injured by helicopter.

E. Coordinate with Ambulance Coordinator(s) and Treatment Unit Leader.

F. Patient destination will be determined by medical personnel and/or consultation with hospital alert system, local EMS/health agencies, through the Medical Communications Coordinator.

OPERATIONAL CONSIDERATIONS

1. Command location for patient transportation function
2. Develop an ambulance traffic pattern to avoid confusion
3. Security (coordinate with logistics)
MEDICAL COMMUNICATIONS COORDINATOR

Definition: Qualified Coordinator

Supervised By: Patient Transportation Group Supervisor

Subordinates: Transportation Recorder and personnel as required

Function: Maintain communications with the hospital alert system and/or other medical facilities to assure proper patient transportation and destination. Coordinate information through Patient Transportation Group Supervisor and the Transportation Recorder.

Duties:
1. Check-in and obtain briefing from Patient Transportation Group Supervisor.
2. Establish communications with hospital alert system.
3. Determine and maintain current status of hospital/medical facility availability and capability.
4. Receive basic patient information and injury status from Treatment Dispatch Manager.
5. Communicate hospital availability to Treatment Dispatch Manager.
6. Coordinate patient off-incident destination with the hospital alert system.
7. Communicate patient transportation needs to Ambulance Coordinators based upon requests from Treatment Dispatch Manager.
8. Maintain appropriate records.
MEDICAL COMMUNICATIONS COORDINATOR

RESPONSIBILITIES

1. Establish and maintain medical communications with the hospital alert system and communicate patient disposition through that system.

2. Obtain standing orders through the hospital alert system.

3. Receive hospital resource availability information from the hospital alert system.

4. Obtain the designation of additional base stations to be used for specialized, individual case medical instructions, if necessary (pursuant to Treatment Area demands).

5. Select mode of transportation for patients leaving the treatment areas.

6. Select patient destination for patients leaving the treatment area.

7. Record and maintain appropriate transportation records.

8. Maintain close liaison and information coordination with the Patient Transportation staff and Treatment Dispatch.

OPERATIONAL CONSIDERATIONS

1. Maintain close coordination of efforts and liaison with the Treatment Dispatch functions.

2. Provide medical input into the decision making process.

3. Anticipate potential patient numbers and consider requesting the response of one or more hospital emergency response teams.

4. Standing Orders.
AIR/GROUND AMBULANCE COORDINATOR

Definition: Personnel as assigned

Supervised By: Patient Transportation Group Supervisor

Subordinates: Personnel as required

Function: Manage the Air/Ground Ambulance Staging Area and dispatch ambulances as requested.

Duties: 1. Check-in and obtain briefing from Patient Transportation Group Supervisor.

2. Establish appropriate staging area for ambulances.

3. Establish routes of travel for ambulances for incident operations.

4. Establish and maintain communications with the Air Operations Branch Director.

5. Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager. Provide ambulances upon request from the Medical Communications Coordinator.

6. Maintain records as required.

7. Assure that necessary equipment is available in the ambulance for patient needs during transportation.

8. Establish immediate contact with ambulance agencies at the scene.

9. Request additional transportation resources as appropriate.

10. Provide an inventory of medical supplies available at ambulance staging area for use at the scene.
AIR/GROUND AMBULANCE COORDINATOR

RESPONSIBILITIES

1. Manage all Air/Ground Ambulance staging area activities.

2. Develop organization sufficient to handle assignment.

3. Coordinate activities with the Patient Transportation Supervisor.

4. Plan layout of staging area - consider immediate and future needs.

5. Recommend additional resources as necessary.

6. Establish location of staging area and notify incident personnel of location when established.
   a. Apparatus
      1) Control apparatus parking
      2) Law enforcement assistance
   b. Loading Location
      1) Control
      2) Communications

7. Assure that necessary equipment is available in the ambulance for transportation needs.

8. Provide a medical supply resource inventory at ambulance staging area.

OPERATIONAL CONSIDERATIONS

1. Assess resource needs
   a. Command, communications
   b. Equipment, supplies
   c. Apparatus
   d. Personnel
   e. Relief personnel
   f. Law enforcement

2. Consult with Treatment Dispatch

3. Establish safe helispot(s).
4. Coordinate with Incident Air Operations Branch Director.

5. Assess resource needs
   a. Command, communications
   b. Equipment, supplies
   c. Apparatus
   d. Personnel
   e. Relief personnel
   f. Law enforcement
MEDICAL SUPPLY COORDINATOR

Definition: Qualified Personnel as assigned

Supervised By: Medical Group/Division Supervisor

Subordinates: Personnel as required

Function: Acquire and maintain control of appropriate medical equipment and supplies from units assigned to the Medical Group.

Duties:
1. Check-in and obtain briefing from Medical Group/Division Supervisor.
2. Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group/Division.
3. Request additional medical supplies (medical caches).
4. Distribute medical supplies to Treatment and Triage Units.

* If Logistics Section is established, this position would coordinate with the Supply Unit Leader.
MORGUE MANAGER

Definition: Qualified Personnel as assigned

Supervised By: Triage Unit Leader

Subordinates: Personnel as required

Function: Assume responsibility for Morgue Area activities until relieved of that responsibility by the Office of the Coroner.

Duties:
1. Check-in and obtain briefing from Triage Unit Leader.
2. Assess resource/supply needs and order as needed.
3. Coordinate all Morgue Area activities.
4. Keep area off limits to all but authorized personnel.
5. Coordinate with law enforcement and assist the Coroner's Office as necessary.
7. Maintain appropriate records.
MORGUE MANAGER

RESPONSIBILITIES

1. Manage all Morgue Area activities.

2. Keep area off limits to all personnel except those needed.

3. Coordinate with law enforcement and assist the Coroner's Office, as necessary.


5. Maintain records, including deceased identity (if available), where the deceased was found, etc.

6. Establish on-incident morgue location if necessary.

7. Advise Triage Unit Leader of location.

OPERATIONAL CONSIDERATIONS

1. Assess resource needs
   a. Communications
   b. Equipment and Supplies
   c. Personnel
   d. Relief Personnel
   e. Law Enforcement

2. Give Job Assignments
   a. Security (coordinate with Logistics Section)
   b. Records
   c. Placement Control

3. Morgue Location
   a. Remote from triage area
   b. Not readily available to other patients
   c. Accessible to vehicles - ambulance, law enforcement and the Coroner's Office.

CONFORM TO COUNTY CORONER'S POLICY - Mortality Management Guidelines - Appendix C

36
MEDICAL BRANCH GLOSSARY

• **ALS (ADVANCED LIFE SUPPORT)** - Allowable procedures and techniques utilized by EMT-P and EMT-II personnel to stabilize critically sick and injured patient(s) which exceed Basic Life Support procedures.

• **ALS RESPONDER** - Certified EMT-P or EMT-II.

• **BLS (BASIC LIFE SUPPORT)** - Basic non-invasive first-aid procedures and techniques utilized by EMT-P, EMT-II, EMT-I, and FIRST RESPONDER personnel to stabilize critically sick and injured patient(s).

• **BLS RESPONDER** - Certified EMT-I or FIRST RESPONDER.

• **DELAYED TREATMENT** - Second priority in patient treatment. These people require aid, but injuries are less severe.

• **EMT (Emergency Medical Technician)** - An individual trained in Basic Life Support according to the standards prescribed by the Health and Safety Code and who has a current and valid EMT-I certificate in the State of California issued pursuant to the Health and Safety Code. This definition shall include, but not be limited to, EMT-I(NA) and EMT-FS and EMT-IA.

• **EMT-II (Emergency Medical Technician II)** - An individual with additional training in limited Advanced Life Support according to the standards prescribed by the Health and Safety Code and who has a current and valid certificate issued pursuant to the Health and Safety Code.

• **EMT-P** - An individual EMT-I or EMT-II who has received additional training in Advanced Life Support according to the Health and Safety Code and who has a current and valid county certificate issued pursuant to the Health and Safety Code; formerly Mobile Intensive Care Paramedics.

• **EXPANDED MEDICAL EMERGENCY** - Any medical emergency which exceeds normal first response capabilities.

• **FIRST RESPONDER** - Personnel who have responsibility to initially respond to emergencies such as firefighters, police officers, California Highway Patrol Officers, lifeguards, forestry personnel, ambulance attendants and other public service personnel. California law requires such persons to have completed a first-aid course and to be trained in cardiopulmonary resuscitation.

• **HOSPITAL ALERT SYSTEM** - A communications system between medical facilities and on-incident medical personnel, which provides available hospital patient receiving capability and/or medical control.
• HOSPITAL EMERGENCY RESPONSE TEAMS - Prearranged hospital teams that respond to the incident upon request.

• IMMEDIATE TREATMENT - A patient who requires rapid assessment and medical intervention for survival.

• QUALIFIED - A person meeting the certification and or requirements established by the agency that has jurisdiction over the incident.

• MAJOR MEDICAL EMERGENCY - Any emergency which would require the access of local mutual aid resources.

• MEDICAL GROUP/DIVISION ORGANIZATIONAL STRUCTURE - This is designed to provide the Incident Commander with a basic expandable system for handling patients in a multi-casualty incident.

• MEDICAL TEAM - Combinations of medical trained personnel who are responsible for on-scene patient treatment.

• MEDICAL SUPPLY CACHE - A cache consists of standardized medical supplies and equipment stored in a predetermined location for dispatch to incidents.

• MICU - Mobile Intensive Care Unit refers to a paramedic equipped vehicle. It would include drugs, medications, cardiac monitors and telemetry, and other specialized emergency medical equipment.

• MINOR TREATMENT - These patients' injuries require simple rudimentary first-aid.

• MORGUE (Temporary on-Incident) - Area Designated for temporary placement of the dead. The Morgue is the responsibility of the Coroner's Office when a Coroner's representative is on-scene.

• MULTI-CASUALTY - The combination of numbers of injured personnel and type of injuries going beyond capability of an entity's normal first response.

• PATIENT TRANSPORTATION RECORDER - Supervised by the Patient Transportation Supervisor. Responsible for recording pertinent information regarding off-incident transportation of patients. See Appendix "C"

• START - S.T.A.R.T. - Acronym for Simple Triage And Rapid Transport. This is the initial triage system that has been adopted for use by the California Fire Chief's Association.
• STANDING ORDERS - Policies and Procedures approved by the local EMS Agency for use by an EMT-II or EMT-P in situations where direct voice contact with a Base Hospital cannot be established or maintained.

• TRIAGE - The screening and classification of sick, wounded, or injured persons to determine priority needs in order to ensure the efficient use of medical personnel, equipment and facilities. See Appendix "A"

• TRIAGE PERSONNEL - Responsible for triaging patients on-scene and assigning them to appropriate Treatment Areas.

• TRIAGE TAG - A tag used by triage personnel to identify and document the patient's medical condition. See Appendix "C"

* For Definitions of ICS Terms, other than Medical Branch Terms, see Field Operations Guide ICS 420-1.
APPENDIX A - RECOMMENDED TRIAGE PRINCIPLES

FIRESCOPE RECOGNIZES THE ADOPTION OF THE S.T.A.R.T. PROGRAM FOR TRIAGE BY THE CALIFORNIA FIRE CHIEF'S ASSOCIATION

There are several principles that must be learned to effectively triage and deliver disaster style medicine. The objective of triage is to accomplish the greatest medical good for the greatest number of patients.

A primary goal of triage is to select the patients in greatest need of urgent care. It is recognized that triage in a mass-casualty situation offers little time or resources for doing CPR, taking blood pressures, or even counting pulse rates. However, minimal intervention to stabilize the airway or to control hemorrhage is done at the same time as the initial triage.

The START plan allows the first responders to triage patients in 60 seconds or less, depending on three simple observations. These physical assessments are: ventilation, perfusion, and mental status. The START plan does not attempt to make diagnoses. A START Field Guide is located on the following pages and Appendix F has further information regarding START training.

Triage Personnel must tag ALL patients. IT IS A TIME CONSUMING AND OFTEN FATAL MISTAKE TO TRIAGE IN THE FIELD WITHOUT TAGGING A PATIENT. Patients are tagged so that rescuers arriving later can immediately turn their attention to the patients most in need. A Triage Tag has been adopted by the California Fire Chiefs Association. See Appendix "C"

Triage Personnel must rate or place the injured into one of four categories:

1. Deceased (non-salvageable)
2. Immediate
3. Delayed
4. Minor

Deceased: No ventilations present even after attempting to position the airway

Immediate: Ventilations present only after positioning the airway;

- Or respirations over 30 per minute;
- Or capillary refill takes over 2 seconds;
- Or patient fails to follow simple commands.

Delayed: Any patient who does not fit the Immediate Category nor the Minor Category.

Minor: These patients are separated from the general group at the start of triage by ordering "any one who can walk" followed by an area assignment for the patients to walk to.
S.T.A.R.T. FIELD GUIDE

VENTILATION

No

Yes

Position Airway

>30/Minute

<30/Minute

Immediate

Assess Perfusion

Non-Salvageable

Immediate

Radial Pulse or Capillary Refill

>2 Seconds

<2 Seconds

Control Bleeding

Immediate

Assess Mental Status

Mental Status

Fails to Follow Simple Commands

Immediate

Can Follow Simple Commands

Delayed
APPENDIX B - MORTALITY MANAGEMENT GUIDELINES

WORKING GUIDELINES RECOMMENDED BY ADHOC CORONER’S COMMITTEE DURING DISASTER OPERATIONS

In the event of a major disaster within the State of California, it may be several days before dead can be collected and processed by the Department of the Chief Medical Examiner-Coroner.

Therefore, the following guidelines have been prepared to aid local agencies in handling the dead until the Coroner can relieve those agencies of that responsibility.

Handling the Dead

When it becomes necessary to remove the dead from disaster sites because rescue work is in progress or the health and safety of the community is threatened, specific procedures must be followed:

1. Do not remove any personal effects from the body at any time. Personal effects must remain with the body at all times.

2. Attach tag or label to the body with the following information:
   a. Date and time found.
   b. Exact location where found, including floor/room number, etc.
   c. Name/address of decedent, if known.
   d. If identified, how, when, and by whom.
   e. Name/phone of person filling out tag.
   f. If the body is contaminated, so state with type of contamination.

3. Place each body in a separate disaster pouch or in plastic sheeting and tie securely to prevent rewrapping. Securely attach a second tag with the same information stated in Item No. 2 to the outside of the sheeting or pouch.

4. If personal effects are found and thought to belong to a body, place them in a separate container and label as in Item No. 2. Do not assume any loose effects belong to a body and do not attach to the body but store separately.

5. Move the properly tagged body with its personal effects to a convenient location, i.e., garage or other cool building, preferably one with refrigeration. In case of extreme heat or direct sunlight, move the body as soon as possible.

Note: Portable air-conditioning may be obtained or self-contained refrigerated van/trucks or rail cars can be used. Do not use a vehicle or storage area with floors that can become permeated with body fluids or other liquids.
6. Notify your local law enforcement agency of the location and, if known, the identity of the body. They, in turn, will notify the Coroner at which time the Coroner will estimate the time of arrival.

7. Keep insects and other animal life away from the body. Insect spray may be used as necessary.

8. The dead and their personal effects must be secured or safeguarded at all times until the arrival of the coroner or the Coroner's authorized representative.
APPENDIX C - FIELD FORM INSTRUCTIONS

THE FOLLOWING FORMS ARE PROVIDED AS EXAMPLES ONLY: After a reasonable evaluation period, standard forms will be developed.

1. TRIAGE TAG - Page 49 and 50. Explains how the Treatment Personnel will fill out the Triage Tags.

2. MULTI-CASUALTY BRANCH WORKSHEET - Form ICS-MC-305 - Page 51. An abbreviated patient flow chart is included with space for names of persons filling the positions. At the bottom is a checklist for other things to be considered, and space for hospital team identification and names of cooperating agencies.

3. MULTI-CASUALTY RECORDER WORKSHEET - Form ICS-MC-306 - Page 52. The top portion of the form is self-explanatory. Column 1 is the Ambulance Company Name. Column 2 the Ambulance ID number. Column 3 is the Patient Triage Tag Number. Column 4 is the patient's priority: Immediate (I), Delayed (D), or Minor (M). Column 5 is the Hospital Destination that the patient is being sent to. Column 6 is for recording the time the ambulance is dispatched off-scene. This form is for use by Treatment Dispatch and or Recorder(s). Retain this form when completed.

4. MULTI-CASUALTY HOSPITAL RESOURCE AVAILABILITY - Form ICS-MC-308 - Page 53. Space is provided for the hospital name and the number of beds, critical and non-critical, available (A) and used (U). There are two columns for up to 36 hospitals per form.

5. MULTI-CASUALTY AMBULANCE RESOURCE STATUS - Form ICS-MC-310 - Page 54. The Ambulance Resource Status checklist is a form for keeping resource status. Space is provided for the agency name and unit identification number, as well as their time in and time out of staging areas.

6. MEDICAL SUPPLY RECEIPT & INVENTORY FORM - Form ICS-MC-312 - Page 55. The source, type and quantity of medical material obtained must be documented. Such records should be kept current and may require the use of a recorder assigned specifically to conduct this task. The ‘Supply Receipt & Inventory Form’, shown as an example on page 55, is designed to be used by the Medical Supply Unit Coordinator or his/her delegate. In reviewing this form, it becomes very helpful when supplies or equipment are received, that they are identified with markers or tape. Sources supplying such equipment should be encouraged to identify their equipment/supplies so as to facilitate the inventory or possible incident reimbursement of such supplies. Incident reimbursement of any supplies will only be based upon supplies or equipment listed on the original form. The original form should be placed in the Medical Supply Unit and will comprise the total unit inventory.
Part I of the Triage Tag is used for documentation by Triage Personnel if time is available.

Left and right corners are yellow and are perforated along the lines shown.

One corner can be retained by the Treatment Unit Leader, the other can be retained by the Patient Transportation Supervisor. The hospital destination can be marked on the tabs.

Area to record initial injuries and other appropriate data. If bandage and dressing is used to cover the injury, the description can be circled and an arrow drawn to identify the injured site.

Area to record initial vital signs, time and orientation.

Perforated along the line shown. Black with white lettering "DECEASED". Red with black lettering "IMMEDIATE". Yellow with black lettering "DELAYED". Green with black lettering "MINOR".

Leave all parts attached in MINOR care, or tear off bottom parts to indicate triage priority.

If the triage priority of the patient changes, remove the entire bottom portion, leaving the injury information, and add a second tag identifying the new triage priority and the reason for the change.
Part II of the tag can be used by the treatment teams for documentation as time allows.

Additional area for injuries, complaints, or medical history.

Drugs or solutions administered to the patient.

Additional area for treatment instructions.

Personal information if possible.
MULTI-CASUALTY BRANCH WORKSHEET

INCIDENT NAME  DATE  TIME

INCIDENT COMMANDER  MULTI-CASUALTY BRANCH DIRECTOR

MEDICAL GROUP/DIVISION SUPERVISOR

TREATMENT UNIT LEADER

IMMEDIATE TREATMENT MANAGER

HOSPITAL TEAM

DELAYED TREATMENT MANAGER

HOSPITAL TEAM

MINOR TREATMENT MANAGER

TREATMENT DISPATCH MANAGER

TRIAGE UNIT LEADER

TRIAGE PERSONNEL

MORGUE MANAGER

MEDICAL SUPPLY COORDINATOR

PATIENT TRANSPORTATION GROUP SUPERVISOR

MEDICAL COMMUNICATIONS COORDINATOR

AIR AMBULANCE COORDINATOR

GROUND AMBULANCE COORDINATOR

OTHER

MEDICAL CACHES
AIR AMBULANCES
LAW ENFORCEMENT
RADIO FREQUENCIES
CORONER
RED CROSS
CHAPLAIN
BUSES
MENTAL HEALTH
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MEDICAL SUPPLY RECEIPT AND INVENTORY FORM

INCIDENT NAME: ___________________________ INCIDENT NO.: ____________

A. Supplies/Equipment received from: ___________________ DATE: __/__/____

Agency: ___________ Unit ID#: ___________ Name: __________________
(Whenever possible, use masking tape and markers to identify all equipment)

B. Supplies/Equipment Received by:

NAME: ________________ INCIDENT POSITION: __________________

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*Unit – list a measurable description of the item (gauge, gm, ml, bag, doz., etc.)

Form distribution: (Use carbon paper)

Original – Medical Supply Coordinator  Copy – Source of Supply

INCIDENT REIMBURSEMENT OF ANY SUPPLIES/EQUIPMENT WILL BE BASED ONLY UPON ORIGINAL FORM LISTINGS

ICS-MC-312 (1/8/92)
APPENDIX D

MULTI-CASUALTY MEDICAL SUPPLY CACHE SAMPLE

The following Medical Supply Cache System is designed to provide the rapid response of standardized medical supplies and equipment necessary to support emergency treatment and triage at multi-casualty incidents.

This cache is designed to treat up to 50 patients.
STRUCTURE

The Medical Supply System can be made up of the Medical Supply Cache, Medical Implementation Cache, Triage Packet, and O2 Manifold System.

I. Medical Supply Cache

   a. Six boxes per cache, each of the six boxes to contain the following 29 items, with the box containing the oxygen manifold system clearly marked with green tape.

   b. Contents:

      1. 2 each Bandage Elastic Coban
      2. 12 each Bandage Kerlix
      3. 24 each Bandage Bandaid 1"
      4. 2 each Bandage Triangular
      5. 4 each Dressing Vaseline 3" X 3"
      6. 25 each Gauze Sponge 4" X 4"
      7. 4 each Ice Packs Instant
      8. 4 each Dressing 8" X 7 1/2"
      9. 6 each Pads Eye Sterile
     10. 2 each Sheets Burn Sterile
     11. 4 each Tape Adhesive 1"
     12. 4 each Tape Adhesive 2"
     13. 20 each Alcohol Wipes
     14. 1 each Stethoscope
     15. 1 each Blood Pressure Cuff
     16. 1 each Airways, sizes 0, 3 and 5
17.  4 each Normal Saline 1000cc with set up (or equivalent)
18.  1 each Scissors Bandage Utility
19.  2 each C-collars
20.  2 each 6' 18" Wooden Backboards with straps (see vendor supplement)
21.  1 each Trauma Box (see vendor supplement)
22.  1 set Leg, Arm, Cardboard splints
23.  4 each Armboard 3" X 18"
24.  4 each Administration Set (Adult)
25.  4 each 16 Ga. Medicut (or equivalent)
26.  2 each 18 Ga. Medicut (or equivalent)
27.  2 each Oxygen Nasal Cannula
28.  2 each Oxygen Mask (Adult)
29.  5 sets Disposable Rubber Gloves

c. Dimensions

1. Height 14"
2. Width 20"
3. Length 80"

d. Cache weight approximately 200 Pounds
II. Medical Group/Division Implementation Supplies

a. Treatment Area Identification Runners (3' X 15')

1. Red - Immediate Treatment Area
2. Yellow - Delayed Treatment Area
3. Green - Minor Treatment Area

b. Identification Vests (Letter/Slip On)

Bright Kelly Green with White Letters to be lettered as follows: (see vendor supplement)

1. Medical Group/Division Supervisor
2. Patient Transportation Group Supervisor
3. Triage Unit Leader
4. Treatment Unit Leader
5. Medical Communications Coordinator
6. Immediate Treatment Manager
7. Delayed Treatment Manager
8. Minor Treatment Manager
9. Medical Supply Coordinator
10. Morgue Manager
11. Recorder (6)
12. Ambulance Coordinators (1 each Air and Ground)

c. Triage Packet Contents:

1. 1 each vinyl zippered envelope 12" X 15"
2. 1 each Triage Tag Instructions with 50 Triage Tags
3. 1 each ruled paper tablet

4. 1 roll 1" masking tape

5. 5 each #2 pencils

6. 2 each black felt tip marking pens

7. 1 each Medical Group/Division Structure and Function Sheets

8. 25 each Patient Disposition Sheets

9. 1 each List of local phone numbers

d. O2 Manifold System Contents: (Bottles to be provided at scene)

1. 3 each Portable assembly containing three, 4 Patient manifolds that will serve a total of 12 Patients, oxygen at a preset flow rate of 10 L.P.M. (see vendor supplement).

2. 1 each Preset regulator, 3000# reduced to 50#

3. 1 each 10' oxygen hose to two 5' oxygen hose to connect the manifolds in line to the regulator.
APPENDIX E
HOSPITAL EMERGENCY RESPONSE TEAM (H.E.R.T.) SAMPLE

Definition: A minimum of three medical personnel, optimum of five medical personnel, which includes a team leader (Base Hospital ER Physician and 1 MICN preferred) and any combination of physicians, nurses or physicians' assistants. H.E.R.T Teams will be requested through the Incident Commander.

Supervised by: Treatment Unit Leader

Function: Assume responsibility for patient assessment and treatment as assigned.

Duties:
1. Report to the Incident Command Post for assignment.
2. Perform medical treatment and other duties as assigned.
3. Remain at the Treatment Unit unless otherwise reassigned.
4. Respond to the scene with appropriate emergency medical equipment.
APPENDIX F
VENDORS SUPPLEMENT

The objectives of this Vendors Supplement are to suggest some of the equipment used for multi-casualty management.

Therefore, this Vendors Supplement is offered to assist agencies in locating manufacturers of the specialized equipment used.

Should any agency wish to use their own resources in manufacturing this equipment, the specifications for each piece of equipment is also included with the vendor.

Mention in this supplement does not express or imply endorsement, recognition or recommendation by the FIRESCOPE decision process.

Backboard to be constructed of 5/8" Finland birch plywood grade BB.

Runners to be constructed of White Oak, Red Oak or Birch, 3/4" thickness minimum. (60 X 1 X 3/4) ends to be mitre cut.

All edges and hand holes to be rounded over with 1/4" router rounding over bit.

Note:
1 Ends cut to 2 3/8" radius

2 Hand holes 4 5/8" X 1 5/8" with 13/16" end radius

3 Rails to be attached using carpenters glue at least 3 wood screws and stapled or nailed at 8" intervals

Scale 1" = 1'
MULTI-CASUALTY DISASTER TAG

PURCHASING INFORMATION
ADDRESS:
California Fire Chiefs Association
825 "M" Street
Rio Linda, CA. 95673
916-445-9882

AMOUNT:
Orders must be in lots of 100.
BANDING KIT

The following item is what is used to band the Medical Supply Cache:

Polypropylene Strap-pac Kit

#501-1017 Strap-pac  5,000 1/2" X 4000' (tensile strength 500 lbs.)

Self-dispensing carton, portable and convenient to use.

Kit contains 4,000 foot coil of strapping, hand tentioner and 250' 1/2" wire buckles.

Order from Marfred Paper Company, Inc.
(818) 896-0550   (213) 875-3184   (714) 250-1085
12708 Branford
Sun Valley, CA 91353
START

The film, with training materials, is available in a three-quarter inch video or one-half inch VHS. To order, call (714) 760-5689 or write Hoag Memorial Hospital Presbyterian, 301 Newport Boulevard, Box Y, Newport Beach, California 92663, Attention: Paramedic Department. Allow three to four weeks for delivery.

The START Triage Plan is endorsed by FIRESCOPE.
APPENDIX G

THE FOLLOWING IS AN EXAMPLE OF AN INTER-COUNTY PARAMEDIC AND MOBILE INTENSIVE CARE NURSE CERTIFICATION AGREEMENT

This agreement is made pursuant to the authority found in Section 6502 of the Government Code, which provides that public agencies by agreement may jointly exercise any power common to the contracting parties.

The agreement allows for patient treatment and transport to occur across designated county boundaries under specific circumstances.
INTER-COUNTY PARAMEDIC AND
MOBILE INTENSIVE CARE NURSE CERTIFICATION AGREEMENT

THIS AGREEMENT is made and entered into this 29th day of April, 1986,
by and between COUNTY OF LOS ANGELES
and COUNTY OF SAN BERNARDINO

RECITALS

A. The Medical Director of the Local Emergency Medical Services Agency (Local EMS Agency) for the County of Los Angeles and the Medical Director for the Local EMS Agency of the County of San Bernardino, pursuant to the Health and Safety Code and the California Administrative Code (Title 22), are each certifying EMT-Paramedics (EMT-P's) and Mobile Intensive Care Nurses (MICN's) in the delivery of advanced life support and other emergency medical care services within their respective jurisdictions.

B. The Health and Safety Code and the California Administrative Code vest the exclusive authority to certify EMT-P's and MICN's in the medical director of the Local EMS Agency for
that county in which such EMT-P's and MICN's provide advanced life support and other emergency medical services.

C. The Health and Safety Code and the California Administrative Code further give a medical director of a Local EMS Agency discretion in establishing training, performance, and examination standards required for certification as an EMT-P or MICN in his/her county.

D. Because of this discretion, the standards for certification which exist in the County of Los Angeles are different from those which exist in the County of San Bernardino and do not permit automatic certification in the County of Los Angeles of persons who are certified as EMT-P's or MICN's in the County of San Bernardino. Similarly, the standards which exist in the County of San Bernardino do not permit automatic certification in the County of San Bernardino of EMT-P's or MICN's who are certified in the County of Los Angeles.

E. Since a County of Los Angeles EMT-P or MICN may not also be certified in the County of San Bernardino, there is some question relative to the legal ability of an EMT-P or MICN certified in Los Angeles County to provide advanced life support and other emergency medical services in San
Bernardino County when such certified person is required to transit common county borders for the purpose of either continuing patient care during transport of a patient to a general acute care hospital or responding to request from a public agency located in San Bernardino County for rescue and medical services. Similarly, there is a question relative to the legal authority of an EMT-P or MICN certified by the Medical Director of the Local EMS Agency of the County of San Bernardino to provide advanced life support and other emergency medical services under the same circumstances within the territory of Los Angeles County.

F. The Medical Directors of the Local EMS Agencies of the Counties of Los Angeles and San Bernardino believe that it is in the best interests of the citizens of both Counties that an EMT-P or MICN certified in one of the Counties be permitted to provide advanced life support and other emergency medical services in the other County under the limited circumstances described hereinabove. Therefore, the Medical Directors of such Local EMS Agencies have concurred that, upon their execution of this Agreement as well as that by the Counties' respective governing bodies, certification of an EMT-P or MICN by either Medical Director shall be
recognized as authority for permitting the delivery of advanced life support and other emergency medical care services, under the limited circumstances described, in the County in which said person is not certified.

G. This Agreement is made pursuant to the authority found in Section 6502 of the Government Code, which provides that public agencies by agreement may jointly exercise any power common to the contracting parties.

THEREFORE, the parties agree as follows:

1. **TERM:** This Agreement shall remain operative and effective until terminated by either party. Either party may terminate the Agreement at any time by giving written notice to the other party at least ninety (90) days prior to the date of termination.

2. **SERVICES IN ADJOINING COUNTY WHEN PROVIDED:** An EMT-P or MICN, certified by the Medical Director of the Local EMS Agency of the County of Los Angeles, may provide advanced life support and other emergency medical care services in San Bernardino County. An EMT-P or MICN,
certified by the Medical Director of the Local EMS Agency of the County of San Bernardino, may provide advanced life support and other emergency medical care services in Los Angeles County.

Such services, however, may be provided only when one of the following circumstances exists:

A. When a mobile intensive care unit, staffed by EMT-P's or MICN's, or both, and operating via telecommunication under the direction of a paramedic base hospital located in either County, is requested by such hospital to accompany the patient during transport to a general acute care hospital and such transport necessitates crossing into the County in which any member of the mobile intensive care staff has not been certified. Any such transport must originate in the County in which the mobile intensive care unit is approved to provide advanced life support and is based.

B. When, pursuant to a mutual aid agreement or other legal authority, a County or local governmental law enforcement or fire protection agency, located in
either County, requests advanced life support and other emergency medical services from a paramedic agency located in the other County, and such services are not reasonably available from a paramedic agency located in the County of the requesting law enforcement or fire protection agency. Services provided by the responding mobile intensive care unit or helicopter must be under the direction via telecommunication of a base hospital located in either County.

3. COOPERATION BETWEEN COUNTIES: Within ten (10) days of the date of execution of this Agreement, the Medical Director of each County's local EMS Agency shall provide the other with current written information regarding the delivery of advanced life support and other emergency medical care services under his/her County's pre-hospital care and emergency medical services program. Such information shall include, but not be limited to, copies of the County's existing paramedic base hospital agreements and copies of all specific medical and communication protocols applicable to the delivery of advanced life support
and other emergency medical care services by EMT-P's and MICN's.

Following receipt of this information by the receiving Medical Director, he/she shall disseminate such materials, together with a copy of this Agreement, to each of the paramedic agencies and paramedic base hospitals participating in his/her County's emergency medical services program. Such Medical Director concurrently shall advise in writing the participating paramedic agencies and paramedic base hospitals that they may furnish advanced life support and other emergency medical care services within the territory of the other County only in accordance with the terms of this Agreement, and that in doing so, they shall follow the county of origin's policies, rules, and regulations governing the conduct of its emergency medical services program which are reflected in the written materials provided.

Any changes in a County's emergency medical services program which directly affect the field delivery of
emergency medical care services in such County shall immediately be communicated in writing to the Medical Director of the Local EMS Agency of the other County for distribution to the paramedic agencies and paramedic base hospitals in his/her County.

4. **SCOPE OF SERVICE:** When a mobile intensive care unit from one County accompanies a patient during transport into the other County or responds to a request for emergency medical care services from a law enforcement or fire protection agency in the other County, all in accordance with the conditions set forth in Paragraphs 2 and 3 hereinabove, an EMT-P or MICN with the mobile intensive care unit or helicopter may perform those emergency medical care functions authorized by the California Administrative Code. In no event, however, may an EMT-P or MICN perform a medical procedure for which he or she has received no training.

5. **TRAUMA CAR:** When any member of the mobile intensive care staff is providing emergency medical care for a trauma patient under the terms of this Agreement, that
care shall follow the policies, rules, and regulations governing the conduct of the EMT-P's or MICN's in the County of his/her certification. If the trauma patient meets triage criterion, then the patient shall be transported to the closest designated Trauma Center that is receiving trauma patients regardless of the County in which the Trauma Center is located. In the event that a County does not have triage and Trauma Center designation, then the County of Los Angeles policies, rules, and regulations shall apply.

6. **SELF CONTAINED UNDERWATER BREATHING APPARATUS**

(S.C.U.B.A. DIVING ACCIDENT: When any member of the mobile intensive care staff is providing emergency medical care for a S.C.U.B.A. diving accident patient, that care shall follow the policies, rules, and regulations governing the conduct of the EMT-P's or MICN's in the County of his/her certification. If the S.C.U.B.A. diving accident patient is in need of a hyperbaric chamber then the patient shall be transported to the closest chamber that is equipped, staffed, and prepared to administer care appropriate to the needs of the patient. The altitude of the
chamber and enroute altitudes should be factors considered in the determination of patient destination. In the event that a County does not have policies and a chamber system, then the County of Los Angeles policies, rules, and regulations shall apply.

7. **HELICOPTER SERVICE**: When an emergency medical services helicopter is used for providing emergency medical care, that care shall follow the policies, protocols, rules, and regulations governing the conduct of helicopters and mobile intensive care staff for the County in which that helicopter and personnel are based. In the event that a County does not have any policies, protocols, rules, and regulations then the County of Los Angeles policies and protocols shall be followed. In all cases except trauma, and S.C.U.E.A. diving accidents, the helicopter shall deliver its patients to the closest basic emergency facility with a licensed helipad. In the case of trauma, Paragraph 5 hereinabove shall apply, and in the case of S.C.U.E.A. diving accidents, Paragraph 6 hereinabove shall apply.
8. **THERE IS NO OBLIGATION TO FURNISH SERVICES:** This Agreement does not require either County, or any paramedic agency or paramedic base hospital located in a county, to furnish advanced life support and other emergency medical care services within the territory of the other County.

9. **PARAMEDIC AGENCY COMPENSATION:** This Agreement shall not affect the rights of any paramedic agency or paramedic base hospital located in either County to recover compensation for advanced life support and other emergency medical care services to which it may be entitled.

10. **THIRD PARTY BENEFICIARY:** This Agreement shall not be construed as, or deemed to be an Agreement for the benefit of *anyone not* a party hereto and anyone who is not a party hereto shall not have a right of action hereunder for any cause whatsoever.

11. **PRIOR AGREEMENT SUPERSEDED:** This Agreement supersedes the agreement dated February 13, 1980, between the
County of Los Angeles and the County of San Bernardino, further identified as a County of Los Angeles Agreement No. 36197.

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its Chairman and the seal of said Board to be hereto affixed, and attested by the Executive Officer-Clerk thereof, and the Board of Supervisors of the County of San Bernardino has caused this Agreement to be subscribed by its Chairman and the seal of said Board to be hereto affixed, and attested by the Clerk thereof.

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- 12 -
COUNTY OF LOS ANGELES

By
   Chairman, Board of Supervisors

ATTEST:

LARRY J. MONTEILH, Executive Officer-Clerk of the Board of Supervisors of the County of Los Angeles

By
   Deputy

APPROVED AS TO FORM:

DE WITT W. CLINTON
Count Counsel

By
   Deputy

APPROVED AS TO CONTRACT ADMINISTRATION:

COUNTY OF LOS ANGELES
Deparitit of Health Services

By
   Chief, Contracts and Grants Division

APPROVED
COUNTY OF LOS ANGLES, Local EMS Medical Director

By
   Joseph K. Indenbaum, M.D.,
   Medical Director EMS Agency
   (Los Angeles County's EMT-P Certifying Authority)

KD:pt
AGREEMENT/AD8
2/11/86

COUNTY OF SAN BERNARDINO

By
   Chairman, Board of Supervisors
   Robert L. Hamrock

MAR 10 1986

APPROVED AS TO CONTENT:

By
   George R. Pettersen, M.D.,
   Director of Public Health of the County of San Bernardino

APPROVED AS TO FORM:

ALAN K. MARKS
County Counsel

By
   Deputy

APPROVED AS TO CONTRACT ADMINISTRATION:

By
   Edward J. Gallagher, M.D., M.P.H.,
   Chairman of the Inland Counties Emergency Medical Agency Governing Board

APPROVED
COUNTY OF SAN BERNARDINO, Local EMS Medical Director

By
   Conrad Salianas, M.D.,
   Medical Director of the Inland Counties Emergency Medical Agency
   (San Bernardino County's EMT-P Certifying Authority)

ADOPTED
APP 29 1986

BOARD OF SUPERVISORS
County of Los Angeles

Larry J. Monteih
EXECUTIVE OFFICER