Carroll County Department of Fire & EMS
Standard Operating Procedure

DOCUMENT DETAILS

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Applicability: **[X] Volunteer** **[X] Career**

I. PURPOSE

The Mass Casualty Incident Operations Policy is designed to serve as a guideline for emergency response personnel. The purpose of this plan is to allow for the organized approach, response, and quick mitigation of multiple patient and mass casualty incidents. If necessary, this plan can be modified based on number of patients, severity of injuries, and special circumstances.

II. DEFINITIONS

ALS Unit – A staffed unit capable of providing Advanced Life Support. A dispatched ALS unit can be an ambulance, or chase vehicle.

Ambulance – An ambulance is a staffed medical vehicle capable of transporting ALS and BLS patients.

Casualty Collection Point (CCP) – A temporary location to place patients until a formal treatment area is created; this location may be used to relocate patients from hot or warm zone or while hazard mitigation remains the priority.

EMS Task Force – A dispatch designed to manage a multiple patient incident where the number of patients on scene can be transported by the units on scene. Designed to accommodate 5-10 patients.

Incident Commander (IC) – The individual responsible for the overall management of all incident operations.

JumpSTART – A protocol for patients from birth to 14 years of age which provides for primary triage of victims in most need of immediate treatment and transportation and very limited-care; Triage will be based on breathing, respiratory rate, perfusion, and mental status; Emergency care will be restricted to opening airways and controlling severe hemorrhage.

Mass Casualty Incident (MCI) – Classically described as a medical incident that requires more than the immediately available resources or is an incident that requires resources beyond the normal day-to-day operation. An MCI may overwhelm an individual department, service, hospital, or community.

Mass Casualty Support Unit (MCSU) – A medical cache unit designed to carry supplies and equipment to specifically address the resource needs of a mass casualty incident (MCI). These units are designed to rapidly deploy equipment to treatment areas. Carroll County Department of Fire & EMS MCSU has three of these units each capable of treating 25 patients.

MCI Levels – Used to reflect the size and severity of incident, number of patients, and amount of resources needed.

A. **MCI 1 –** first level, for 11-25 patients.
B. **MCI 2 –** second level, for 26-50 patients.
C. **MCI 3 –** third level, for 50-100 patients.
D. **MCI 4 –** forth level, for 100-999 patients
E. **MCI 5 –** fifth level, for 1000 or greater patients

Medical Ambulance Bus (MAB) – An EMS unit designed to transport up to twenty (20) non-ambulatory patients.

Multiple-Patient Incident – A low-impact incident that can be handled through a traditional response and with readily available resources in which patients are assigned directly to an EMS unit and without establishment of treatment and transport areas.

Porters – Individuals assigned to assist in the movement of injured patients to designated Triage, Treatment, and Transport Areas.

Rescue Task Force – Combined team of ALS clinicians and law enforcement officers utilized during an active assailant event.

Simple Triage And Rapid Transport Triage (START Triage) – The triage method designated by the Maryland Medical Protocols for patients 15 years of age and older which provides for primary triage of victims in most need of immediate treatment and transportation and very limited care; Triage will be based on respiration, perfusion, and mental status; Emergency care will be restricted to opening airways, positioning patients in the recovery position, and controlling severe hemorrhage.

Staffing Assist (SA) Unit – An Engine, Truck or Rescue Squad, Utility staffed with a minimum of three qualified personnel.

III. PROCEDURES

A. Dispatch

1. The EMS Task Force, MCI 1, MCI 2, MCI 3, MCI 4, and MCI 5 level dispatches were developed to enable Carroll County Department of Fire & EMS to respond quickly and effectively to a multiple-patient or mass-casualty incident. The EMS Task Force, MCI 1, MCI 2, MCI 3, MCI 4 or MCI 5 will be dispatched in addition to the initial assignment. For instance, the EMS Task Force may be requested in addition to the "vehicle accident with entrapment assignment" for an entrapment call with greater than 5 patients. Units assigned or dispatched to the EMS Task Force, are dedicated in their assignment and should remain performing the duties assigned below. Units dispatched on an MCI 1, MCI 2, MCI 3, MCI 4 or MCI 5 should report to staging and wait for an assignment.

2. The EMS Task Force, MCI 1, MCI 2, MCI3, MCI 4 or MCI 5 assignments will be dispatched based upon the number of reported or confirmed patients. The calculation for resources is based upon the number of patients that will be transported with an assumption of transported patients being triaged as 30% red, 30 yellow, and 40% green. However, command staff should recognize that resources may be reassigned should patient counts vary significantly from this distribution.

3. When 5 or more patients are reported to the 911 call taker, the dispatcher will advise the responding Chief Officer/Shift Commander, who should consider requesting an EMS Task Force.

B. Initial Unit Arrival and Communications

1. The first arriving unit will give an Initial On-Scene Report (ISOR) including the correct location, approximate number of patients, and scene hazards.

2. The first arriving unit must determine the actual number of patients and request the appropriate assignment: EMS Task Force, MCI 1, 2, 3, 4, or 5.

3. Command must be established

4. If there are greater than 10 patients, the IC shall declare the incident a "Mass Casualty Incident (MCI)" and instruct ECC to contact EMRC. The IC shall ensure the appropriate MCI assignment is dispatched based upon the identified number of patients.

5. The IC will designate and announce the location of a Casualty Collection Point.

6. Unless otherwise directed by command, patient triage shall be completed immediately by the first arriving ambulance crew utilizing Maryland EMS Protocol. Accurate patient

numbers and triage categories (red, yellow, green, or deceased) shall be reported to command as soon as possible.

C. On-Going Communications

1. As soon as the information is available, Command or their designee should re-contact EMRC and provide the following information:

    a. Type, general description, and location of the incident.

    b. Age range of the patients.

    c. Estimated number of patients by priority including total number of patients.

    d. Any hazardous agents involved.

D. Scene Operations

1. In an EMS Task Force, units shall perform the duties assigned.

E. Development of the Incident Command System (ICS)

1. Command may assign roles and responsibilities based upon the complexity of the incident and anticipated duration until all patients are transported. Command may also assign aides to the positions below. In general, unit officers shall be assigned positions within the ICS and crews shall be assigned treatment or porter roles.

    a. **Medical Group Supervisor –** reports to the IC or the EMS Brand Director (if established) and supervises the Triage Unit Leader, Treatment Unit Leader, Transportation Group Supervisor, and Medical Supply Coordinator.

    b. **Triage Unit Leader –** reports to the Medical Group Supervisor, supervisees triage crew. Responsible for triage management and movement of patients from the triage area.

    c. **Treatment Unit Leader –** reports to the IC or the Medical Group Supervisor (if established) and oversees the Treatment Area Managers and the Treatment Dispatch Manager. The Treatment Unit Leader assumes responsibility for establishing the treatment areas, initiating treatment for all patients, coordinating patient movement within the treatment area(s) and directing patient movement to the transport loading location(s).

    d. **Transportation Group Supervisor –** reports to the Medical Group Supervisor or EMS Branch Director (if established) and supervises the MCC, Transport Recorder and Air/Ground Ambulance Coordinator (if established). Responsible for the coordination of patient transportation.

    e. **Medical Communications Coordinator (MCC) –** reports to the Transportation Group Supervisor and maintains a real-time patient destination bed count via

communications with EMRC. In the EMS Branch, there shall only be one MCC per incident – regardless of size or scope of the incident.

f. **Transport Recorder –** reports to the Transportation Group Supervisor and/or Air/Ground Ambulance Coordinator (if established).

g. **Porters –** reports to the Triage Unit Leader, are assigned when non-ambulatory patients need to be moved from the impact area or Casualty Collection Point (CCP) to the Treatment Area.

h. **Transport Loaders –** reports to the Air/Ground Ambulance Coordinator as directed. Position is assigned when transport functions are needed due to the demands of the incident. The Transport Loader works in the transportation loading area for the Air/Ground Ambulance Coordinators and may be assigned transport EMS personnel in loading patients.

i. **Air/Ground Ambulance Coordinator –** reports to the Transportation Group Supervisor and manage the Air/Ground Ambulance Staging Areas and dispatch ambulances as requested.

j. **Staging Manager –** reports to the Transportation Group Supervisor and acts as the liaison between transport units in the Operations Staging Area and Transportation.

EMS Task Force: 5-10 Patients

1. Total Units – not including Initial Assignment:
    a. 5 Ambulances (minimum 2 ALS staffed)
    b. 1 Chase
    c. 2 Staffing Assist Vehicle's
    d. 1 Chief Officer/Shift Commander
2. Staffing Assist Units:
    a. First Arriving – Unit Officer becomes staging officer if not already established. If command does not designate a staging location, the officer will announce the staging location. The crew will assist as designated by command or the Medical Group Supervisor.
    b. Second Arriving – The second arriving unit shall report to staging unless directed otherwise by command.
3. Ambulances

a. Report to staging for assignment, the primary focus of transport units is to transport patients. Transporting units dispatched as part of the EMS Task Force should not engage in activities that could delay availability to transport patients.

b. Chief/Shift Commander – Assume Medical Group Supervisor

c. EMS Chase – Transport Officer and Medical Communications Coordinator

MCI 1: 11-25 Patients

1. Total Units – not including Initial Assignment:

   a. 10 Ambulances (minimum 4 ALS staffed)

   b. 4 Staffing Assist Units

   c. 1 Medical Ambulance Bus

   d. 1 MCSU

   e. 1 Passenger/Transit Bus

   f. 1 Shift Commander

   g. 2 EMS Chase

2. Staffing Assist (SA) Units:

   a. First Arriving – Unit Officer becomes staging officer if not already established. If command does not designate a staging location, the officer will announce the staging location. The crew will assist as designated by command or the Medical Group Supervisor.

   b. Additional Staffing Assist (SA) Units – The remaining dispatched units shall report to staging. Officers may be directed to fulfill roles within the ICS as described below. Crews should prepare to assist in patient care or as porters. When requested, crews should bring EMS supplies to include oxygen, to the incident scene.

3. Ambulances

   a. Report to staging for assignment, the primary focus of transport units is to transport patients.

   b. Transporting units dispatched as part of the MCI 1 should not engage in activities that could delay availability to transport patients.

c. Transport units shall position themselves in staging to quickly exit staging to advance to the incident scene or to transport patients.

4. ALS Units:

   a. Report to staging for assignment. Non-transporting ALS units shall be prepared to immediately upgrade BLS transport units.

   b. ALS providers should also be prepared to be redirected to the scene to begin treatment of patients in the casualty collection point if there are no transport resources available or immediate transport is not feasible.

   c. ALS providers should also be prepared to function as part of a Rescue Task Force. If an ALS provider is moved from staging to a Rescue Task Force, the ALS provider should be replaced within staging.

5. Shift Commander:

   a. Assume Medical Group Supervisor.

6. 1st EMS Chase:

   a. Transport Unit Leader and Medical Communications Coordinator

7. 2nd EMS Chase:

   a. Treatment Officer or other role as assigned by incident command.

8. MAB:

   a. Reports to EMS staging for assignment.

9. MCSU:

   a. Reports to EMS staging for assignment.

   b. MCSU operator remains dedicated to unit in an administrative function and assumes the role of Medical Supply Coordinator.

MCI 2: 26-50 Patients

1. Total Units – not including Initial Assignment:

   a. 15 Ambulances (minimum 7 ALS staffed)

   b. 6 Staffing Assist Units

   c. 2 Medical Ambulance Bus

d. 2 MCSU

e. 2 Passenger/Transit Bus

f. 1 Shift Commander

g. 2 EMS Chase

2. Staffing Assist Units:

a. First Arriving – Unit Officer becomes staging officer if not already established. If command does not designate a staging location, the officer will announce the staging location. The crew will assist as designated by command or the Medical Group Supervisor.

b. Additional Staffing Assist Units: - The remaining dispatched units shall report to staging. Officers may be directed to fulfill roles within the ICS as described below. Crews should prepare to assist in patient care or as porters. When requested, crews should bring BLS supplies to include oxygen, to the incident scene.

3. Ambulances:

a. Report to staging for assignment, the primary focus of transport units is to transport patients.

b. Transporting units dispatched as part of the MCI 2 should not engage in activities that could delay availability to transport patients.

c. Transport units shall position themselves in staging to quickly exit staffing to advance to the incident scene or to transport patients.

4. ALS Units:

a. Report to staging for assignment. Non-transporting ALS units shall be prepared to immediately upgrade BLS transport units.

b. ALS providers should also be prepared to be redirected to the scene to begin treatment of patients in the casualty collection point if there are no transport resources available or immediate transport is not feasible.

c. ALS providers should also be prepared to function as part of a Rescue Task Force. If an ALS provider is moved from staging to a Rescue Task Force, the ALS provider should be replaced in staging.

5. Shift Commander

a. Assume Medical Group Supervisor

6. 1st EMS Chase

    a. Transport Unit Leader and Medical Communications Coordinator

7. 2nd EMS Chase

    a. Treatment Officer or other role as assigned by incident command.

8. 1st and 2nd MAB:

    a. Report to staging for assignment

9. 1st and 2nd MCSU:

    a. Reports to EMS staging for assignment.

    b. MCSU operator remains dedicated to unit in an administrative function and assumes the role of Medical Supply Coordinator.

10. 1st and 2nd Passenger/Transit Bus:

    a. Reports to EMS staging for assignment.

MCI 3 > 50-100 Patients

1. Total Units – not including Initial Assignment

    a. 20 Ambulances (minimum 10 ALS staffed)

    b. 8 Staffing Assist Units

    c. 3 Medical Ambulance Bus

    d. 3 MCSU

    e. 3 Passenger/Transit Bus

    f. 1 Shift Commander

    g. 2 EMS Chase

2. Staffing Assist Units:

    a. First Arriving – Unit Officer becomes staging officer if not already established. If command does not designate a staging location, the officer will announce the staging location. The crew assist as designated by command or the Medical Group Supervisor.

b. Additional Staffing Assist Units – The remaining dispatched units shall report to staging. Unit officers may be directed to fulfill roles within the ICS as described below. Crews should prepare to assist in patient care of as porters. When requested, crews should bring BLS supplies to include oxygen, to the incident scene.

3. Ambulances:

   a. Report to staging for assignment, the primary focus for transport units is to transport patients.

   b. Transporting units dispatched as part of the MCI 3 should not engage in activities that could delay availability of transport patients.

4. ALS Units:

   a. Report to staging for assignment. Non-transporting ALS units shall be prepared to immediately upgrade BLS transport units.

   b. ALS providers should also be prepared to be redirected to the scene to begin treatment of patients in the casualty collection point if there are no transport resources available or immediate transport is not feasible.

   c. ALS providers should also be prepared to function as part of a Rescue Task Force. If an ALS provider is moved from staging to a Rescue Task Force, the ALS provider should be replaced within staging.

5. Shift Commander:

   a. Assume Medical Group Supervisor

6. 1st EMS Chase

   a. Transport Unit Leader and Medical Communications Coordinator

7. 2nd EMS Chase

   a. Treatment Officer or other role as assigned by incident command

8. 1st and 2nd MAB:

   a. Report to staging for assignment

9. 1st, 2nd and 3rd MCSU:

   a. Reports to EMS staging for assignment

   b. MCSU operator remains dedicated to unit in an administrative function and assumes the role of Medical Supply Coordinator.

10. 1st, 2nd and 3rd Passenger/Trainset Bus

MCI 4 100-999 Patients – MCI 5 1000 Patients

1. Total Units – not including Initial Assignment – Follow MCI -3 response guidelines.
2. Request surrounding counties activate their highest-level MCI response for deployment response.

IV. RECISION

This Standard Operating Procedure rescinds all directives regarding MCI Policy or similar content previously issued for personnel of the Carroll County Department of Fire & EMS.

V. RELATED STANDARD OPERATING PROCEDURES / DOCUMENTS

VI. ATTACHMENTS