EL DORADO COUNTY
EMS AGENCY

August
2024

# *Multi-Casualty Incident (MCI) Plan*

# Contents


Section 1: Background ..... 2
Authority ..... 2
Strategic Aim ..... 2
Purpose ..... 2
Definitions and Acronyms ..... 3
Assumptions ..... 5
Section 2: MCI Levels ..... 6
Level: Pre-Alert ..... 6
Level 1 ..... 6
Level 2 ..... 7
Level 3 ..... 8
Level IV: *Catastrophe* ..... 8
Section 3: Medical Operations ..... 10
Triage Group ..... 11
Key Points: ..... 11
Transport Group ..... 12
Key Points: ..... 12
Treatment Group ..... 13
Key Points: ..... 13
Mobilization to Demobilization ..... 14
Section 4: Special Considerations ..... 15
Haz-Mat ..... 15
Active Threats ..... 16
Crime Scenes and Evidence ..... 16
Section 5: Position Task Sheets ..... 17
Medical Branch Director ..... 17
Triage Group Supervisor ..... 17
Transport Group Supervisor ..... 18
Treatment Group Supervisor ..... 19
Triage Personnel ..... 19
Stretcher Bearer ..... 20
Morgue Unit Leader ..... 20
Medical Communications Unit Leader (Med-Comm) ..... 20
Ambulance Unit Leader/Marshal ..... 21
Loader ..... 21
MICN ..... 21
Section 6: Service Area Amendments ..... 22
Annexes ..... 23
Annex 1 ..... 23
Annex 2 ..... 24

# Section 1: Background

## Authority

The El Dorado County Multi-Casualty Incident Response Plan (*'MCI plan'* or *'the plan'*) is a product of the El Dorado County Emergency Medical Services Agency (EDCEMSA) pursuant to its authority under California Health and Safety Code Division 2.5 and California Code of Regulations, Title 22, Division 9 and the El Dorado County Emergency Medical Service and Medical Transportation Ordinance (Ch. 8.74). The plan was drafted in alignment with the El Dorado County Emergency Operations Plan (2023) and the California Public Health and Medical Emergency Operations Manual (2011).

## Strategic Aim

*Ensuring all victims of multi-casualty incidents in the County of El Dorado are rapidly delivered from the incident scene to definitive care, whilst minimizing harm and maximizing survivability.*

## Purpose

This planning document intends to articulate the operational objectives that satisfy the strategic aim of an MCI response (*see above*). It does not intend to preempt command decisions by anticipating timelines or over-specifying ground-level tactics and procedures. Rather, the stakeholder audience is prompted to understand the aim and objectives fundamentally, then develop agency-level policies and training initiatives to align with those elements. The expected result is an active state of County-wide preparedness for Multi-Casualty Incidents.

> *"In preparing for battle I have always found that plans are useless, but planning is indispensable."* -Gen. Dwight D. Eisenhower

## Definitions and Acronyms

***Base** or **Base Hospital:** A hospital authorized by LEMSA to provide online physician medical control to prehospital providers. The two base hospitals operating in the County of El Dorado are Marshall Medical Center (CSA 7) and Barton Memorial Hospital (CSA 3).*

***California Medical Assistance Team** (CAL-MAT):* Aspecialized medical response team, mobilized by the California Emergency Medical Services Authority (EMSA), to support local medical response efforts in coordination with other state and local agencies.

***Communications Center** (Comm Ctr):* Facility tasked with managing emergency communications (911 calls, radio traffic with responders, etc.) in a given service area. The two communications centers serving El Dorado County are operated by the City of South Lake Tahoe Police Department (CSA 3) and the Cal Fire Amador-El Dorado Unit (CSA 7).

***County Service Area (CSA):*** One of two distinct geopolitical units of the County, delineated by the summit of the Sierra Nevada range. CSA No. 3 consists of the Lake Tahoe Basin, the City of South Lake Tahoe, and the Meeks Bay and Tahoma areas; with County Service Area No. 7, comprised of the western slope of the County, and the City of Placerville.

***Control Facility**:* A hospital authorized by the LEMSA to direct patient dispersal during Multi-Casualty Incidents. In most cases, the 'base hospital' (see above) is the default control facility in an MCI.

***Department Operations Center (DOC):*** An operational unit within a single organization or agency that is responsible for managing and coordinating its response to a disaster or emergency.

***Disaster Medical Assistance Team (DMAT):*** Specialized, multi-disciplinary medical response team deployed under the National Disaster Medical System (NDMS) in a federally declared disaster.

***Disaster Medical Services Kit (DMS Kit):*** Commercially produced MCI management kit stocked on most EMS units in service throughout the County. Kits contain triage tags, registers, and various tools used in the conduct of an MCI response.

***Emergency Medical Services Operations Committee (EMSOC):*** Committee convened by the El Dorado County Emergency Services Authority to address operational matters in CSA #7.

***Emergency Operations Center (EOC):*** Fixed facility tasked with coordinating and supporting the deployed command structure in the field during major incidents. The El Dorado County EOC is operated by the Sheriff's Office of Emergency Services (OES).

***Flash Report**:* Electronic situation report submitted by the MHOAC Duty Officer to the Region IV Disaster Medical Health Specialist (RDMHS). This serves as the initial notification to the region, as well as updates

***Hospital Command Center (HCC):*** Operations center within a healthcare facility, mobilized to oversee and coordinate operational activities in situations requiring critical decision-making and efficient resource allocation.

***Joint Powers Authority (JPA):*** A single legal entity formed under the agreement of two or more entities, to share responsibility over a common public function.

***Incident Command System (ICS):*** A nationally standardized approach to command, control, and coordination of emergency response, as reflected in the National Incident Management System (NIMS) and Standardized Emergency Management System (SEMS).

***Local Emergency Medical Services Agency (LEMSA):*** The County agency responsible for the management of the EMS system; including the development of policies, plans, and treatment protocols.

***Medical Advisory Committee (MAC):*** Committee charged with clinical review of EMS policies and procedures. Chaired by the EMS Medical Director.

***Medical Health Operational Area Coordinator (MHOAC):*** Official responsible for coordinating medical and health-related resources in an operational area and requesting regional medical-health support for large incidents. Responsibility is split between the LEMSA (Medical) and the Public Health (Health). Staffed 24-7 by the MHOAC Duty Officer.

***Mobile Intensive Care Nurse (MICN):*** A Registered Nurse (RN) authorized by the LEMSA to issue instructions to prehospital emergency medical care personnel and facilitate distribution of casualties to receiving facilities.

***Multi-Casualty Incident (MCI):*** Any incident wherein the number of injured persons exceeds the day-to-day operating capacity of the service area; often requiring additional resources and the distribution of patients to multiple hospitals.

***START** (simple triage and rapid treatment):* A triage algorithm focused on responsiveness, mobility, and respiratory status. **See Annex 1.**

***jumpSTART**:* A variation on START, developed specifically for pediatric trauma. **See Annex 2**.

***Triage: (primary)*** The initial assessment of casualties as they are found, to rapidly categorize them based on the severity of their injuries or medical conditions. ***(Secondary)*** The comprehensive assessment of casualties, typically occurring in a treatment area, to confirm or reclassify the initial triage category and help drive treatment and transport decisions.

## Assumptions

The guidance in this document derives from a set of planning assumptions. Stakeholders should remain adaptable and prepared to logically adjust operations should real-world circumstances deviate from the hypothetical:

| Assumption | Rationale |
|---|---|
| *Reasonable measures are in place to ensure responder safety.* | Nothing in this document should be construed as overriding occupational safety and health best practices. While emergency operations imply higher risk than most work, no indicated response function shall be performed without due regard for responder safety. |
| *There will be information gaps.* | It is understood that points in the MCI response will depend on first impressions and estimates. Decision makers *(i.e., call taker, first arriving unit, triage officer, etc.)* should not allow accuracy concerns to delay decisive reporting of their initial impression. |
| *Stakeholders/Responders have a working knowledge of the Incident Command System (ICS).* | This document does not intend to supersede or abbreviate specific training in the ICS or the associated State or Federal policy frameworks (SEMS/NIMS). Decisions about expansion or consolidation of ICS roles should maximize principles of unity of command and span of control. |
| *Stakeholders/Responders are competent in the use of all clinical and scene management tools at their disposal.* | This document does not intend to supersede or abbreviate operational training in triage, field treatment, transport, or any associated tools. It is the responsibility of each provider agency to equip and train their personnel pursuant to applicable agreements/contracts. |
| *The incident is primarily an acute medical event.* | Efforts have been made to align with existing State and local emergency frameworks, however, non-medical objectives, such as security, hazard containment, search and rescue, or firefighting, are not in scope. No guidance is offered on how those objectives should be pursued in parallel to medical objectives. |
| *The incident is occurring at a point location.* | In cases where a multi-casualty event does not have a single incident location, an MCI may take on the character of a 'Public Health Emergency' or may develop *at the hospital itself*. In such cases, medical operations should adhere to the guidance of Public Health officials and align with the established emergency operations plan of any surge-affected facility. |
| *Medical operations are overseen at the 'Branch' level.* | This document assumes a medical 'Branch' organized under the operations section, with associated tasks at the Division/Group level. Larger, more complex incidents may be expanded geographically or by function, locating medical operations at the Division/Group level, with associated tasks at the Unit level. |

## Section 2: MCI Levels

The activities outlined in this section are illustrative of what will likely be managed by each entity during an MCI. They are presented to strengthen understanding amongst stakeholders.

| Level: Pre-Alert | |
|---|---|
| *Patient #* | *Description* |
| UNK | • Comm Ctr receives notification suggestive of a potential MCI. |
| Response* Timeline | Recovery** Timeline |
| **N/A** | **N/A** |
| **Comm Ctr** | • Dispatch resources according to response plans for the incident type.<br>• Convey 'MCI Pre-Alert' to responding units and enter same into dispatch notes.<br>• Alert Base of MCI pre-alert |
| **Base** | • Assign MICN to manage communications.<br>• MICN will initiate bed poll on a pre-Alert and cancel if not confirmed. |
| **EOC** | N/A |
| **MHOAC** | N/A |

| Level 1 | |
|---|---|
| *Patient #* | *Description* |
| 5-10 | • Patient volume greater than can be handled by the usual initial response.<br>• Can be managed with 'on-duty' resources in the service area, with limited aid.<br>• Minimal/temporary impact on routine EMS operations. |
| Response* Timeline | Recovery** Timeline |
| **~ 1 hour** | **< 2 hours** |
| **Scene** | • First on scene confirms MCI.<br>• Incident Command (IC) established.<br>• IC updates dispatch on incident details and clarifies resource needs.<br>• Command transferred to non-transport staff as soon as practical.<br>• IC will implement the Medical Group or Branch of the Incident Command System.<br>• IC or medical group communicates patient volume and acuity to base MICN ASAP (may delegate). |
| **Comm Ctr** | • Manage communications.<br>• Mobilize resources per IC request.<br>• Notify MHOAC Duty Officer of confirmed MCI.<br>• Notify Fire Operational Area Coordinator of confirmed MCI.<br>• Notify base hospital of confirmed MCI. |
| **Base** | • MICN to facilitate dispersal of casualties based on bed poll.* |

| | |
|---|---|
| | • Maintain direct communications with scene regarding incoming patient volume and acuity. |
| **EOC** | • Not likely necessary. IC may request notification if there is potential for complexity. |
| **MHOAC** | • Duty Officer to monitor. |

**While every effort shall be made to minimize impact to hospital operations through proportional distribution of priority patients, casualties should not be held on scene if transport is available.*

| Level 2 | |
|---|---|
| *Patient #* | *Description* |
| 10-20 | • Number of patients may be greater than can be handled by on-duty resources in the County Service Area (CSA).<br>• Support from neighboring CSA when geographically practical.<br>• Mutual aid may be utilized from neighboring OA through automatic or mutual aid agreements (or MOU), with potential need for regional support.<br>• Routine 911 response impacted for a significant period.<br>• Complicated patient logistics may require prolonged treatment on scene with ongoing triage/sorting. |
| Response Timeline | Recovery Timeline |
| **1 - 4 hours** | **~ 8 hours** |
| **Scene** | • IC will implement the Medical Group or Branch of the Incident Command System.<br>• Likely divisions of **Medical Branch** into **Triage**, **Treatment, Staging** and **Transport Groups.**<br>• Group positions individually assigned as personnel levels support.<br>• Depending on complexity and expansion potential, mutual aid may be utilized from neighboring OA through automatic or mutual aid agreements (or MOU), with potential need for regional support. |
| **Comm Ctr** | • Facilitate scene communications.<br>• Manage communications with relevant agency dispatch centers.<br>• Mobilize all support from within the OA, as well as mutual aid.<br>• |
| **Base** | • Base remains the control facility to the extent of capacity.<br>• MICN to direct transport units outside the OA based on bed poll.<br>• Consider opening hospital command center (HCC).<br>• Inform MHOAC of need to relinquish control to Region IV.<br>• Notify dispatch and scene of any destination changes. |
| **EOC** | • Advise EDSO Dispatch to alert on call OES Deputy and advise of situation.<br>• Standby, or “Minimal Activation” may be requested by IC or may be initiated by OES. |
| **MHOAC** | • MHOAC Duty Officer to submit Region IV flash report.<br>• Any medical/health needs that cannot be met from within the OA or MoU mutual aid, will be requested by the Duty Officer. |

| Level 3 | |
|---|---|
| *Patient #* | *Description* |
| 20-40 | • Number of patients exhausts all EMS resources in both County Service Areas, as well as all routine mutual aid sources (Folsom, Carson-Douglas, etc.)<br>• No capacity for routine 911 response without regional support. |
| Response Timeline | Recovery Timeline |
| **4 – 24 hours** | **Days** |
| **Scene** | • Notify Fire OAC for mutual aid support.<br>• Anticipate establishment of Unified Command (UC).<br>• All ICS position below IC/UC should be individually staffed.<br>• Establish single POC with responsibility for communications to Base regarding patient volume, acuity and transports pending *(Med Branch Manager or Transport Group Supervisor)*<br>• Consider options for temporary morgue, as needed. |
| **Comm Ctr** | • Facilitate scene communications. |
| **Base** | • Likely open HCC.<br>• Likely implement surge plan.<br>• Ensure liaison with MHOAC to coordinate assistance through RDMHC and State |
| **EOC** | • Potential for EOC activation (Level II or III) to support IC/UC. |
| **MHOAC** | • Remain in direct communication with region, base and others.<br>• Anticipate medical/health resource requests (e.g., ambulance strike team, etc.)<br>• Anticipate possible EOC activation. |

| Level IV: *Catastrophe* | |
|---|---|
| *Patient #* | *Description* |
| 40+<br>(Critical/Red) | • The incident is affecting all or a large part of the County, as well as other OAs.<br>• Area Command structure likely.<br>• State and/or Federal assistance likely.<br>• Patients from multiple incident scenes likely being transported to different receiving facilities, including mobile/temporary hospitals. |
| Response Timeline | Recovery Timeline |
| **Days** | **Weeks** |
| **Scene(s)** | • Multiple incident scenes with distinct command posts likely.<br>• Anticipate integration of CAL-MAT or Federal (DMAT) resources.<br>• Medical Branch Director to ensure Transport Group Supervisor is in |

| | |
|---|---|
| | communication with the correct receiving facility for each patient *(This may be dynamic!)*<br>• **Triage, Treatment, Transport** to endeavor toward *'greatest good for greatest number'* in light of the circumstances. |
| **Comm Ctr** | • Facilitate communications. |
| **Base** | • Likely hand off patient dispersal to regional control and revert to receiving hospital status.<br>• Coordinate with MHOAC and RDMHS to leverage assistance from Cal EMSA, HHSA and Federal.<br>• Prioritize continuity of operations. |
| **EOC** | • Full-scale activation.<br>• Representatives from State response agencies (CalOES, EMSA, etc.) will likely be present in the County EOC.<br>• Med/Health Branch staffed to support clinical activities on scene(s) and facilitate patient movement to definitive care.<br>• SOC activation likely |
| **MHOAC** | • Duty Officers likely staffing the EOC under Med/Health and/or Planning.<br>• Facilitate continuity of Med/Health operations in the field. |

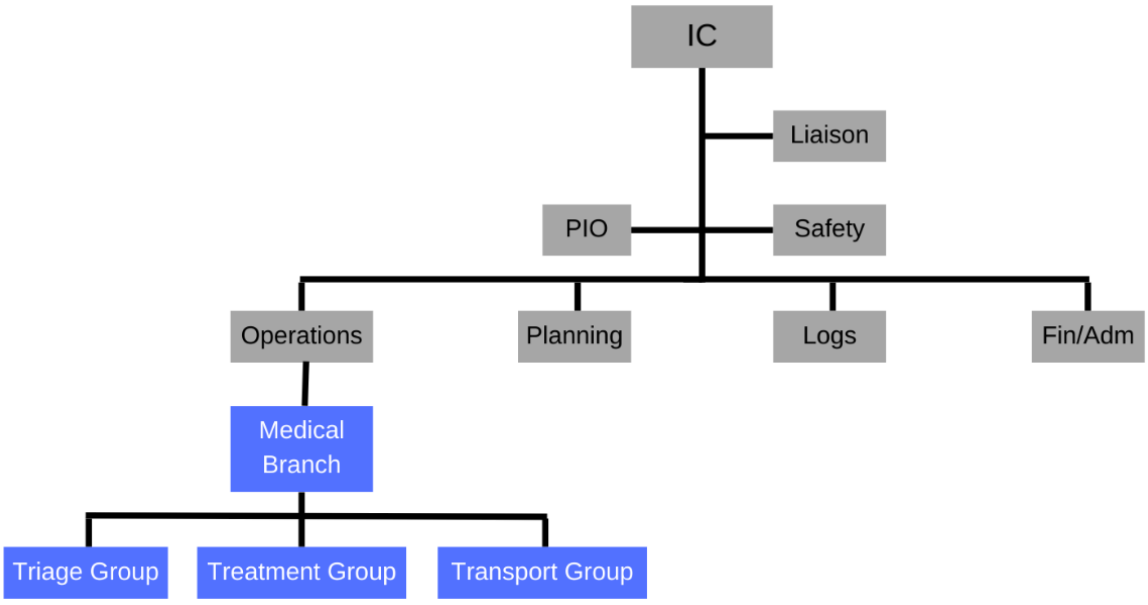
## Section 3: Medical Operations

There are three primary medical functions in an MCI:

1. **Triage**: The process of quickly assessing and categorizing patients based on a field impression of their condition. Triage helps prioritize treatment and transport efforts.
2. **Transport**: Involves the movement of patients from the incident scene to medical facilities for definitive treatment. This may include the utilization of various transportation resources such as ambulances, helicopters, or other transport vehicles as determined by the needs of the patient and resource availability.
3. **Treatment**: Involves providing medical care to patients based on their triage category, typically whilst awaiting transport. This can include immediate life-saving interventions and/or stabilization efforts.

The first arriving unit (initial IC) is responsible for all three functions until sufficient resources arrive and responsibility can be delegated. A fully expanded ICS will locate all three medical functions at the **Group** level, organized under the **Medical Branch**.

All personnel should be familiar with the ICS supervisory position titles (Section *Chief*, Branch *Director*, Group *Supervisor,* Unit *Leader,* etc.) and employ these terms consistently. Care should be taken to avoid committing transport resources to non-transport objectives. All personnel should anticipate roles changing as resource levels and functional demands on scene change.



## Triage Group

**Main Objective:** *Identify and classify victims based on their condition to ensure the allocation of treatment and transport resources by priority.*

The initial triage begins upon arrival of the first EMS resource. After ensuring scene safety, responders should size-up the incident scene, determine the approximate number of victims, communicate the MCI level to dispatch, and establish Command. **Primary Triage** should commence according to the START (adult) and JumpSTART (pediatric) algorithms. Aside from airway positioning, BLS hemorrhage control (i.e. tourniquet application), and pulse checks, medical care should be withheld until all victims have been identified and classified. Depending on the composition of the first arriving crew (2-4 personnel) and the number of 'Immediate' victims, some personnel may be assigned to treatment once Primary Triage is complete. Remaining **Triage Group** to conduct **Secondary Triage** and prepare for **morgue operations** as needed.

### Key Points:

- The IC is the Triage GS until they can either relinquish command or delegate a new Triage GS.
- IC to update dispatch on the distribution of Minor, Delayed, Immediate, and Expectant patients as soon as it's known.
- Large area incidents, or those involving decontamination, may require collection and aggregation of patients to a Casualty Clearing Station (CCS). In such cases, IC should consider ingress and egress of transport units, as well as scene hazards and environmental conditions upon initial staging, as this may impact operations later.
- 'Litter teams' or 'stretcher bearers', who move victims from their point of origin to the 'Treatment Area' should be organized under the Triage Group but should offload patients per the instruction of the Treatment Group.
- If necessary, a **Morgue Manager** should be appointed when staffing levels support.

## Transport Group

**Main Objective:** *Expeditious transportation of victims from the incident scene to an appropriate medical facility.*

For trauma victims (*the most common MCI disease process*), transportation to definitive care is the most important intervention we can deliver. As patients are identified and prioritized through triage, the Transport Group:

a) Manages communications with the control facility,
b) conducts movement of transport units to and from the scene, and
c) maintains a record of patients transported from the scene.

Ideally, these three tasks are divided amongst three **Unit Leaders** (Med-Com Unit, Ambulance Unit, Recording Unit), however, as with all ICS responsibilities, tasking will be dictated by resource availability and span of control. If Unit Leader roles must be split between two individuals, the most logical combination merges **Med-Com** and **Recording**.

### Key Points:

- Each 'unit' within the transport group may be a single coordinator or may be assisted.
- **Med-Com UL** shall relay all details about patient acuity, patient volume, and patient movement to the MICN at the control facility, as well as update the **Medical Branch Director**.
- In larger incidents where a staging area is established external to the Medical Branch, the **Ambulance UL** shall have direct communication with the **Staging Area Manager**. In the absence of a separate Staging Manager, the **Ambulance UL** should identify and communicate a staging location to prevent route congestion.
- The **Ambulance UL** will benefit from the assistance of 'Loaders' who can facilitate the movement of triaged patients to waiting ambulances.
- The **Recording UL** shall track all patient departures from the scene and verify that Med-Com has advised the control facility. Tracking may be accomplished through the maintenance of an ad-hoc register (paper), collation of triage tag 'stubs' in the receipt holder of the DMS kit, or by scanning the bar code on an incident management digital platform.
- No casualty shall be transported in an unsafe manner. If a patient cannot be properly secured and attended to en route to the hospital due to lack of space, wait for the next available unit.

## Treatment Group

**Main Objective:** *Improve victim survivability to definitive care through the delivery of appropriate medical management, prioritizing the greatest benefit for the greatest number of victims.*

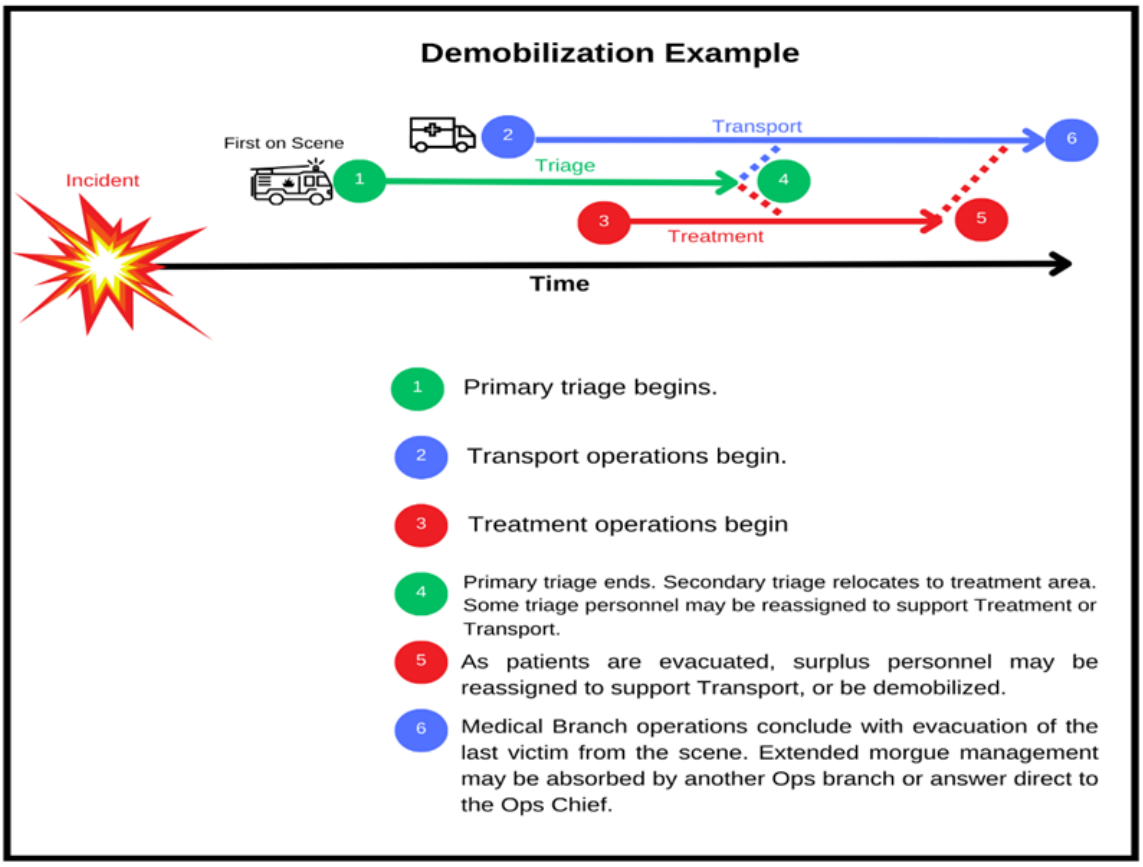
The necessity of extended treatment on scene *increases* as available transport resources *decrease*. Inversely, if transport resources are abundant and patient loading can commence without delay, formation of a Treatment Group may be unnecessary. When formed, the Treatment Group is responsible for medical interventions and extended management as patients await transport. How this function is performed will be highly dependent on scene conditions.

### Key Points:

- A tight grouping of victims who are out of danger, safely accessible by providers, and near the ambulance loading area may be best treated where they lie. If constructing a 'Treatment Area' will take time and cause unnecessary patient movement, *don't do it.*
- Victims distributed over a wide area, or who require removal from potential danger, should be moved to a 'Treatment Area' prior to treatment.
- Treatment Areas are traditionally proposed as delineated zones for Red (immediate), Yellow (delayed), and Green (minor) patients, however – the **Treatment Group Supervisor** should carefully consider the benefits/risks of any layout, also being mindful of the fact that patient condition and their resulting triage category may change. *Design a safe, provider-friendly treatment area that facilitates easy patient care and transfer.*
- Amongst the Immediate/Red category patients, those requiring basic interventions to correct imminent life threats (**BLS airway management** and **hemorrhage control)** are the top priority. *Staff your treatment area according to the level of care required, making the best use of BLS and ALS personnel.*
- The initial field triage may not have employed triage tags (ribbons or other improvised marks may have been used). When possible, utilize triage tags (or bar-coded tags) during treatment to begin a more orderly system of MCI documentation and patient tracking. *This may best be performed by reassigned **Triage Unit** personnel.*

## Mobilization to Demobilization

The IC/Med Branch Director should prepare for an orderly demobilization from the earliest stages of the response. Since triage, treatment, and transport operations are not synchronous, there are likely to be imbalances of both human and material resources between those functions at different times. Group Supervisors should resolve those imbalances by re-assigning personnel to other groups as the workload shifts.



# Section 4: Special Considerations

## Haz-Mat

**Priority:** Responder safety

**Objectives:**

- Render casualties safe to handle.
- Treat the casualties.
- Transport as required.

**Keys:**

- Toxicants may enter the body by several routes, but the most common route for **mass exposure** is **inhalation**.
- Inhaled toxicants that self-disperse over a wide area tend to be **gases** or **vapors** (*not oily, not sticky*).
- In cases of gas or vapor exposure, complex **patient decontamination is usually unnecessary**.
- Moving the casualty to fresh air and removing clothing accomplishes ~90% effective decontamination.
- **Chlorine** ($Cl^2$), **ammonia** ($NH^3$), **carbon monoxide** (CO), and **hydrogen sulfide** ($H_2S$) are the most common inhalable toxicants in industrial society. All are effectively treated with fresh air, O2, and symptomatic BLS care.

**Caution:**

- A toxicant that does not vaporize at normal temperature and pressure will not have a mass effect unless it is mechanically or explosively dispersed.
- An MCI resulting from an explosion or intentional dispersal of a toxicant is likely an industrial accident or an act of terrorism.
- In cases of Haz-Mat accidents or terrorism, EMS should remain in a rear position and be prepared to receive decontaminated patients from trained Haz-Mat responders until any affected area has been rendered safe.

## Active Threats

**Priority:** Responder Safety

**Objectives:**

- Make access to casualties as quickly as safety permits.
- Address resolvable life threats.
- Transport ASAP

**Keys:**

- Anticipate incorporation into a multi-disciplinary Rescuse Task Force.
- Coordinate all actions with law enforcement and proceed only after they've cleared EMS to enter.
- Employ the correct PPE based on the nature of the threat.
- Think about egress before making ingress (pre-identify your options).

## Crime Scenes and Evidence

**Priority:** Safety and Patient Care

**Objectives:**

- All clinical objectives remain primary
- Scene preservation

Keys:

- Be mindful of the scene's integrity and avoid disturbing potential evidence unnecessarily. (*Use your best judgment to determine what may be evidence*).
- When possible, utilize a single entry and exit corridor between the affected scene and any established treatment or ambulance loading areas.
- If you must disturb evidence in the course of rendering care, communicate the activity through your reporting line and document your actions thoroughly.

## Section 5: Position Task Sheets

| Role: | Medical Branch Director |
|---|---|
| Answers to: | Operations Section Chief |
| Directs: | Triage Group Supervisor<br>Treatment Group Supervisor<br>Transport Group Supervisor |
| Responsibilities: | • Work closely with IC/OSC to implement overall medical response strategies and objectives.<br>• Liaise with other Ops branches as needed.<br>• Ensure smooth integration of medical operations into the overall incident response.<br>• Provide strategic guidance and direction to subordinate group supervisors to ensure alignment with incident priorities.<br>• Receive and process information from within the medical branch, for dissemination outside the branch - *and vice versa*.<br>• Ensure group supervisors have everything they need to meet their objectives. |

| Role: | Triage Group Supervisor |
|---|---|
| Answers to: | Medical Branch Director |
| Supervises: | Triage Personnel<br><br>Stretcher Bearers<br><br>Morgue Unit Leader |
| Responsibilities: | • Personal safety, as well as that of all group personnel.<br>• Communicate with the Medical Branch Director to understand the overall strategy and ensure triage operations align.<br>• Regularly report the status of triage operations to the Medical Branch Director.<br>• Cooperate with Transport and Treatment Group Supervisors to optimize branch functions.<br>• Ensure clarity of roles and tasks for those working under the triage group.<br>• Oversee the triage process in its entirety, to quickly identify and correct bottlenecks or inefficiencies.<br>• Ensure triage personnel correctly utilize the adopted triage modality (START/jumpSTART), as well as any organizational tools associated with that modality (i.e. DMS kit, triage tags, etc.)<br>• Direct stretcher bearers in the process of transporting casualties from their point of origin to secondary triage and/or treatment areas.<br>• Coordinate with the morgue unit leader to establish procedures for handling the deceased.<br>• Anticipate changes in patient flow or resource availability and adjust operations accordingly. |

| Role: | Transport Group Supervisor |
|---|---|
| Answers to: | Medical Branch Director |
| Supervises: | Med-Com Unit Leader<br>Ambulance Unit Leader<br>Recording Unit Leader |
| Responsibilities: | • Personal safety, as well as that of all group personnel.<br>• Communicate with the Medical Branch Director to understand the overall strategy and ensure transport operations align.<br>• Regularly report the status of transport operations to the Medical Branch Director.<br>• Cooperate with Triage and Treatment Group Supervisors to optimize branch functions.<br>• Ensure the transportation of patients from the incident scene to receiving medical facilities.<br>• Ensure clear communication between the Ambulance Unit and any off-site Staging Area Manager, if utilized.<br>• If no staging area manager is assigned, determine the best location for transport units to stage prior to being called forth by the Ambulance Unit Leader.<br>• Ensure Med-Comms Unit Leader is in communication with the base MICN, and is prepared to direct transporting units to the proper destination.<br>• Ensure Recording Unit Leader is tracking all departures from the incident scene.<br>• Maintain ultimate responsibility for the secure packaging of all casualties transported from the scene.<br>• Anticipate changes in patient volume or transport needs and adjust staffing and resources accordingly. |

| Role: | Treatment Group Supervisor |
|---|---|
| Answers to: | Medical Branch Director |
| Supervises: | Immediate Unit Leader<br>Delayed Unit Leader<br>Minor Unit Leader<br>Supply Unit Leader |
| Responsibilities: | • Personal safety, as well as that of all group personnel.<br>• Communicate with the Medical Branch Director to understand the overall strategy and ensure treatment operations align.<br>• Regularly report the status of treatment operations to the Medical Branch Director.<br>• Cooperate with Triage and Transport Group Supervisors to optimize branch functions.<br>• Oversee clinical operations in Immediate (Red), Delayed (Yellow), and Minor (Green) treatment areas if established.<br>• Allocate resources effectively, considering the number and acuity of casualties in each category.<br>• Facilitate the rapid fulfillment of treatment supply needs (such as medical consumables) through the direction of the Supply Unit Leader.<br>• Anticipate changes in patient flow or resource availability and adjust operations accordingly. |

| Role: | Triage Personnel |
|---|---|
| Answers to: | Triage Group Supervisor |
| Responsibilities: | • Personal safety<br><u>In assigned area of responsibility/affected zone:</u><br>• Observe and note scene hazards.<br>• Relay need for specialty rescue (i.e. HAZMAT, high-angle, trench, water, etc.) if indicated.<br>• **Locate all casualties.**<br>• **Classify all casualties according to START or jumpSTART workflow.**<br>  ○ *Use the best triage tagging method rapidly deployable.*<br>• Relay information about casualties and acuity distribution to Triage GS.<br>• Assist stretcher bearers in prioritizing and performing evacuation.<br><u>Prior to patient transport (in Treatment Area):</u><br>• Communicate with treatment, transport, and other triage personnel.<br>• Perform Secondary Triage.<br>• Facilitate relocation of casualties based on updated triage category.<br>• Incorporate standard triage tags or electronic tracking as soon as possible.<br>• Anticipate reassignment. |

| Role: | Stretcher Bearer |
|---|---|
| Answers to: | Triage Group Supervisor |
| Responsibilities: | • Personal safety<br>In cooperation with partners and triage personnel:<br>• Approach casualty on direction of triage personnel.<br>• Using appropriate tools, package casualty with due regard for airway maintenance and the principle of 'Do no harm'.<br>• Transfer casualty as safely as possible, from their point of origin to the receiving point established at the time (*treatment area or ambulance loading area*).<br>• Off-load casualties to the location indicated by triage category, or according to the instructions of the GS.<br>• Repeat until reassigned. |

| Role: | Morgue Unit Leader |
|---|---|
| Answers to: | Triage Group Supervisor |
| Responsibilities: | • Personal safety<br><br>In cooperation with Triage GS:<br>• Determine a location and establish the temporary morgue site, with due regard for functionality as well as minimizing public view if possible.<br>• Ensure the respectful handling and processing of deceased individuals, making efforts to respect privacy and keep personal belongings co-located with decedents.<br>• Prepare for transfer of morgue operations to coroner appointee. |

| Role: | Medical Communications Unit Leader (Med-Comm) |
|---|---|
| Answers to: | Transport Group Supervisor |
| Responsibilities: | • Personal safety<br>• Primary point of communication from the incident to the base/control facility.<br>• Liaise with base MICN to convey initial casualty count and acuity distribution *(How many red? How many yellow? etc.)*<br>• In cooperation with base MICN, and pursuant to MCI bed polling, determine the best destinations for the casualties awaiting transport.<br>• Liaise with Ambulance Unit Leader to confirm destinations of units departing the scene.<br>• Liaise with Recording Unit Leader for patient tracking information.<br>• Regularly update base and Transport Group Supervisor regarding changes on scene. |

| Role: | Ambulance Unit Leader/Marshal |
|---|---|
| Answers to: | Transport Group Supervisor |
| Supervises: | Loaders |
| Responsibilities: | • Personal safety<br>• Oversight of all activities in the casualty loading area, including safe loading and appropriate provider/casualty ratio in the transport unit *(No unsecured patients, no overwhelmed providers)*<br>• Verifies patients are prioritized for transportation *(triage tags or electronic register).*<br>• Summons staged (or en route) ambulances to the loading area.<br>• Liaise with MedComm to confirm proper destination for all casualties departing the scene.<br>• Liaise with Recording Unit Leader to ensure accurate records of all casualties, transport units, and destinations. |

| Role: | Loader |
|---|---|
| Answers to: | Transport Group Supervisor |
| Responsibilities: | • Personal safety<br>• Assist with the safe packaging and loading of casualties into waiting ambulances.<br>• Communicate with Recording UL as needed. |

| Role: | MICN |
|---|---|
| Answers to: | Control Facility Supervisor |
| Responsibilities: | • Consider size and nature of incident and call in additional resources.<br>• Establish Med-net / cell phone communications with Med-Comm.<br>• Assigned MICN will remain dedicated to the incident, radio/phone until all patients are dispersed from scene.<br>• Activate MCI bed Polling and coordinate with Med-Comm for patient dispersal.<br>• Contact receiving facilities with notification of patients dispersed to them<br>• Document event and complete all necessary forms. |

## Section 6: Service Area Amendments

The two El Dorado County Service Areas, CSA #3 (East Slope) and CSA #7 (West Slope), differ with regard to population density, topography, climate and responder agency composition among others.

| | East Slope | West Slope |
|---|---|---|
| **Base/Control Facility:** | Barton Memorial Hospital | Marshall Medical Center |
| **Transport Provider(s):** | Cal Tahoe JPA<br>Lake Valley FPD | EDC Emergency Services Authority |
| **ALS First Response:** | • City of South Lake Tahoe FD<br>• Lake Valley FPD | • Cal Fire-Cameron Park<br>• El Dorado County FPD<br>• El Dorado Hills FD<br>• Garden Valley FPD<br>• Georgetown FPD<br>• Rescue FPD<br>• Diamond Springs FD |
| **Ops Oversight:** | • CQI Committee | • EMSOC |
| **Dispatch:** | City of South Lake Tahoe | Cal Fire – Emergency Command Center |
| **Nearest Mutual Aid:** | Carson-Douglas, Nevada | Folsom/Sacramento |

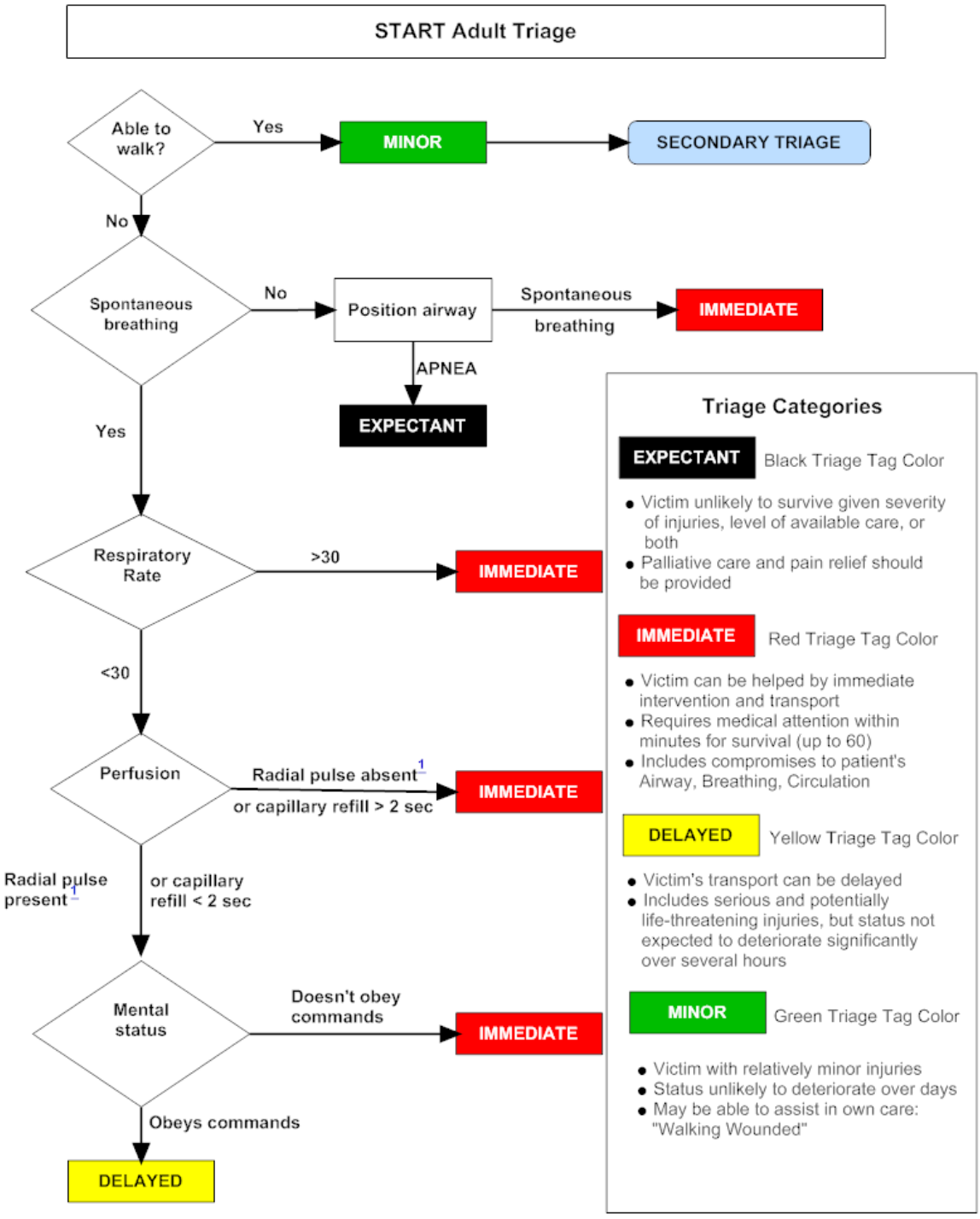
The minimal procedural specificity of this document yields to the distinct operational character of the two CSAs and the unique needs of both stakeholder groups.

Each CSA is afforded the opportunity to amend this document with specific tactics, procedures, and other arrangements as may be agreed upon by them.

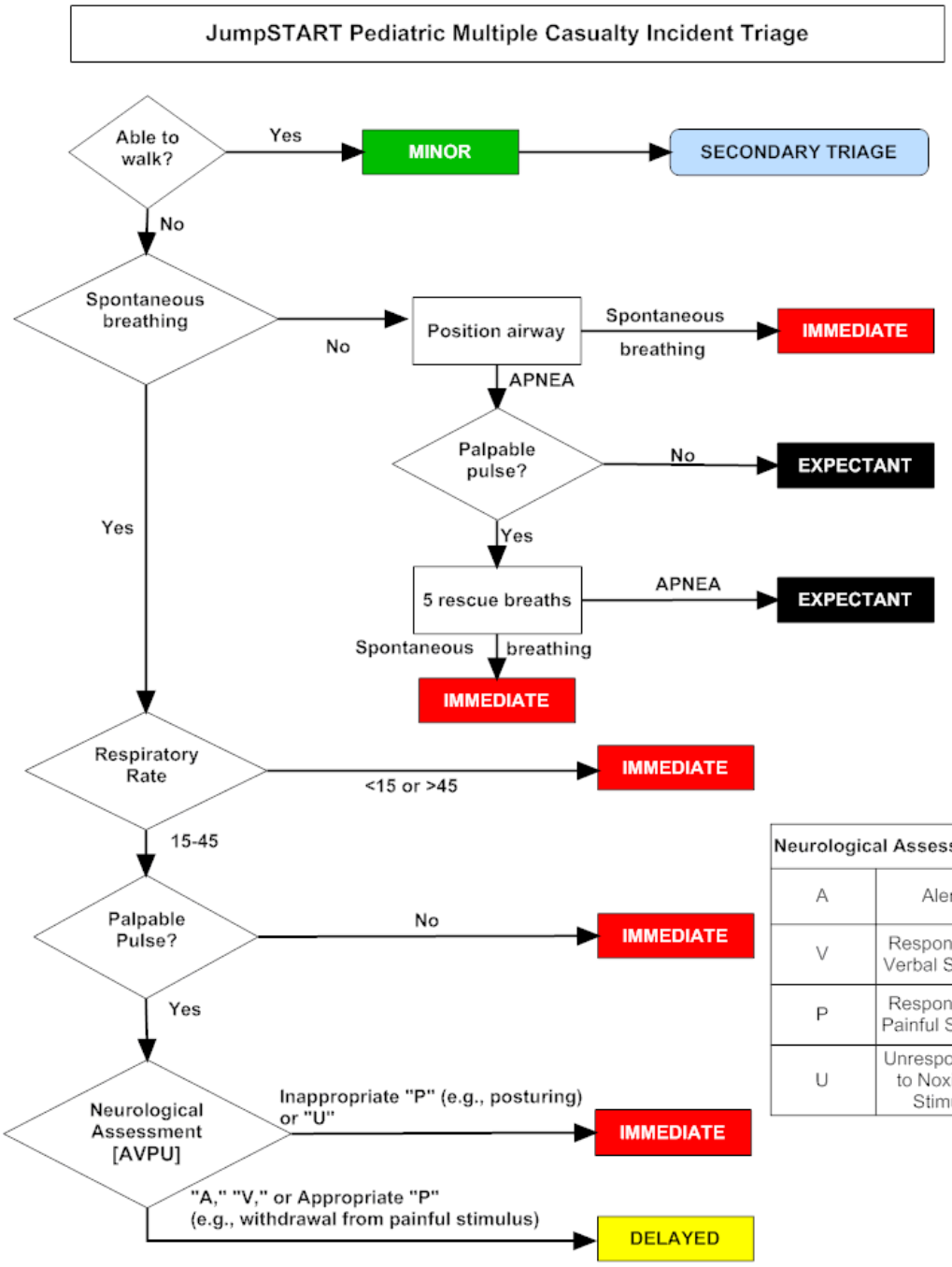
The **EMSOC** (West Slope) and **CQI Committee** (East Slope), or any MCI subcommittees thereby appointed, may prescribe tactical policy directives applicable to their service area through consensus. Once agreed upon, those directives will be presented to the MAC and, upon approval of the EMS Medical Director, will be amended to this plan.

# Annexes

## Annex 1



## Annex 2




| Neurological Assessment | |
|---|---|
| A | Alert |
| V | Responds to Verbal Stimuli |
| P | Responds to Painful Stimuli |
| U | Unresponsive to Noxious Stimuli |

Use JumpSTART if the Patient appears to be a child.

Use an adult system, such as START, if the patient appears to be a young adult.