

Mass Casualty Incident Management

A practical approach to solving complex operational dilemmas

A.J. Heightman, MPA, EMT-P

BIOGRAPHY

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A.J. Heightman, MPA, EMT-P, is best known as the Editor-in-Chief of *JEMS*, the Journal of Emergency Medical Services. He is also Editorial Director for all Elsevier Public Safety publications including: *JEMS*, Fire-Rescue Magazine, Law Officer Magazine, APCO's Public Safety Communications Magazine and the *EMS Insider* newsletter.

A.J. has served as a Vice President of JEMS Communications, Director of the Emergency Care Information Center and Director of the JEMS Conference Division. Prior to joining the staff of Jems in 1995, A.J. served as Director of Operations for Cetronia Ambulance in Allentown, Pennsylvania from 1992-1995.

For seventeen years, A.J. was the Executive Director of the Eastern Pennsylvania Emergency Medical Services Council and the regional MEDCOM Advanced Medical Communications System (1975-1992). The Eastern Pennsylvania regional EMS System is one of the most advanced multi-county EMS systems in the country. The system is comprised of 150 BLS and ALS services; 17 acute care hospitals; two regional Trauma Centers; two pre-hospital helicopters system and advanced medical communications center serving a population of 1.2 million residents. During A.J.'s tenure at Eastern PA EMS, over 11 million dollars in State, Federal and Local funds were obtained to develop and expand the EMS System.

He also served as a Paramedic and Command Officer for Bethlehem Township Volunteer Fire Department for 20 years, a combination volunteer/paid department that offers multi-jurisdictional BLS/ALS/Rescue service throughout Northampton County, PA. While at Bethlehem Township, A.J. helped develop and supervise the "Medic-1 Paramedic Response System", which provided ALS service to 11 urban, suburban and rural municipalities.

A.J. is a graduate of Temple University and received his Masters Degree in Public Administration from Lehigh University. A certified EMS and rescue instructor, A.J. has served on the faculty of university EMS degree programs; community college emergency service training divisions and fire academies. Nationally recognized for his unique teaching style and audio-visual programs, A.J. was one of the original participants in the National Disaster Life Support program and has studied and specializes in the instruction of techniques designed for the efficient management of Mass Casualty Incidents.

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A practical approach to solving complex operational dilemmas

Presented by

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Jems Communications

OVERALL PROGRAM OBJECTIVE

At the completion of this Mass Casualty Incident Management Program, participants will understand the basic principles and procedures for the successful management of Mass Casualty Incidents (MCIs).

SPECIFIC OBJECTIVES

1. Provide participants with factual and graphic information and examples of how to manage and function cooperatively at actual, or potential, Mass Casualty Incidents of any size or scope.
2. Review problems encountered at actual MCI scenes, along with steps which can be taken by individuals and organizations to correct on-scene system errors or deficiencies and improve their overall management of MCI scenes.
3. Provide participants with course materials and handouts designed for their use in the on-going education of their personnel about MCI management.
4. Enable participants to feel more comfortable in their knowledge and ability to function in an EMS command or participatory role at any size incident.

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PREPARING TO HANDLE MASS CASUALTY INCIDENTS

Basic Issues

1. "DISASTER Management" is not a good description for the planning and daily operational procedures that must be followed to be ready to handle Mass (Multiple) Casualty Incidents on a daily basis. (In reality, any incident can become a "disaster" if not handled appropriately.)
2. In reality, a "*Mass Casualty Incident*" is simply any incident where you are confronted with more than one patient and your personnel or equipment resources are taxed beyond normal capacities. What at first appears to be "only an auto accident" often turns out to be a small Mass Casualty Incident (MCI) that needs many of the same functional elements and sectors utilized at a major incident.

*"We know it's going to happen
We just don't know when..."*

3. There is a terrible misconception that we only implement MCI tactics and procedures at "the BIG ONE". This is how "*EMS CLUSTERS*" are formed!
4. Personnel involved in the delivery of emergency services are a strange breed of cat. We challenge ourselves to the "max", often to save the lives of individuals who are either not aware of the seriousness of their condition, or unresponsive and unaware of our presence. We must always act, regardless of the chaos that is presented, based upon our knowledge and good judgment, taking whatever action will most impact the welfare of our patients.
5. Emergency personnel train constantly and will carry out any rational assignment given to them. They usually do not mind constructive criticism. However, you cannot criticize personnel for not doing things for which they have not been trained. Many people become frustrated at Mass Casualty Incidents because they have never been taught techniques to expedite the treatment and transport of multiple victims. They learn (often too late) that the principles of incident command, communications and control must be utilized at Mass Casualty Incidents must be practiced on a daily basis and be an extension of their standard operating procedures!

Preparing Personnel for Triage and its Aftermath

1. Decisions made at MCIs must be based upon what is in the best interest of the majority of the group injured in the incident. You must work to save as many lives as possible with the limited resources available to you, understanding that it may be impossible to save them all.

- Construction Companies
- Communications Centers
- Emergency Management Officials
- Hospital Emergency Department & Administrative Officials
- Local / County Government Officials
- School Transportation Officials
- School Administrators
- Coroners and Funeral Service Representatives
- American Red Cross Officials
- Medical Helicopter Services
- News Media Representatives
- Evacuation Center Coordinators
- Critical Incident Stress Management Team Leaders
- Airport Public Safety and Administration Representatives
- Fire-Police Officers
- Ham Radio Group Representatives

Essential Elements of a Mass Casualty Incident Plan

1. A pre-determined dispatch and response plan specifically designed for multiple levels of MCI response. (ie. Level 1,2,3) See Appendix 1
2. "Escalation" procedures built into the MCI response plans which are easily understood and utilized. (See Appendix 1)
3. Built-in flexibility that allows on-scene Command personnel to meet MCI scene requirements (ie. The need for fewer or additional units)
4. An organized command, control, communications, triage, staging, rehab and evaluation system which is utilized on a daily basis.
5. Just enough details to be functional and easily remembered.
6. Flexibility built into daily operating procedures to allow for their use at MCI scenes with just slight adjustments being made.
7. Training and day-to-day incident critiques offered to insure that ALL emergency response personnel are familiar and comfortable with the requirements of the MCI operational SOPs. (They have to believe in it !)

STANDARDIZED ITEMS FOR MCI SUCCESS

1. Written MCI Standard Operating Procedures (See **SAMPLES - Appendix 2**);
2. **TRIAGE TAGS** and other MCI items that can be used on any size and type of incident; (**Samples provided**);
3. Abbreviated MCI SOP and Triage details available on visor / clipboard decals;
4. Standard Emergency Scene Access Tags to control personnel access (**See Appendix 3**);
5. Standard MCI Operational Checklists for use by key scene management and communications center personnel (**See Appendix 4**);
6. Standard "Transportation Officer - Patient Status Sheets" to insure the proper distribution and tracking of all patients (**See Appendix 5**);
7. Small bicycle safety cones (\$1.00 each) to allow personnel to delineate on-scene "Cattle-Chutes", specific patient flow patterns, and restricted areas;
8. Cyalume (30 minute) High Intensity color-coded light sticks.

MANAGING SCENE HAZARDS

1. "Hazardous Materials" such as aviation fuel; chemicals; sharp metal and other scene debris; and exposure to AIDS and Hepatitis, must be on the minds of all personnel involved in any mass casualty incident.
2. "TUNNEL VISION" will often cause emergency personnel to walk through debris such as glass, metal and battery acid because they become overwhelmed by the sheer devastation that is before them.
3. At least one SAFETY OFFICER must be in operation *at any complicated emergency scene* to ensure that personnel are properly dressed and taking all appropriate precautions.
4. The odds of 1 out of 150 passengers on a crashed commercial passenger jet having an infectious disease such as Hepatitis or AIDS are high. These incidents, with all their associated blood and body fluid "debris", must be treated like Medical "Haz Mat" scenes.
5. "All-in-one" Tyvek coverall suits (coverall-hood-booties) can be rapidly donned for maximum protection with minimal effort at any messy scene. Teams should be properly dressed and briefed before packaging deceased victims at any incident where exposure risks are greatly increased.

SAFETY OFFICER

1. A Safety Officer should be deployed at all scenes involving hazards, complicated operations, or multiple units. The Safety Officer should utilize a pre-planned checklist to ensure important safety parameters are implemented and monitored.
2. Safety Officers are responsible for making sure:
 - Proper protective clothing is being worn
 - Restricted or "HOT" zones are established and policed
 - Tired personnel are sent to "REHAB" (Has direct authority to do so)
 - Safe operations are underway and unsafe operations are corrected
 - EMS personnel do not enter hazardous areas unprotected or alone
 - Patients are properly covered during extrication
 - Ground hazards are removed, marked, or neutralized (eg. Unused tools; loose air hoses; holes in the ground...)
 - Adequate lighting (and heat for patients) is available
3. Personnel should be "staged" or "pooled together" if not yet needed:
 - If no direction or commands are given to on-scene personnel, unassigned personnel will find "something to do" or move to a "lookout" area, which is often too close to a hazardous scene.
 - Safety Zones and "HOT areas" must be established. When something breaks loose or goes wrong, a common reaction is for individuals to "run in the opposite direction". This may be in the direction of downed power lines or other hazard.

MANAGEMENT OF EMOTIONS

1. Enroute to, and after arriving at the scene of an MCI, the emotions of all personnel have to be kept under control.
2. An inexpensive hand-held Public Address System can be worth its weight in gold to assist in managing crowds and emotions at a chaotic scene.

*"The most authoritative voice
often commands the most attention"*

3. The news media, off-duty personnel, members of the general public, and all other "unofficial" personnel at the scene of your incident must be identified and controlled throughout their activities at the scene. You can gain control of the scene early and restrict unauthorized access by:
 - Using Scene Access Tags or other appropriate system;
 - Deploying scene tape as early as possible. (Bystanders can be "drafted" for this job to free up other personnel.);
 - Tagging individuals who are "emotionally out-of-control" as *Priority 1* and having them transported away from the scene as rapidly as possible. This could be via Police or other secure / safe / controlled means.

REMEMBER: Emotions can be contagious!

4. The action taken in the first 5 minutes after arrival at a major scene most often determines the overall outcome and success of the operation.

***"MURPHY" is on ALL CALLS with us.
We are the ones who determine how much trouble he gets into!***

SCENE REPORTS ARE ESSENTIAL

1. You must describe the basic facts known to you as soon as you arrive on the scene - to allow communications centers, hospital facilities, and incoming units maximum time to prepare to deal with the incident.

Example: "Ambulance 247 is on-scene, this is a car vs. a 40 passenger School Bus, moderate damage to both vehicles, no apparent entrapment, but we have one fatality and 8 patients. Dispatch a Level 1 response to this scene. EMS Command is in place at the southeast corner of 5th and Walnut Streets."

2. Before you call in your initial on-scene report:
 - View as much of the scene as possible within 30 seconds of your arrival;
 - Process initial comments and any "panic sensations" or comments presented to you immediately upon your arrival at the scene;
 - Process your thoughts into a logical order;

- Think about what needs to be said and how it can be conveyed in as few words as possible to limit air time (Jot down brief notes if time permits)
 - Say to yourself "Relax and don't say anything stupid";
 - Think about how your transmissions will be interpreted before you speak. (Remember, "*Send me everything you've got*" is a frightening panic phrase!)
 - Present your report in a manner that paints a quick picture for the person to whom you are communicating
3. You need to announce an MCI "level" (even if you are not requesting a specific MCI level *response*) so all responding agencies and personnel know the approximate patient volume being presented.

*"Your first five (5) minutes of action
will determine your final outcome"*

COMMAND

Who is in Charge? Whose Territory is it? Who is Responsible?

"PRIMARY FOCUS INCIDENT COMMAND"

1. In reality, each agency (EMS, Police, Fire, Rescue, HazMat, Coroner's Office...) is "in charge" of certain aspects at a large scene. Therefore, arguments over who is in charge at a scene should not be occurring.
2. What many people forget is that no two scenes are alike. Therefore, we have to be aware of this and adapt the Command responsibilities to fit the incident at which we are operating.

On-scene arguments and "power struggles" are most often a direct result of a poorly defined and poorly pre-planned Command and on-scene organizational structure

1. The agency with the most knowledge and required involvement at the incident should assume the "PRIMARY FOCUS COMMAND" and appoint an Incident Commander to direct and coordinate the scene.

EXAMPLES OF FOCUSED COMMAND

Structure Fires = Primary Incident Command responsibility will be assumed by the Fire Service. Therefore, a Fire Officer will be the Primary Focus of the Command underway at the Incident. EMS and Law Enforcement Agencies will establish their essential and precautionary sectors, and provide support to the Fire Service as necessary.

Hostage Situations = Primary Incident Command responsibility will be assumed by the Law Enforcement Agency of jurisdiction. A Law Enforcement Official will be the Primary Focus of the command underway at the Incident. EMS and the fire service will establish their essential and precautionary sectors, and provide support to the Law Enforcement Agency as necessary.

Mass Casualty Calls = Primary Incident Command responsibility will be assumed by an EMS Agency. An EMS Officer will be the Primary Focus of the Command underway at the Incident. Fire Service and Law Enforcement Agencies will establish both their essential and precautionary sectors, and provide support to the fire service as necessary.

2. All command personnel need at least one ASSISTANT to help keep them "on-track" and avoid becoming "behind" (or lost) in answering radio transmissions or completing necessary tasks and communications.

IDENTIFICATION OF COMMAND PERSONNEL

1. On-scene personnel will not be aware of individuals in charge of important functions if they cannot identify each commander's area of authority. Remember that EMS personnel, fire officers and police officers often dress identical, making it difficult, if not impossible, to differentiate training levels, rank, or scene command responsibilities.

***Identifiable vests of distinctly different colors
must be utilized early at all MCI scenes.***

COLOR-CODING COMMAND PERSONNEL IS ESSENTIAL

PROBLEMS CAUSED BY IDENTICALLY COLORED VESTS

- Identical colored items cannot be differentiated at a distance
- It is almost impossible to differentiate between EMT and Paramedic uniforms (You must be able to rapidly identify and ALS personnel)

VEST SOLUTIONS:

- Solid-colored Football Scrimmage Vests can be silk-screened with the appropriate command titles (cheap and effective)
- Solid-colored Mesh Vests can be obtained from various suppliers.

TIP: Have a radio pocket sewn on each command vest along with a tab on which to hook a speaker microphone.

USE OF CYALUME Light Sticks

CYALUME light sticks (30 min - High Intensity type) offer great method for easy identification of key personnel during night operations. (Tape a RED one on the helmet of the Triage Officer; BLUE on the helmet of the EMS Commander; GREEN on the Transportation Officer...)

ASSIGNMENT SHEETS / CHECKLISTS ARE INVALUABLE

Each sector officer, and any other key areas assigned on-scene or off-site responsibilities, needs to have an assignment sheet/checklist which lists all

important set-up and operational assignments. These assignments should be presented in priority order wherever applicable.

Reasons why assignment sheets/checklists are invaluable include:

- Important items are listed in sequential or priority order;
- Checklists serve as "memory joggers" (eg. Request for coroner);
- Help orient anyone who has never functioned in a key role;
- They serve as a means to insure that requested actions were handled (if we can forget, so too can our Communications Center);
- A good way to review what actions have been carried out;
- An excellent way to begin critique preparations and post-incident actions.

EMS COMMAND OFFICER RESPONSIBILITIES

THE EMS COMMAND OFFICER (Blue Vest) ROLE

1. The on-scene EMS "*Air Traffic Controller*" throughout the incident
2. EMS resource manager
3. "Coach of the team" & "cheerleader"

ACTIONS FOR THE FIRST FIVE (5) MINUTES OF SCENE OPERATIONS

1. Present early scene reports and request an MCI response, if necessary;
2. Position at, or transmit the exact location of, the Command Post;
3. Provide a clear and concise INITIAL EMS SCENE REPORT to COMM Center;
4. Wear the BLUE EMS Officer vest or other means of identification;
5. Obtain a dedicated radio frequency to coordinate responding EMS Units;
6. Advise the comm center of EMS Unit approach routes and Staging areas;
7. Have "near" hospitals notified early about the scope of the incident;
8. Transmit the location of the "Equipment Stockpile Area" to incoming units;
9. Transmit the location of the "Patient Loading Sector"

ADDITIONAL RESPONSIBILITIES

1. Activates early call-out and/or deployment of emergency personnel, by necessary functions.

2. Provides on-going reports and updates to Incident Commander, other Command Officers and involved Communications Centers.
3. Requests key agencies for assistance (eg. Emergency Management Agencies; American Red Cross; Coroner's Office; Bus Companies; neighboring Police Agencies for traffic route clearance or positioning to direct ambulances to hospital facilities)
4. Escalates or reduces the Mass Casualty Incident "Level", as necessary.

COMMUNICATIONS

PORTABLE RADIO FACTS

1. Restricted to a limited range, unless repeaters are being utilized.
2. Limited battery life (You need to have spare batteries available).
3. You can utilize "*Talk-Around*" capabilities on any repeated frequency to establish a "private" (simplex) radio link to all Command personnel.

REMOTE SPEAKER / MICROPHONES and HEADSETS

1. Invaluable tools in a high-noise environment.
2. Puts the speaker / microphone near your ear where it can be heard and accessed optimally in a noisy and confusion-filled environment.
NOTE: A radio stuck in your back pocket will send radio messages in the wrong direction.
(Also known as "BUTT DEFLECTION")
3. Free up your hands to allow you to hold and write on a clipboard.
4. Headsets focus sound and maintain the attention of scene commanders.

VEHICULAR REPEATER SYSTEMS

Allow 5 watt portable radios to have 100 watts of power and expanded range capability. (Modification cost: \$1,500 per vehicle)

PORTABLE PA SYSTEMS, HORNS, ALERT TONES and WHISTLES

Rapidly command attention and assist commanders in providing direction and getting work accomplished quickly.

DIGITAL / CELLULAR PHONES, COMPUTERS and FAXES

1. Helpful tools / multiple uses (Use in place of busy radio channels).
2. Watch for "Cell lock-up" during large incidents when everyone, especially the news Media, is using their digital/cellular phone.
3. Evacuation Zones can be computer generated or faxed directly to a scene.
4. Computers can be used on site for entry or use of data (eg. Track evacuees, process evacuation zones, log actions or retrieve assignments/priorities, identify hazards, check available resources...)

USE OF "RUNNERS" AND ASSISTANTS ("RADAR")

1. No commander can function optimally without at least one (1) good assistant ("*Radar*"). This is one of the most important keys to success at any MCI scene.
Watch and learn from past episodes of "MASH" just how important "RADAR" was to the success of Colonel Potter in conducting efficient operations in a chaotic environment.
2. Use "RUNNERS" to send messages to other areas on the scene of an incident instead of competing for airtime on over-crowded radio frequencies.

COMMAND POST INFORMATION

1. A Command Post (CP) serves as a focal point and "hub" of all operations:
2. Identify only one (1) area as the central Command Post (CP)
3. Specialty Command Posts are functional, but an investment \$\$\$.
4. It is optimal if the Command Post has noise and environmental controls.
5. Best if the CP has the capability of viewing the scene directly.
6. Command Cabs and designated space in Rescue Units - can be effective.
7. Simple "Fold down" desks/shelves mounted in a vehicle are inexpensive and very functional.
8. Consider use of the EMS "Command Ambulance":
 - It's already committed to the scene and stripped of it's equipment;
 - It offers good lighting, heating and cooling capabilities;
 - Most often - good visibility from existing windows;
 - You can easily add headsets to existing radio control heads (They reduce noise and focus attention) Headsets at multiple positions are helpful;
 - A stretcher adjusted to a low-level position, with a backboard on top, can serve as a desk/writing surface;
 - A GREEN LIGHT can be added inexpensively.

9. The use of the color **GREEN** stands out better than other colors:
 - **Green Light** - Stands out better at night scenes
 - **Green Flag** - Stands out better during daylight operations
 (Suggestion: Use BOTH and cover all bases)
10. Without a joint Command Post or clear and direct communications, we often suffer from "Whisper-Down-The-Alley" Syndrome.
(*Relayed* communications are often misinterpreted or relayed incorrectly)
11. Personnel must be aware of the "Chain-of-Command" and procedures to be followed when transferring command responsibilities, so we do not compromise scene operations or actions already underway.

TRIAGE OFFICER

Despite the urgent need for triage and treatment action, at large scenes it is important for the Triage Officer to put on the RED VEST or identification item immediately.

TIP: "Assistants" can wear Red Vests turned inside out, so their vests do not show *Triage Officer*, but they are viewed as a part of the Triage Team.

TRIAGE OFFICER RESPONSIBILITIES

1. Triage can be managed utilizing more than one approach:
 - ◆ SMALL scene = one person may be able to "DO IT ALL"
 - ◆ LARGE scene = "TRIAGE MANAGER" must oversee the Triage functions:
2. Appoints multiple Triage Assistants (If necessary) and assigns areas/supplies.
3. Assigns the Triage Assistants to perform Triage in a specific sector and provide a report back to the Triage Officer of the number of patients triaged and basic assessment of overall patient severity - as soon as possible
4. In all cases, the Triage Officer must make sure a primary patient scan is carried out rapidly on all patients.
5. Makes sure only critical "ABC" care is rendered during initial triage.

***"At an MCI, CPR becomes a judgment call -
based upon the number and severity of casualties present -
and the number of EMS Providers and transport vehicles available"***

6. Serves as the on-scene EMS PERSONNEL MANAGER.
7. Oversees the Triage and Treatment Areas throughout the Incident
8. Assigns personnel to manage, and remain at, each individual Treatment Area. (RED / YELLOW / GREEN treatment sectors) Makes sure there is an ALS emphasis in Priority Areas 1&2 initially.)
9. Continues to assign EMS personnel to patient care tasks until patient demands are met.
10. Assigns personnel to manage, and remain at, the Temporary Morgue Area. (BLACK sector)
11. Insures there is constant re-evaluation and "re-Triaging" of all patients.
 - ◆ Initially (First Triage);
 - ◆ At the Patient Treatment / Collection Areas;
 - ◆ Whenever someone reports a change in a patient's condition;
 - ◆ Immediately prior to the patient's departure from the scene
12. Works with the Transportation Officer to insure the rapid removal of all patients from the scene on a priority basis. (Sends people to the "on-deck" transportation or "departure" area, but does not get heavily involved in the actual transportation functions.)

TRANSPORTATION OFFICER

INTRODUCTORY TRANSPORTATION OFFICER NOTES

Even at a single vehicle accident, it is routinely 10-15 minutes before the first patient is ready for transport from the scene. Therefore, the "Transportation Officer" has at least 10-15 minutes to:

- ◆ Establish Vehicle Staging Areas;
- ◆ Have Patient Collection / Treatment Areas set up and operational ;
- ◆ Create a well-defined "on-deck" area to be used as the area where patients will temporarily be placed for distribution to incoming ambulances;
- ◆ Establish the location to be used for the Equipment Stockpile Area;
- ◆ Obtain a radio channel to be used throughout the incident for Transportation Sector-to-Hospital communications.
- ◆ Establish EARLY RADIO CONTACT WITH HOSPITALS, to alert them of the scope of the incident and enable them to prepare to receive casualties.

REMEMBER - You can make a temporary "Trauma Center" out of non-Trauma Centers if you notify the non-Trauma Centers EARLY INTO THE INCIDENT and give them adequate time to mobilize staffing, operating rooms...

TRANSPORTATION OFFICER RESPONSIBILITIES

1. Responsible for establishing and insuring proper placement and staging of all EMS ground and air units.
2. Selects a "STAGING OFFICER" immediately (This could be a civilian you select to help you direct "EMS Traffic".)
3. Works in conjunction with EMS Command to make sure incoming EMS crews are clearly aware of the following:
 - Vehicle approach routes to follow;
 - Roadways or travel routes blocked or impeded by the incident;
 - Vehicle Staging and Patient Loading Areas;
 - Location of Equipment Stockpile Areas;
 - Key equipment needed from the EMS Units upon their arrival;
 - The need for drivers to stay with (or near) their vehicles.
4. Selects and sets-up Patient Collection Areas and Equipment Stockpile Areas as close to the Vehicle Loading/Staging Areas as possible. (Transportation Sector must then notify the Triage Officer as to the location of these areas)
5. "Patrols" the Transportation area like a "hungry panther", anxious to have patients removed from the scene - as fast as possible - with critical patients transported first, whenever possible.
6. Stays out of the actual Triage / Treatment areas. He/she should have patients placed "ON-DECK" by the Triage Sector so the Transportation Officer does not get "trapped" in the confusion of the Patient Collection and Treatment Areas.

TIP: The use of Traffic cones, small bicycles cones, or lengths of fire hose to form an "ON-DECK" area helps restrict entry, "patient shopping", or "free-lancing" by on-scene personnel. They add true "definition" to the area.
7. Responsible for Patient / Crew / Ambulance / Hospital assignments.
8. Makes sure the Transport Sector is the sole contact point with receiving Hospitals or communications centers for patient reports, resolution of transportation issues, and patient distribution to hospitals. (Ambulances should not contact hospitals directly during an MCI unless their patient's condition deteriorates enroute to the hospital facility.)
9. Responsible for implementing a system for the constant distribution / charting / tracking of patients. (Patient distribution / record maintenance)
 - Ensures the Triage Tag Tracer Stub is completed for all patients;
 - Implements staff to assign patients to ambulance crews and designate to where the patient is to be transported;
 - Makes sure Tracer Stubs are being given to a Transport Assistant;
 - Ensures only one person in the sector is notifying the receiving Hospitals;

- Assign another Transportation Assistant to chart the information on the Transportation Patient Status Sheet.
 - Requests that all Hospitals provide periodic status updates as to their capability to continue receiving patients (One less headache for at-scene personnel).
10. Considers the use of portable computers at the MCI scene. They can be easily deployed to track evacuated individuals and/or injured patients. (Refer to Appendix 6)
- A database can be rapidly searched as relatives begin to show up at the scene and inquire about the "whereabouts" of their loved ones. Data searches can be carried out by name, room number, evacuation site, condition, etc.
11. Is aware that "helpful citizens" may transport patients to hospitals prior to the arrival of EMS and the impact or overload effect this will have on "Near Hospitals". (Early hospital notification of an incident will help hospitals prepare for unexpected arrivals.)
12. Ensures that ambulance crews are available to transfer patients from "Near Hospitals" to other specialty care hospitals.
- Try to have "non-involved" EMS Units perform this task since it is more valuable to return "familiar crews" to the incident scene.
13. Utilizes the more distant "Peripheral Hospitals" (> 20 minutes travel time from the scene) to receive Third Priority patients and reduce the flow / burden on "Near Hospitals". This will also reduce delays in treatment and help prevent hospital emergency departments from missing injuries due to overcrowding.
14. Considers the use of Buses to:
- Transport low priority patients to more-distant hospitals (Send along a portable radio - spare battery - EMS kit and suction unit);
 - Keep patients warm during inclement weather conditions;
 - Serve as portable on-scene facilities for briefing News Media representatives, family members, or personnel from other emergency agencies;
 - Serve as portable on-scene facilities to conduct initial Critical Incident Stress Defusings or Debriefings.
- TIP: Make prior arrangements for activation of, and payment for use of, buses. (The question is: Can you get me two buses at 2 a.m. and who will guarantee payment?)
15. Makes sure there are adequate lighting capabilities at the scene.

You cannot treat what you can't see!

16. Makes sure the entire area is searched for victims. Keep in mind that victims:
- ◆ Are often thrown a distance from the scene;
 - ◆ Often walk away in a confused state due to injuries or the overall shock of a catastrophic incident;
 - ◆ Often walk or crawl to what they perceive is the safety or assistance of a nearby home or building.

Consider the need for, and use of, dog teams and other specialty units at large scenes - especially those where the devastation is spread over a large area.

HOSPITAL ACTIONS AFTER MCI NOTIFICATION

1. Notify hospital administrators and supervisors
 2. Implement in-house Disaster / MCI plans
 3. Assign one nurse or team to remain at the hospital's EMS radio system
 4. Hold hospital staff at shift change
 5. Call in needed personnel (Extra ED Physicians, nurses, surgeons, O.R. Teams, and security personnel)
- TIP: During large MCIs, have hospitals request that physicians leaving their offices to bring along their nursing and clerical staff. They know how the physician works, and can be invaluable in assisting with care, charting, and other nursing or clerical activities.
6. Place extra EMS supplies and exchange items near the ED entrance, to expedite "turn-around" of ambulances;
 7. Deploy hospital Triage (First Encounter) personnel at the emergency department entrance to meet incoming ambulances / patients;
 8. Have Security staff clear parking areas, helipad areas, and access roads / driveways and implement their MCI/Disaster Plan traffic patterns into, and out of, the emergency department area. (NOTE: Normal ambulance approach and parking patterns may not be efficient if receiving multiple ambulances simultaneously during an MCI.)
 9. Have a team of extra physicians and nurses ready to respond to the scene, if needed or requested.
 10. Prepare extra ALS supplies to be sent back to the MCI scene on the first ambulances that arrive at their emergency department from the MCI scene.

Vital supplies that can be sent to the scene include:

- ◆ Boxes of IV Fluids - tubing - catheters
- ◆ Endotracheal tubes
- ◆ Suction catheters
- ◆ Airways - Oxygen masks & Bag-Valve-Masks
- ◆ Roller gauze and tape

VEHICLE STAGING

1. Staging is an old concept (practiced in all walks of life) which we must utilize.
2. Traffic "Grid-lock" must be avoided at and near the scene! Commanders must have this on their mind early into management of the scene.
3. "Staging" of incoming EMS units greatly reduces "log jams" and "grid lock" at or near the scene, and improves the speed, flow, and efficiency of all operations.
4. Positive results have been shown by the Fire Service through use of staging at major forest fires. It works as effectively for EMS vehicles.
5. Taxi cab operators practice "off-site" staging effectively - why don't we?
(TECHNIQUE = whistle or voice contact & "finger-display" of the # needed.)
6. First-in EMS Units often "nose-in" too close at the scene and become "trapped" at major incidents. We have to consciously work to avoid this happening. (In reality, this "beached" unit will serve as the EMS Command unit positioned at the central Command Post, and not be used for patient transport.)
7. If Command personnel hear more than two (2) responding units contact Command for response route directions or staging instructions, this should alert them (and the Communications Center) that STAGING and RESPONSE ROUTES need to be established!
8. On-scene Commanders should have Communications Centers alert incoming units about BLOCKED ACCESS ROUTES so they can select alternate routes early into their response.
9. Non-essential apparatus should be staged, positioned, or re-positioned so they do not block access to in-coming or essential on-scene units.
10. Ineffective staging, or vehicle approach / parking problems, should be corrected as soon as a problem is identified:
 - ◆ Correct inefficient vehicle approach routes, parking or staging patterns.
 - ◆ Positioned vehicles so they never have to back up (Dangerous).
 - ◆ Do not let vehicles park "nose-to-nose". They will get "boxed in" when the next unit parks behind them. Correct this as soon as you detect it occurring. A unit parked nose-to-nose with another should be turned around immediately.
11. Tabletops exercises and the use of "Toys" offer good staging practice. These training exercises can be conducted during inclement weather, or during "off-periods" of call activity.

12. Vehicle numbering should allow scene commanders to identify the units from all sides and from a distance.
13. Drivers should be requested to remain with their units. We can call-up units simply by raising the appropriate number of fingers, or asking that: "the next 4 ambulances from staging - move up to the patient collection area".
14. MCI Managers must also "stage", control and properly utilize "extra" personnel, or those individuals not being fully utilized, at the scene of an MCI.
15. Once staged, personnel can be deployed in teams to carry out necessary MCI tasks:
 - ◆ Assist in setting up tarps for Patient Collection Areas
 - ◆ Moving patients
 - ◆ Rescuing patients from confinement
 - ◆ Roping-off or "scene taping" the incident area

The "BLACK HOLE" Phenomenon

Drivers will resist traveling into a "Black Hole", *a route whose pattern or termination point is a mystery to them*. If the driver is not told that a road or exit route ahead is clear or "open all the way through", they will most often back up and exit the way they entered - because they are sure that way is clear!

SOLUTION:

The Staging Officer or Transportation Officer should inform drivers of "secured" exit routes so they are comfortable that their vehicle will not become "trapped" if they travel into the unfamiliar area.

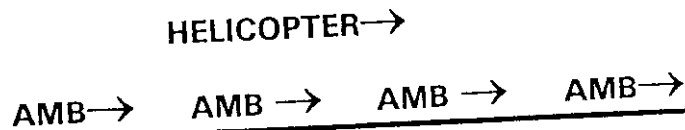
Example: If you know that the police have secured both ends of a dark dog-leg alley, tell the incoming drivers they will be able to flow into the scene one way, and out through the other end of the alley - secured by police.

HELICOPTER USE AT MCIS

1. Consider use of multiple helicopters (Separate staging area).
2. Keep in mind that non-medical helicopter can be utilized to shuttle urgently needed supplies to the scene as well as to receiving hospitals.
3. Don't be too anxious to land helicopters close to an MCI scene. "Rotor wash" can cause debris, luggage, body parts, and hazardous materials to be blown all over the area. Helicopter landings also draw additional spectators to the scene. Then you have crowd control problems to solve.
4. TIP: Have a helicopter sector / LZ established in a nearby parking lot or field and assign an ambulance crew to do nothing but shuttle your helicopter cases to that helicopter site.

- Helicopters also need to be staged, particularly when more than one is utilized. If possible, stage them to utilize the same "exit pattern" as ground vehicles so there is less confusion and "ducking" caused by incoming or outgoing helicopters.

HELICOPTER EXIT PATTERN:



METHODS OF VEHICLE STAGING / DEPLOYMENT

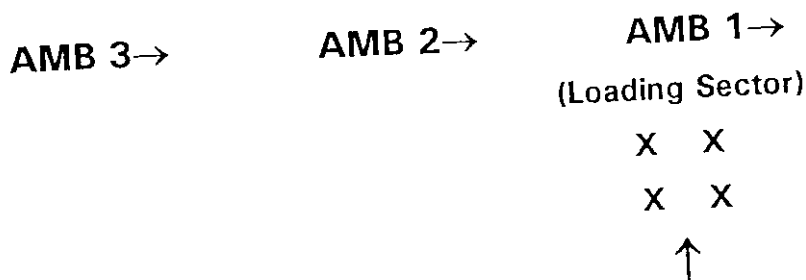
DIRECT / STRAIGHT-LINE

(one behind the other)

Vehicles are parked in a straight-line formation with sufficient room allowed between units so that any driver can pull away from the scene and not have to maneuver his unit from between two others.

TIP: You should be able to see the contact point where the wheels of the vehicle in front or yours touch the ground. This means there is enough room left between the vehicle in front of you and your vehicle, to enable you to pull out of the straight-line staging area in the event you need to leave the scene prior to the vehicle in front of yours.

DIRECT / Straight-line Staging



Area "1" (RED)

```

X X X X
X X X X
X X X X
  
```

Area "2" (YELLOW)

```

X X X X X
X X X X X
X X X X X
  
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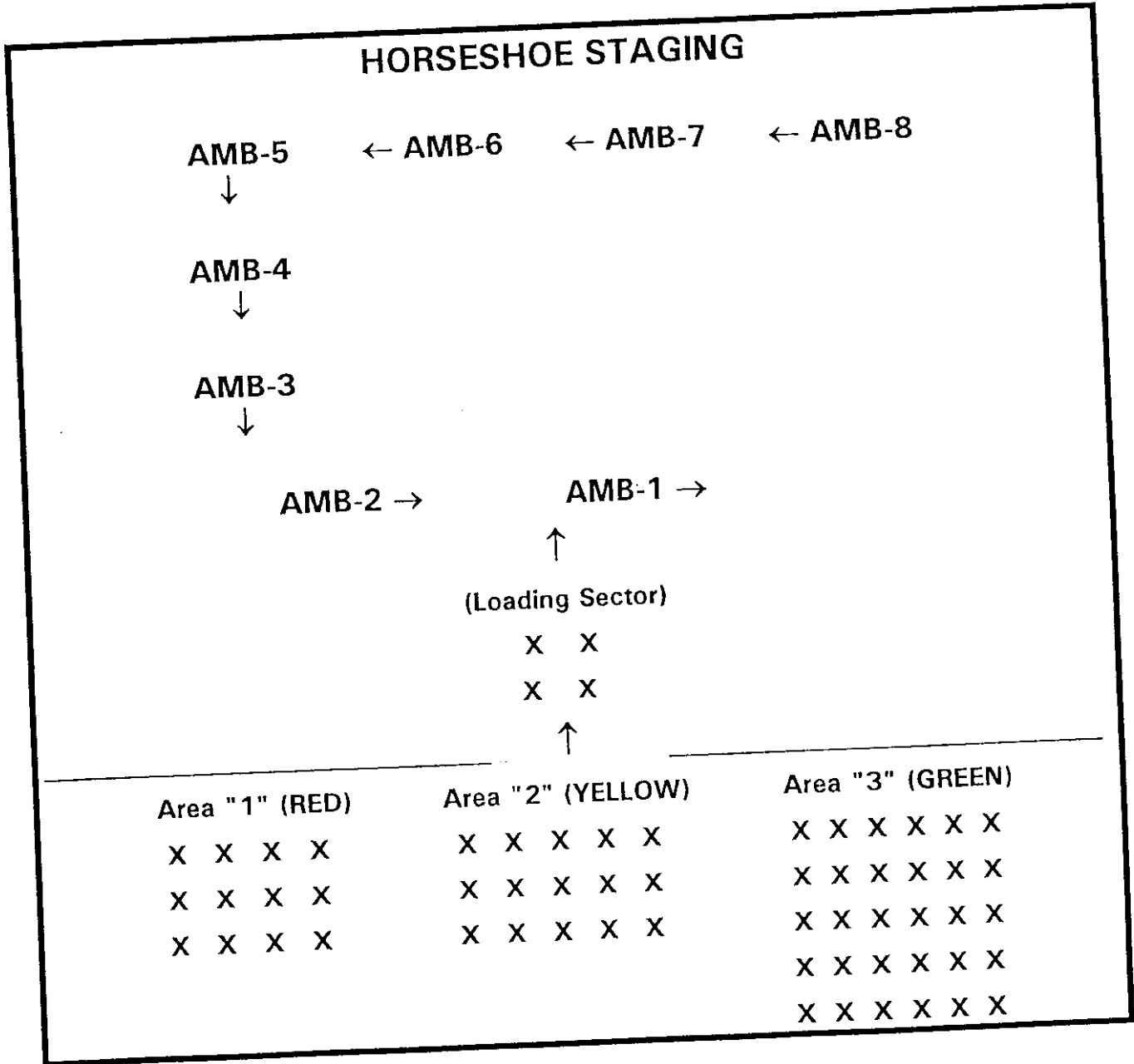
Area "3" (GREEN)

```

X X X X X X
X X X X X X
X X X X X X
  
```

"HORSESHOE" STAGING

Vehicles approach the scene and are positioned in a "horseshoe" pattern to expedite entry into, and exit from, the patient collection area.



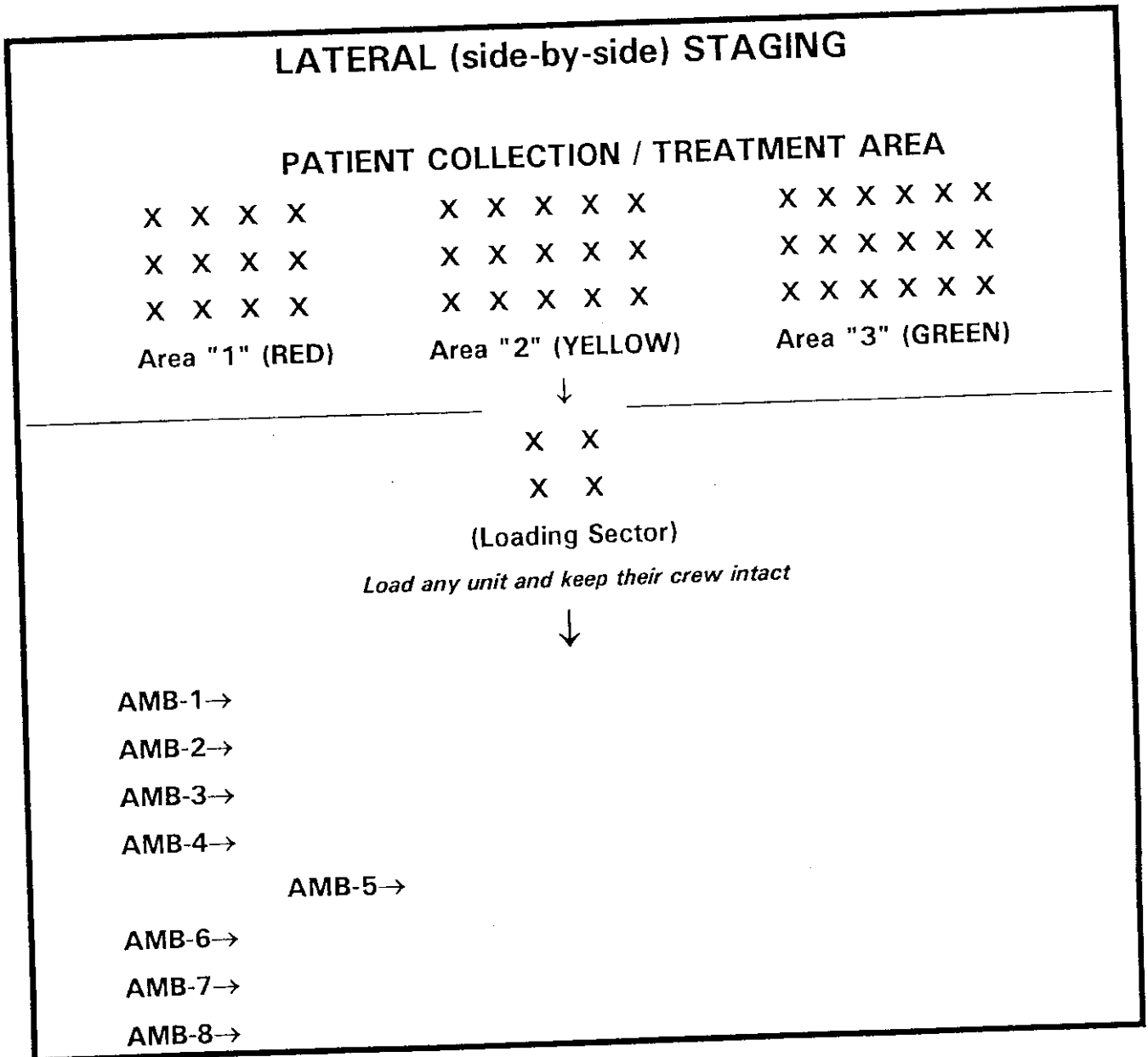
LATERAL STAGING

(side-by-side)

Ambulances are directed into a side-by-side parking pattern.

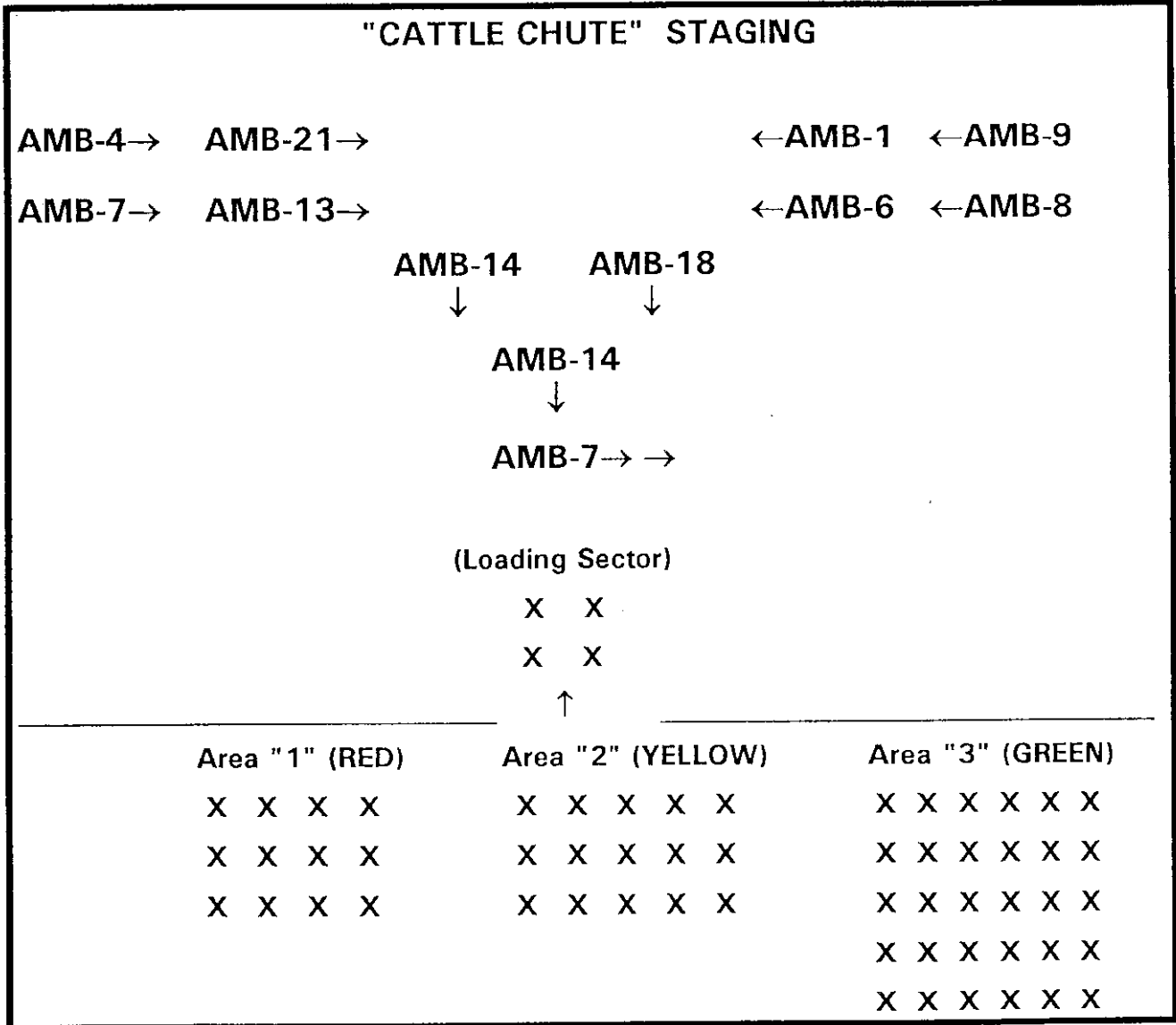
ADVANTAGES

1. This pattern allows crews to be assigned patients and return directly to their own ambulance to transport the patients to a hospital facility. They are therefore familiar with equipment location and can function more comfortably in their own ambulance vehicle.
2. Ambulances are never blocked in by any other vehicles. Whenever a crew returns to their ambulance vehicle, they can leave immediately and not have to wait for any other vehicles to leave before them.



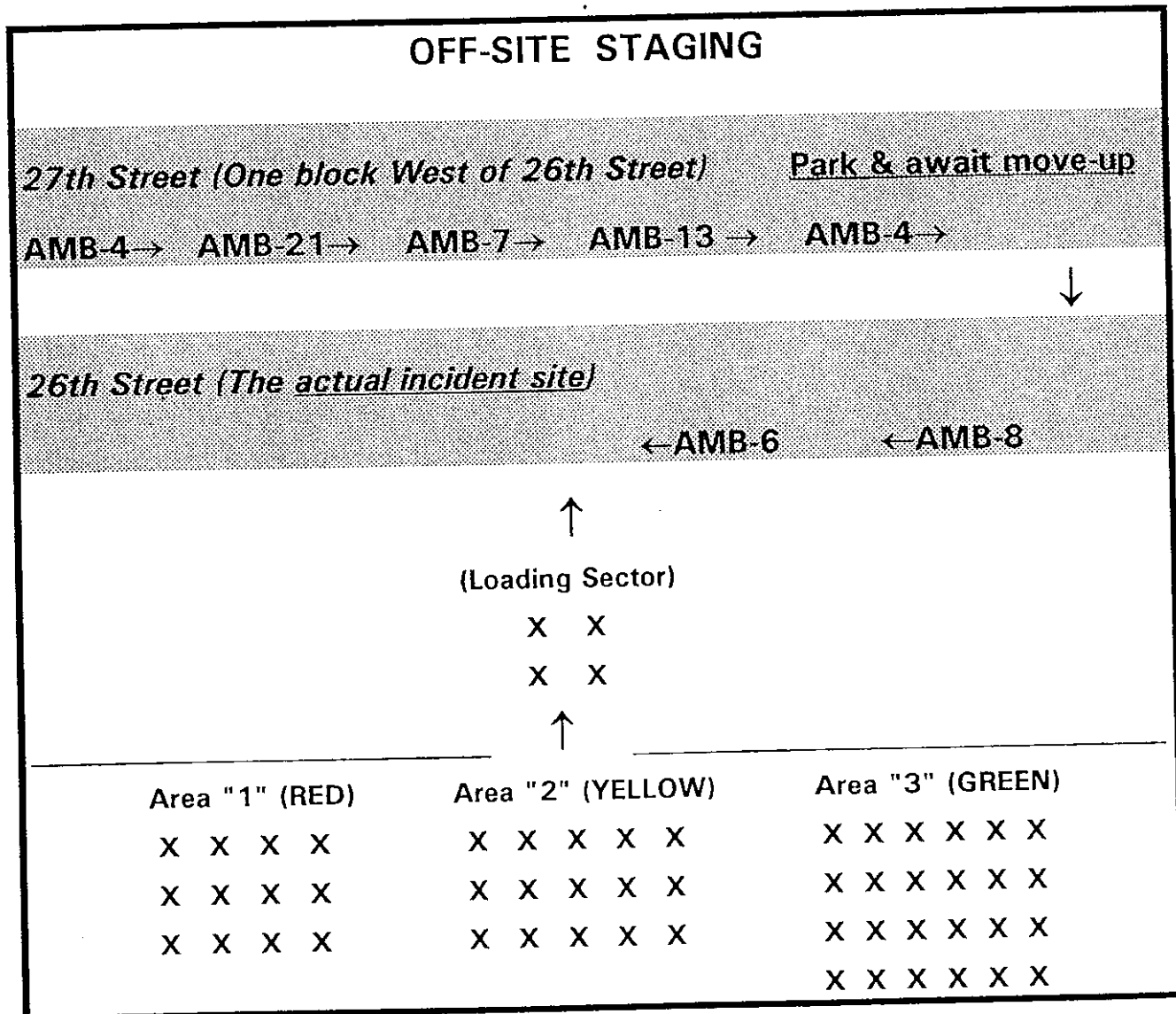
"CATTLE CHUTE" STAGING

Multiple approach areas feed into one (1) single file pattern



OFF-SITE STAGING

Have incoming ambulances report to an area close to, but not directly at, the incident scene. Ambulances are then called up as needed. (Examples: All units stage "one block west" of the scene; All positioned in a K-Mart parking lot; All units park in a north-to-south pattern on 15th Street)



SITE "PASS - THROUGH" AND RELOCATION TO STAGING

Same as OFF-SITE staging pattern except:

- ◆ Units arrive at a designated spot near the actual incident
- ◆ Drop off supplies and personnel near the incident
- ◆ Drivers remain with their units
- ◆ Units relocate to the designated off-site staging area
- ◆ Units are called-up from the off-site staging area, as needed

EQUIPMENT STOCKPILE AREA

1. The rapid deployment of equipment and use of coordinated / organized EQUIPMENT STOCKPILE AREAS are essential to expedite the treatment and transport of victims
2. The TRANSPORT OFFICER should specify to incoming units (may be done through Comm Center relay) what specific items are needed and where they are to be delivered - *the designated Equipment Stockpile Area*.
Be specific about what you want brought to your Equipment Stockpile Area. For example: "**Bring all lifting and moving devices to the equipment stockpile area**"
3. Ambulance supplies in trays help you move supplies to stockpile areas rapidly
4. Assign someone to organize and manage the Equipment Stockpile Area
5. Organize equipment into functional and easy-to-identify groupings (eg. Backboards and Straps; Airway Management; Dressings and Bandages...)
6. Don't kill your back - Load 5-10 backboards onto one wheeled stretcher and use it as an equipment carrier (TROLLEY) to roll the items to the site.
7. Extra backboards and EMS supplies carried on Engine companies and Rescue vehicles are a valuable resource. Request them through the Fire and Rescue Sector Officers.

ESTABLISHMENT OF PRE-PLANNED EQUIPMENT STOCKPILES:

1. Can be stored at EMS-FIRE-POLICE facilities;
2. Stored at central vehicle maintenance and delivered by designated personnel;
3. Store at airports and regional resource locations.
4. Store at nursing homes; hospitals; high-rise buildings; prisons and other high-volume resident areas;

ADVANTAGES

- ◆ The backboards are available to help rapidly evacuate a large facility, often before emergency crews arrive on the scene.
- ◆ They are available at central locations in your coverage area, available to be picked up by Fire Department pickup truck or other vehicles.

TIP: Many facilities will buy or have backboards made, and store them in an easily accessed location, at no cost to your service. This is a great community service project, a "win-win" for and the facility you are working with.

**LABEL YOUR EQUIPMENT ITEMS OR YOU MAY
LOSE THEM AFTER THE INCIDENT IS OVER**

PATIENT COLLECTION AND TREATMENT AREAS

1. Patient Collection and Treatment Areas are like a "Ports in a storm", a place to temporarily shelter and "process" our patients until we can get them to hospital facilities.
2. Well-organized Patient Collection and Treatment Areas, clearly separated by color-coded patient priority sections, are crucial to success at large MCI scenes! Chaotic collection areas can add to confusion, detract from prioritized treatment, and cause delays in patient transport from the scene.
3. Easy to use equipment supply bags should be placed in the patient treatment areas as early as possible. (See **Appendix 8**)
4. Color-coded patient collection and treatment areas clearly identify priority areas and have a significant impact on coordinating patient transfer.

Items that can be utilized to denote Patient Collection Areas:

- ♦ Color-coded Salvage Covers: Can be carried on ambulances, special services units, or fire department vehicles and be rapidly deployed at MCIs or serve as regular salvage covers at fire scenes. These color-coded salvage covers offer a dry protected area to place and treat victims and are one of the best means of visually separating patient treatment areas at a large scene.

SUGGESTION: Ask your Fire Support Services to buy colored tarps (RED - YELLOW - GREEN) vs plain green, the next time they buy salvage covers.

- ♦ Color-coded traffic cones (Add numbers to assist "color-blind" personnel)
- ♦ Colored flags (Colored material will work)
- ♦ White floor-wash style signs with reflective numbers (Hinges on the top - easily folded - and easily stored in "M-tank" oxygen storage compartment.)
- ♦ Color-coded Cyalume Lightsticks (30 min. high-intensity style works the best)

USE OF "CATTLE-CHUTES" TO CONTROL PATIENT TRAFFIC

1. Traffic cones; small bicycle safety cones; or lengths of fire hoses, deployed in a "Cattle-chute" format (positioned from a wide area to a narrow end point), will coordinate and control the transfer of patients from the field to the patient collection areas.

This is a key to success - It indirectly "forces" personnel to travel where we want them. Very few patients "sneak by the system" if a "cattle chute" is established early into an incident and utilized throughout the operation.

TIP: A Triage Officer can stand at the point of the "chute" and either re-tag or tag patients as they are carried through.

2. Traffic or Bicycle Cones are also excellent for creating a Transportation Officer work area - from the patient collection areas to an "on-deck" area (like a

baseball "on-deck" batter's circle) - to expedite assigning patients to crews and units for transport from the scene.

TRUST ME - CATTLE CHUTES WORK EXCEPTIONALLY WELL !!

TRIAGE

A French word which means "SORTING".

Large-scale Triage is the toughest job anyone in EMS will ever do. Therefore, emergency personnel must be properly prepared for decision-making, death, and emotional trauma.

TRIAGE - TAGGING - TREATMENT - TRANSPORTATION

1. Initial Triage consists of an initial "walk-through" so an approximate patient count can be made and patients are tagged according to the apparent severity of their injuries.
2. Early patient care is limited to the correction of life-threatening conditions that can be completed rapidly for patients who have a chance to survive
3. Mass Casualty Kits should be carried and utilized initially at MCIs, in place of routine trauma kits

MCI bulk essentials that should be carried

- ◆ Airways labeled by size
 - ◆ Large suction bulb syringes
 - ◆ Military Combat Trauma Dressings with "tails"
 - ◆ Gloves (Multiple pair stuffed inside one glove)
 - ◆ "SAM" (Structural Aluminum Malleable) Splints
 - ◆ "Seal-Easy" Ventilation Masks (Respironics) - Fits ages 3 to 100...
 - ◆ Trauma Shears
 - ◆ Boxes of 1" Transpore Tape (easy to use) and DUCT Tape
 - ◆ Triage Tags wrapped and labeled in lots of 25, with pens
 - ◆ Long color-coded wire ties or painted clothespins
 - ◆ Cyalume Light Sticks (30 minute high-intensity type)
 - ◆ Lumber crayons - for marking areas / objects
4. Use "Battlefield" tactics, equipment and treatment techniques - Don't waste time cutting dressings or tape. Emphasis should be placed on rapid care and movement to a "quiet" ambulance for transport to an assigned hospital.

5. Have gauges on all spare oxygen tanks so you can care for multiple patients.
6. Perform initial TRIAGE rapidly:
 - ◆ Rapid use of color-coded wire-ties, tape, or "clothespins".
 - ◆ Tags pre-strung and in lots of 25 (Help you calculate an accurate patient count. Subtract the number of tags remaining after Triage is completed, from the total at the start of your triage activities).
7. The larger the scene, the more you will need to divide Triage responsibilities among one or more "Triage Assistants" (SECTORIZATION of Triage)
8. Triage may have to wait for patients to be removed from confined or dangerous areas. Therefore, the Triage Officer should select an optimal location at which to be positioned and "process" patients as they are removed from a structure or other difficult access location. ("TRIAGE POST")
9. There are many varieties of Triage Tags that are effective. The key to success in Triage and MCI management is for personnel to utilize their Triage tags on a routine basis. The "MULTI-TAG" System was designed specifically to make triage tagging an easy adaptation from routine call management. Use of the same card / tag on a daily basis will insure that personnel are very familiar with the system when an MCI occurs and use it quickly and efficiently. (See **Appendix 9**)

Keep in mind that we most often error on the side of the patient and initially over-triage many patients. If your Tags are color-coded RED on the area closest to the main body of the tag, you have to use a second tag to lower a patient's priority. This is not efficient.

Because initial triage should be based upon your first impression of the patient, it is more efficient and cost effective to utilize tags that have the highest priority (RED) at the end position on the tag, with other priorities in descending order, closer to the body of the tag. If a patient is initially "RED-IMMEDIATE", and later determined at re-triage to be a lower priority, you can simply tear off the higher priority that is no longer needed, to be able to quickly downgrade the patient. Therefore, you will not have to use a second tag for this patient.

10. For all non-ambulatory patients, use the LEFT ANKLE AREA as the patient triage tag fixation point:
 - ◆ Easy to access and use on supine patients
 - ◆ Positions the tag so it is in the isle of the ambulance, easily reached by a Transport Officer at the scene or receiving hospital staff members when the patient arrives at the hospital.
 - ◆ Less susceptible to being cut off in the field, or at the hospital, as clothing is removed.

11. Emotionally "out-of-control" patients should be tagged Priority "1" and removed from the scene to avoid "accelerated emotional" crisis. (Make sure the receiving hospital is made aware why you tagged the patient "Priority 1".)
12. Emergency personnel who become injured should also be tagged "Priority 1" and sent from the scene ASAP to reduce associated stress on their partners and friends.

Note: If you remove emergency personnel from the scene, notify one of their department command officers so they are aware of your actions and do not conduct a search for a "missing person".
13. A procedure (and form) needs to be in place to rapidly process multiple patients who are refusing treatment or transport at the scene. (See Appendix 11)

MANAGEMENT OF THE DECEASED

Handle the Dead With Care & Dignity

1. EMS, Fire and Rescue personnel are expected to assist in the tagging, charting, packaging and removal of deceased patients and body parts.
2. Our role in this process serves to:
 - ◆ Show respect for the dead;
 - ◆ Reduce the pain experienced by the family members and friends who have to witness the body removal. (Remember that even though family members don't want to watch this process, their psychological state of mind and grief will often force them to watch as much of the process as possible - to stay in contact with their loved one as long as they can, and make sure their loved one is handled with care.)
3. Package the dead as carefully as you would if they were still alive - for the benefit of the families and rescuers that watch the 11 O'clock News.

"It looked like they put her in a garbage bag"

4. Do not carry the deceased only by the big, floppy, body bag!
 - ◆ This is a workers compensation claim waiting to happen!
 - ◆ It is awkward for those moving the body around corners and down stairs;
 - ◆ It does not allow rescuers any mechanical advantage in maneuvering the "dead-weight".
 - ◆ It places a tremendous strain on the backs of those carrying the bag.

5. Use a rigid lifting and moving device to carry deceased from the scene.

Orthopedic "scoop" stretchers work well because:

- ◆ The break-away feature helps "distance" the rescuer from the emotional trauma of lifting a limp or crushed body onto a device;
- ◆ The curved designed of this stretcher keeps the body from shifting.

Packaging and moving the deceased:

1. Place the deceased patient into a "presentable" body bag

NOTE: If the body is extremely traumatized, and it is acceptable to the coroner, medical examiner and/or investigators, first place the body on a sheet or a non-absorbent covering. The head can be wrapped in a towel or plastic covering. (Both techniques offer rescuers a great psychological buffer for the rescuer.)

2. Place the body bag onto a rigid lifting and moving device;
3. Secure the "patient" onto the lifting and moving device the same as if they were paralyzed (Minimal head and body movement);
4. If time and resources permit, cover the body bag with a clean white sheet before securing it onto the lifting and moving device. This is more symbolic. (The CLEAN-WHITE sheet signifies purity and exhibits more respect for the "patient".)
5. Have a team of four (4) rescuers (minimum) carry the deceased "patient" from the scene via a careful and dignified "carry-out".

(NOTE: This should be viewed by the carry-out crew as a "ceremonial" task, performed with dignity and respect for the deceased and the family members who may realistically see the "carry-out" on television, in the newspaper, or in a news magazine.)

6. VICKS "VapoRub" placed under the nose of body recovery personnel, with a regular exposure control mask in place, will fool their sense of smell and mask the odor of burnt flesh and other unpleasant odors from blood and body fluids.
7. Have rescuers that are packaging deceased patients or handling body-parts wear two (2) pair of latex gloves, taped at the cuffs to reduce the chance of fluid / debris entry. This provides them with "physical and emotional distancing".
8. Have personnel utilize small shovels and individually labeled plastic "red bags" to handle small body parts and debris so they never really have to touch the objects and develop a "touch impression".

REMEMBER:

Less chance of physical exposure = less chance of emotional exposure

9. Discuss the difficult assignment of packaging the deceased, and often body-parts, with your personnel. Allow anyone the opportunity to "do another job" if they prefer not to participate in this activity.
10. Verify the credentials of Priests / Clergy who present themselves on the scene. There have been documented incidents and arrests of individuals who posed as priests and handed out business cards for "hungry" law firms to emotionally vulnerable family members at the scene of large scale MCIs.

REHABILITATION AND SCENE BREAKDOWN

1. Rescuer REST and REHABILITATION ("R & R") is a vital phase of any emergency scene. Rehab SOPs need to be developed and adopted in conjunction with all emergency agencies in your response district. (See **Appendix 12**)
2. The REHAB and Safety Officers must have the authority from Incident Commander to "*Throw the Flag*" to stop rescuer activity and send them to REHAB. Throughout the REHAB phase of operations, the REHAB Officer's job is to "rescue and restore" the rescuers.
3. Establish REHAB in an environmentally-controlled area (if possible) close to the activity area and next to the SCBA rehab area, if one is established.
4. Consider hot and cold weather problems that will / may develop.
5. Feed the Troops, but develop your "menu" carefully with an awareness of the nature of your incident, and the impact the food you are serving will have on the recipients. For example, do not feed rescuers performing body recovery duties food such as: spaghetti; pizza; barbecued chicken; or scrambled eggs.
6. Use on-scene *diffusings* and post-scene Critical Incident Stress Management (CISM) teams and processes.

7. Watch for "trapped or residual emotions" and stop damaging "imprinting" from occurring or continuing

REMEMBER:

Your brain holds images & thoughts like a camera

8. Protect your co-workers like you would your brothers, sisters, or children. Their feelings and emotions are no different!
9. Computers can be used to prepare an easy-to-search, collate and read critique very soon after an incident occurs. Let the computer assist you in doing this tough task. (See Appendix 7)
10. Don't forget these additional important tasks:
 - ◆ Scene wrap-up;
 - ◆ Equipment and personnel restoration / decontamination;
 - ◆ Final media session;
 - ◆ Post-incident critiques / analysis / operational improvements / training.

CONCLUSION:

"If you prepare your personnel operationally for the multiple tasks required at an MCI, they will be better able to handle the physical and emotional aftermath"

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