Appendix C
MCI and Disaster Management
The EMS Perspective

Purpose

The Suffolk County Department of Health Services, Division of EMS, in its role as the Regional Program Agency, has developed this plan to provide the guidance, structure and format necessary to enable the emergency medical services agencies operating within the Suffolk County EMS System to respond effectively and efficiently to incidents involving multiple patients and agencies, and to coordinate the on-site triage, treatment and transport of patients in a systematic and controlled manner. While each agency’s responding unit(s) may come under the general supervision of its highest ranking officer, it is imperative to the success of the response that the unit(s) be fully integrated into the incident command structure.

Geographical boundaries dividing fire and ambulance districts generally determine the initial agency having jurisdiction (AHJ). Mutual aid agreements at the local level allow for the deployment of immediate additional staffing and equipment resources.

The purpose of a countywide plan for multi-casualty incidents is to achieve an overall understanding of structure needed to control and coordinate multiple resources from multiple agencies. This MCI plan is an appendix to the Suffolk County Comprehensive All-Hazards Plan and is designed to be used in conjunction with other plans and agreements, based on the demands of an event. This plan reflects a contemporary approach to response to multi-casualty incidents to save the greatest possible number of people from death or serious disability, accomplished through prompt and coordinated triage, field treatment, prioritization of transportation to designated medical facilities, and central coordination and communications.

Mission Statement

The Emergency Medical Services (EMS) component of the Incident Command System (ICS) provides an on-scene organizational structure that supports the effective management of EMS resources and promotes a systematic approach to prehospital emergency medical care in the multi-jurisdictional response. The ICS provides a format for accountability, inter-operable communications, and continuity of management through the escalation, stabilization, de-escalation and termination phases of an incident and encourages the most effective and efficient utilization of resources. By practicing ICS, EMS managers and providers take proactive steps to ensure that all patients receive timely and appropriate emergency medical care and transportation. Under the National Incident Management System (NIMS) concept of Unified Command, EMS may function in the Logistics Section in a supportive role, and/or in the Operations Section as a branch of the response when casualties are present.

Continued.
Definition of a Multi-Casualty Incident

A Multi-Casualty Incident (MCI) is typically defined as one in which the number of people killed or injured in a single event is large enough to strain or overwhelm initial local EMS providers, and where patient needs exceed initial provider resources, typically between 10 and 100 patients. An MCI may be the result of a natural phenomenon or it may result from human activity. An MCI may be traumatic in nature, causing mechanical injuries, penetrating trauma or blunt trauma, or it may be medical in nature and may involve toxic, biological, or bacterial agents. An MCI may be open (easily accessible) or closed (limited access/egress), and may be active (on-going with increased injury potential) or controlled (minimal potential for further injury).

By contrast, a Mass Casualty Incident, often referred to as a “Disaster,” is defined as when an event produces significant numbers of injured, more than 100, and severely over-taxes the capacity of an entire community and medical system.

Unified Command

This plan does not replace, nor is a substitute for, the individual agency-specific plans for mutual aid as required by 10NYCRR, Part 800, NY State EMS Code. Rather, this plan is designed to provide the framework for universal application linking ambulance services, communications centers and hospitals, and to ensure a consistent and uniform approach to managing resources through multi-agency coordination efforts.

Incident Command System (ICS)/National Incident Management System (NIMS) - EMS Components

The Incident Command System (ICS) provides an on-scene organizational structure that supports all on-scene activities during the incident. Each area of responsibility is filled by personnel in the order of their arrival. This provides for a strong and visible command structure and discourages chaos. The System allows for continuity of command and the orderly transfer of command with the subsequent arrival of personnel with higher skill and/or authority. The references in this documented are based on guidance from the National Incident Management System (NIMS), as required through Homeland Security Presidential Directive (HSPD) 5 – Management of Domestic Incidents, for field command and management functions.

Regardless of the overall circumstances surrounding the incident, the duties of arriving medical personnel will usually be similar and reflect the disciplines of staging, triage, treatment, transport, and emergency incident rehabilitation, integrated with discipline-specific efforts undertaken by other first responders, such as firefighters, law enforcement personnel, and specialty units. It is critical that EMS Operations be fully integrated with other operations, under the general supervision of the Operations Section Chief assigned by the Incident Commander.
In these types of events, EMS is in a primary response role where an EMS Branch, under the general supervision of the Medical Branch Director, and then specific task-oriented groups, under the general supervision of a Group Supervisor, are assembled to ensure that casualty management is a prime response objective.

For incidents where there are no casualties, and EMS is in a supportive role, the EMS Branch may report to the Logistics Section Chief.

Unified Command refers to the sharing of developing incident management strategy, based on the demands of the incident, following the doctrine of protecting life, property, and the environment. Management by Objective (MBO) means that the highest ranking responder of each discipline jointly determines the response actions, from their perspective. Incident Command may transition from one discipline to another, based on dynamic progression of the event. As a rule, the highest ranking individual from the AHJ over the event assumes command and the responsibilities associated with it.

Chain of command and unity of command refers to the orderly line of authority within the ranks of the event management organization, and that every individual has a designated supervisor that he/she reports to. These actions eliminate confusion that may be caused by multiple conflicting directives.

**Goals and Objectives**

1) To implement a simple, well-organized approach to Multi-Casualty Incident (MCI) management, operating within a unified command structure, as a component of the overall Incident Action Plan (IAP).

2) To ensure that all patients receive appropriate and timely emergency medical care and transport in accordance with their needs.

3) To utilize a common triage system (S.T.A.R.T.) that is accurate, quick, and easy to perform with minimal medical training.

4) To provide accountability for and continuity of patient management within a unified command structure.

5) To ensure that emergency medical triage and care is performed, when indicated, in conjunction with other activities that may be indicated, such as decontamination, public health surveillance, or antidote/prophylaxis administration.

*Continued.*
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6) To maintain accountability in managing resources and to ensure efficient and effective use of those resources by:

- providing a coherent, easily implemented on-scene organizational structure;
- coordinating and supporting all EMS activities during an incident;
- filling areas of responsibility by arriving personnel in order of their arrival;
- assuring that adequate resources are available, used properly and are accounted for;
- minimizing or eliminating confusion, chaos and panic;
- providing for continuity of command and for the orderly transfer of command;
- providing for orderly escalation, stabilization, and de-escalation phases of response; and
- providing for accountability and continuity of patient care management.

**Scene Safety/Mechanism of Illness/Injury**

The foundation of every patient assessment begins with a determination of the safety of the scene and the mechanism of injury/illness. This approach is of the utmost importance on events that produce large numbers of casualties, with a similar casualty pattern. This essential first step ensures that EMS providers have available the appropriate level of personal protection to engage in response, or to summon other responders that do. In addition, accessing the scene provides valuable information to mutual aid agencies, specialty units, and receiving hospitals, allowing each to effectively respond in the short term, and the long term, based on the demands of the incident.

When confronted with an event where patient needs exceed EMS resources, the first arriving unit(s) **should declare an MCI on the radio**, as they simultaneously request additional units. Upon declaration of an MCI, the first arriving unit should assume a “**Command Posture**” and refrain from triaging and treating presenting patients. Initial actions should include the following actions:

- Cordon off the area, deny access, establish a perimeter;
- Perform hazard analysts/risk assessment;
- Establish Staging Area; and
- Request additional support through dispatch.

**First Arriving EMS Units/Personnel**

First arriving units should consider the **3 “N”s** in the initial decision-making process:

- **Number**: assess and report the number of patients.
- **Nature**: determine and report the nature of the incident.
- **Needs**: determine and plan for additional resources.

(EMS, Field Physicians, County Staff/Coordinators, HazMat, Technical Rescue, Heavy Rescue, Public Health, Police, Fire, Public Utilities, Emergency Management, American Red Cross, Medical Examiner, etc.)

Continued.
First arriving units should be prepared to provide pre-arrival information and/or instructions to subsequent waves of responders that includes:

- **Mechanism of Injury**
- **Anatomic Findings** (nature of injuries / injury pattern)
- **Numbers of patients** (estimate)
- **Numbers of deceased patients** (estimate)

First arriving units should be prepared to have receiving hospitals polled for resource availability and to provide early notification to hospitals that includes:

- **Mechanism of Injury**
- **Anatomic Findings** (nature of injuries / injury pattern)
- **Numbers of patients** and approximate triage category breakdown

**NOTE:** Suffolk County Medical Control serves as the focal point for all communications between the scene and each hospital (See Appendix C-1).

This plan covers the emergency medical branch structure and is designed to integrate the EMS discipline into an event. Assumptions are made that Command Staff and General staff positions, including Public Information Officer (PIO), Safety Officer (SO) and Liaison Officer (LO) are deployed and out of the scope of this document. Likewise, other branches and groups that are likely to operate at an MCI are out of the scope of this document.

**EMERGENCY MEDICAL BRANCH STRUCTURE**

<table>
<thead>
<tr>
<th>Title</th>
<th>Radio Designation</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>1. EMS Operations Chief</td>
<td>“EMS Operations”</td>
<td>Command Post</td>
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<tr>
<td>2. Triage</td>
<td>“Triage Branch Director”</td>
<td>Triage Area</td>
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<tr>
<td>3. EMS Staging</td>
<td>“EMS Staging Branch Director”</td>
<td>Staging Area</td>
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<tr>
<td>4. Treatment</td>
<td>“Treatment Branch Director”&quot;</td>
<td>Treatment Area</td>
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<tr>
<td>5. Transportation Group</td>
<td>“Transport Branch Director”</td>
<td>Transport Area</td>
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<tr>
<td>6. Rehabilitation Group</td>
<td>“Rehab Branch Director”</td>
<td>Rehab Sector</td>
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<tr>
<td>7. Morgue Group**</td>
<td>“EMS Morgue Branch Director”</td>
<td>Temporary on-site</td>
</tr>
<tr>
<td>8. Other Group assignments as dictated by the nature and objectives of the incident.</td>
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</tbody>
</table>
**The Suffolk County Department of Health Services Office of the Medical Examiner (MEO) maintains the county’s Mass Fatalities Plan, and is responsible for operating at events that result in large numbers of fatalities. In some cases, the EMS System may need to include an interface with the MEO, to ensure that victims that expire while on-site, or fatalities that may be moved to access live or potentially live patients, are appropriately addressed.**

The first order of business is for the first arriving ambulance crew to report to the Incident Commander (IC) and assume “EMS OPERATIONS.” EMS Groups are to be set up as the needs of the incident dictate. The EMS Operations Chief evaluates the situation, reviews the actions taken by the first arriving unit, develops and implements an effective plan of action to continue managing the situation. As needed, the EMS Operations Chief may request and deploy additional resources and divide the operation into geographical divisions and/or functional groups, assigning units and other officers as circumstances dictate.

*NOTE: Any group supervisor has the authority to designate appropriate subject matter experts (SMEs) or other personal assistant(s) to carry out the duties of the position within the Incident Command System. Said parties would assume the radio title “Deputy (Insert Group Name Here) Supervisor.”*

**Briefing of Arriving EMS Units**

The transmission of initial information from first arriving units should consist of:

- Confirmation of the incident and situation report;
- Staging locations, access routes, and direct assignment;
- Command Post location;
- Nature of the incident (active or controlled, open or closed);
- Estimated number and types of patients present;
- Hazards present that may require additional specialty resources; and
- Requests for additional units

**EMS OPERATIONS SECTION CHIEF**

LOCATION: Command Post

REPORTS TO: Incident Commander

RADIO DESIGNATION: “EMS Operations”

COMMUNICATES WITH: EMS Branch Directors

*Continued.*
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DUTIES:

Determine the approximate number of patients and extend/type of injuries.

Determines medical needs of patients based on scope and nature of incident, casualty patterns and/or mechanism of injury.

Works with the command staff to address patient care needs and objectives, prioritizing with other response objectives.

Implements or assists IC in implementing EMS component of the Incident Action Plan (IAP).

Makes initial contact with arriving personnel and makes group assignments as appropriate medical personnel arrive.

Remains in contact with group supervisors and keeps the IC informed on the progress of patient triage, treatment, transportation, and allocation of available resources.

Notifies Medical Control to contact local hospitals as to potential casualties, initiate patient tracking/resource allocation system. Remains in contact with Medical Control as necessary. Transfers responsibility to Transport Branch Director when established.

Requests emergency support personnel from Suffolk County.

Informs IC of patient care and transport progress.

Disbands Branches/Groups and reassigns personnel as determined by the evolution of the incident.

Works in conjunction with the Medical Examiner or designee to preserve forensic evidence and set up temporary morgue.

Notifies hospitals and Medical Control to stand-down when appropriate.

TRIAGE BRANCH

LOCATION: Triage Area

REPORTS TO: EMS Operations Section Chief

COMMUNICATES WITH: Treatment Branch
                EMS Staging Branch
                Triage Branch

RADIO DESIGNATION: “Triage Branch Director”

Continued.
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DUTIES:

Prior to triage, assures security of hot zone and scene safety.

Implements the START and/or JUMP-START triage protocol (See Appendix C-2).

Assists the EMS Operations Section Chief with the decision to triage patients where they are found or remove patients to triage area, based on level of training, qualifications to operate within a hazardous environment, and level of Personal Protective Equipment (PPE). Establishes triage model (single funnel or double funnel) and triage area as necessary (See Appendix C-3).

Establishes triage teams (each team consists of 1 EMT and 2 litter bearers) and directs the field triage effort.

Assures adequate manpower pools for triage/litter bearer functions.

Accounts for the number of victims and the potential for additional victims.

Communicates with EMS Operations and Treatment Branch Director regarding location of a Casualty Collection Point (CCP) and Treatment Area. Assures that subdivisions of Treatment Areas are clearly marked, i.e.: CRITICAL/IMMEDIATE and DELAYED.

Communicates resource needs to EMS Operations, EMS Staging and Medical Control.

Maintains integrity of scene throughout triage operation.

Tracks all victims leaving Triage Area.

Evaluates and re-assesses operation of Triage Branch.

Helps prevent bottlenecks.

Updates EMS Operations on Triage status.

Notifies EMS Operations when Triage is complete.

In consultation with other sector commanders, re-assigns Triage personnel as necessary.

Note: The morgue is only intended for patients who expire while being transported to, or in the Treatment Area. All other victims who are tagged “DEAD/NON-SALVAGABLE” are to be left in place. Dead/Non-Salvageable individuals should only be moved if access to live patients is restricted.

Continued.
EMS STAGING BRANCH

LOCATION: EMS Staging Area

REPORTS TO: EMS Operations Section Chief

COMMUNICATES WITH: All arriving ground units
SCPDD Aviation Command
EMS Operation
Transport Branch Director

RADIO DESIGNATION: “EMS Staging Branch Director”

DUTIES:

Maintains visible position, in an area large enough to support incoming vehicles.

Secures high volume vehicle(s) to transport all ambulatory patients.

Maintains check in/check out log for all vehicles.

Establishes and maintains a manpower pool. Designates assistant to check credentials and institute responder accountability system.

Maintains log of available apparatus and manpower.

Holds all transport vehicles in a secure area until assigned.

Provides updates to Transport Branch, EMS Operations.

Clearly identifies traffic patterns for access and egress.

Releases apparatus and manpower as requested.

Continued.
EMS TREATMENT BRANCH

LOCATION: Treatment Area

REPORTS TO: EMS Operations Section Chief

COMMUNICATES WITH: EMS Staging Branch Director
Medical Control, as needed
EMS Triage Branch Director
Transport Branch Director

RADIO DESIGNATION: “Treatment Branch Director”

Shares patient care decisions with Medical Director, or designee and other EMS Field Physicians.

DUTIES:

Assures Treatment Area is secure and well identified (out of Hot Zone).

Designates specific Treatment Areas (critical/immediate or delayed).

Directs patients to appropriate treatment areas.

Directs treatment teams and Field Physicians to appropriate treatment areas.

Assures that patient re-assessment continues (secondary triage) and modifies treatment/transport plan as determined by the evolution of the incident.

Tracks all patients arriving in Treatment Area.

Tracks all patients leaving Treatment Area by coordinating with Transport Sector.

Reports special needs to EMS Staging Supervisor, EMS Operations, or Medical Control.

Continued.
Appendix C / MCI and Disaster Management / The EMS Perspective - Continued

EMS TRANSPORT BRANCH

REPORTS TO: EMS Operations Section Chief

COMMUNICATES WITH: Treatment Branch Director
 EMS Staging Branch Director

RADIO DESIGNATION: “Transport Branch Director”

DUTIES:

Secures multi- transportation vehicle(s) from staging area for ambulatory patients.

Secures ambulance transport for patients by priority from EMS Staging.

Records and tracks all ambulances and multi-patient transport vehicles on-site and off-site.

Ensures all transport assignments are accurate with regard to triage designation and re-assigns if necessary (tertiary triage).

Tracks all victims leaving the scene and informs all receiving hospitals directly or via Medical Control.

Establishes and controls traffic patterns into and out of transport area.

Assures all transport requirements are met, and consults with Treatment Branch Director concerning selection of destination hospitals.

Coordinates with SCPD Aviation Commander for helicopter utilization and secures helicopter L.Z. in cooperation with SCPD Aviation Sector Commander.

Provides updates to EMS Operations.

Reports last departure to EMS Operations.

Communicates with Medical Control regarding hospital status, changes in status and patient tracking.

NOTE: The Transport Supervisor should consider the following factors when making destination hospital selections:

- Number of patients.
- Type of injury pattern(s) and number of patients by priority.
- Previous number of patients transported to each hospital.
- Prevailing weather conditions.
- Hospital capability during incident as reported/verified by Medical Control.
- Trauma center designations with consideration of not separating family members.

Continued.
EMS REHABILITATION & SAFETY

LOCATION: Rehab Area

REPORTS TO: EMS Operations

COMMUNICATES WITH: EMS Operations
Rehab Teams

RADIO DESIGNATION: “Rehab Branch Director”

DUTIES:

Maintains visible position, in an area large enough to support rehab activities. Rehab area should be set up close enough to the scene to promote easy access, but far enough away to allow the safe removal of personal protective equipment (PPE) and self-contained breathing apparatus (SCBA). Whenever possible, rehab area should be sheltered from ambient weather conditions.

Maintains check in/check out and evaluation log for all personnel.

Provides adequate medical coverage for response contingent.

Supervise the provision of medical evaluation, treatment and monitoring, fluid/nutritional replenishment, relief from extreme climate conditions, and rest.

Secure and maintain adequate supply of resources: fluid; food; medical supplies; dry clothing.

Note: It is advisable to have a SAFETY OFFICER present at all scenes involving hazards, complicated operations, or multiple units in operation. For the purposes of this document, it is assumed that SAFETY OFFICER assignments will generate from the agency in which jurisdiction the incident has occurred, recognizes that the SAFETY OFFICER is a member of the command staff, and that EMS providers will not be permitted to operate in an environment for which they are not properly equipped or for which they have not received the appropriate training.
EMS MEDICAL DIRECTOR

EMS Medical Director or designee will respond to the command post and consult with the IC and the EMS Operations Section Chief to assure that adequate patient care resources are available. The EMS Medical Director or designee shall support the IC and EMS Operations in the formation, implementation, and re-assessment of the EMS component of the Incident Action Plan (IAP).

LOCATION: Command Post, may be re-assigned to Triage and/or Treatment Areas as necessary

REPORTS TO: EMS Operations Section Chief

COMMUNICATES WITH: EMS Operations

RADIO DESIGNATION: “Suffolk MD-1”

DUTIES:

Assist in the development, implementation and supervision of the medical action plan.

Determines the logistical needs of the site, and communicates same to appropriate support personnel.

Act as liaison between IC and EMS Operations.

Attends briefings and assists the public information officer as necessary.

Coordinates receiving hospital capabilities with Suffolk County Medical Control.

Provide situational awareness reports to the Department of Health Services, and coordinate integration of additional Health Services resources as dictated by the demands of the event.

Provide situational awareness reports to the NY State Department of Health, and coordinate integration of additional NY State Health Department assets as dictated by the demands of the event.

Activates the Suffolk County Disaster Medical Response Team and either assigns or assumes the position of the SCDMRT Leader based on the demands of the incident and the availability of personnel.
SUFFOLK COUNTY DISASTER MEDICAL RESPONSE TEAM (SCDMRT)
(May substitute Designated EMS Field Physician as available)

LOCATION: Treatment Area (Primary assignment)
          Triage Area (Secondary assignment)

REPORTS TO: Treatment Branch Director or Triage Branch Director

RADIO DESIGNATION: EMS Field Designated Physician identifier

DUTIES BY POSITION:

SCDMRT Leader

The central point of coordination of the SCDMRT lies with the SCDMRT Leader. The SCDMRT Leader is responsible for managing and supervising all medical monitoring and/or emergency medical care activities and will be incorporated into the ICS as a sector commander in direct communication with EMS command and the EMS Medical Director.

DUTIES:

Develops and implements the SCDMRT component of the Incident Action Plan (IAP).

Coordinates, supervises, and evaluates all on-site SCDMRT activities.

Coordinates integration with EMS providers and EMS Branches.

Maintains the sign-in and sign-out log for all SCDMRT personnel/coordinates response and stand-down activities of SCDMRT with EMS command.

Provides situation reports and assures that all SCDMRT personnel are informed of status changes.

Coordinates activities with Triage, Treatment and Transport Branches.

Performs additional tasks as assigned by EMS Operations or the EMS Medical Director.

Medical Team Leader

The Medical Team Leader reports to the SCDMRT Leader and is responsible for assisting in the implementation of the action plan and supervising a Medical Team. Medical teams will consist of Physicians, Advanced Life Support Providers, and Basic Life Support Providers.

Continued.
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DUTIES:

Provides clinical evaluation and treatment as dictated by the incident.

Coordinates, supervises, and evaluates Medical Team functions.

Determines the logistical needs of the Medical Team, and communicates same to SCDMRT leader.

Acts as the Safety Officer for the Medical Team.

Provides the SCDMRT Leader with situation reports, regular updates, and status changes.

Communicates with the SCDMRT Leader and keeps the Medical Team informed of status changes.

Performs other duties as assigned by the SCDMRT Leader.

Medical Team Member (Physicians/EMT-Ps, EMT-CCs, EMT-Bs)

Drawing resources from EMS providers, Medical Teams will be formed to deliver prehospital emergency medical care consistent with the needs of the patients and the objectives of the incident action plan.

DUTIES:

Provides prehospital emergency medical care as dictated by the demands of the emergency.

Assists with triage, treatment and transportation decisions.

Communicates with the Medical Team Leader concerning changes in number of patients, clinical condition and removal from scene.

Participates in the Critical Incident Stress Management (CISM) process by evaluating responders during routine rehabilitation activities, by passive observation and reporting.

Provides medical monitoring and rehabilitation of emergency responders.

Identifies and reports health risks that may occur during prolonged operations.

Perform other duties as assigned by the Medical Team Leader.
FOR SPECIAL SITUATIONS, CONSIDER THE FOLLOWING ASSETS THAT MAY BE REQUESTED THROUGH SUFFOLK COUNTY FRES:

- Decontamination Strike Team
- Urban Search and Rescue (USAR) Team
- Critical Incident Stress Management (CISM) Team
- Community Mental Health Team
- Radiological Response Team
- Antidote Cache
- Medical Examiner’s Office
- Decontamination Trailers
- Rehab Support Trailer
- MCI Support Trailer
- Oxygen Cascade System
- Incident Management Assistance Team (IMAT)
- Chemical Protective Clothing (CPC) Trailers/Suit Rescue Teams
- Mobile Command Post
- Hazardous Materials Response Assistance
- Public Health Response Assistance
- Deputy Fire/EMS Coordinator Response to Scene and Hospitals
- American Red Cross Response
- Others as necessary

Continued.
Appendix C-1
Suffolk County Medical Control Functions During a Multi-Casualty Incident

Medical Control is a resource available to any EMS agency for incidents involving multiple patients. The role that Medical Control assumes will be at the direction of the IC.

By augmenting existing DFRES communications responsibilities, Medical Control can assume hospital resource allocation and patient tracking duties, thereby allowing dispatchers to concentrate on inter-agency response traffic. Utilizing a single communication point between the scene and multiple hospitals will reduce confusion regarding destination hospitals, decrease radio traffic by ambulances departing the scene, and assist in patient accountability.

Upon receiving notification of an MCI, Medical Control will poll hospitals, beginning with hospitals located in Suffolk County, and then Nassau County and beyond, depending on the nature and magnitude of the incident, for bed availability, specialty service availability and limitations, etc. Medical Control will communicate this information back to the Transport Officer and maintain an open line of communication with the Transport Officer and the hospitals. As ambulances depart the scene, the Transport Officer shall notify Medical Control of triage priority and the number of patients departing. Medical Control will make the appropriate hospital notifications and keep the Transport Officer informed as hospital resources are depleted.

At the conclusion of an event, Medical Control may be able to supply demographic data to emergency managers suitable for an after action report. Information can be reported as follows:

- patients transported;
- patient totals by triage priority;
- categorize injury patterns;
- patient totals by hospital;
- patient totals by agency; and
- scene departure times.

Once Suffolk County Medical Control has been contacted by field personnel for assistance with transportation management, all subsequent communications should go through Suffolk County Medical Control. Ambulance crews should not call hospitals directly with separate patient presentations.

Continued.
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Appendix C-2
Simple Triage and Rapid Transport
The S.T.A.R.T. System of Patient Classification in an MCI

In an attempt to provide EMS providers in Suffolk Region with trauma triage guidelines that are consistent with those guidelines established for use in Nassau County, New York City, and the lower Hudson Valley, the S.T.A.R.T. system will be used in Suffolk County during all disaster and MCI responses. In the wake of the Federal Department of Defense attempts to educate EMS providers and EMS systems about the increased risk of terrorist use of weapons of mass destruction, it becomes readily apparent that the potential use of nuclear, chemical, and biological weapons knows no jurisdictional boundaries. In the event of an occurrence that results in large numbers of casualties, inter-regional cooperation is essential.

The S.T.A.R.T. System of triage is a rapid assessment approach that should be applied in any MCI. Since Triage and the level of on-scene trauma care may vary throughout the region based on resource availability, the initial S.T.A.R.T. assessment may be followed by more detailed examination influencing triage categorization if resources permit. S.T.A.R.T. evaluation requires little equipment and can be performed where patients are found, or in the triage sector, as dictated by the mechanics of the event. S.T.A.R.T. evaluations can also be performed in the treatment sector and can aid the rescuer in the re-assessment process.

S.T.A.R.T. was developed in order to rapidly triage multiple patients at the scene of an incident in order to maximize efficient utilization of resources. S.T.A.R.T. is based on the evaluation of Ventilation, Perfusion/Pulses and Neurological Status. This evaluation places a patient into a category, which ultimately determines the priority in which a patient will be removed to a hospital. Patients are classified as either ambulatory/injured (green), dead/non-salvageable (black), critical/immediate (red), or delayed (yellow). Colors may be used to readily identify patient classification, and correspond with triage tags.

S.T.A.R.T is a rapid survey that can be done by persons with limited medical training. Each patient assessment can be performed easily by one rescuer and should take no more than 60 seconds. The first assessment that falls into the critical/immediate category ends the survey. Treatment is limited to one attempt at clearing the airway of debris and repositioning the head or controlling severe bleeding. No other patient care is rendered during the triage process.

Continued.
PRIMARY TRIAGE PROCEDURE

Primary triage is performed upon initial encounter with the patient –

- Ensure appropriate level of PPE.
- Verbal request for all ambulatory persons to self-relocate to a safe area of refuge.
- Approach remaining patients, performing START Triage as indicated below.
- Attach triage tag to patient’s upper extremity whenever possible.
- If ambient light is inadequate, include RED mini-light stick on CRITICAL/IMMEDIATE patients.
- Limit interventions to opening the airway and rapid bleeding control.
- Remove, or summon litter-bearers to remove patients to appropriately identified treatment area.

The S.T.A.R.T assessment is performed as follows:

**Ventilation**

If inadequate, rescuer may clear airway by removing debris or repositioning the head.
No respiratory effort = dead/non-salvageable
Respirations above 30 or patient requires assistance maintaining airway = critical/immediate

If respirations adequate, assess perfusion/pulses.

**Perfusion/Pulses**

Capillary refill greater than 2 seconds or absence of radial pulse = critical/immediate.
Capillary refill less than 2 seconds or palpable radial pulse = assess neurological status
(Severe bleeding should be corrected NOW!)

**NOTE:** Capillary refill may be an unreliable sign under certain circumstances, i.e.: dark environment, cold weather, underlying medical conditions that may produce circulatory compromise. A systolic BP of 90 mmHg or below can be substituted for capillary refill greater than 2 seconds.

**Neurological Status**

Unconscious = critical/immediate
Altered level of consciousness = critical/immediate
Normal mental responses = delayed

Reminder Note: The first assessment falling in the critical/immediate category finishes the patient assessment. The patient is tagged and the rescuer moves on to the next patient. The only patient care that should be considered during the triage process is the correction of life-threatening emergencies (blocked airway, severe bleeding, etc.).
**S.T.A.R.T. Flow Chart**

Yes
Can Patient Walk --------> Delayed (Yellow)
| (Or first to leave in multiple casualty transport vehicle for stable patients)
| No

Respirations >30/min. <------------- Assess Ventilations <----- < 30/min.
| | |

Critical/immediate (RED) Inadequate Assess Circulation
| | Capillary Refill >2 sec. No radial or BP <=90 S.
| | Capillary Refill < 2 sec
| | Strong Radial Pulse
| Clear Airway |
| Reposition Head |

Patient Not Breathing <----------------- Spontaneous Breathing Assess Mental Status
| | |
| | Follows Commands--------> No-------- |
| | Yes |

Non-salvageable (BLACK) Critical/Immediate* (RED) Delayed (YELLOW) Critical/Immediate* (RED)

*If time permits, should be seen by Field Physician or Paramedic at Field Treatment Area for initial stabilization.

**SECONDARY TRIAGE PROCEDURES**

Secondary triage is performed periodically throughout the patient’s encounter with EMS providers, at various echelons or care, including:

- Arrival in the triage area;
- Arrival in the treatment area;
- Arrival in the transport area; and
- While enroute to hospital; and includes
- RE-ASSESS using START Triage
- Obtain Glasgow Coma Score (GCS), respiratory rate and effort, secondary physical exam; and vital signs
- Re-affirm or re-prioritize triage category
Appendix C-3
Single Funnel/Double Funnel Approach to Patient Movement

In an MCI or disaster, the situation may present hazards that prevent EMS responders from performing triage within an impact or “hot zone.” Chemical exposure, toxic vapors, oxygen deficiency, structural instability, or the technical rescue environment may not be suitable for this activity since EMS providers generally have limited PPE available to them.

EMS providers need to consult with the IC and/or perform a hazard analysis and risk assessment to determine if triage should be performed in place, where patients can then be funneled to a treatment area (single-funnel), or where patients must be extricated from the impact zone, funneled to a triage point, and then funneled again to a treatment area (double-funnel).
Appendix C-4
Critical Incident Stress Management (CISM) Team

The CISM team, operated by the Suffolk County Division of EMS, consists of specially trained personnel associated with emergency response organizations, and includes religious and social services personnel. The CISM team may be requested and deployed to the scene of an incident by the IC, and will be integrated into the organizational structure, reporting to the Logistics Section Chief.

The team may be requested for an on-scene mobilization by calling Suffolk County FRES Communications at 924-5435.

The CISM Team also provides individual and group defusings/debriefings post-event. Typically, defusings occur immediately after the event, and debriefings occur 24-72 hours post event. Any responder may request the services of the team by calling Suffolk County FRES at 924-5435.

Continued.
## Appendix C-5

**Community Risk Assessment Strategy for Developing MCI Response Strategy**

<table>
<thead>
<tr>
<th>Issues to Address</th>
<th>Points for Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is a community assessment?</strong></td>
<td>A review of the community to identify hazards, special situations, population densities, fire load, potential for over-the-fence incidents, transportation accidents, presence of critical infrastructure, etc.</td>
</tr>
</tbody>
</table>
| **Why do a community risk assessment?** | It will help you know what to expect.  
It will prevent unnecessary planning for unlikely events.  
It will facilitate realistic planning for events likely to occur.  
It will draw your attention to your realistic response capabilities during daytime, evening, or week-end hours.  
It will serve as a foundation for your MCI plan.  
It will create an awareness of new hazards, or changes in the community that alter the response. |
| **How is a risk assessment conducted?** | Review the Following:  
- population-number’s and density  
- commercial and industrial properties  
- transportation systems  
- environmental risks  
Identify potential risks based upon your community’s experience, as well as that of others similar.  
Based upon experience:  
- Consider the potential for specific types of incidents  
- Evaluate the potential harm from each incident  
- Identify the resources needed to respond to each incident  
- Identify needs of specific population groups, such as children, seniors, those with special health care needs, and non-English speaking persons |
| **“Processing” suggestions** | Once you’ve evaluated the potential risks, evaluate each for potential hazards and impacts.  
Acquaint yourselves well with your community and area resources.  
Consider the personnel needed to perform all the tasks associated with a potential incident.  
Consider Continuity of Operations for the parts of the community not affected by the MCI. |
| **How will conducting a risk assessment impact the MCI Plan?** | It will help you determine the type of planning needed.  
It will focus your attention on the types of response to emphasize.  
It will help you identify needed resources.  
It will indicate the type and quantity of mutual aid and specialty support services required.  
It will provide basic information about the response times for mutual aid and specialty support services.  
It will help re-determine available radio frequencies that all partners have access to. |

*Continued*
Appendix C-5

Sample ICS / NIMS Org Chart

NOTE: ICS Positions and Org Charts are designed to be modular, and scalable, based on demands of the incident. This diagram is a simple generic format to depict typical MCI response, in a typical response - relationship configuration.
Appendix C / MCI and Disaster Management / The EMS Perspective - Continued

RD: October, 1998
REVISED:  June, 1999
            January, 2000
            January 2004
            January, 2010
            July, 2011
            April, 2013