

Incident Command & Effective Management Of Large Scale Emergencies

Prepared for the

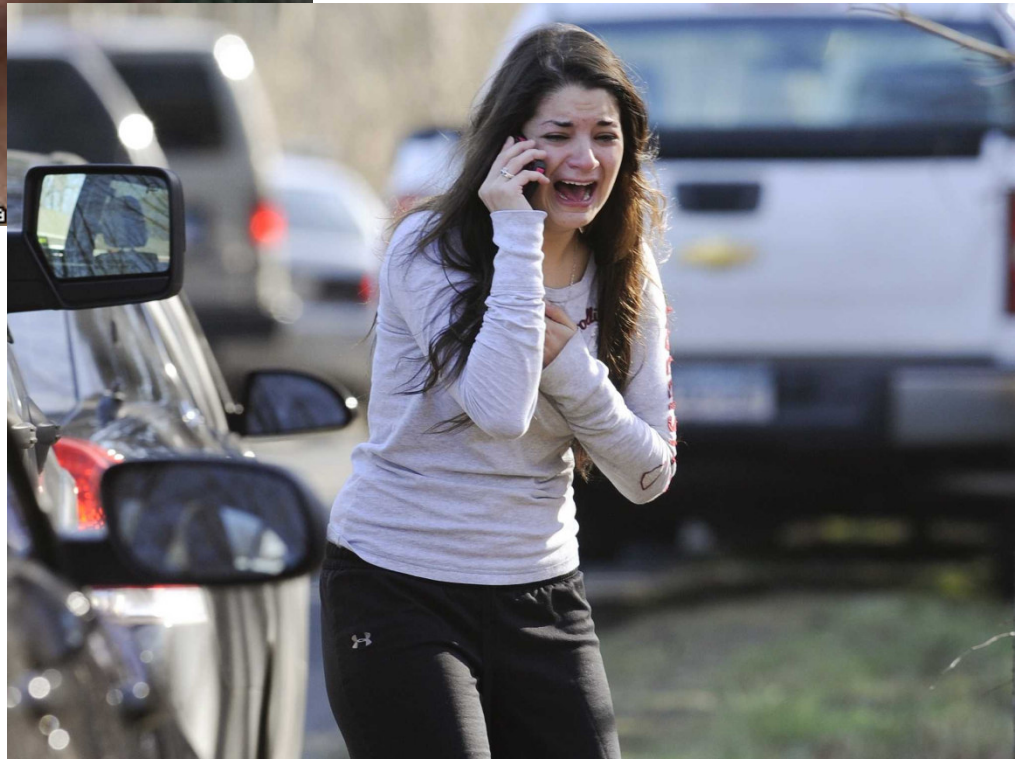
Active Shooter Awareness Seminar
East Farmingdale F.D.



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Suffolk County Department of Health Services
Division of Emergency Medical Services



AP Photo / Rocky Mountain



Problem Defined

- ◆ We become accustomed to our “bread & butter” responses
- ◆ Typical response centers around multiple resources for few patients
- ◆ Major Incident response changes the focus to *few resources for multiple patients*
 - ***Active Shooter compounds the problem due to inherent time delays and the impact on the “golden hour”***
- ◆ *Goal is to add organization to chaos and operate as efficiently as possible AND adjust for modifications in scene operations*

View from First Due - How does this change your response??



THREAT – *The latest acronym*

◆ **T**HREAT SUPPRESSION

◆ **H**EMORRHAGE CONTROL

◆ **R**APID **E**XTRICATION TO SAFETY

◆ **A**SSESSMENT BY MEDICAL PROFESSIONALS

◆ **T**RANSPORT TO DEFINITIVE CARE

THREAT CONCEPTS

- ◆ Simple, basic and proven
- ◆ FACT: *Life threatening bleeding from extremity wounds are best treated with tourniquets*
- ◆ FACT: *Internal bleeding from penetrating chest and trunk trauma are best treated by surgeons*

Standard Equipment



The Future



Tranexamic
Acid
TXA

EMS or TEMS?

- ◆ National Tactical Officers Association Position Statement
 - Based on military experience and civilian events in Combine, Liddleton, Tuscon, Boston, Newton

- ◆ Incorporate sound medical tactics with law enforcement tactics

- ◆ Standard of care for law enforcement tactical operations

- ◆ Recognizes that police officers are often the initial responders to active violent incidents and they need the ability to control life-threatening hemorrhage, triage casualties, establish secure casualty collection points, and coordinate care with existing EMS responders.

EMS or TEMS?

- ◆ Will to operate in violent austere environments
- ◆ Training and certifications in TEMS
- ◆ Purchase and utilize ballistic PPE
- ◆ Casualty care and extraction equipment



Incident Command System (ICS)

◆ The Incident Command System:

- Standardized, on-scene, all-hazard incident management concept
- Allows its users to adopt an integrated organizational structure to match the complexities and demands of single incidents or multiple events without being hindered by jurisdictional boundaries
- Facilitates management of competing objectives



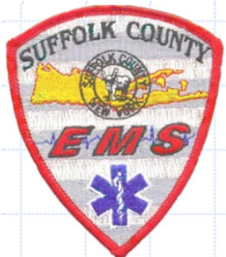
National Incident Management System (NIMS)

- ◆ Built upon foundation of ICS – does not replace it!
 - Balance between flexibility and standardization
 - Modular and scalable
 - Multi-agency/multi-discipline coordination
 - Information management
 - Resource typing / Personnel Qualifications
 - Interoperability
 - Common language



National Incident Management System (NIMS)

- ◆ Management by Objectives (MBO)
- ◆ Reliance on an Incident Action Plan (IAP)
- ◆ Manageable Span of Control
- ◆ Integrated communications
- ◆ Common Terminology / Plain English
- ◆ Transfer of Command
- ◆ Responder Accountability
 - Check-in, track thru response, demobilization
- ◆ Resource Typing / Personnel Qualifications



Use of Plain English

- Communications should be in plain English or clear text.
- Do not use radio codes, agency-specific codes, or jargon.

Even if you use radio codes on a daily basis, why should you use plain English during an incident response?



Why Plain English?

- ◆ EMT = Emergency Medical Treatment
- ◆ EMT = Emergency Medical Technician
- ◆ EMT = Emergency Management Team
- ◆ EMT = Eastern Mediterranean Time (GMT+0200)
- ◆ EMT = Effective Methods Team
- ◆ EMT = Effects Management Tool
- ◆ EMT = El Monte, CA (airport code)
- ◆ EMT = Electron Microscope Tomography
- ◆ EMT = Email Money Transfer

Why Plain English?

**This is Unit 1, we
have a 10-37, multiple code 2s**

**This is Acme Ambulance 1, we have an
unsecured scene and multiple casualties
need police and additional ambulances**

Unified Command

- Enables all responsible agencies to manage an incident together by establishing a common set of incident objectives and strategies.
- Allows Incident Commanders to make joint decisions by establishing a single command structure.
- Maintains unity of command. Each employee only reports to one supervisor.



Incident Command Post



Agency 1



Agency 2



Agency 3



**Agency 1
Incident
Commander**



**Agency 2
Incident
Commander**



**Agency 3
Incident
Commander**

Command Staff

- ◆ Incident Commander
 - Overall responsibility by jurisdictional authority
- ◆ Public Information Officer (PIO)
 - Interface with public and the media, develops accurate information, press briefings, interviews
- ◆ Safety Officer (SO)
 - Monitors operation and advised IC on all matters relating to operational safety
- ◆ Liaison Officer (LO)
 - Point of contact for representatives of other governmental / private agencies



Command Staff

- ◆ Typically includes police, fire, EMS
- ◆ May expand based on incident needs
 - Legal Counsel
 - Public Health Official
 - Chief Public Engineer
 - Mental Health Official
 - Discipline-specific Subject Matter Expert (SME)



SCHOOL LIAISON AT UCP

“SAFE SCHOOLS” Legislation

Requires school district personnel to liaison with emergency responders

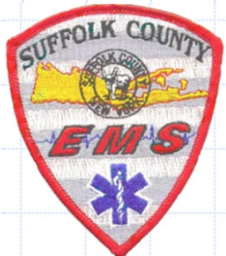
accountability

family reunification centers

short term / long term mental health needs

Elements of an Incident Action Plan

- ◆ Every IAP must have four elements:
 - What do we want to do?
 - Who is responsible for doing it?
 - How do we communicate with each other?
 - What is the procedure if someone is injured?



MEDICAL PLAN	1. Incident Name	2. Date Prepared	3. Time Prepared	4. Operational Period				
	5. Incident Medical Aid Station							
Medical Aid Stations	Location			Paramedics		Yes	No	
6. Transportation								
A. Ambulance Services								
Name	Address		Phone	Paramedics		Yes	No	
B. Incident Ambulances								
Name	Location			Paramedics		Yes	No	
7. Hospitals								
Name	Address		Travel Time		Helipad		Burn Center	
			Air	Ground	Yes	No	Yes	No
8. Medical Emergency Procedures								
Prepared by (Medical Unit Leader)					10. Reviewed by (Safety Officer)			

INCIDENT ACTION PLAN SAFETY ANALYSIS			1. Incident Name			2. Date			3. Time		
Division or Group		Potential Hazards						Mitigations (e.g. PPE, buddy system, escape routes)			
	Type of Hazard:	Type of Hazard:	Type of Hazard:	Type of Hazard:	Type of Hazard:	Type of Hazard:	Type of Hazard:	Type of Hazard:			
Prepared by (Name and Position)											

GENERAL INFORMATION				1. STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS							2. EMPLOYER'S INFORMATION					
REGISTRATION NO. _____ STATEMENT NO. _____ DATE OF STATEMENT _____ NAME OF EMPLOYER _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE NO. _____ NAME OF EMPLOYEE _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE NO. _____				TYPE OF STATEMENT (a) Initial Statement (b) Supplemental Statement (c) Reconsideration STATEMENT NO. _____ DATE _____				SOCIAL SECURITY NO. _____ EMPLOYER'S EMPLOYMENT NO. _____ EMPLOYEE'S EMPLOYMENT NO. _____ DATE OF EMPLOYMENT _____ POSITION TITLE _____ FUNCTION DESCRIPTION _____ EMPLOYEE'S STATEMENT OF WORKING CONDITIONS _____ EMPLOYER'S STATEMENT OF WORKING CONDITIONS _____							DATE OF STATEMENT _____ STATEMENT NO. _____	
NO.	DATE	DESCRIPTION OF WORKING CONDITIONS	CAUSE OF WORKING CONDITIONS	PREVIOUS COMPLAINTS	COMMENTS	STATEMENT NO.	DATE	STATEMENT NO.	DATE	STATEMENT NO.	DATE	STATEMENT NO.	DATE			

DEMobilIZATION CHECK-OUT (ICS 221)

1. Incident Name: _____		2. Incident Number: _____	
3. Planned Release Date/Time: Date: _____ Time: _____		4. Resource or Personnel Released: _____	5. Order Request Number: _____
6. Resource or Personnel: You and your resources are in the process of being released. Resources are not released until the checked boxes below have been signed off by the appropriate overhead and the Demobilization Unit Leader (or Planning Section representative).			
LOGISTICS SECTION			
<input type="checkbox"/>	Unit/Manager	Remarks	Name Signature
<input type="checkbox"/>	Supply Unit		
<input type="checkbox"/>	Communications Unit		
<input type="checkbox"/>	Facilities Unit		
<input type="checkbox"/>	Ground Support Unit		
<input type="checkbox"/>	Security Manager		
<input type="checkbox"/>			
FINANCE/ADMINISTRATION SECTION			
<input type="checkbox"/>	Unit/Leader	Remarks	Name Signature
<input type="checkbox"/>	Time Unit		
<input type="checkbox"/>			
OTHER SECTION/STAFF			
<input type="checkbox"/>	Unit/Other	Remarks	Name Signature
<input type="checkbox"/>			
PLANNING SECTION			
<input type="checkbox"/>	Unit/Leader	Remarks	Name Signature
<input type="checkbox"/>	Documentation Leader		
<input type="checkbox"/>	Demobilization Leader		
7. Remarks: 			
8. Travel Information: Estimated Time of Departure: _____ Room Overnight: <input type="checkbox"/> Yes <input type="checkbox"/> No Destination: _____ Actual Release Date/Time: _____ Travel Method: _____ Estimated Time of Arrival: _____ Manifest: <input type="checkbox"/> Yes <input type="checkbox"/> No Contact Information While Traveling: _____ Number: _____ Area/Agency/Region Notified: _____			
9. Reassignment Information: <input type="checkbox"/> Yes <input type="checkbox"/> No Incident Name: _____ Incident Number: _____ Location: _____ Order Request Number: _____			
10. Prepared by: Name: _____ Position/Title: _____ Signature: _____			
ICS 221		Date/Time: _____	

Continuity of Operations

IMAT

◆ As resources are committed to the scene

Attention must be paid to continuity of operations....

...."whose protecting the rest of the community?.....



Suffolk County MCI Plan

- ◆ Exists as an Annex of the Suffolk County Comprehensive All-Hazards Plan
 - To implement a simple, well organized approach to MCI Management and Operating within the ICS Framework and following unified command principles
 - To Ensure that all patients receive timely triage, care and transport, maximizing available resources
 - Utilize common triage system
 - Provide accountability of patients
 - To establish a central routing & bed clearance process
 - To provide job action tasks to EMS Section Chief / Medical Branch Directors



Suffolk County MCI Plan

- ◆ Phases of Emergency Response
- ◆ Integration with other responders
- ◆ Platform for Agency-Specific SOP/SOGs
- ◆ Types of Large Scale Emergencies
 - Fire, HazMat, Mechanical Hazards
 - Medical MCI / Trauma MCI
 - Natural vs. Man-Made
 - Un-secure Scene
 - Static vs. Dynamic Scene
 - WMD
 - ◆ Well defined incident w/ epicenter, beginning and end
 - ◆ No “physical scene”, evolving over time in large area



Escalation Phase



- ◆ All elements of response
 - Site security
 - Access
 - Extrication / Extraction
 - Triage
 - Treatment
 - Transport



Stabilization Phase

- ◆ All elements of response are well underway
 - adequate supply based on demand
 - units deployed or staged



De-escalation Phase

- ◆ Deliberate and controlled reduction in resources
 - return units to regular duty (“stand down”)
 - equipment decontamination and pick-up
 - begin debriefing



Termination Phase

- ◆ No more patients, no more potential for injury
 - scale down EMS operations
 - securing the scene
 - securing the equipment
 - complete debriefing
 - complete documentation



Responding to an MCI

- ◆ DO NOT respond unless directed to do so
- ◆ Proceed to the staging location as per dispatch instructions
- ◆ While enroute - contact medical command for assignment



Responding to an MCI

- ◆ Follow direction and orders
 - If no direction is provided: ASK!!!
- ◆ NEVER Separate the vehicle, stretcher, and driver of the ambulance



Access

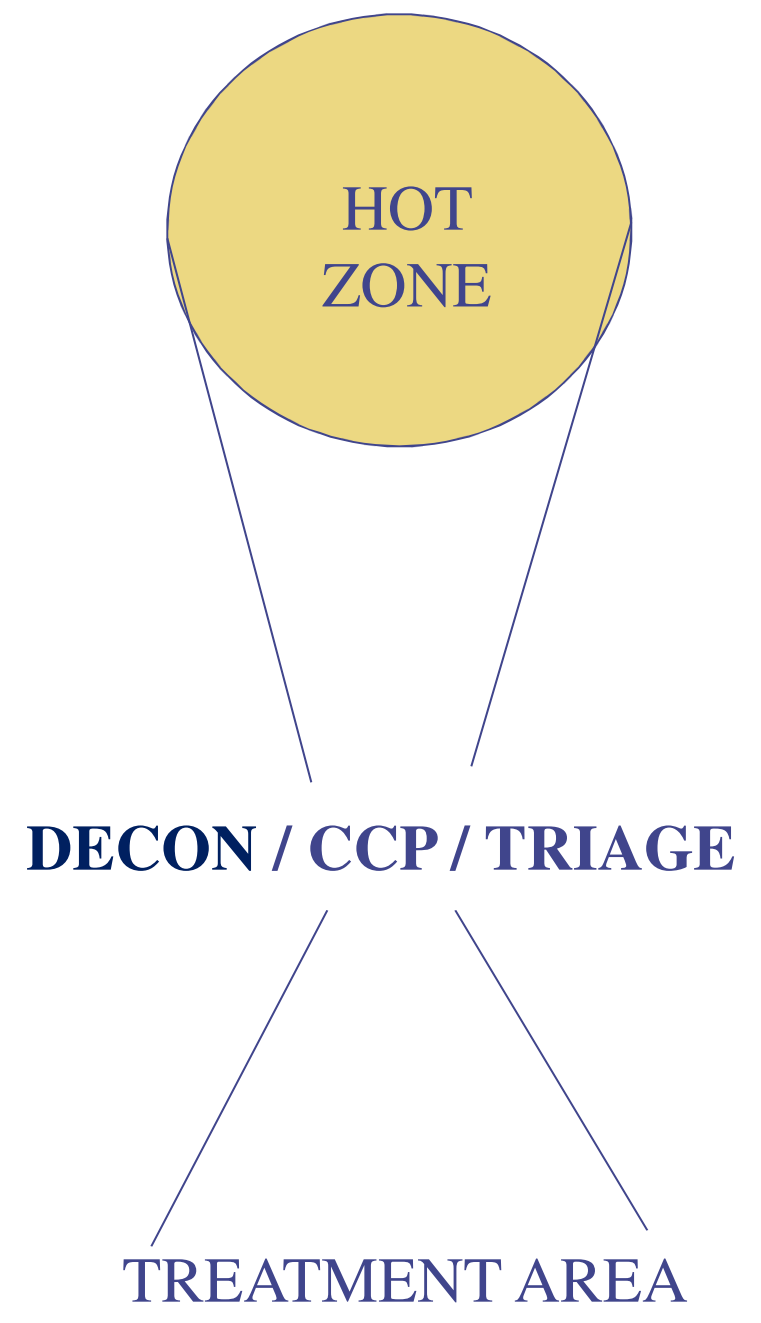
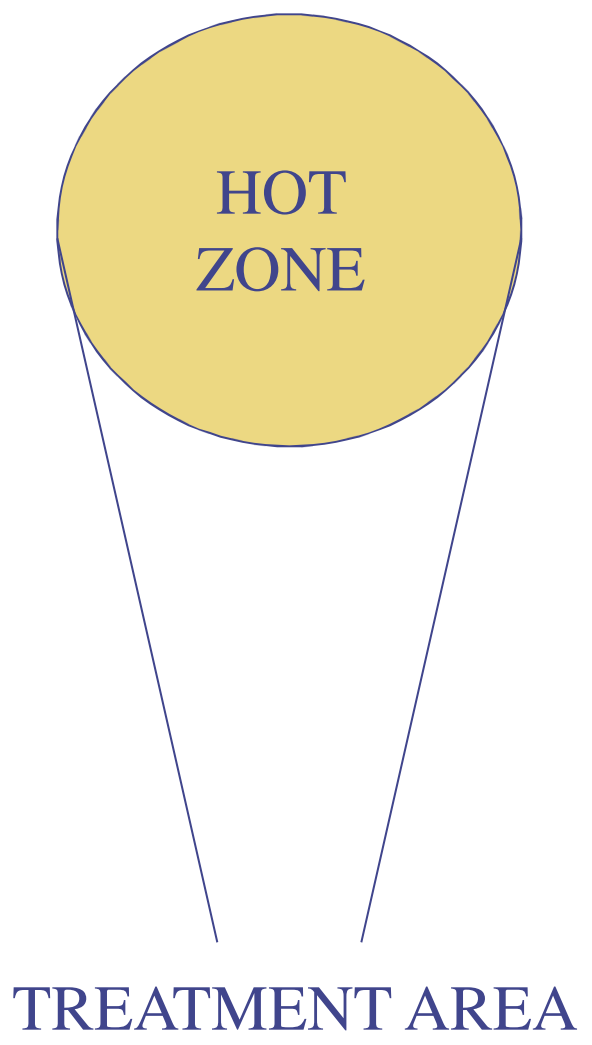
- ◆ Scene Access
- ◆ Patient Access
- ◆ Perimeter Control
- ◆ Egress and Transport



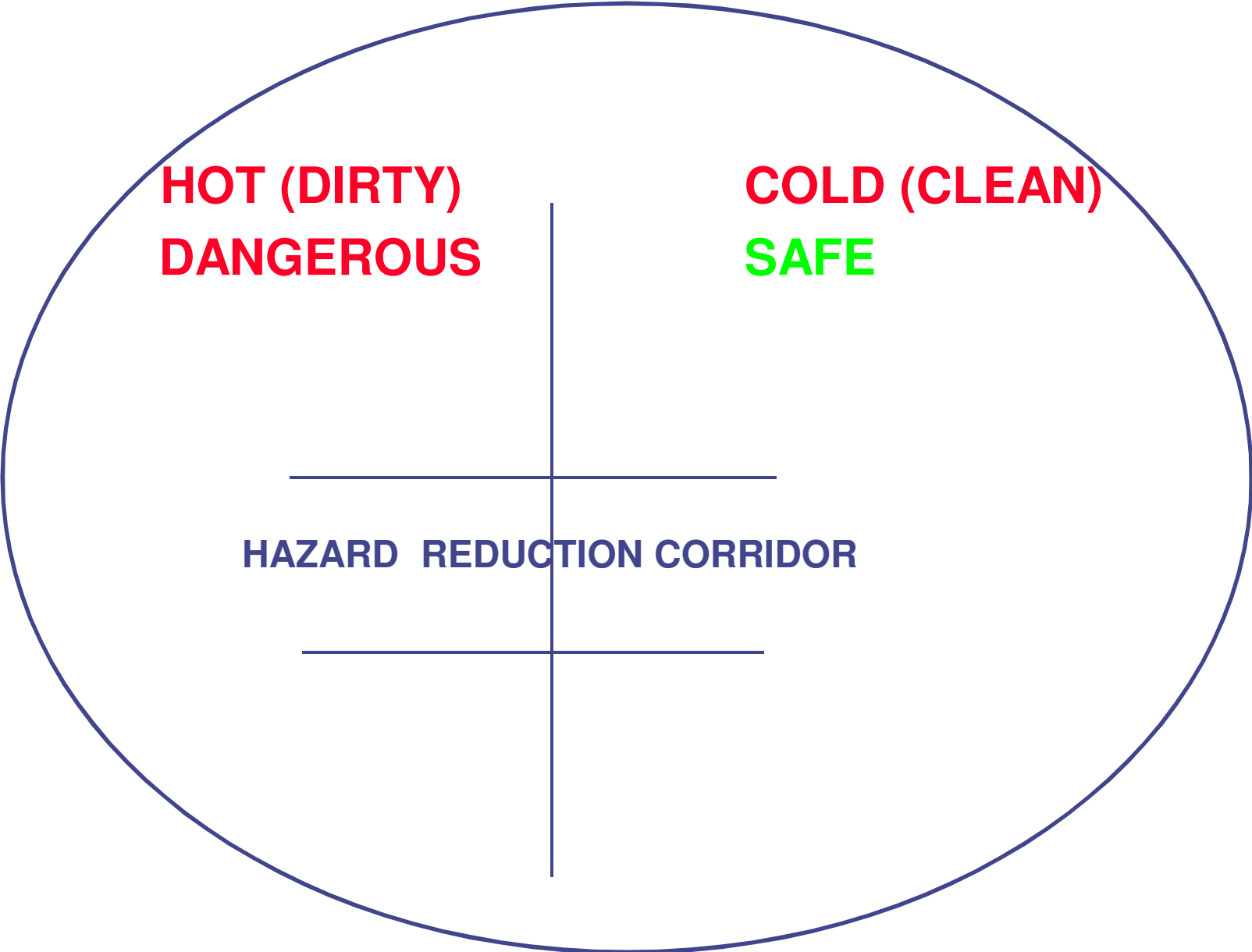
Extrication / Extraction



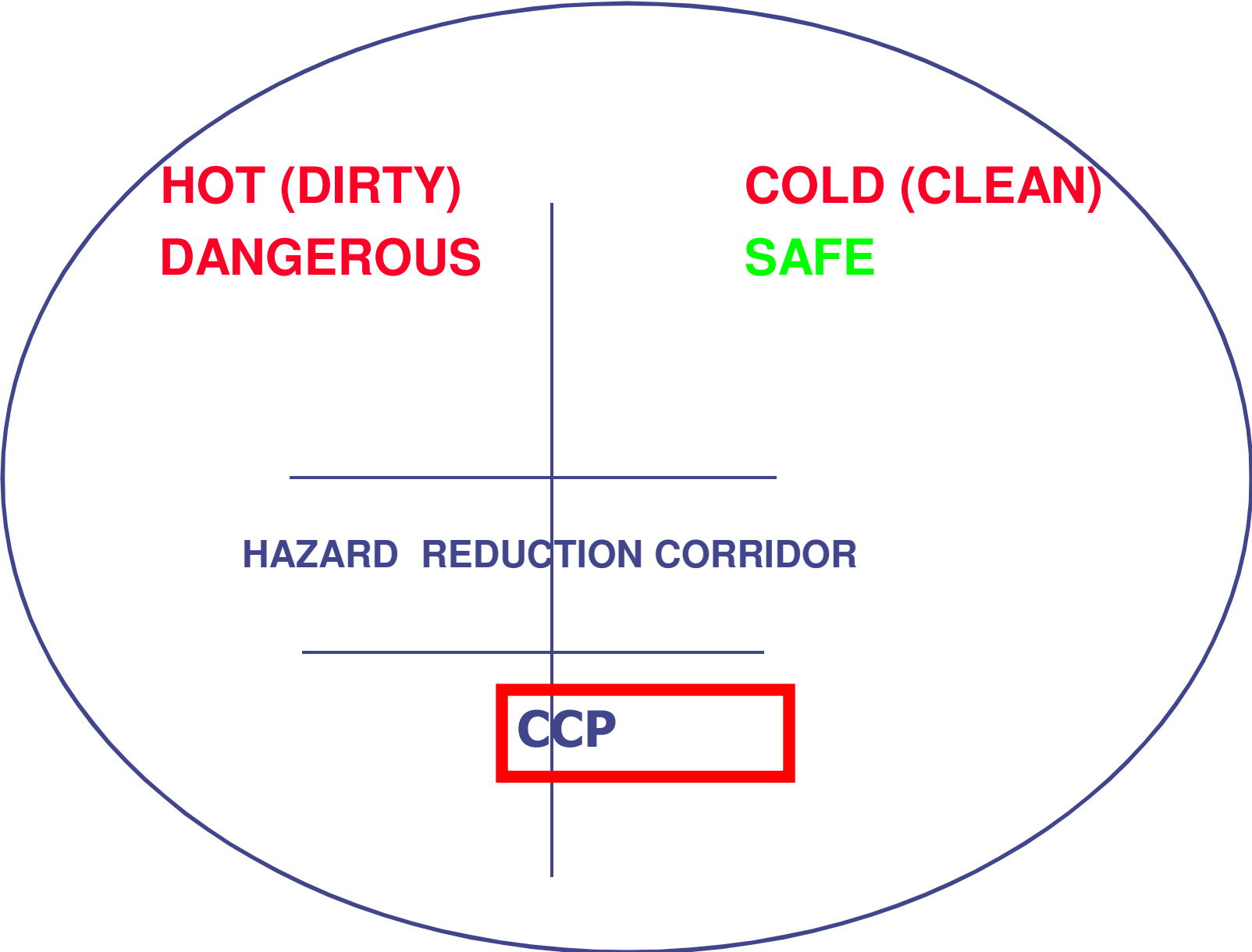
- ◆ Specialized equipment
- ◆ Outside resources
- ◆ Tactical Law Enforcement
- ◆ Technical Rescue



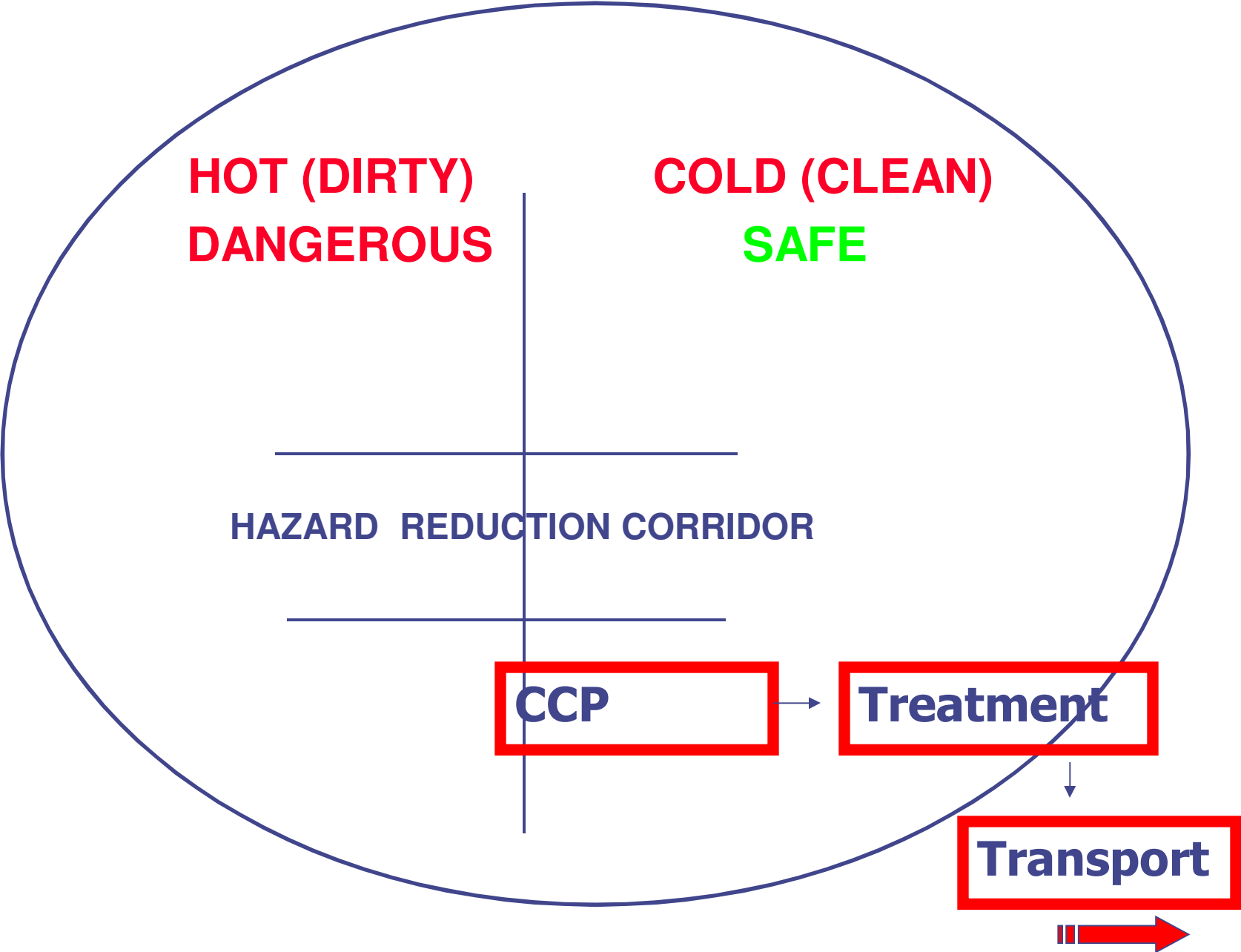
Control Zones



Control Zones



Control Zones



First Arriving EMS Unit

- ◆ Take 4 deep breaths!
- ◆ Survey, size-up, evaluate scene
- ◆ Confirm incident with dispatcher
- ◆ Establish command posture and identify staging locations



Scene Size-Up

- ◆ **Multi Casualty Incident:** Any medical or trauma incident involving multiple patients, where patient needs exceed EMS resources
- ◆ **Mass Casualty Incident:** Where numbers of casualties are significantly disproportional to community resources.
- ◆ **Major Disaster:** An emergency of such magnitude that severely overtaxes the capacity of an emergency response system to adequately deal with the sick or injured; Robert T. Stafford Disaster Relief and Emergency Assistance Act.
- ◆ **Incident of National Significance:** Incident at a location of nationwide character, including federal, state, local and tribal aspects of governance and policy



Initial Response Sequence



- ◆ Establish manpower pool / equipment drop
- ◆ Obtain initial hospital capability & bed inventory (Medical Control)
- ◆ Establish triage sector
- ◆ Establish treatment sector
- ◆ Establish Transport sector
- ◆ Other sectors as needed



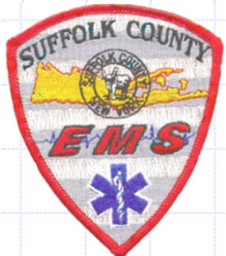
First Arriving Units – “3 Ns”

- ◆ **N**umber of actual/potential victims
 - Nature of injury, casualty pattern
- ◆ **N**ature of the incident
- ◆ **N**eeds
 - Law Enforcement/ESU, Fire, EMS, HazMat, Technical Rescue, Public Health



Suffolk County Medical Control

- ◆ Initiate polling of hospitals to advise of incident, expected impact, and obtain critical asset information
 - Beds
 - Services
 - ◆ Operative, Post-operative, Surgical ICU, Ortho, Neuro, Trauma, Decon,



Suffolk County Medical Control

- ◆ Facilitates single point of contact between scene and multiple hospitals
- ◆ Provides physician level direction for transport decisions if needed
- ◆ Maintains data on
 - Patients transported, by agency, hospital and triage priority
 - Scene departure times
 - Impact on hospitals as services utilized



Pre-arrival Instructions to Responders

- ◆ Staging location
- ◆ **M**echanism of Injury
- ◆ **A**natomic Findings (nature of injuries or injury pattern) e.g.. blast or crush injury
- ◆ **N**umber of patients
- ◆ **S**ector assignments



Initial Size up Example



- ◆ East Farmingdale EMS is establishing EMS Command. We have an unsecured scene at a reported shooting. Multiple children and adults fleeing from multiple entrances. Several patients obvious mortal wounds in sight. Several sectors cars on scene. 15 additional ambulances are requested to stage south side of the railroad station and await instructions. All responding units will operate on MedCom West.



Progress Report

- ◆ Each time a sector is established
- ◆ Identify sector officer
- ◆ Conditions change
- ◆ A sector is closed
 - All patients are triaged
 - All patients are moved to treatment area
 - All patients are transported



On-going EMS Response Sequence

- ◆ Continue triage, treatment and transport by priority to nearest capable hospital, integrate at CCP / safe area
- ◆ Continually monitor hospital capabilities (Medical Control) through Transport sector

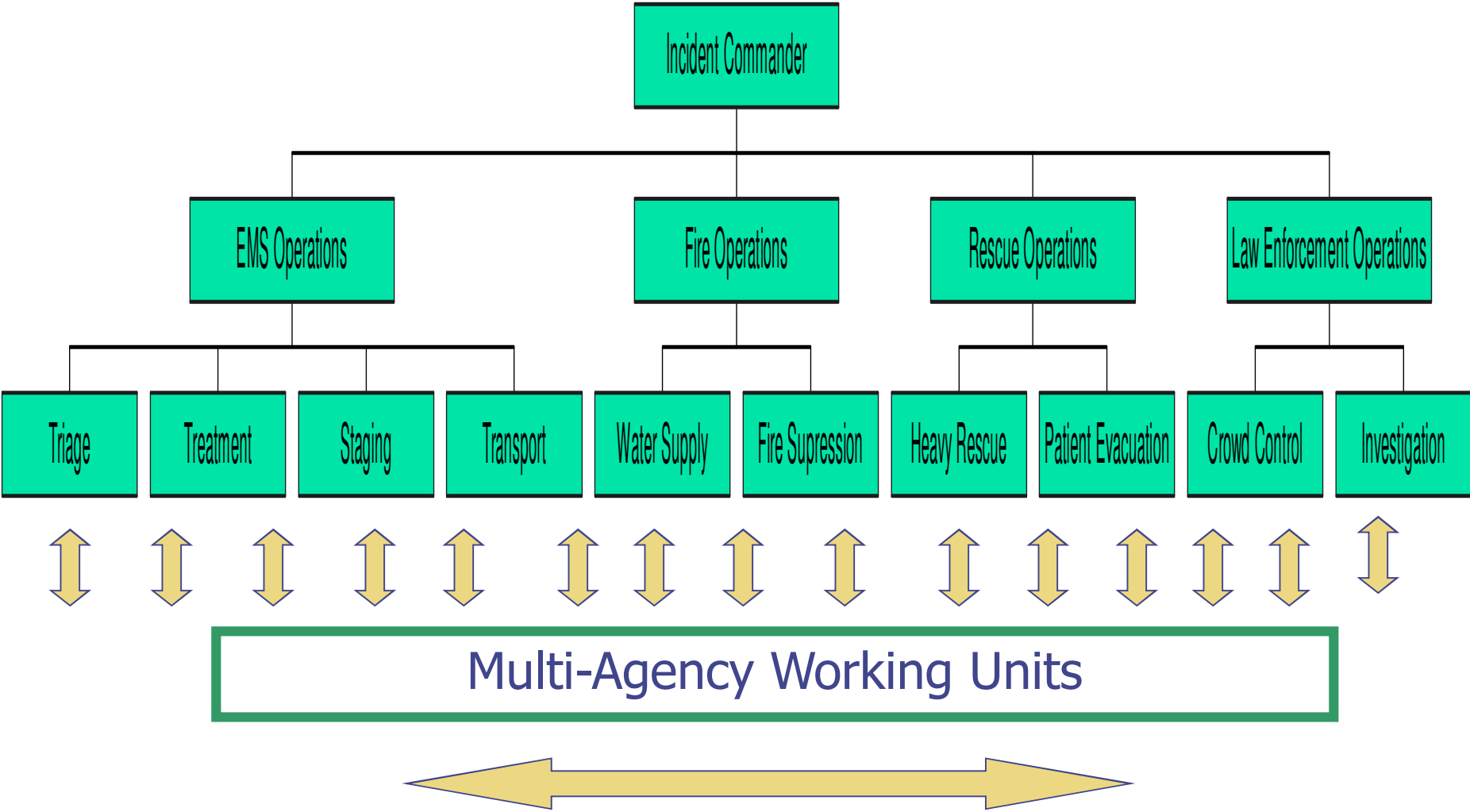


Medical Branches

- ◆ Staging
- ◆ Triage
- ◆ Treatment
- ◆ Transport
- ◆ Medical Monitoring – Rehab
- ◆ Safety

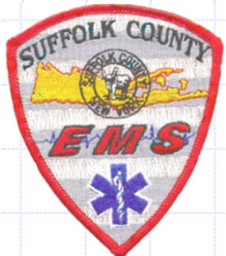


ICS Organizational Chart



EMS Section Chief

- ◆ Location - Command Post
- ◆ Reports to - Incident Commander
 - Make initial assignments based on terminal objectives established by unified command
 - Notifies Medical Control / Initiates Hospital Polling
 - Assist with incident management strategy
 - Keeps IC appraised of patient care and transport progress, and ambulance / manpower availability
 - Communicates with law enforcement liaison
 - Disbands sectors and reassigns personnel as necessary



Triage Branch Director

- ◆ Location – Triage Area
- ◆ Reports to - EMS Section Chief
 - Assures scene safety
 - Maintains integrity of scene during triage ops.
 - Evaluates triage & extrication needs
 - Assembles and directs triage teams
 - Tracks all patients leaving triage area
 - Reports special needs to EMS staging, treatment, transport
 - Keeps EMS Section Chief apprised of triage status and when triage is complete



Treatment Branch Director

- ◆ Location – Treatment Area
- ◆ Reports to - EMS Section Chief
 - Share in patient care decisions
 - Assembles and directs patient care teams, assures appropriate medical supplies and equipment
 - Designates treatment areas by priority
 - Tracks all patients in treatment area
 - Coordinates activity with triage transport, and staging sectors
 - Assures patient re-assessment and modifies transport plan as necessary
 - Reports special needs to the EMS Section Chief



Transport Branch Director

- ◆ Location - Transport Area
- ◆ Reports to - EMS Section Chief
 - Ensures all transport assignments are accurate
 - Designs and coordinates traffic pattern into / out of sector, ensures smooth and safe vehicle flow
 - Maintains check-in/checkout log w/ patient tracking
 - Coordinates patient movement with Suffolk County Medical Control, maintains communications throughout
 - Communicates with command, triage, and staging to maintain adequate resources throughout

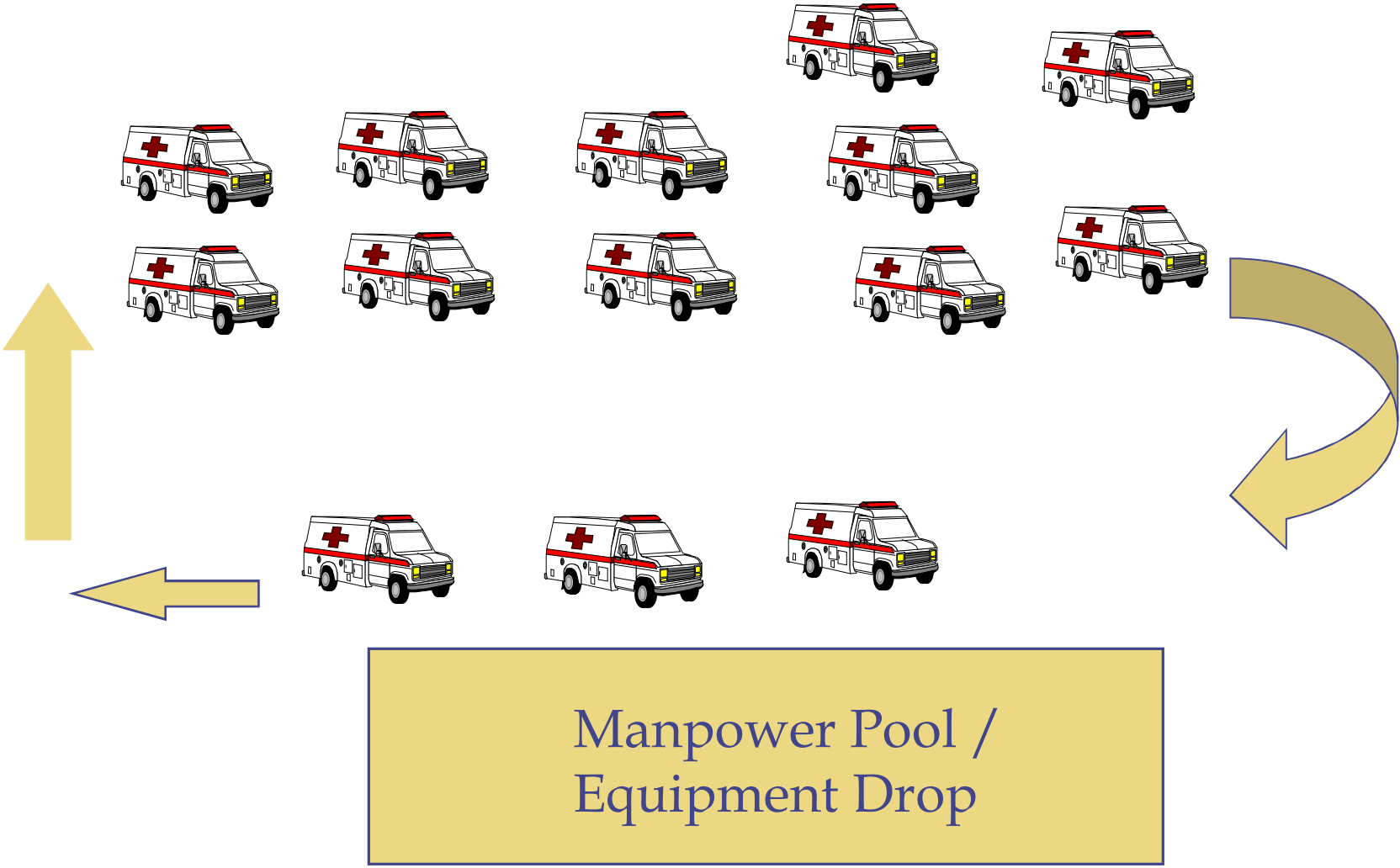


EMS Staging Branch Director

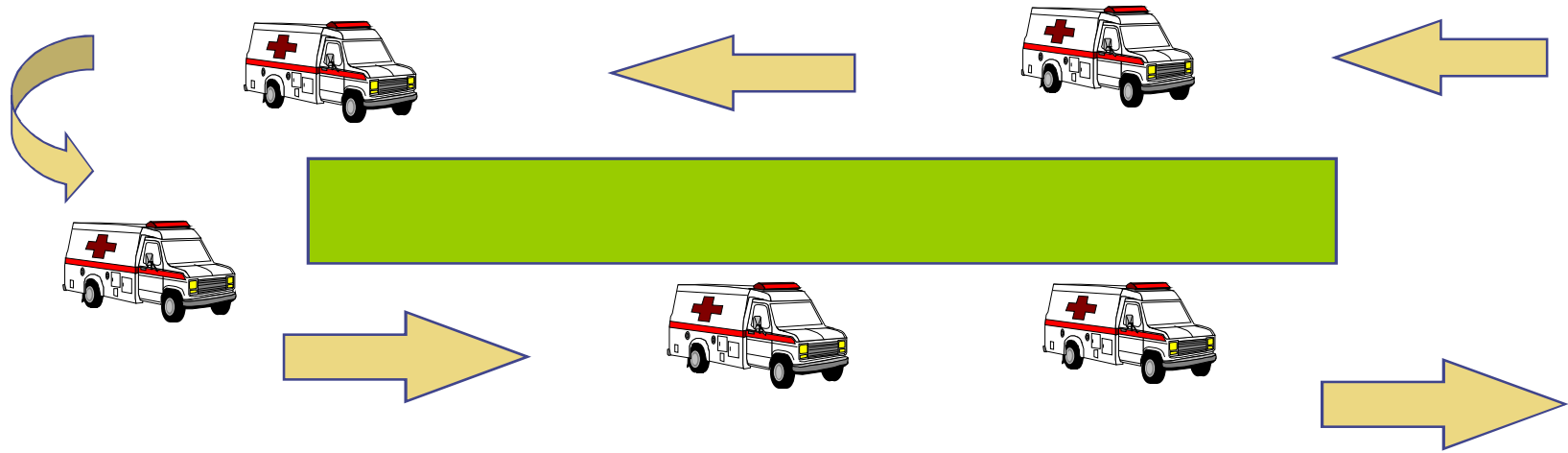
- ◆ Location - Staging Area
- ◆ Reports to - EMS Section Chief
 - Maintains visible position large enough to support incoming vehicles
 - Secures high occupancy vehicle(s)
 - Maintains check-in/checkout log
 - Holds transport vehicles until assigned
 - Calls for additional vehicles as supply is depleted
 - Prevents bottlenecks, establishes safe traffic patterns into/out of staging area
 - Checks credentials of all medical personnel and assigns to manpower pool as necessary
 - Communicates with triage, treatment sectors



Site Pass-Through and Relocation



Horseshoe Staging



Transport Sector

“Cattle Chute” Staging

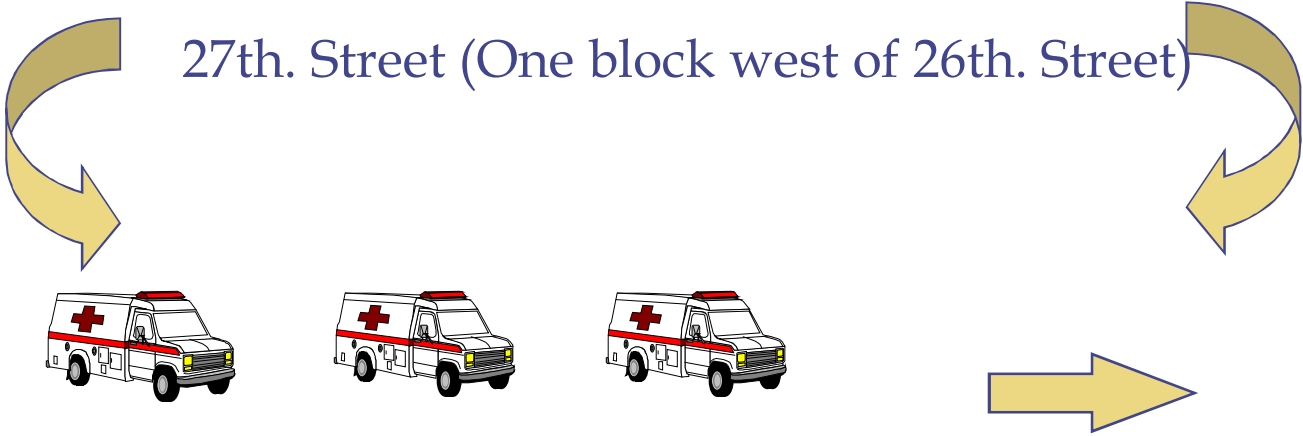


Transport Sector

Off-Site Staging



27th. Street (One block west of 26th. Street)



Transport Sector
26th street





Rehab Branch Director

- ◆ Location – Rehab Area
- ◆ Reports to - EMS Section Chief
 - Maintains visible position large enough to support incoming manpower
 - Close enough to access/far enough to be safe
 - Establish rehab guidelines
 - Oversee rehab teams
 - Maintains check-in/checkout log
 - Secures required fluids/nutrition/medical supplies, other supplies
 - Have the authority to issue disposition



Special Sector Operations



◆ Other **Branches** or **Divisions** as required by incident

- Helicopter LZ
- Technical Rescue
- Dive Team
- Morgue
- Decontamination
- Tactical Law Enforcement
- Tactical EMS



Scene Management - TRIAGE

- ◆ Initial Triage - "START", establish Incident Command System
- ◆ Patient Identification
- ◆ Secondary Triage and Treatment
- ◆ Tertiary Triage, Staging and Transportation
- ◆ Facilitate patient flow



Active Shooter Triage

- ◆ Consider time from injury to extraction
- ◆ Consider bleeding control attempts already in place
- ◆ Think decompensation
- ◆ Check in with transport and keep moving to hospital

Before You Pull Out The Tags!

- ◆ Before you can send patients to hospitals, you must have **ambulances available** and get a destination from Medical Control or the Transport Officer.
- ◆ Before you can get a destination, you need to know **approximately how many patients and their general casualty pattern**
- ◆ Before you can identify what category a patient is in, they need to be **carried from the CCP to the treatment area**



The Movement of Patients

- ◆ The next major consideration is how to move your patients to either ambulances, or if none are available, to treatment areas. **This will require methods to carry them (flats, stretchers, backboards) and personnel (litter bearers).**
- ◆ Litter bearers are grouped as Litter Teams and report to the Triage Officer for assignments. The preferred number of people for a litter team is 4, however it can be done by 2 in most cases. **Plan to assign many of your initial resources to this function or you will get way behind the curve.**
- ◆ **As the equipment gets used, it must be replaced. Have a plan that will keep you in carrying devices, such as, having the ambulance leave backboards to replace the ones they are taking with patients.**



Triage

- ◆ Developed in 1792 by Dominique Larrey, Chief Surgeon in the Napoleonic-Era Military
- ◆ From the French “to select” or “to sift”
- ◆ Evolved to:
 - Those likely to live regardless of care
 - Those likely to die regardless of care
 - Those where immediate care might make a positive difference

S.T.A.R.T. System of Triage

- ◆ Rapid assessment
- ◆ Requires only limited medical training
- ◆ Based on three vital functions



Primary Disaster Triage

- ◆ Triage based on *physiology*
 - How well the patient is able to utilize their own resources to deal with their injuries
 - Which conditions will benefit the most from the expenditure of limited resources



Ethical Justification

This is one of the few places where a "utilitarian rule" governs medicine: the greater good of the greater number rather than the particular good of the patient at hand. This rule is justified only because of the clear necessity of general public welfare in a crisis

A. Jonsen and K. Edwards, "*Resource Allocation*" in *Ethics in Medicine*, Univ. of Washington School of Medicine, <http://eduserv.hscer.washington.edu/bioethics/topics/resall.html>

S.T.A.R.T. System

- ◆ Each patient assessment should take no more than 60 seconds
- ◆ Each patient gets tagged either:
 - ◆ Dead Non/Salvageable
 - ◆ **Critical/Immediate**
 - ◆ Delayed
 - ◆ **Walking Wounded**



The Future: Orange Tag



Nº 565959

Nº 565959

11/11/2011

**EMERGENCY
TRIAGE
TAG**



Nº 565959

CONTAMINATION:

NO YES



Residence: _____

Phone: +3500 _____

Medical History: _____

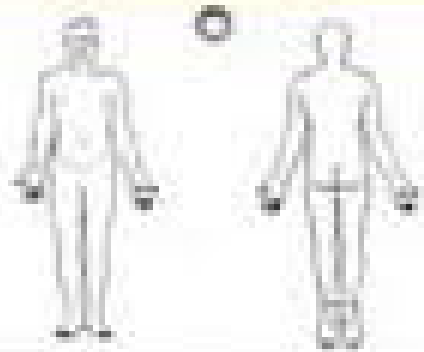
Special Allergies: _____

Time: _____

Time: _____

Height: _____

Weight: _____



Name: _____

Address: _____

Emergency Contact: _____

Personal Information: _____

Sex: _____

Age: _____

DOB: _____

Height: _____

DECEASED

IMMEDIATE

DELAYED

MINOR

DECEASED

IMMEDIATE

DELAYED

MINOR

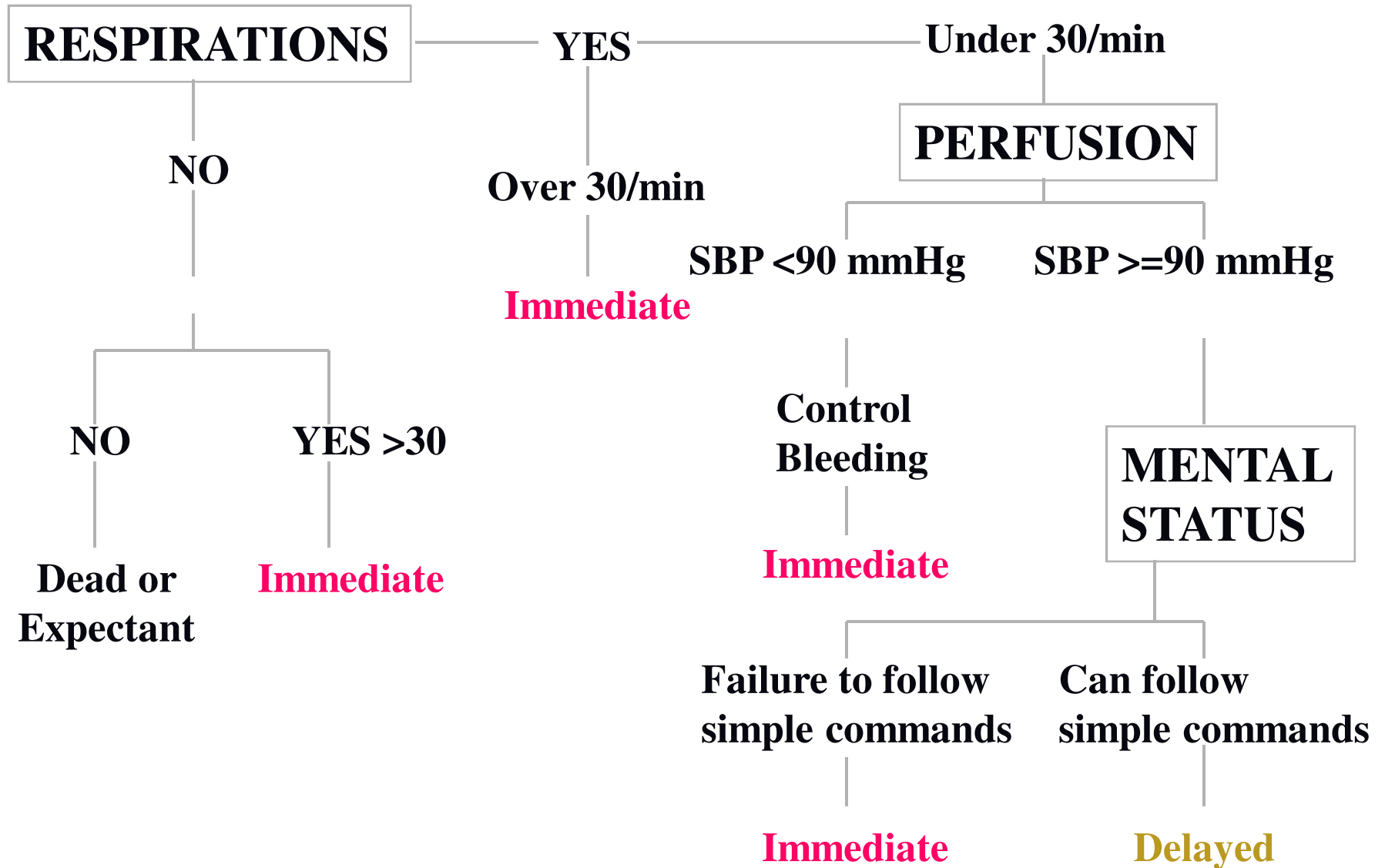


S.T.A.R.T. SYSTEM

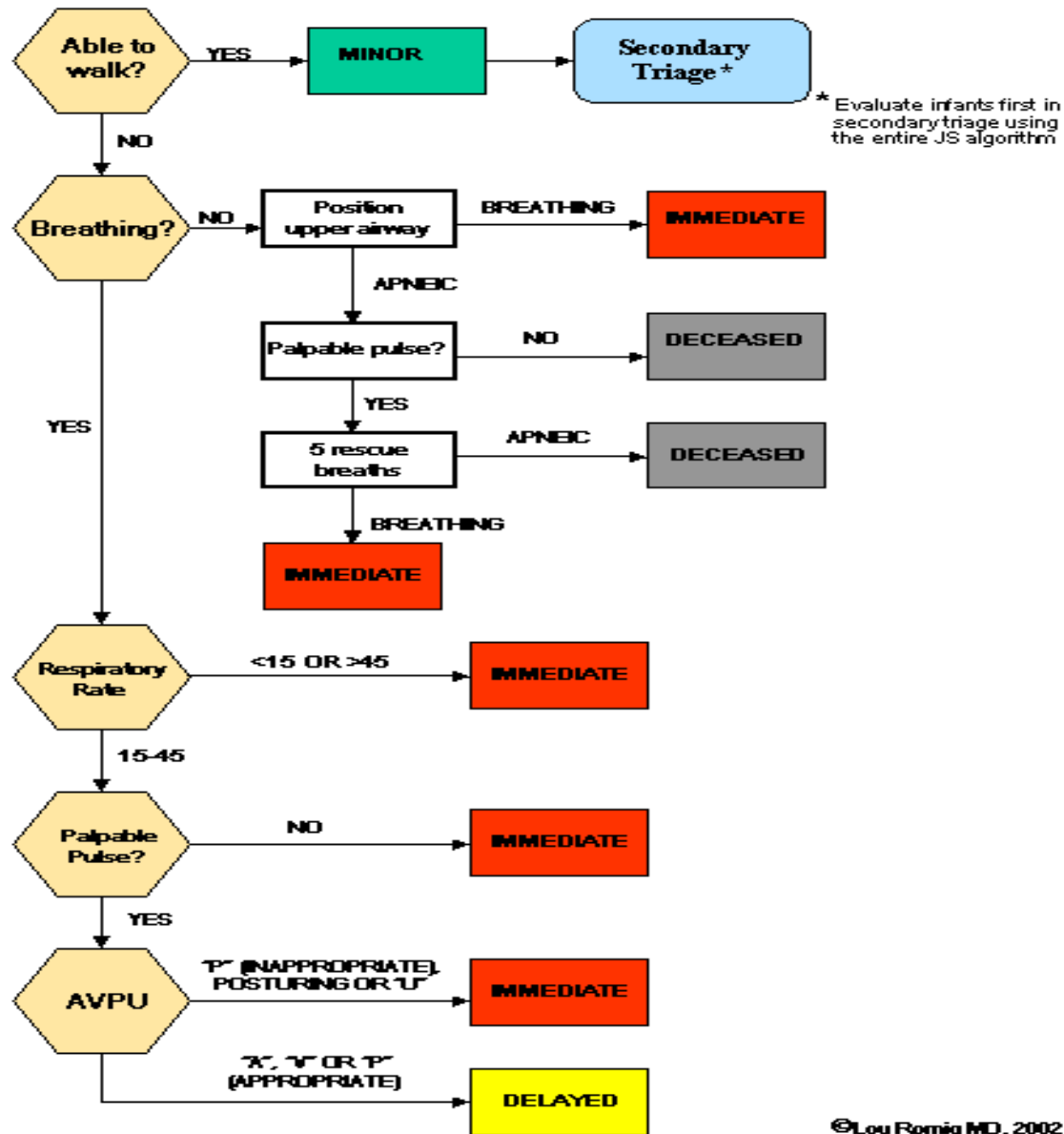
- ◆ Anybody who can obey commands and walk out of harms way on their own is initially a **Green Tag** patient....move on to the non-ambulatory patients



START Method Triage



JumpSTART Pediatric MCI Triage



NATO Guidelines



Red

Airway obstruction, cardiorespiratory failure, significant external hemorrhage, shock, sucking chest wound, burns of face or neck



Yellow

Open thoracic wound, penetrating abdominal wound, severe eye injury, avascular limb, fractures, significant burns other than face, neck or perineum

NATO Guidelines



Green

Minor lacerations, contusions, sprains, superficial burns, partial-thickness burns of $< 20\%$ BSA



Black

Head injury with GCS < 8 , burns $> 85\%$ BSA, multisystem trauma, signs of impending death

Hospital Triage - Emergency Severity Index (ESI) Level 1

- ◆ **Cardiac arrest.**
- ◆ **Respiratory arrest.**
- ◆ Severe respiratory distress.
- ◆ SpO2 <90.
- ◆ **Critically injured trauma patient who presents unresponsive.**
- ◆ Overdose with a respiratory rate of 6.
- ◆ **Severe respiratory distress with agonal or gasping-type respirations.**
- ◆ **Severe bradycardia or tachycardia with signs of hypoperfusion.**
- ◆ **Hypotension with signs of hypoperfusion.**
- ◆ **Trauma patient who requires immediate crystalloid and colloid resuscitation.**
- ◆ Chest pain, pale, diaphoretic, blood pressure 70/palp.
- ◆ Weak and dizzy, heart rate = 30.
- ◆ Anaphylactic shock.
- ◆ Baby that is flaccid.
- ◆ Unresponsive patient with a strong odor of alcohol.
- ◆ Hypoglycemia with a change in mental status.
- ◆ Intubated head bleed with unequal pupils.

Short Term Recovery

- Short term Critical Incident Stress Management (CISM) for First Responders
- Long term Community Mental Health Needs



SUMMARY

- ◆ Response to the active shooter scenario is an emotionally charged, quickly evolving situations
- ◆ Active shooter events are primary law enforcement-centric until threats are neutralized
- ◆ Response requires a unified approach with common tactics and common communications
- ◆ People will die, our goal is to limit mortality and morbidity by working together in a controlled, efficient manner.



QUESTIONS?



*Prepared for the Active Shooter Awareness Seminar
East Farmingdale, NY, January 12, 2014*