SALT LAKE EMS DISTRICT
(Official Protocol No.06)

Protocol No. 06

MASS CASUALTY INCIDENT PLAN

Revised 2003

The Salt Lake EMS District has adopted the Utah Mass Casualty Incident Plan. **Several modifications particular to the Salt Lake EMS District have been made, and introductory sections and definitions omitted. Refer to the complete plan for details.**

1. **Assess scene and set up incident command (unified command)**

2. **Consider additional resources (i.e. law enforcement, ambulances, rescue and heavy rescue units, haz-mat, automatic and mutual aid)**

3. **Assign sectors/divisions as required (i.e. safety, triage, treatment, decon, transport)**

4. **Notify area hospitals (Through dispatch, hospital common, individual channels, or cellular)**

5. **Refer to the Utah Mass Casualty Incident Plan for details.**

JURISDICTION AND COMMAND

Each agency shall retain full command authority within its jurisdiction at all times. Agencies that are assisting in support of a single jurisdiction will function under the direction of that jurisdiction's designated Incident Commander and ICS for effective use of resources.

In multi-jurisdictional incidents, Incident Commanders will establish a Unified Command by planning and coordinating strategies for controlling resources and the overall incident at a single location command post.

STATE OR FEDERAL MAJOR DISASTERS: Refer to the Utah Mass Casualty Incident Plan

Prior to activation of the State EOC, the Bureau of EMS can respond immediately at the request of a local jurisdiction. Call (pager) 1-800-612-8695, available 24 hours a day, seven days a week.

MASS CASUALTY INCIDENT STANDARD RESPONSE LEVELS

A mass casualty incident may be declared at the scene by the initial responding units. Considerations for initiation of an MCI should include location, number of victims, weather, exposures, HazMat, potential cause (WMD) and resources available.

LEVEL I: NORMAL RESPONSE

An event that is handled through normal local response without reducing the agency's capability to respond to other emergencies.

LEVEL II: COMMUNITY EMERGENCY RESPONSE

An event that may require a substantial commitment of local resources**.**

LEVEL III: MINOR DISASTER RESPONSE

An event that is likely to extend beyond the response capabilities of one agency and their mutual aid agreements and results in a multi-jurisdictional response. Incident Command should consider requesting a local state of emergency, activate local emergency operations center (EOC), consider activating the State EOC.

LEVEL IV: MAJOR DISASTER RESPONSE

An event that will exceed local response capabilities and require a broad range of state and federal assistance. Activate local, county and state EOCs.

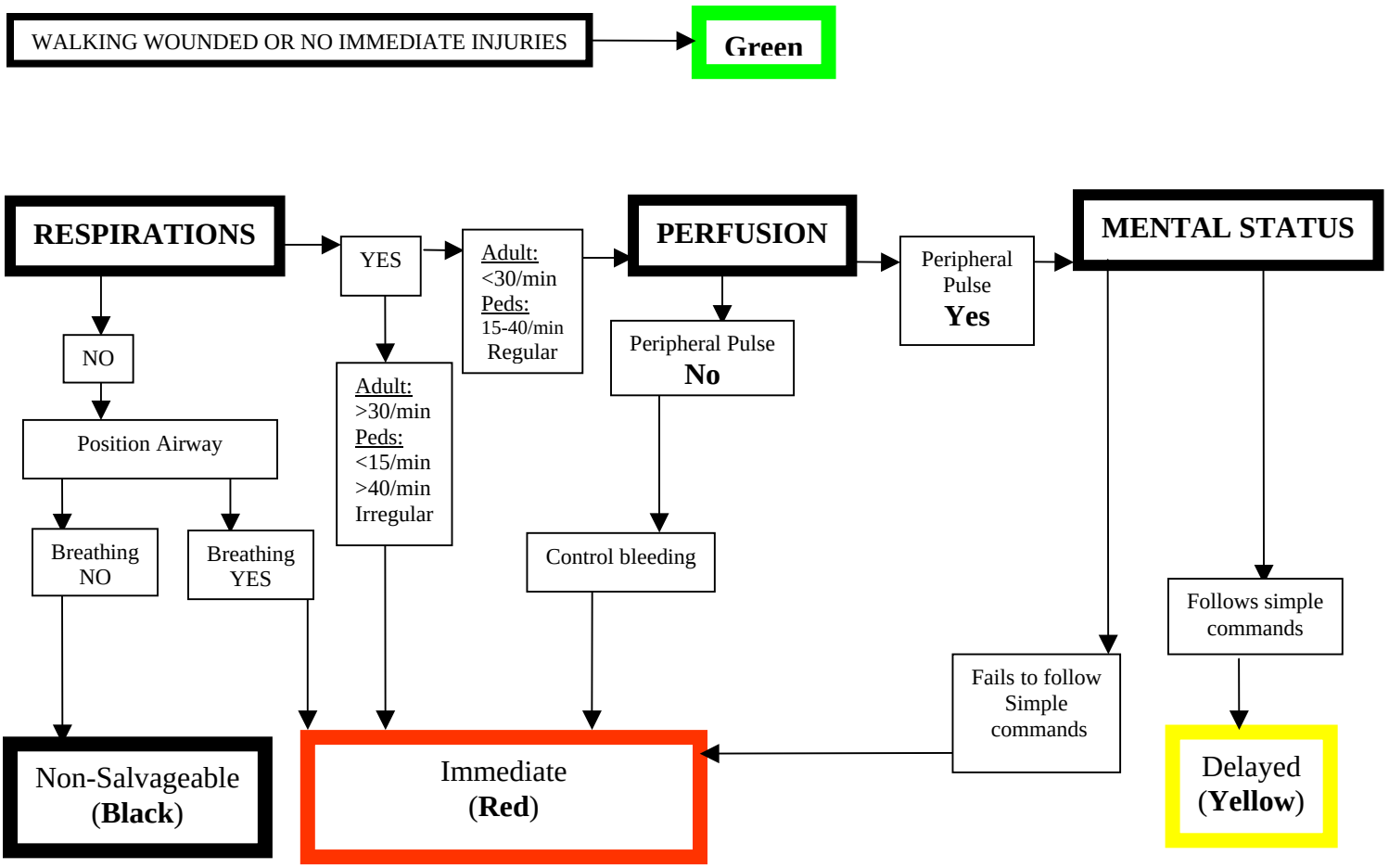
LEVEL V: CATASTROPHIC DISASTER RESPONSE

An event of such a magnitude that massive state and federal assistance is required. local, county, state and federal EOCs.

TRIAGE

The "START System" (Simple Triage and Rapid Transport) is a method of rapidly assessing and triaging mass casualty patients. The triage group should implement the "START" system whenever an incident involves four or more patients.
Only BLS airway maneuvers and bleeding control by direct pressure are done during triage: any other treatment gets done in treatment area.

S.T.A.R.T. Triage



START BELT SYSTEM

The START belt system consists of a belt similar to a fanny pack that contains the following.

5m - rolls of surveyors tape (green, yellow, red, black/white and blue.
3 each 4x4's
3 each 5x9's
5 each 4" Kerlix
Adult and pediatric sized oral airways.

Perform a primary survey on all patients using the START method of triage. During the rapid evaluation, simple hemorrhage control and airway protection techniques are used. The only treatment should be completed by adjusting the airway, placing an oral airway, or placing a dressing to stop bleeding.

TREATMENT

IMMEDIATE (RED) TREATMENT AREA:

Repeat START Triage. Retriage as indicated.

The immediate zone is for the treatment of critical patients **identified by START as** requiring - **lifesaving interventions: Intubate for airway protection and assistance of <u>spontaneous</u> ventilation. Cricothyrotomy for upper airway obstruction. Vent chest if tension pneumothorax with hypotension suspected. Three-sided valve dressing to sucking chest wounds. Moist dressing to eviscerations. IV fluids to begin resuscitation in hypotensive burn victims (don't delay transport of other hypotensive patients for IV starts if this can be done en route). Control bleeding. Vital signs. Reassess frequently.**

After retriage and treatment, apply appropriate triage tag and give as much info as possible. Replace wristband if Priority has changed.

DELAYED (YELLOW) TREATMENT AREA:

Repeat START Triage. Retriage as indicated.

Control bleeding. Vital signs. ALS treatment for non-life-threatening injuries as indicated. Dress wounds & burns, and splint extremities as time and equipment allow. Moist dressing to eviscerations. Reassess frequently.

After retriage and treatment, apply appropriate triage tag and give as much info as possible. Replace wristband if Priority has changed.

WALKING WOUNDED (GREEN) TREATMENT AREA:

Ambulatory patients who do not need urgent medical assistance should be removed from the scene as soon as possible to reduce confusion. These patients may be gathered together at an assembly area for further assistance. At least one medically trained individual should be assigned to monitor their status until transportation can be arranged.

Repeat START Triage. Don't assume someone doesn't have serious injuries just because they're ambulatory. Retriage as indicated. Replace wristband if Priority has changed. Control bleeding. Vital signs. Dress wounds & burns, and splint extremities as time and equipment allow. Reassess frequently.

After retriage and treatment, apply appropriate triage tag and give as much info as possible. Replace wristband if Priority has changed.

DECEASED (BLACK) - Patients tagged with black tape are to be left in place.

ADDITIONAL INFORMATION TAPES/WRISTBANDS:

DECONTAMINATED (BLUE TAPE) - These patients will be triaged according to the START system based upon their injuries. In addition, a blue surveyors tape or wristband will be added to indicate that decontamination of the individual has taken place. Patients involved in a HazMat situation will not be moved into treatment areas without the determination of appropriate decontamination. **Note the type and extent of decontamination on the treatment tag when the patient reaches the treatment area.**

ANTIDOTE GIVEN (ORANGE TAPE) – Patients that have been exposed to a hazardous material and required an antidote to be given will receive an orange tape or wristband after the antidote has been administered. **Note the specific antidote(s), dose(s), and time(s) on the treatment tag when the patient reaches the treatment area.**

TRANSPORTATION

The Transportation Group Supervisor is responsible for providing, coordinating and tracking all patient transportation. **The Transportation Group Supervisor is appointed by the Incident Commander or his/her designee.**

HOSPITALS

In the event of a Mass Casualty Incident, local acute care hospitals with emergency departments will be alerted **as early as possible by the Incident Commander or his/her designee (using hospital common frequency), and/or** by the **IC's** dispatch agency with follow up from the Transportation Group Supervisor.

Hospital information should include:

- Location and type of incident
- Estimated number, severity, and types of injuries
- Special resources needed
- Decontamination needed

Each Hospital should make preparations for the activation of their external disaster plans depending on the number of victims expected.

Upon notice to activate their disaster plan; each hospital should be prepared to provide to the Transportation Group Supervisor the following information:

- Emergency Department Status
- Ability to receive and care for:
  - Immediate (RED) Casualties
  - Delayed (YELLOW) Casualties
  - Walking Wounded (GREEN) Casualties
  - Burns, % OF TOTAL BSA

Each hospital will also internally evaluate the availability of operating rooms, including the number of scrub teams, and note the number of critical care beds available for trauma beds.