Mass Casualty Incidents

The purpose of this protocol is to provide a uniform initial response to a Mass Casualty Incident (MCI).

I. **Definition of MCI**: For the purpose of this document, an MCI will be defined as any incident, which because of its physical size, the number and criticality of its victims, or its complexity, is likely to overwhelm those local resources (including local hospitals), which would typically be available.

II. **Overall MCI Management – DISASTER Paradigm™**
The DISASTER Paradigm™ is part of the National Disaster Life Support (NDLS) Program and provides a framework for management of MCIs. The components may be pursued concurrently.
A. ***D****etection*: Do we have an MCI? If yes, immediately declare to dispatch.
B. ***I****ncident Command*: Establish or interface with the Incident Command System (ICS)
C. ***S****afety and Security*: Immediate action steps to immediately protect responders, casualties, public.
D. ***A****ssess Hazards*: Actively assess (initially and ongoing) for hazards that can harm responders, casualties, public.
E. ***S****uppor*t: Request resources needed to effectively manage incident
F. ***T****riage and Treatment*: Initiate SALT Triage and provide treatment to casualties
G. ***E****vacuation:* Transport of casualties to appropriate hospitals (avoiding overloading individual hospitals) or alternate treatment centers
H. ***R****ecovery:* Return responders and community to pre-incident status and identify lessons learned.

III. **MCI Detection**
A. Actively assess the scene to determine if MCI is (or maybe) present
B. Alert dispatch and assure hospitals and other stakeholders made aware
C. For major incidents (including incidents involving multiple counties/MCA resources) RMCC should be alerted

IV. **Incident Command System**
A. All incidents shall be managed in accordance with the National Incident Management System and the National Response Framework.
B. If Incident Command (IC) has not been established, the most qualified EMS personnel shall assume the role of IC until command is transferred.
C. The IC is responsible for all functions of the Incident Command System (ICS) until other personnel are assigned those functions**.**
D. Establish EMS Branch Director/EMS Group Supervisor
    1. Established by IC
    2. Responsible for all EMS activities
    3. Reports to IC or Operations Chief
E. Establish functional subordinate EMS ICS positions, as appropriate. Note, positions may be combined (e.g., Treatment/Transport) when appropriate.
    1. Triage Unit Leader Role
        a. Report to EMS Branch Director/Group Supervisor

b. Coordinates rapid triage process
c. Determines number/severity of casualties

2. Treatment Unit Leader Role
   a. Within EMS Branch/Group Operations, establish Casualty Collection Point (CCP)
   b. Assigns personnel to treatment area(s)
   c. Supervise care in treatment areas and/or establish subordinate treatment unit leaders for selected casualty types (e.g., Red, Yellow, Green, etc.).
3. Transportation Unit Leader Role
   a. Prioritize transportation of patients from scene assuring high priority patients transported first and departing ambulances maximally utilized.
   b. With information from coordinating resource, assigns destination hospital or alternate care center
   c. Maintains log and tracking of patients transported

V. **Communications**

A. EMS Unit Identifiers for communications:

1. Alpha – A – ALS transport unit
2. Bravo – B – BLS transport unit
3. Charlie – C – Supervisory vehicle
4. Delta – D – Physician vehicle
5. Echo – E – ALS non transport unit
6. Hotel – H – Air Ambulance or Helicopter
7. Romeo – R – Rescue, Extrication or MFR unit
8. Tango – T – BLS non transport unit

B. All communications shall utilize the Unit Identifiers and Unit Numbers per OCMCA Protocol **8.12 Communications with Emergency Facilities**.

VI. **Safety and Security**

A. Responders should don appropriate personal protective equipment (PPE)
B. Identify any immediate threats to responders, patients, or the public

VII. **Assess for Hazards**

A. Actively assess scene for hazards
B. Ongoing assessment for new hazards

VIII. **Support – Request Additional Resources for Incident**

A. Ambulances
   1. Request additional ambulances
   2. Ideally, one ambulance for every two Red/Yellow patients
B. Non-Ambulance Medical Transport
   1. Non-licensed vehicles may be used for emergency transport when licensed ambulances are not readily available.

If an ambulance operation is unable to respond to an emergency patient within a reasonable time, this part does not prohibit the spontaneous use of a vehicle under exceptional circumstances to provide, without charge or fee and as a humane service, transportation for the emergency patient. Emergency medical personnel who transport or who make the decision to transport an emergency patient under this

section shall file a written report describing the incident with the medical control authority. MCL 333.20939

2. Non-Licensed vehicles include (but are not limited to):
    a. Wheelchair vans
    b. Busses
    c. Other public safety vehicles

C. Request specialized resources, as appropriate
1. Local/regional mass casualty resources
2. Decontamination units
3. Air medical units
4. Activate MEDDRUN/CHEMPAC per protocol

D. For major incidents, RMCC may be appropriate for coordination of support

IX. **Triage and Treatment**

A. Initiate SALT Triage - Preferred
1. Sort – Perform global assorting
2. Assess – Perform individual assessment
3. Life Saving Interventions
    a. Control major hemorrhage
    b. Open airway (if child, 2 rescue breaths)
    c. Chest decompression, as needed (Paramedic only)
    d. Auto-injector antidote (e.g., Duodote®)
4. Treatment and Transport

B. Triage other than SALT must be compliant with the Model Uniform Core Criteria for Mass Casualty Incident Triage (MUCC)[1]

C. Categorize Patients
1. **Immediate (Red):** Unable to follow commands or make purposeful movements, OR they do not have a peripheral pulse, OR they are in obvious respiratory distress, OR they have a life-threatening external hemorrhage; provided their injuries are likely to be survivable given available resources. Examples include:
    a. Physiologic and anatomic Trauma Triage Criteria
    b. Major burns (>20% BSA)
    c. Moderate to severe respiratory distress
2. Delayed (Yellow): Able to follow commands or make purposeful movements, AND they have peripheral pulse, AND they are not in respiratory distress, AND they do not have a life-threatening external hemorrhage, AND they have injuries that are not considered minor. Examples include:
    a. Mechanism of injury Trauma Triage Criteria
    b. Isolated fractures/dislocations
    c. Large and/or multiple lacerations with controlled bleeding
    d. Deep burns <20% BSA

[1] Model Uniform Core Criteria for Mass Casualty Triage. Disaster Med Public Health Preparedness.2011;5:125-128, doi: 10.1001/dmp.2011.41.

3. **Minimal (Green):** Able to follow commands or make purposeful movements, AND they have peripheral pulse, AND they are not in respiratory distress, AND they do not have a life-threatening external hemorrhage, AND their injuries are considered minor. Examples include:
    a. Minor wounds (abrasions, isolated laceration)
    b. Contusions
    c. Minor head trauma (GCS 15)
4. Expectant (Gray): unable to follow commands or make purposeful movements OR they do not have a peripheral pulse, OR they are in obvious respiratory distress, OR they have a life-threatening external hemorrhage, AND they are unlikely to survive given the available resources. These patients should receive resuscitation or comfort care when sufficient resources are available. Examples include:
    a. Major head trauma (open skull fracture with exposed brain, blown pupil, etc)
    b. Major burns (>75% BSA)
5. Dead (Black): No spontaneous breathing after establishing a basic airway (and 2 ventilations in a child). Patients triaged as Dead should be reassessed after initial triage to confirm no signs of life.

D. Establish Casualty Collection Point(s)
    1. One or more sites to provide triage and treatment
    2. May be subdivided into treatment areas based on triage category
    3. Emphasis should be on providing lifesaving treatment and rapid transport
    4. Minimal patients can be sequestered in a designated area
    5. Perform secondary triage within each treatment area as able

E. Treatment
    1. Treatment should be provided in accordance with Michigan EMS State Protocols
    2. ALS should be limited to essential medical interventions, including pain relief

X. **Evacuation**

A. Transport Unit Leader should assure all departing ambulances and non-licensed transport vehicles depart scene with highest acuity patients
    1. Assure distribution of patients to appropriate hospitals (e.g., trauma centers)
    2. Maintain a tracking log of patients, acuities, and destinations

B. Non-hospital alternate care centers may be established in major incidents for lower acuity patients

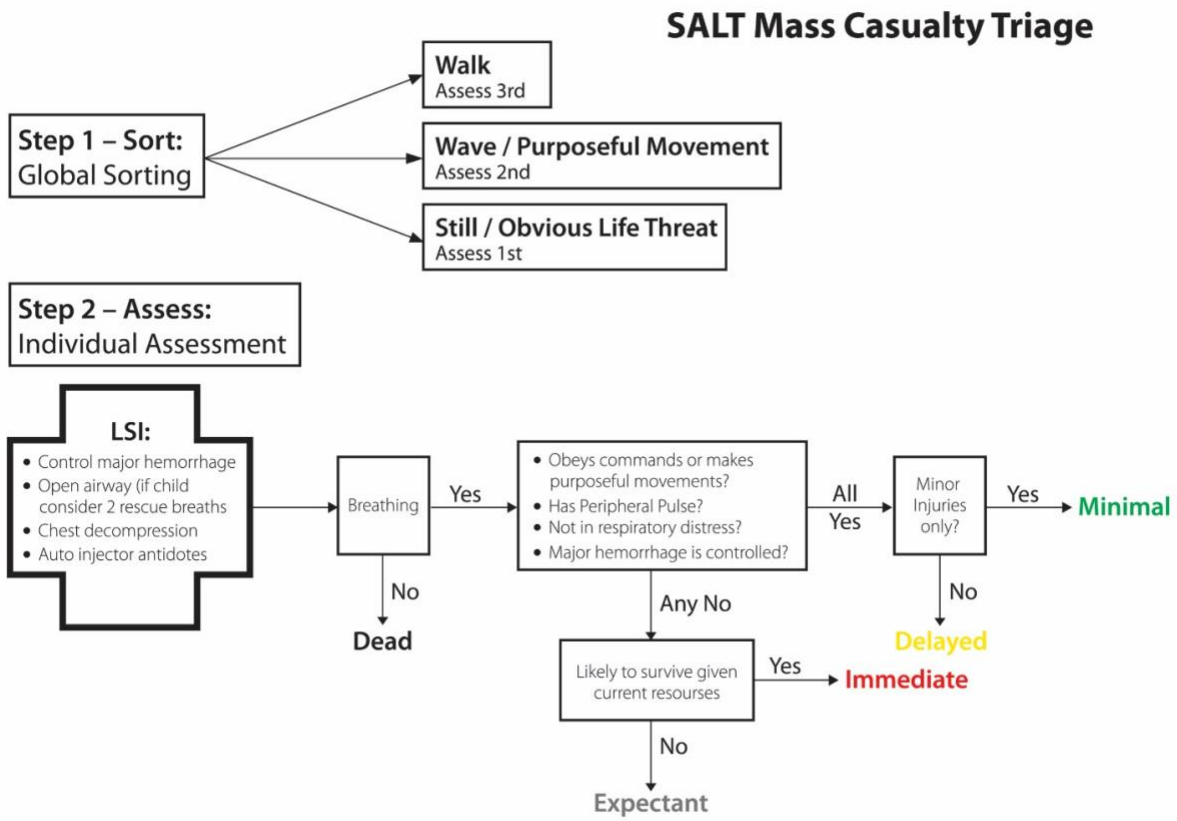
C. Licensed EMS personnel should accompany injured patients when transported in non-licensed vehicles whenever possible

XI. **Recovery**

A. Responder rehabilitation (e.g., hydration, nutrition)

B. Responder recovery (e.g., physical and emotional)

C. Agency recovery (e.g., resupply, workforce recovery) and completion of After Action Review
D. Community recovery



XI. REGIONAL MEDICAL COORDINATION CENTER (RMCC)

The RMCC serves as a regional multi-agency coordination center entity as defined by the National Incident Management System (NIMS). The RMCC serves as a single regional point of contact for the coordination of healthcare resources. The RMCC is intended to optimize resource coordination among hospitals, EMS agencies, medical control authorities and other resources. The RMCC serves as a link to the Community Health Emergency Coordination Center (CHECC).

The RMCC acts as an extension and agent of the Medical Control Authority.

A. RMCC Responsibilities include, but are not limited to:
    1. Maintain communications with all involved entities
        a. EMS Branch Directors
        b. EMS Division/Group Supervisors
        c. EMS Unit Leaders
        d. Hospitals
        e. Local EOCs (when activated)
        f. CHECC (when activated)
        g. Alternate care sites (when activated)
        h. Other RMCCs (as appropriate)
    2. Provide initial and update alerts via available communications resources.
    3. Provide frequent updates to on-scene EMS Branch Directors/Group/ Supervisors (or designee) regarding hospital casualty care capacity.
    4. May relay casualty transport information to receiving facilities.
    5. May relay urgent and routine communications to appropriate entities.
    6. May assist in coordination and distribution of resources.
    7. Other appropriate tasks as necessary for an effective regional medical response.

B. RMCC Immunity from Liability

It is the intent of this protocol that the Regional Medical Coordination Center and the personnel staffing the RMCC and performing the functions are afforded immunity from liability whether or not a Mass Casualty Incident has occurred, as provided through MCL 333.20965 of Part 209 of PA 368 of 1978, as amended. This section specifically provides immunity from liability protection to Medical Control Authorities in the development and implementation of department-approved protocols (see language below):

Sec. 20965 (3) Unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of any of the persons named below, while participating in the development of protocols under this part, implementation of protocols under this part, or holding a participant in the emergency medical services system accountable for department-approved protocols under this part, does not impose liability in the performance of those functions:

(a) The medical director and individuals serving on the governing board, advisory body, or committees of the medical control authority or employees of the medical control authority.
(b) A participating hospital or freestanding surgical outpatient facility in the medical control authority or an officer, member of the medical staff, or other employee of the hospital or freestanding surgical outpatient facility.
(c) A participating agency in the medical control authority or an officer, member of the medical staff, or other employee of the participating agency.
(d) A nonprofit corporation that performs the functions of a medical control authority.
333.20965 Immunity from liability

XII. STATE COMMUNITY HEALTH EMERGENCY COORDINATION CENTER (CHECC)
- A. Operated by MDHHS Bureau of EMS, Trauma and Preparedness
- B. EMS Personnel should be aware of the existence of CHECC but are not expected to directly interface with CHECC.

Protocol Source/References:

Appendix 1:

Definitions:

Incident Command System: The ICS organizational structure develops in a top-down fashion that is based on the size and complexity of the incident, as well as the specific hazard environment created by the incident.

Unified Command: In incidents involving multiple jurisdictions, a single jurisdiction with multi-agency involvement, or multiple jurisdictions with multi-agency involvement, unified command can be implemented. Unified command allows agencies to work together effectively without affecting individual agency authority, responsibility, or accountability

Incident Commander (IC): The IC is the individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. EMS will typically fall under the IC through a subordinate Branch, Division or Group.

Section Chief: A Section Chief may be assigned to Operations, Logistics, Planning, or Administration/Finance depending on the size of the incident. Not all incidents will require all 4 sections to be assigned.

Branch Director: A Branch Director may be assigned under the Operations Section Chief. Branch Directors are responsible for managing a specific discipline including Fire, EMS, Law Enforcement, Public Works, Public Health, etc.

Division Supervisor: A Division Supervisor is assigned to an area that is separated by a barrier. Examples of a Division would be a multi-level structure, include separated by a river, etc. Numbers are primarily used to identify divisions.

Group Supervisor: A Group Supervisor functions within the Operation Section and is assigned to a specific group. Letters of the alphabet are primarily used to identify groups.

Unit Leaders: Units can be assigned to the Command and General Staff or within a Group or Division.

Medical Unit Officer: The Medical Unit Officer is the individual responsible for the management of incident responder medical treatment and rehab.

Safety Officer: The IC shall appoint a Safety Officer who will ensure safety of responders and victims during the incident operations. With the concept of Unified Incident Command there is valid reasoning to have Assistant Safety Officers to include all disciplines involved in the operation. The Safety Officer appointed by the IC shall have the authority designed within the Incident Command System with the input and advice of all Assistant Safety Officers.

Deputies: Deputies are used within the Command and General Staff or Sections of the ICS. A Deputy may be a higher-ranking responder that assists the IC or Section Chief however does not assume Command.

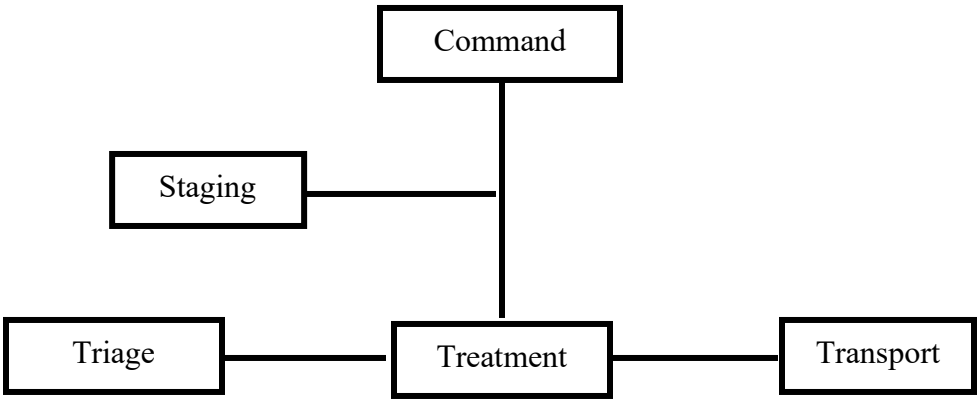
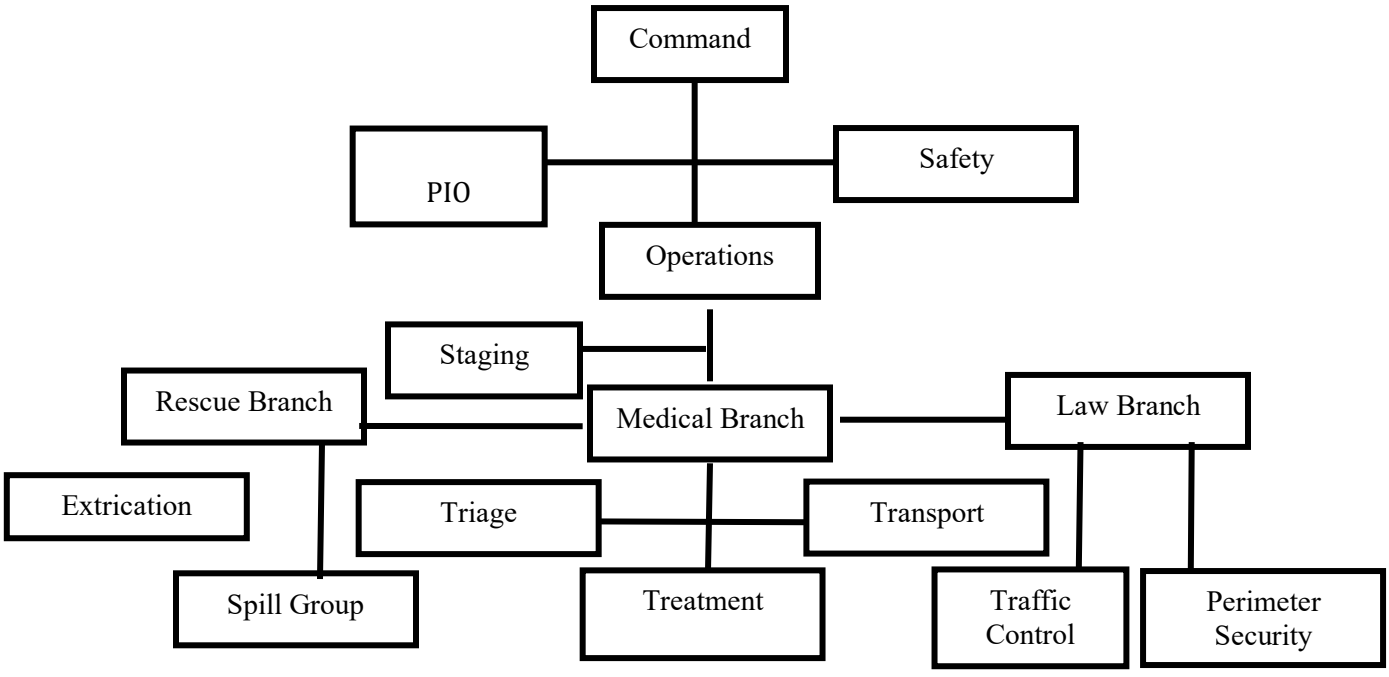
Coordinating Resource: the entity within the local EMS system responsible for the notification and coordination of the mass casualty response. Examples include: medcom, resource hospital, MCA, medical control, dispatch

Regional Medical Coordination Center: The RMCC serves as a regional multi-agency coordination entity as defined by the National Incident Management System (NIMS). The RMCC serves as a single regional point of contact for the coordination of healthcare resources. The RMCC is intended to optimize resource coordination among hospitals, EMS agencies, medical control authorities and other resources. The RMCC serves as a link to the Community Health Emergency Coordination Center (CHECC).

Community Health Emergency Coordination Center: The CHECC serves as a statewide multi-agency coordination entity as defined by NIMS. CHECC is intended to coordinate state-level healthcare and public health resources, to serve as a central point of contact for regional RMCC's, and to serve as a resource to the State EOC. CHECC is expected to be activated following a major disaster or other public health emergency and should be operational within hours of activation.

Appendix 2:

Example ICS Organizational Chart for Simple Incident



Example ICS Chart for Complex Incident