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MEDICAL EMERGENCY RESPONSE PLAN ANNEX G

I. PURPOSE

The purpose of this Medical Emergency Response Plan is to coordinate the efforts of response agencies and hospitals during medical emergencies in the cities and rural areas of Boulder County. The plan is structured to be used in any medical emergency, from a single unit response to a multi-casualty/multi-agency incident. The organizational structure, terms, responsibilities, and operational procedures utilized adhere to the Incident Command System (ICS) principles in use throughout Boulder County.

II. INTRODUCTION

An analysis of disasters in the United States has shown that it is essential for a community to have an organized response to medical emergencies. This Medical Emergency Response Plan, written in coordination with the hospitals, ambulance services, fire departments, law enforcement and emergency response agencies in Boulder County, addresses this need. The plan details the integration of the medical organization into the Incident Command System (ICS) the duties and responsibilities of the medical command personnel within the organization, and how positions are filled at an incident. This plan, written under the MODE concept allows for various levels of response depending on the number of casualties and the complexity of the situation.

III. INCIDENT COMMAND PRINCIPLES

Common Terminology:

It is essential for any management system, especially one that is used in multi-jurisdictional incidents, that there be common terminology for organizational functions, positions, resources, and facilities.

Span Of Control:

Within the ICS, the span of control ranges from one to five. An important consideration in span of control is to anticipate change and prepare for it. This is especially true during rapid buildup of the organization, when effective management is made difficult by too many reporting elements. Span of control is an indicator of when to expand or contract

your organization.

Modular Organization:

The ICS organizational structure expands in a logical, modular fashion based on the complexity and type of incident.

Unified Command Structure:

This simply means jurisdictional authority will not be compromised. All agencies have jurisdictional responsibilities which contribute to the process of determining objectives, selecting strategies, planning, integrating tactical operations. Under a unified command structure, the implementation of the action plan is carried out by a single operations chief.

Consolidated Action Plan:

The Incident Commander establishes overall objectives and selects a strategy providing the basis for a single action plan. For simple incidents, the plan normally will be developed by the IC and passed to subordinates orally. More complex incidents will require a written action plan.

Integrated Communication:

All radio communications between organizational elements should be in clear text. In the ICS, radio contacts are made using abbreviated versions of position titles. This precludes the necessity to know names or numbers of personnel filling specific positions. Every position is required to carry out standardized tasks, so it is irrelevant who is filling the position.

Designated Incident Facilities:

The primary facilities that may be established are:

Command Post:

The location from which all incident operations are directed. Usually Command, Plans, and Logistics functions will be established in and operate out of the Command Post.

Staging Areas:

These are areas established for temporary location of available resources.

Helispots:

These are temporary locations where helicopters can land and take off.

IV. MEDICAL DISASTER RESPONSE MODES

MODE 1 The First Responding Agency Handles The Incident.

The first responding medical personnel in this mode will implement necessary ICS functions and provide for patient care and transport.

MODE 2 Mutual Aid From Nearest Available Resource Is Necessary.

In a Mode 2 there may be a several victims with mutual aid response necessary. The Incident Command structure in Mode 2 may be very basic as in Mode 1 or an expanded system with major functions implemented and positions staffed.

MODE 3 Incident Size And Complexity Exceeds Normal Mutual Aid Resource Capability.

Mode 3 is determined by the size and complexity of the incident. The number of casualties is only one criteria in establishing Mode 3 status. In Mode 3 situations, primary ICS functions are staffed and county-wide resources may be mobilized.

MODE 4 Incident Size And Complexity Exceeds The Capability Of County-wide Resources To Handle The Situation.

Mode 4 would be a complex, mass or multiple casualty incident which would require assistance from outside the county. The IC obtains State and/or Federal assistance through the City/County Office of Emergency Management in the jurisdiction involved.

V. MULTIPLE AGENCY COORDINATING SYSTEM (MACS)

The Multiple Agency Coordinating System (MACS) is an information and resource system intended to facilitate effective use of limited resources between jurisdictions. MACS can be activated for any emergency or disaster that affects more than one jurisdiction, or requires resources beyond the capabilities of the affected jurisdiction. MACS may be activated by the Boulder Regional Communications

Center (BRCC) when the requests from the field can no longer be handled by the Center, or by the Incident Commander in anticipation of requests for resources that will be needed to handle an incident. MACS is activated by notifying BRCC. If State and/or Federal assistance is an anticipated need by the IC, the MACS Resource Allocation Center (RAC) will notify the Emergency Management Office in the jurisdiction involved.

VI. COMMUNICATIONS

All radio communications will occur on normal assigned frequencies. In the case of multiple agencies involvement in an incident, Boulder Regional Communications Center (BRCC) will make frequency assignments. All participants agree to follow the ICS chain of command in the communication process. For example: All requests for medical resources will be made through the Medical Officer. The Medical Officer will channel requests through the system set up by the IC.

The first responding ambulance is responsible for initial notification of the hospital, either Longmont United, Boulder Community or Avista Hospital and will ask for a bed count of all hospitals in Boulder County. The count, when received will be passed on to the medical officer. When the medical officer position is filled, it is his/her responsibility to keep the hospitals informed of field situation.

When notified of a multi-casualty incident, hospitals will assign one person to monitor their radio to assure communications with the field.

VII. RESPONSIBILITIES

The first qualified paramedic or emergency medical technician (EMT) on the scene will assume the duties of the Medical Officer and also begin triage operations. As more medically qualified people arrive additional medical positions will be filled. When triage has been complete triage personnel can begin field care of patients while awaiting transport to hospitals.

If hazardous materials are present in the incident, and decontamination of personal, vehicles, etc.; is required, the fire department on the scene will begin necessary decontamination procedures.

The following procedures and checklists will enable response personnel to organize into an effective unit to rapidly process casualties and prepare them for transport.

VIII. MEDICAL POSITION DESCRIPTION, RESPONSIBILITIES, AND CHECKLISTS

A. Medical Director

The Medical Director (MD) is appointed by the Incident Commander (IC) or Operations (OPS) Chief. This position will be staffed by the most medically qualified individual on scene. This person is responsible for all emergency medical aspects of the incident. Before or until all positions are assigned the Medical Director will perform all duties as outlined in all checklists.

The Medical Director reports to the Operations Chief or the Incident Commander and keeps him/her informed of the situation, number and severity of injured, transportation needs, additional resources needed for triage, field care, and the morgue.

CHECKLIST:

Consider Early:

- ___ Briefing from Operations Chief or Incident Commander
- ___ Assess situation
- ___ Triage area

Appoint staff as needed:

- ___ Triage Supervisor
- ___ Transportation Supervisor
- ___ Field Medical Supervisor
- ___ Morgue Supervisor
- ___ Aides
- ___ Make initial contact with hospitals and advise of situation.
- ___ Make request for additional resources through chain of command.
- ___ Coordinate patient transport with hospitals.
- ___ Keep immediate supervisor informed.
- ___ Coordinate actions with other branches, fire control, hazardous materials, etc.
- ___ Contact coroner.
- ___ Ensure that all work areas are out of danger area.

B. Triage Supervisor

The Triage Supervisor is responsible for directing and coordinating the evaluation and tagging of victims. This includes establishing triage areas and appointing triage teams. Triage tags are in Triage Kits

carried in each ambulance.

CHECKLIST:

- ___ Obtain briefing from Medical Director.
- ___ Assess situation.
- ___ Direct sorting and tagging of victims.
- ___ Keep Medical Director informed regarding:
 - ___ Number and extent of injuries.
 - ___ Need for morgue/coroner.
 - ___ Evaluate and request resources from the Medical Director as needed.

Consider early:

- ___ Triage area
- ___ Triage team(s)
- ___ Ensure proper medical care procedures are followed.
- ___ Expedite movement of victims.
- ___ Maintain record of your activities.
- ___ Arrange patients in triage area for transportation.
- ___ Keep Medical Director informed of situation status.
- ___ Coordinate triage efforts with other medical groups.

C. Transportation Supervisor

The Transportation Supervisor (TS) is appointed by the Medical Director and is responsible for directing and coordinating the transportation of the victims from the triage areas to the hospitals. The Transportation Supervisor will obtain a bed count for area hospitals from the Medical Director.

CHECKLIST:

- ___ Obtain briefing from the Medical Director.
- ___ Assess the situation.

Consider early:

- ___ Medical staging area function.
- ___ Traffic flow plan.
- ___ Coordination of aircraft or coordination with air operations branch.
- ___ Coordinate and direct patient transport from triage area(s) to the hospital(s).
- ___ Maintain patient manifest and record of status.
- ___ Contact Medical Director for additional resources needed.
- ___ Keep Medical Director informed.

D. Morgue Supervisor

The coroner is the Morgue Supervisor, but until he arrives on the scene, the Medical Director will appoint an acting Morgue Supervisor to establish a morgue area. He/she will be responsible for the security of the area. The morgue supervisor is responsible for identification of the dead. The coroner's office will prepare and maintain a list of the dead.

CHECKLIST:

- ___ Obtain briefing from Medical Director.
- ___ Assess situation.
- ___ Appoint and brief staff as needed:
 - ___ Aides
 - ___ Litter bearers
- ___ Advise Coroner's officer of situation.
- ___ Designate morgue area isolated from casualty area.
- ___ Cover and tag bodies.
- ___ Maintain security of all personal belongings and keep with body.
- ___ Do not move bodies or personal effects without authorization from the coroner. If bodies must be moved identify the original location with photos, grid drawings, etc.
- ___ Do not allow bodies or any personal effects to be removed from the scene without authorization of Coroner's office.
- ___ Remain on scene as aide to Coroner.

E. Triage Teams(s)

- ___ Obtain briefing from Triage Supervisor.
- ___ Obtain triage tags from Triage Supervisor.
- ___ Assess situation.
- ___ Begin triage of victims.
- ___ Tag victims with triage tags.
- ___ Keep Triage Supervisor informed of status and patient numbers.
- ___ When triage is complete, report to Triage Supervisor for next assignment.

F. Field Care Supervisor

Normally, this function will not be filled, but if time permits and resources are available an area might be established under a field care supervisor. He/she will direct on-site medical care.

If on-site medical care is established the triage teams will be transferred to the supervision of the Field Care Supervisor once their triage responsibilities are completed.

Directions For Use Of The Disaster Tags For

Boulder County

First note the tag is made of **plastic** paper. It is waterproof and tear-resistant. **Use an indelible ink pen to write on the tag.** The ink will not run, even if the tag gets wet, nor will the tag get soggy and fall apart.

The tag has several areas for differing information. An explanation for each section follows:

- C Identification Numbers: Left hand corner to be removed at the disaster site and put on record sheet. Right hand corner to be removed by transport crew and kept with their records. The tag will remain with the patient during transport and be placed with the encounter sheet in the hospital Emergency Room.
- C Name, sex, age, hair and race: Obtain any information you can to aid identification. At least record sex, approximate age, race and hair color. If possible, get an address and phone number and place them above the name.
- C To be filled out by the Clergy. (Last rights)
- C Vital Signs: BP = Blood pressure; P = pulse; R = respirations; LOC = level of consciousness. It is important to record the time the vital signs were taken to facilitate triage or condition evaluation.
- C Triage Classification: Five classifications for disaster triage.

CLASS I RED Immediate Priority

Victims whose chances of survival depend on immediate emergency care.

CLASS II YELLOW Delayed Priority

Victims who need emergency care prior to transportation but whose survival is not dependent on immediate care.

CLASS III GREEN Minimal Priority

Victims who apparently require simple emergency care needs or those who appear uninjured and only require observation.

CLASS IV BLUE Critical (No Priority)

Victims with fatal injuries whose chances of survival are improbable even with ideal medical care.

CLASS V BLACK Deceased (No Priority) The obviously deceased victim.

It is important to record the time the triage classification is determined.

RETRIAGE:

By crossing out the initial triage category and using the next column, the patient can be redesignated appropriately. Again, record the time.

- C Assessment: physical exam, i.e., pupils, objective and subjective evaluation, neuros, deformities, and fractures.
- C Figures: If appropriate, indicate the major areas of injury.
- C Medicine: i.e., morphine, dextrose, **with dosages and times**.
- C IV and Treatment: IV's, intubation, thoracentesis, M.A.S.T. pants, tourniquet. **With times**.
- C Previous history and present medications and allergies.

This design has been approved by the Boulder County EMS Council and the City/County Office of Emergency Management. The design is standardized throughout the Denver-Boulder area.

FRONT OF TAG

BACK OF TAG

**Medical Triage and Transportation
Double Funnel System**

Medical Emergency Response Plan Hospital Bed Count

**Hospital: ST ANTHONY'S
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: DEN HEALTH
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: UNIVERSITY
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: SWEDISH
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: ST JOES
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: ST LUKES
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: LUTHERAN
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: PORTER
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: PRESBYTERIAN
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: VETERAN'S
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: AURORA MED.
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: WARDENBURG
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: BO COMMUNITY
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: AVISTA
Bed Count:**

	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Hospital: LONGMONT
Bed Count:**

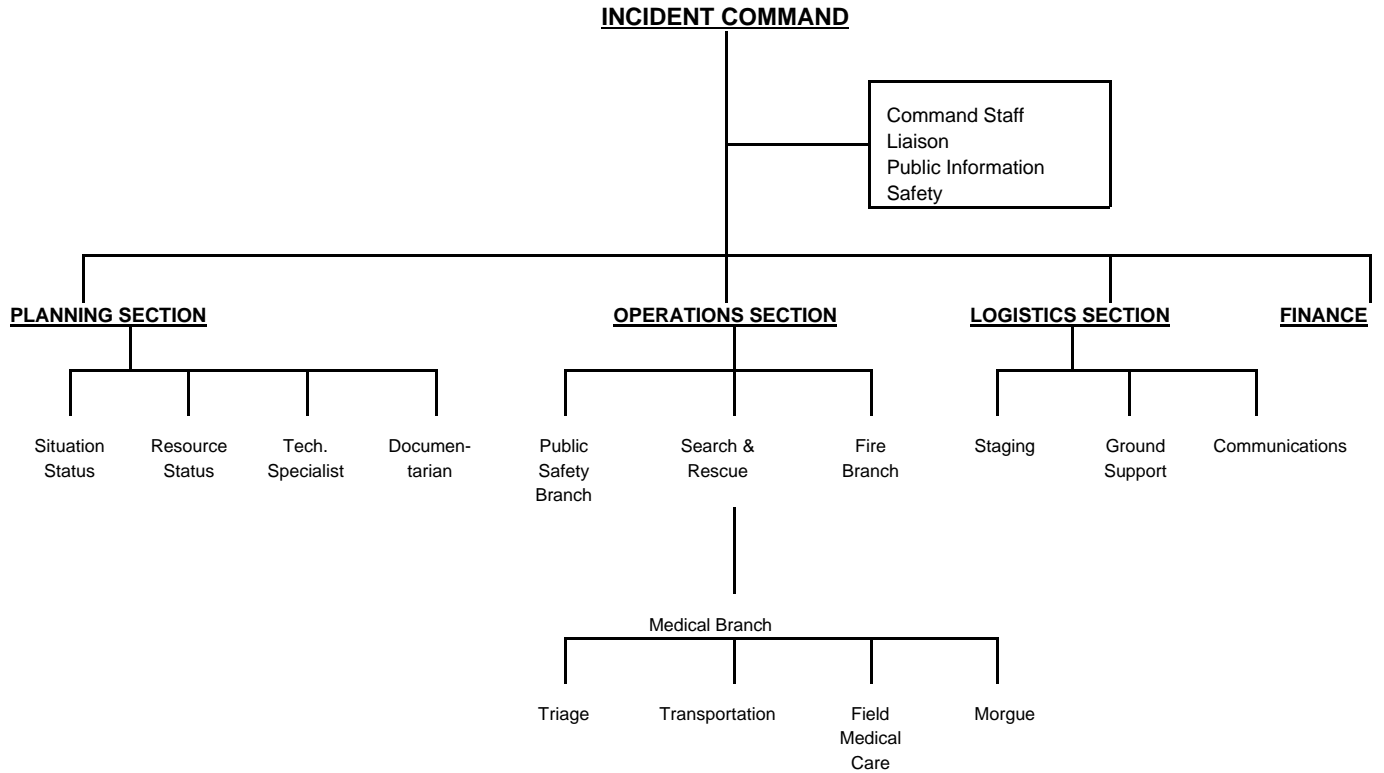
	I	II	III	IV
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

ORIGINAL TRIAGE TOTALS

CLASS		TOTALS
I		
II		
III		
IV		
V		
TOTAL # PATIENTS		

REMARKS

ICS Medical Emergency Organization Chart



Inter-Hospital Disaster Communications

Upon receiving radio or telephone communications from your sponsored ambulance responding to a scene of a possible multi-casualty incident you should initiate the following actions.

1) Collect information from your field contact person.

- A. Location of incident: _____
- B. Type of incident (MVA, Haz-Mat, etc.) _____
- C. Number of victims requiring hospital attention:

Red patients: _____
Yellow patients: _____
Green patients: _____

2) Inform your field contact person that you will contact him/her in _____ minutes on radio frequency _____ with directions for diversion of patients to specific hospitals.

3) If your hospital can handle all of the victims call your field contact person and advise that all victims are to be transported to your facility.

4) If your hospital cannot handle all of the victims call other hospitals in the scene proximity to determine the following:

- A. Number of O.R. suites available and any time delays anticipated;
- B. Number of I.C.U. beds available;
- C. Number of beds available for yellow/green patients.

<u>Hospitals Contacted/Phone #</u>	<u>O.R. Suites</u>	<u>I.C.U. Beds</u>	<u>Misc. Beds</u>
#1 _____			
#2 _____			
#3 _____			
#4 _____			

D. Inform hospitals contacted about the situation and that you will call back with the numbers of each category of patients to expect.

5) Paper allocation of patients to each hospital:

A. Red patients to:

Hospital #1 _____ Hospital #2 _____ Hospital #3 _____ Hospital #4 _____

B. Yellow patients to:

Hospital #1 _____ Hospital #2 _____ Hospital #3 _____ Hospital #4 _____

C. Green patients to:

Hospital #1 _____ Hospital #2 _____ Hospital #3 _____ Hospital #4 _____

6) Contact your field contact person and relay patient/hospital allocations.

7) Re-contact the above hospitals to inform them of patients to expect.

8) Prepare your facility to receive patients.

**MEDICAL EMERGENCY RESPONSE PLAN
ANNEX G**

GENERAL INFORMATION

TRIAGE TAGS:

Description and directions for use of the triage tag, adopted for use in Boulder County, are found on pages G-4 and G-5. These tags are contained in the Triage Kit, carried in every ambulance unit in Boulder County. Tags are also available at area hospitals.

DOUBLE FUNNEL MEDICAL TRIAGE AND TRANSPORTATION SYSTEM:

A description of the Medical Triage and Transportation Double Funnel System is found on Page G-6. This optional triage system may be effective in some multi-casualty incidents.

HOSPITAL BED COUNT FORM:

A form for listing the bed count of all metro area hospitals is found on Page G-7.

TRANSPORTATION SUPERVISOR'S LOG:

A form that can be used by the Transportation Supervisor to detail patient information and destination is found on Page G-8.

INCIDENT COMMAND SYSTEM MEDICAL EMERGENCY ORGANIZATION CHART:

The Incident Command System (ICS) Medical Emergency Organization Chart is found on Page G-9.

DUTY CHECKLISTS:

Duty checklists for the Medical Officer, Triage Supervisor (with inserts for First Aid and Transport Teams and Triage Teams), Transportation Supervisor (with an insert for a Medical Staging Area Manager) and Morgue Supervisor are included with this Medical Emergency Response Plan. These checklists contain short duty statements and a sample Incident Command Organization Chart and can be used by field personnel.