STANDARD OPERATING GUIDELINE

Number 106-01

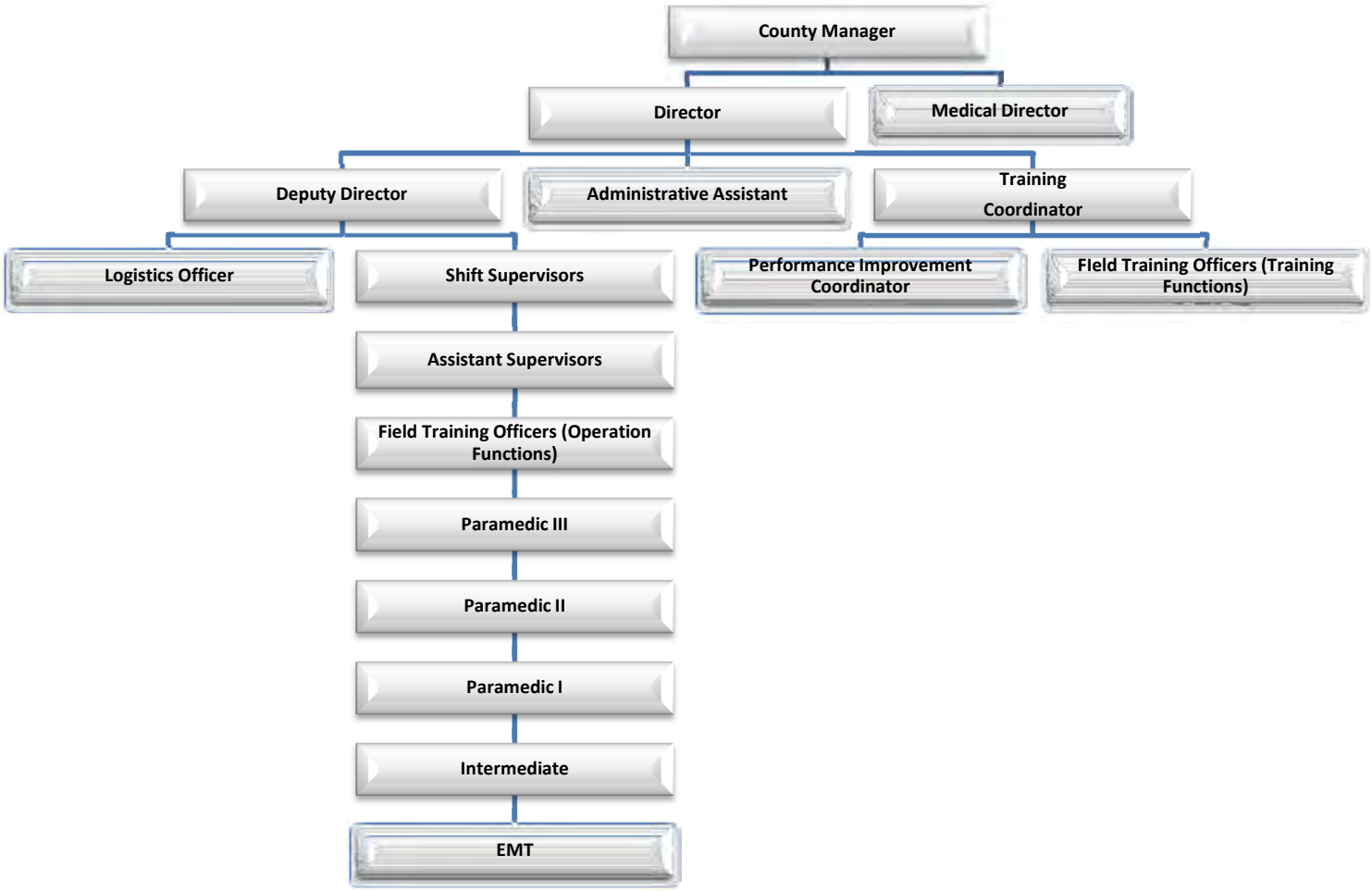
Incident Management

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
02/01/2002	08/01/2016	RONALD D. ROMBS	1 OF 4

PURPOSE: The intent of this policy is to ensure an effective chain of command and to define specific functions under the Incident Command System (ICS).

SCOPE: This procedure applies to all providers within the Lincoln County Emergency Medical Services (LCEMS) System.

PROCEDURE: The Emergency Medical Services chain of command is as follows:



The established chain of command shall be utilized for day to day operations (routine direction, consultation, conflict resolution, grievance resolutions, etc.) and to ensure an optimal span of control for any scale of incident. All personnel shall utilize the NIMS to ensure on-scene operations are performed under a Unified Command System.

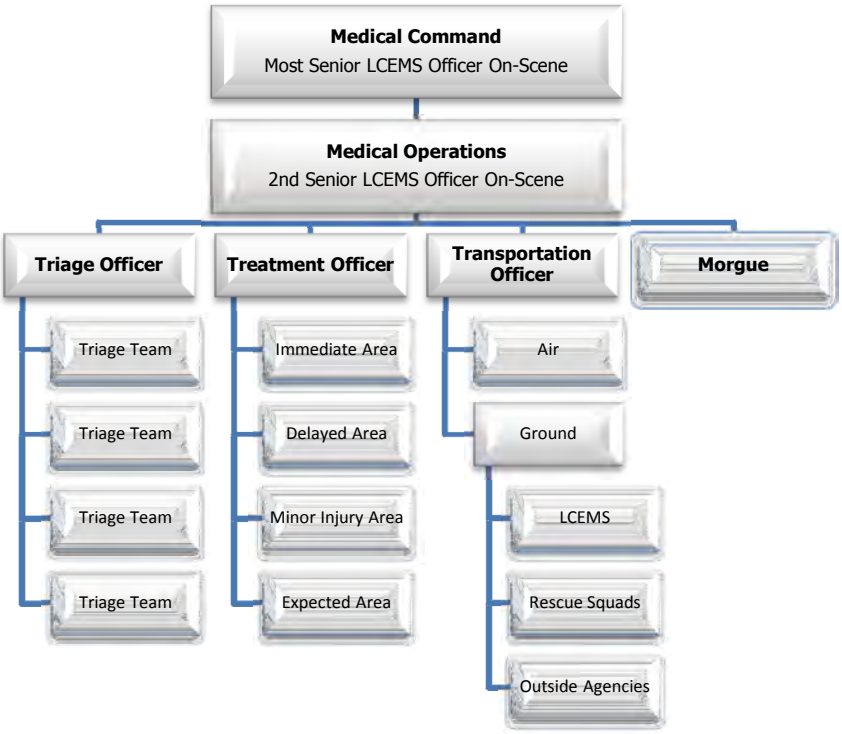
A multi-casualty incident (MCI) exists when the number and/or severity of patient care needs outnumber immediately available resources. In the event of a MCI, it shall be the responsibility of the primary EMS provider to direct, coordinate, and implement the MCI Plan.

The primary responsibilities of the primary EMS provider include:

- Maximum use of other available emergency personnel
- Ensuring all personnel work in a distinct, coordinated effort
- Initiating the Simple Triage and Rapid Treatment (START) system and provide life-saving treatment to the victims on the scene
- Ensuring Advanced Life Support (ALS) treatment is initiated for victims awaiting transport
- Ensuring appropriate transport to the most appropriate hospital
- Generally, EMS personnel shall not operate within the hot zone of a hazardous materials or weapons of mass destruction incident scene.
- EMS personnel shall, whenever possible, limit their exposure to known or suspected contaminated persons.

From the moment an MCI is identified, it is crucial for all personnel involved to follow proper protocols and established procedures to protect victims and reduce the incidence of death or injury. Typically, the most senior LCEMS member on the scene shall establish EMS Command until relieved by an officer from LCEMS. This level of command is usually sufficient for daily operations.

Larger scale or incidents of national significance may require the involvement of many EMS staff positions.



For large scale operations, HAZMAT incidents and special operations, EMS Command shall ensure adequate medical site support for emergency responders. These resources are committed to support of the responses personnel, not the actual event.

In the event of absence of management personnel from LCEMS, the following chain of succession shall be followed:


Director
Lincoln County Emergency Medical Services
Deputy Director
Lincoln County Emergency Medical Services
Training Coordinator
Lincoln County Emergency Medical Services
On-Duty Shift Supervisor
Lincoln County Emergency Medical Services
On-Duty Most Senior Assistant Shift Supervisor
Lincoln County Emergency Medical Services
On Duty Assistant Shift Supervisor
Lincoln County Emergency Medical Services
On-Duty Field Training Officer
Lincoln County Emergency Medical Services
On-Duty Senior Paramedic On-Scene
Lincoln County Emergency Medical Services
On-Duty Senior Technician On-Scene
Lincoln County Emergency Medical Services
On-Scene Senior Technician
Other Service

STANDARD OPERATING GUIDELINE

Number 106-02

Emergency Recall

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
02/01/2002	08/01/2016	RONALD D. ROMBS	1 OF 2

PURPOSE: The intent of this policy is to ensure that emergency recall information for Lincoln County Emergency Medical Services (LCEMS) personnel is maintained and updated.

SCOPE: This procedure applies to all LCEMS employees.

PROCEDURE: All Shift Supervisors shall be responsible for maintaining a current emergency recall roster in the format below. Rosters shall be updated annually or within 24 hours of receiving updated information.

Upon recall activation by the LCEMS Director or designee, the On-duty Shift Supervisor shall page employees. Each Shift Supervisor shall contact their respective Assistant Supervisors. The Assistant Supervisors shall be designated as the primary communicators.

As employees receive a page, they shall contact their assigned primary communicator and advise them of their status. The primary communicators shall contact employees that do not respond to the initial page. The primary communicators shall then contact the On-duty Shift Supervisor and advise them of their respective employees' status.

ONLY THE PRIMARY COMMUNICATOR SHALL CONTACT THE EMS BASE. ALL INFORMATION AND INSTRUCTIONS SHALL BE INCLUDED IN THE INITIAL PAGE. FOLLOW THE INSTRUCTIONS RECEIVED. DO NOT CONGEST THE PHONE LINES.

Alert Notification and Recall

LCEMS Management personnel may implement notification and recall of personnel selectively by individual, shift or department wide. During partial recalls, the On-duty Shift Supervisor shall maintain personnel accountability.

During total recalls, personnel accountability shall be maintained by the LCEMS Emergency Operations Center representative.

Lincoln County Emergency Medical Services
Emergency Recall List

Shift		**Revised Date**	
Supervisor		**Primary Contact Number**	
Most Senior Assistant Supervisor		**Primary Contact Number**	
Assistant Supervisor		**Primary Contact Number**	

Name	Primary Contact	Secondary Contact	Assigned Primary Communicator	Responded (Y/N)	Available (Y/N)

STANDARD OPERATING GUIDELINE

Number 106-03

START Triage System

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
02/01/2002	08/01/2016	RONALD D. ROMBS	1 OF 4

PURPOSE: The intent of this policy is to establish a procedure to effectively and rapidly triage large numbers of patients.

SCOPE: This procedure applies to all Lincoln County Emergency Medical Services (LCEMS) System employees.

POLICY: The Simple Triage and Rapid Treatment (START) method has proven to be an effective and rapid approach for triaging large numbers of patients. LCEMS has adopted the START method of triage and use of the METTAG System for use at all Multiple/Mass Casualty Incidents (MCI's).

The START method is based on **three clinical findings** and each patient's triage assessment should be completed in **less than 60 seconds**:

- **R** (respiratory status)
- **P** (perfusion/hemodynamic status)
- **M** (mental status)

Using the START method and METTAG System, triage officers divide, evaluate and tag victims by attaching the corresponding colored tags/ribbons directly to the victim.

The METTAG system uses a four-color tag (with an Expectant tab option) to identify patients during triage. The four colors have the following meanings:

1. **RED** – CRITICAL/IMMEDIATE – RPM falls outside of acceptable limits.

2. **YELLOW** – DELAYED – RPM within acceptable limits but the patient has significant injuries.

3. **GREEN** – MINOR – Patient is ambulatory, non-emergent condition, does not require emergent medical attention, minor injuries, transportation may or may not be necessary.

4. **BLACK** – DECEASED – Patient is confirmed apneic after the airway is opened and the patient is mortally wounded/obviously dead.

5. **BLACK WITH EXPECTANT TAB** – MORTALLY WOUNDED / NON-SALVAGABLE – Patient is mortally wounded and is not expected to survive.

NOTE: *Each patient shall have a colored triage tag/ribbon attached.* ***ONLY life-threatening problems are corrected during triage.*** *Medical treatment during triage is limited to opening the airway and controlling major external bleeding.*

PROCEDURE: The senior Paramedic assigned to the first arriving LCEMS units shall:

- Clear the area of operations of any ambulatory patients (walking wounded/injured), by advising them to walk to and remain at a designated location. These patients will be further evaluated, triaged and treated by additional arriving units as assigned by the Incident Commander/EMS Command.

- Begin triaging the non-ambulatory patients

Triage Tagging Considerations:

- Tags are to be attached to the patient in plain sight.

- Tags shall not be attached to clothing or other items that may be removed during treatment. If a patient is in an automobile or other structure not in plain view, the tag may be attached to the outside of the vehicle or structure for rapid identification. Once the patient is removed, remove the tag and attach it to the patient.

- As patients are being loaded into the ambulance, the removable identification strip is provided to and maintained by the Transportation Officer.

- Upon arrival at the receiving hospital, the other removable identification strip is removed and maintained by the ambulance crew. These identification strips contain a number system that identifies the patient. Additional patient information may be obtained at a later time.

Color-coding Considerations:

- **RED**: Patients assigned a RED tag are to be given first priority in evacuation and require immediate emergency medical care. Patients with the following conditions may be placed in the RED category:

    1. Uncorrected respiratory problems.
    2. Witnessed cardiac arrest.

3. Severe blood loss with significant bleeding.
4. Unconsciousness.
5. Several major fractures including suspected pelvic fracture, flail chest fracture of the cervical spine, fracture of joints with absent distal pulses, and/or femur fracture.
6. Profound shock.
7. Burns complicated by respiratory tract injury.
8. Open or closed chest or abdominal wounds including severe crushing injuries.

*****During MCI, it may be necessary to abort resuscitation efforts of a patient in cardiac arrest to prevent the worsening of another patient's condition*****

- **YELLOW:** Patients assigned a YELLOW tag are to be given secondary priority in evacuation and require emergency medical care, however, do not pose an immediate life threat. Patients with the following conditions may be placed in the YELLOW category:

1. 2nd degree burns covering more than 30% BSA.
2. 3rd degree burns covering 10% BSA.
3. Burns complicated by major soft tissue injury or minor fractures.
4. 3rd degree burns involving the critical areas of the hands, feet or face (not involving the respiratory tract.)
5. Moderate blood loss, bleeding controlled.
6. Back injuries with or without spinal cord damage.
7. Conscious with serious head injury.
8. CSF in nose or ears.
9. Rapid rise in systolic pressure.
10. Projectile vomiting.
11. Respiratory rhythm change.
12. Pulse rate less than 60 BPM.
13. Swelling and discoloration beneath the eyes.
14. Unequal pupils.
15. Seizures.
16. Weak or no motor strength.
17. Poor reaction to secondary stimulation.

- **GREEN:** Patients assigned a GREEN tag are to be given third priority in evacuation and do not require immediate emergency medical care. Patients with the following conditions may be placed in the GREEN category:

    1. Minor injuries such as abrasions, contusions or fractures (finger, toes, etc.)
    2. 1st degree burns of less than 20% BSA, excluding hands, feet and fact.
    3. 2nd degree burns of less than 15% BSA.
    4. 3rd degree burns of less than 2% BSA.

- **BLACK W/ EXPECTED TAB:** Patients assigned a BLACK W/ EXPECTED TAB are to be given fourth priority in evacuation and are not expected to survive even with immediate emergency medical care. Patients with the following conditions may be placed in the BLACK W/ EXPECTED TAB category:

    1. Obviously mortal wounds in which death appears reasonably certain, including:

        a. 2nd and 3rd degree burns of more that 60% BSA.
        b. 2nd and 3rd degree burns of more than 40% BSA with other major injuries such as fractures, severe head injuries or chest injuries.
        c. Head injuries where brain matter is exposed and patient is unconscious.
        d. Head injuries where patient is unconscious and has major fractures.

STANDARD OPERATING GUIDELINE

Number 106-04

Forcible Entry

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
02/01/2002	08/01/2016	RONALD D. ROMBS	1 OF 2

PURPOSE: The intent of this policy is to establish guidelines for gaining access to patients in structures and vehicles during emergency situations and calls of unknown patient condition or location.

SCOPE: This procedure applies to all Lincoln County Emergency Medical Services (LCEMS) System employees.

POLICY: LCEMS units may be dispatched to calls for assistance where CMED has no direct communications with the patient (i.e. Medical Alarm Activations, third party callers, unknown condition etc.).

When dispatched to these types of calls, as with all responses, personnel should place their safety and the safety of all emergency responders as their primary concern.

All attempts to enter any secured residence or vehicle shall be made via the least invasive means as necessary to gain access to the patient.

On arrival, the crew shall knock on the door and announce their arrival. If there is a response from someone inside the residence, the crew shall obtain instructions (location of spare key, phone number of key holder, etc.) on gaining access to the structure and/or vehicle. Once the crew ensures that all persons inside the residence are aware they will be making entry, personnel shall make entry per the instructions of the patient.

When there are no other means to gain access to the patient, entry may be forced only AFTER the following conditions are met:

- The patient is visible or can be heard requesting assistance.
- All doors and windows are checked for access.
- The on-duty Shift Supervisor is contacted.
- Law Enforcement response is requested.

When entry can be made without exposing emergency responders to risk and the delay awaiting Law Enforcement arrival would cause undue harm to the patient, personnel may force entry prior to the arrival of Law Enforcement. Otherwise, personnel shall await the arrival of Law Enforcement. If Law Enforcement is on scene and is willing to force entry, allow them to do so.

When forcible entry is required, all personnel shall wear all issued protective equipment (i.e. helmet, goggles, gloves, Globe jacket and pants.)

NOTE: *Personnel shall **NOT** kick doors in, breakout large expensive window panels, or cause unnecessary damage to the structure or vehicle.*

Upon approval of the on-duty Shift Supervisor, personnel may make entry into the residence, following the requirements outlined in this guideline.

- Attempt all doors and windows to ensure they are not unlocked.
- Select a small pane of glass on a door to break out and reach in and unlock the door.
- Select a window with a small, single pane of glass to break out and unlock the window.
- With automobiles, select the smallest window pane possible so that the door can be unlocked. Avoid using the front windshield for gaining access if at all possible.
- Assure the residence and/or vehicle is secured prior to departing the scene by either Law Enforcement or the on-duty Shift Supervisor.
- Document specific details of the situation in the ePCR.
- Complete a Special Report for Forced Entry.

When forcible entry is requested or made into a residence and/or vehicle, the on-duty Shift Supervisor shall:

- Use his/her judgment in authorizing a forcible entry into a residence and or vehicle.
- Assure that the least amount of damage possible is made to personal property.
- Assure the residence and or vehicle is secured prior to departure from the scene.
- Photograph damage resulting from the forcible entry and upload photographs electronically in the appropriate file.
- Complete a Special Report for Forced Entry.

If personnel cannot physically see or hear a patient inside the structure and/or vehicle, and no contact has been established, DO NOT force entry. Contact CMED to obtain as much information regarding the potential patient and request Law Enforcement's assistance to exhaust all resources for locating a potential patient.

STANDARD OPERATING GUIDELINE

Number 106-05

Mutual Aid Response

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
01/12/2004	08/01/2016	RONALD D. ROMBS	1 OF 1

PURPOSE: The intent of this policy is to establish proper procedure for LCEMS units responding into other counties under a request for mutual aid.

SCOPE: This procedure applies to all Lincoln County EMS (LCEMS) employees.

PROCEDURE: It is the intent of LCEMS to provide mutual aid to other EMS agencies in North Carolina when call volume and staffing permits required support.

Communications

Upon receipt of a request for a mutual aid response, Lincoln County Communications (CMED) shall dispatch the closest appropriate LCEMS unit. The appropriate LCEMS unit shall acknowledge the dispatch and respond to the assignment.

Once CMED acknowledges the responding LCEMS unit, the crew shall change their radio frequency to the requesting agency's EMS radio frequency and shall advise CMED of the same. The responding crew shall maintain contact with CMED via portable radio to monitor and respond to Lincoln County radio traffic.

Acknowledgment of arrival on scene, transport status, etc., shall be made to both the requesting agency's communications as well as Lincoln County CMED.

Scope of Practice

While providing mutual aid, LCEMS technicians shall adhere to LCEMS protocols, policies and procedures under their current level of certification and scope of practice approved by the North Carolina Office of Emergency Medical Services (NC OEMS) and LCEMS.

STANDARD OPERATING GUIDELINE

Number 106-06

System Status Levels and Deployment Strategies

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
02/04/2003	08/01/2016	RONALD D. ROMBS	1 OF 2

PURPOSE: The intent of this policy is to establish a procedure defining System Status Level definitions and to ensure proper unit deployment.

SCOPE: This procedure applies to all Lincoln County EMS (LCEMS) employees.

PROCEDURE: The on-duty Shift Supervisor shall monitor unit status and deploy available Advanced Life Support (ALS) transport units to assure a minimum of one ALS transport unit is each zone when possible.

Lincoln County EMS System Status levels are defined as follows:

1. **System Status Three** – Three (3) ALS transport units available.
2. **System Status Two** – Two (2) ALS transport units available in the county.
3. **System Status One** – One (1) ALS transport unit available in the county.
4. **System Status Zero** – No (0) ALS transport units available for immediate response. EMS is totally dependent on Rescue Transport or mutual aid from surrounding counties.

ALS unit deployment during critical System Status levels shall be modeled after the following:

1. **System Status Three** – assure one available ALS unit (preferably transport capable) is deployed to each zone.
2. **System Status Two** – assure that one available ALS unit (preferably transport capable) is deployed half way east and one unit is half way east.
3. **System Status One** – assure that one available ALS unit (preferably transport capable) is deployed to Central base.

All available Quick Response Vehicles (QRV's) shall be deployed in the absence of available transport capable ALS units to assure ideal ALS coverage in each zone.

In the event of Status One or Status Zero, the on-duty Shift Supervisor shall request Mutual Aid from surrounding counties in accordance with ***LCEMS SOG 102-01***.

Personnel shall monitor radio traffic and be physically enroute for all coverage deployments within one minute of dispatch or notification, waiting until responding units check enroute to advise CMED of their deployment assignment.

Personnel shall remain at their assigned deployment location until they are assigned to a response, additional ALS units become available for response or as directed by the on-duty Shift Supervisor to relocate.

All units shall expedite their availability and complete documentation requirements on an available status.

The on-duty Shift Supervisor shall assist in expediting unit availability by responding to CHS Lincoln emergency room to assist crews with patient reporting, documentation, cleaning, restocking and/or decontamination as needed.

The on-duty Shift Supervisor shall retain the authority to authorize placing routine transfers from hospitals on temporary hold when System Status is Status Two (2) or lower. The on-duty Shift Supervisor shall notify CMED and the transferring hospital that the transfer has been placed on hold. Once System Status is at least Status Three (3) AND no more than one ALS unit is currently out of the county, the on-duty Shift Supervisor shall then expedite any transfers that are on hold.

STANDARD OPERATING GUIDELINE

Number 106-07

Minimum Staffing Requirements

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
07/01/2003	08/01/2016	RONALD D. ROMBS	1 OF 1

PURPOSE: The intent of this policy is to establish minimum staffing requirements for all ambulances operated in Lincoln County Emergency Medical Services (EMS) System, pursuit ant to NCGS 131E-158.

SCOPE: This procedure applies to all Lincoln County EMS (LCEMS) System providers.

PROCEDURE: As required by NCGS 131-E-158 all EMS providers in the LCEMS System shall ensure that minimum staffing requirements are maintained to perform within appropriate scope of practice, whenever they are engaged in active EMS medical transport.

LCEMS shall maintain a minimum of one (1) Paramedic and one (1) Emergency Medical Technician on paramedic level ambulances.

LCEMS shall maintain a minimum of two (2) Emergency Medical Technicians on basic level ambulances.

LCEMS shall maintain a minimum of one (1) Paramedic on Paramedic level Quick Response Vehicles.

System Providers

West Lincoln Rescue Squad shall maintain a minimum of one (1) Emergency Medical Technician and one (1) Medical Responder on basic level ambulances.

Exemption

This SOG may be abandoned in times of a declared disaster, when resources may dictate that a non-credentialed individual be utilized as an emergency vehicle operator.

STANDARD OPERATING GUIDELINE

Number 106-08

Mass Gathering Plan

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
12/01/2007	08/01/2016	RONALD D. ROMBS	1 OF 2

PURPOSE: The intent of this policy is to provide a process for coordinated planning to assure adequate medical response and resources for all Lincoln County Mass Gatherings.

SCOPE: This procedure applies to all Lincoln County Emergency Medical Services (LCEMS) system providers.

PROCEDURE: A mass gathering event is defined as any event involving the expected or actual presence of hundreds of people in a venue or area for a specific purpose or time. This plan defines the responsibilities of LCEMS system in providing the safety and medical care for people at mass gatherings.

Once informed of an event, the LCEMS Deputy Director shall be responsible for:

- Participating in related planning meetings
- Review and approval/denial for medical coverage of all related Special Event/Public Event applications
- Coordination of all medical coverage
- Ensuring creation and completion of an incident-specific operations plan that shall be forwarded to the appropriate planning committee and event participants as required. This plan shall be based on the National Incident Command System's (NIMS) model, include an Incident Action Plan (IAP) and provide clear definitions of event-specific response, triage, treatment, and transport capabilities.

The following tasks may be assigned to individuals or teams during mass gatherings. (These tasks may be expanded or condensed depending on the needs for each specific mass gathering.)

- **Event Medical Operations** – Oversees all aspects of the medical operation at the event
- **Event Triage** – Directs and conducts medical assessment of casualties and transport of injured to a central treatment area as necessary.
- **Event Treatment** – Directs the treatment of the sick and injured in the mass gathering area.
- **Event Transportation Officer** - Directs the transport of injured or ill persons to medical facilities for further treatment and function as a liaison with the on-duty Shift Supervisor to coordinate use of transport units.

Based on the type and venue of the event, there may be a need to include specialty teams, such as the bike team, foot medics and

golf cart team in the LCEMS event plan, to facilitate appropriate medical coverage.

Interface with routine EMS operations

Depending on the size of the mass gathering, some of the medical functions may be provided by on-duty LCEMS resources. When dedicated units are utilized to provide medical support at a mass gathering, those units shall only be reassigned from the mass gathering as a result of an overwhelming system need (MASCAL). Units may only be diverted from a mass gathering assignment by the on-duty Shift Supervisor, Training Coordinator, Deputy Director or the Director.

At the completion of the mass gathering medical assignment, the on-duty Shift Supervisor shall complete an After Actions Review and submit it to the Deputy Director within twenty-four hours. The After Action Review shall include completed copies of any forms utilized for documentation during the mass gathering.

LINCOLN COUNTY
EMERGENCY MEDICAL SERVICES
STANDARD OPERATING GUIDELINE NUMBER 106-09

MASS CASUALTY PLAN

INCIDENT RESPONSE AND MANAGEMENT GUIDELINES

July 1, 2007
Last Update: July 27, 2016

"Committed to Improving the Health & Safety of Our Community"
Lincoln County Emergency Medical Services
720 John Howell Memorial Drive • Lincolnton • North Carolina • 28092
Phone: (704) 736-9385 • Fax (704) 736-1924

MASS/MULTI CASUALTY INCIDENT

Lincoln County Emergency Medical Services (LCEMS) has defined a Mass/Multi Casualty Incident (MCI) as any incident involving five or more victims with life threatening or serious illness or injury. An MCI may also be stated as an incident involving five or more red and/or yellow-tag victims or an incident that overwhelms current available EMS operations.

PURPOSE

This plan provides guidelines for all emergency response agencies functioning within the LCEMS System so that a multi-agency response to a Mass/Multi Casualty Incident can be effectively coordinated. This plan provides a system through which multi-agency responses will be effectively planned, organized, and coordinated across command jurisdictions. This plan defines an effective command organization intended to eliminate confusion and enhance response capabilities during an MCI.

This plan also provides methods to manage medical operations during an MCI to prevent unnecessary loss of life. This plan establishes an effective Mass/Multi Casualty Incident organization, defines the activities and responsibilities assigned to Medical Command during a MCI, and establishes procedures to process information to support Mass/Multi casualty incident management, planning and decision making.

CONCEPT OF OPERATION

This plan is based on the National Incident Management System (NIMS). Through a unified command system, agencies develop common terminology, compatible communication systems, coordinated planning procedures, and efficient Standard Operating Guidelines (SOG).

In brief, the Incident Command System (ICS) is a management tool consisting of procedures for organizing personnel, facilities, equipment, and communications at the scene of any MCI. This plan includes terminology, assignments, and responsibilities and should be studied carefully. In the event of a MCI, it shall be the responsibility of the primary provider in whose area the disaster occurs, to direct, coordinate, and implement the MCI Plan.

The major complications that EMS personnel encounter during a disaster are the limited number of credentialed personnel available and the response of personnel working without authority or independent of the organized effort. These problems are addressed by narrowing the responsibilities and expectations of EMS personnel responding to the disaster scene.

Primary responsibilities include:

1) Maximum use of other emergency personnel (as available).
2) Concentration on patients most likely to be saved (START triage).

3) Rapid transport having priority over Advanced Life Support (ALS) on the scene.
4) Providing ALS while enroute to hospitals.
5) Providing on-scene ALS for those patients having to wait for transport.
6) All responding personnel working in a distinct, coordinated effort.

From the moment a MCI is identified, it is crucial for all personnel involved to follow proper protocols and established procedures to protect victims and reduce the incidence of death or injury to responders, victims, bystanders and members of the media.

The following paragraphs define the responsibilities of the telecommunicator taking the MCI call, how the first arriving medical personnel establish Incident Command (IC), and how to establish Medical Operations. Additionally, guidance and definitions are provided for initial and secondary triage as well as staging and transport guidelines.

The first unit on the scene must not blindly rush to individual patients, but briefly stop and make a rapid assessment of the situation. Actions and decisions in the first few minutes will influence the entire response and management of the incident. Proper actions and decisions will avoid confusion, chaos, and inefficiency.

SECTION I -- COMMUNICATIONS

Obtaining adequate information regarding an incident is essential to making an effective and safe entry into any MCI scene. The Communications Center (CMED) shall query callers to obtain as much information about the incident as possible.

CMED shall notify the on-duty Shift Supervisor and EMS Administration (EMS-1, EMS-2, EMS-3) either via radio or by pager. Information, including the nature of an incident, the means of access to scene, etc. shall be relayed to all responding units on appropriate radio channels.

As soon as practical, the telecommunicator should obtain the location of staging and other essential information from IC. Safety information should be collected from IC and relayed to other responding units as soon as possible (i.e. power lines down, chemicals involved, spectators in the roadway, emergency vehicles blocking traffic, armed suspect still on the scene, etc.).

CMED should also notify CMC-Lincoln and the three closest hospitals to the incident that an MCI has occurred and keep them abreast of conditions including the number of casualties.

SECTION II -- FIRST ARRIVING PERSONNEL ON SCENE

The first dispatched unit that arrives on scene shall establish an **Incident Command (IC)** as well as assign an **incident name**. It is IC's responsibility to coordinate with other responding agencies in an effort to establish a well managed **Unified Command** effort. The designation of EMS Command shall remain with the first arriving EMS unit until properly transferred to another EMS officer or the MCI operations have concluded. It is important to note that every person in any emergency response agency has the potential to be the lead person during a MCI. The first arriving unit **does not** need supervisory confirmation for activation of the Mass Casualty Plan.

EMS Command should brief CMED about the situation and the nature and numbers of resources that will be needed. A brief description of the incident, obvious conditions, the approximate number and severity of injured, and safety conditions should also be reported to CMED. CMED should be advised as the situation changes.

Once Command has been established, the telecommunicator should relay information to the scene through IC. The following procedures shall be instituted immediately upon arrival.

A. Initial Actions

1) Transmit a brief initial radio report. **(Arrival Report)**
2) Establish ***Incident Command and name the incident***. **(Command)**
3) Evaluate the situation, identify if the incident is an MCI. **(Scene Size Up)**
4) Identify location of staging area and means of access. **(Staging)**
5) Develop a strategy to manage the scene. **(Action Plan)**
6) Secure perimeter utilizing Law Enforcement. **(Perimeters)**
7) Assume effective IC position. **(Command Post)**
8) Brief responding support agencies by radio on all frequencies. **(Communications)**
9) Request appropriate additional assistance. (**Mutual Aid)**
10) Report casualty estimate through CMED to CHS Lincoln and the three closest hospitals to the incident. **(Hospital Alert)**

B. Scene Coordination

Emergency Responders shall secure access to the scene to prevent accidents and protect the injured. Also, they shall identify routes for emergency vehicles that will be arriving. In some cases, it may be necessary to designate parking spaces until a staging area is established. In addition, they shall evaluate the need for control lines and safety control zones.

C. Establishing Medical Operations

The first arriving paramedic shall assume the responsibility of **Medical Operations**. The **Medical Operations Officer** is responsible for all emergency medical activities at the scene including both care and transportation provided to victims and to responders that require medical attention during the incident. The **Medical Operations Officer** shall report to or establish a command post (usually a vehicle) in cooperation with other responding agencies.

It is possible in most minor incidents for **Medical Operations** to supervise Triage, Extrication, on-scene Treatment, and Transport of victims. In a larger incident it will be the Medical Operations Officer's responsibility to assign officers to each of the tasks defined below:

- **Triage –** Determination of the number of victims, their status and priority for treatment. In a MCI, the triage process progresses from a primary survival scan to qualitative triage to quantitative triage. Color-coded Triage SMART tags shall be used to identify patients, their status and treatment requirements.
- **Extrication –** The specialized strategy of removing a victim from entanglement or entrapment, and the transfer of victims to a casualty collection point for on-scene treatment. Extrication must be performed by qualified personnel with specialized training.
- **Treatment –** The extent of patient treatment in the field will vary with the type of incident (small scale Type V vs. large scale Type I with Federal Response), and the type of illness or injury (e.g., trauma vs. radiation incident). On a MCI the patients are moved to a casualty collection point for treatment as compared to a routine EMS incident, where patients are usually treated where found.
- **Transport** – Transfer of the patient from the incident to an appropriate hospital. Transport options include ground or air ambulance, bus, police car or private vehicle. The exact method of transfer shall be determined by the type of incident, the type of illness or injury, and the availability of transport vehicles.

SECTION III -- INITIAL TRIAGE

After EMS Command is established the next arriving medical personnel (if not Paramedic QRV) should begin Triage. These personnel will report to Medical Operations (or Triage Officer) with the number and severity of injured. When faced with more than one patient, it is the medical responder's duty to afford the greatest number of people the greatest chance of survival. To accomplish this, care and transport is provided according to the seriousness of a victim's injury or

illness. To determine severity, a rapid survey of each patient is performed and each patient is assigned to a priority group.

The patients are classified and tagged utilizing the SMART TRIAGE Tag system into one of four groups based on severity:

- **Red**: Correctable Life-threatening Illness or Injury – Examples include respiratory obstruction, suspected heart attack, severe bleeding, severe head injuries, cervical spine injuries, open chest or abdominal wounds, fractures without distal pulses, femur fractures, critical or complicated burns or burns involving respiratory complications, severe shock, tension pneumothorax.
- **Yellow**: Serious But Not Life-Threatening Illness or Injury – Examples include moderate blood loss, moderate to critical burns without complications, open or multiple fractures (open increases priority), eye injuries, other medical emergencies including stable drug overdose.
- **Green**: "Walking Wounded" – Examples include soft tissue injuries, simple fractures, sprains, minor to moderate burns.
- **Black**: Dead or Fatally Wounded – Examples include exposed brain matter, cardiac arrest (no pulse for over 20 minutes except with cold water drowning or severe hypothermia), decapitation, severed trunk, and incineration.
- **Red** with **Gray** tab: "Expectant" – Life-threatening illness or injury that is expected not to survive illness or injury – Examples include extensive full thickness burns, severe head injuries, bradycardia with agonal respirations, etc.

The initial triage process should only take 3 - 5 seconds for each patient. The only treatment intervention to be performed at this stage is opening the airway through head positioning. Patients will receive treatment once they reach the treatment area. Only patients requiring prolonged extrication will receive treatment where they lie.

SECTION IV -- SECONDARY TRIAGE AND TREATMENT

As more trained medical personnel arrive on scene, they shall be directed by Medical Operations to complete initial triage. Victims should be taken to a casualty collection point or treatment area and be physically separated into treatment groups based on their priority. It is in the Treatment Sector that

medical personnel should begin treatment and packaging for transport as directed by a Treatment Officer.

Utilizing Simple Triage and Rapid Treatment (START) protocols, patients shall be separated into four treatment groups. The "walking wounded" should be separated from the other injured as soon as possible. Trained personnel shall continue to monitor them but they should ideally be separated from the more severely injured. Fatalities should be left in place for investigative purposes, and should only be moved to a temporary morgue when the Medical Examiner or lead law enforcement officer on scene dictates.

The condition of victims in the treatment areas should be continually assessed until the last victim has left the scene of the incident. If a victim's condition worsens they should be moved to an increased priority group. Triage is a continual process. If a victim's condition improves, they may be moved to a lower priority group.

Advanced Life Support (ALS) should be reserved for patients having to wait for transport. Under no circumstance should transport be delayed for treatment purposes, especially in cases when treatment can be performed en-route to the hospital. Trauma victims will be saved in the operating room, not in the field, thus rapid transport is the key.

SECTION V -- STAGING AND TRANSPORTATION

All emergency units responding to the incident should respond to a Staging Area designated by the IC. The Staging Area will be under the direction of a Staging Officer, who shall advise responding units of their assignments as they arrive. Transport units and their personnel shall remain in this area until they are advised by the Staging Officer. Depending on the size and the estimated extent of the incident, the staging area should allow for restroom facilities, refreshments and shelter for responding personnel. Once a Staging Area is established, no unit should respond to the scene without having been directed by the Staging Officer.

The Transport Officer is responsible for communicating with each treatment sector to determine the number and priority of victims. This information will assist in determining the number of transport units needed.

The Transportation Officer shall determine the mode by which each victim will be transported; whether by helicopter, ground ambulance, bus, or other apparatus. Taken into consideration are availability of resources, weather conditions for helicopter operations and available Helispot, proximity to the nearest hospitals, and the number and nature of injuries. Ground ambulances can transport up to two red-tag victims at the same time with a minimal crew. Buses can transport large numbers of "Walking Wounded" under minimal medical supervision.

Requests for additional resources shall be processed by the CMED. EMS Command should request mutual aid by number and type of units or personnel needed, not by specific agency. CMED shall contact the closest surrounding agencies for mutual aid, and the responding units will be advised to respond to the Staging Area. It is imperative that the responding units be given clear directions to the Staging Area as many will not be familiar with the area, and the Communications Center may not have radio contact with them.

The Transport Officer shall maintain a patient manifest listing to which hospital each patient is transported. Patient reports including priority group and general injury descriptions shall be given by the Transport Officer to the hospital prior to transport. This way the hospitals know what to expect, do not receive patients they are incapable of handling, and do not receive a disproportionate share of patients. In large-scale incidents ambulances shall not give radio reports to the hospital unless a serious decline in patient condition occurs.

	3 to 5 patients		6 to 10 patients		11 to 15 patients		> 16 patients	
	Unconfirmed	Confirmed	Unconfirmed	Confirmed	Unconfirmed	Confirmed	Unconfirmed	Confirmed
Initial Response Red = Delta Black = Alpha R.S. = Rescue Squad	1 ALS Unit 1 R.S. Ambulance 1 Supervisor	2 ALS Units 1 R.S. Ambulance 1 Supervisor	1 ALS Unit 1 ALS Unit 1 Supervisor 1 R.S. Ambulance	2 ALS Units 1 Supervisor 2 R.S. Ambulances M-12 Service Support Vehicle	1 ALS Unit 2 ALS Units 1 Supervisor 1 R.S. Ambulance 2 R.S. Ambulances M-12 Service Support Vehicle Notify TLC	3 ALS Units 1 Supervisor 3 R.S. Ambulances M-12 Service Support Vehicle Disaster Medical Unit Notify TLC	1 ALS Unit 2 ALS Units 1 Supervisor 1 R.S. Ambulance 2 R.S. Ambulances M-12 Service Support Vehicle Notify TLC	3 ALS Units 1 Supervisor 3 R.S. Ambulances M-12 Service Support Vehicle Disaster Medical Unit Notify TLC
Mutual Aid Response+	Maintain Status 2	Maintain Status 2	Maintain Status 2	Maintain Status 2 & 1 ALS Unit to Scene	Maintain Status 2 1 ALS Unit to County Line	Maintain Status 2 1 ALS Unit to Scene	Maintain Status 2 2 ALS Unit to County Line Notify 4 R.S. Ambulances**	Maintain Status 2 3 ALS Unit to Scene 4 R.S. Ambulances to scene**
Aero Medical Response all requests coordinated by Med Comm Air Dispatch Center	Request Availability Of Flight Services 1 Helicopter	Request Availability Of Flight Services 1 Helicopter	Request Standby 1 Helicopter Request Availability Of Flight Services 1 Helicopter	Auto Launch 1 Helicopter Request Standby 1 Helicopter	Auto Launch 1 Helicopter Request Availability Of Flight Services 1 Helicopter	Auto Launch 2 Helicopters Request Standby 2 Helicopters	Auto Launch 1 Helicopter Request Availability Of Flight Services 2 Helicopters	Auto Launch 2 Helicopters Request Standby 2 Helicopters
LCEMS Notification	None	None	EMS 2 EMS 3	EMS 1 EMS 2 EMS 3 Notify on call ME & ME-1	EMS 2 EMS 3	EMS 1 EMS 2 EMS 3 Notify on call ME & ME-1 Recall Shift Supervisor	EMS 1 EMS 2 EMS 3 Notify on call ME & ME-1 Notify All Off Duty Shift Supervisors	EMS 1 EMS 2 EMS 3 Notify on call ME & ME-1 Recall All Off Duty Shift Supervisors
LCEMS Recall	None	None	None	None	None	Recall Standby Shift	None	Recall Standby Shift
Hospital Notification*	None	Notify CMC-L	Notify CMC-L & 2 closest hospitals	Notify CMC-L & 2 closest hospitals	Notify CMC-L	Notify CMC-L & 3 closest hospitals	Notify CMC-L & 3 closest hospitals	Notify CMC-L & 3 closest hospitals
Additional Resources	None	None	None	Notify CMC, Presby & NEMC Interfacility Transfer Units	Notify CMC, Presby & NEMC Interfacility Transfer Units	2 Interfacility Transfer Units to CMC-L Notify LC School for Bus to Scene	Notify CMC, Presby & NEMC Interfacility Transfer Units	2 Interfacility Transfer Units to CMC-L Notify LC School for bus to scene Notify NCOEMS Notify NCAREMS

* Obtain Number & Category Of Pts Hospital Can Receive

** Rescue Squads From Other Counties

+ Mutual Aid Response Counties

MEDIC (Mecklenburg)
Catawba
Gaston
Cleveland
Cabarrus
Burke
Iredell

"Committed to Improving the Health & Safety of Our Community"

Lincoln County Emergency Medical Services
720 John Howell Memorial Drive • Lincolnton • North Carolina • 28092
Phone: (704) 736-9385 • Fax (704) 736-1924

STANDARD OPERATING GUIDELINE

Number 106-10

Weather Emergencies

EFFECTIVE DATE:	REVISION DATE:	APPROVED BY:	PAGE:
03/01/2010	08/01/2016	RONALD D. ROMBS	1 OF 3

PURPOSE: The intent of this policy is to ensure adequate staffing levels for response to requests for services and to ensure employee safety during weather related emergencies.

SCOPE: This procedure applies to all Lincoln County Emergency Medical Services (LCEMS) employees.

PROCEDURE: The Director or designee shall be responsible for the declaration, level of declaration, escalation, de-escalation and termination of a weather emergency. The following Weather Emergency Levels are a guideline and may be modified as necessary to accommodate the needs of the organization.

The Director or designee shall implement emergency recall procedures per SOG 106-02, cancel vacations and days off, alter scheduled shifts, and take other appropriate actions to maintain adequate staffing levels.

Except as noted, the on-duty Shift Supervisor shall ensure the completion of all duties prescribed by this policy.

LEVEL 1 WEATHER EMERGENCY

The following actions shall be completed:

- Ensure ***ALL*** LCEMS apparatus (including spare apparatus) have fuel and fluids full.
- Ensure adequate levels of ice melt are available at ***ALL*** LCEMS facilities and shall deliver as necessary.
- Review winter weather driving operations and provide a safety briefing to all employees.
- Monitor road and weather conditions throughout the County and contact the Deputy Director if conditions begin to deteriorate.
- Ensure that all LCEMS apparatus housed at alternate facilities have sufficient space allocated and the units are parked indoors.
- Document in the appropriate daily log all actions completed and requiring completion by the on-coming shift in the appropriate electronic software.
- Ensure that walking & driving conditions at all LCEMS facilities are safe by removing snow and ice (including all

walkways and aprons) using ice melt.

- Staff and deploy additional unit(s) as follows:

Unit	Base	Hours
QRV 30	LCEMS Central Base	24 hour coverage with 0700/1900 shift change time

The Logistics Officer shall monitor the use of ice melt and reorder as necessary to ensure adequate supplies are on hand.

All personnel shall ensure they dress and prepare appropriately for the anticipated/current weather conditions.

LEVEL 2 WEATHER EMERGENCY

In addition to Level 1, the following shall be completed:

Staff and deploy additional units as follows:

Unit	Base	Hours
Medic 18	Pumpkin Center Fire Department	Extend to Medic 8 hours to 24 hour coverage
Medic 6/16	Central Base	24 hour coverage with 0700/1900 shift change time

All personnel shall ensure they make appropriate arrangements to remain at their assigned base between shifts should conditions deteriorate to the point that it is unsafe to commute to their residence. These arrangements shall include but are not be limited to arranging for family care, ensuring an adequate supply of personal hygiene items (toothbrush, toothpaste, razor, spare uniforms, additional clothing, several pairs of clean/dry socks, etc.) and food or snack items.

LEVEL 3 WEATHER EMERGENCY

In addition to Level 1 and 2, the following actions shall be completed:

- Personnel shall **ONLY** be assigned to apparatus with automatic chains or have 4-wheel drive capability.
- All patients shall be transported to the closest appropriate facility regardless of patient requests.
- The Nursing Supervisor at CHS Lincoln shall be notified that LCEMS will only perform **Code STEMI's** and interfacility transfers in which a delay in the transfer would be detrimental to the patient's outcome.

Staff and deploy additional units as follows:

Unit	Base	Hours
Medic 23	North Brook Fire Department	24 hour coverage with 0600/1800 shift change time

LEVEL 4 WEATHER EMERGENCY

If conditions deteriorate to the point that responses may place personnel at undo risk of severe injury or death, the Director or designee shall suspend operations and responses until conditions improve.