RAPPAHANNOCK EMS COUNCIL

Regional Mass Casualty Incident (MCI) Plan

Rappahannock Emergency Medical Services Council, Inc.
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# Record of Change

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I. Preface

The goal of the Rappahannock Emergency Medical Services Council (REMS) Mass Casualty Incident Plan is to prepare on a regional basis for a unified, coordinated and immediate emergency medical services (EMS) mutual aid response by pre-hospital and hospital agencies to, and the effective emergency medical management of, the victims of any type of mass casualty incident (MCI). It includes patients who are involved in any emergency evacuation of any health care facility in the REMS region and/or any such facility outside the region. This document, hereinafter referred to as the MCI Plan, should be the primary reference and standard operating guidance for in-hospital and out-of-hospital training and response to regional MCI’s in the 3,071 square mile REMS Council region, Planning Districts 9 and 16, and Colonial Beach. This document also addresses the field criteria that must be employed when the number of patients exceeds immediately available resources.

Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning district and related jurisdictions which comprise the REMS Council region as provided in the Code of Virginia, Section 32.1-113.
II. Approvals

This Mass Casualty Incident (MCI) Plan was prepared by the Rappahannock EMS Council to develop and maintain a viable MCI capability. This plan complies with applicable internal agency policy and state regulations.

Approved: _______________________________             Date: ____________________

Council Director

__________________________________________
Council President

__________________________________________
Regional Medical Director
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Chapter 1 – General Concepts and Considerations

Introduction
This MCI Plan addresses techniques in EMS field operations that must be employed when the number of patients exceeds immediately available resources.

It is intended as the primary reference for use in developing agency standard operating procedures, training, guidance and assistance for first responders, dispatchers, and medical control personnel in the management of multiple and mass casualty incidents.

EMS efforts in a multiple or mass casualty incident will begin with the first arriving unit and expand to meet the needs of the incident. The first arriving unit should establish Incident Command. That unit is responsible to assess scene Safety, conduct a scene Size-up and Send that information to the Emergency Communications/911 Center, begin to Set up the triage and treatment areas, and begin to triage victims using the START and JumpSTART triage methods.

The three priorities of incident management are:
1. Life Safety
2. Incident Stabilization
3. Property Conservation

The incident command structure will expand or contract as needed based on the size and complexity of the incident, and maintain the span of control. Only those functions/positions that are necessary will be filled and each element must have a person in charge.

In most multiple or mass casualty incidents (MCIs), the following ICS functions/positions must be staffed: incident command, staging area, extrication, triage, treatment and transportation. In a small scale incident, one person may assume more than one function, i.e. triage and treatment may be done by the same person or transportation and staging can be handled by the same person. In a larger incident, the Incident or Unified Commander may establish a Medical Group or Medical Branch to oversee some or all of the above functions.

Larger agencies may be capable of managing greater numbers of patients without mutual aid whereas other agencies may need mutual aid resources from several jurisdictions to manage an incident of the same magnitude.

Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning district and related jurisdictions which comprise the region.
**Plan Purpose**

The purposes of the MCI Plan’s Mutual Aid Response Plan are to:

1) Provide a standardized action plan that will assist in the coordination and/or management of a unified and immediate regional EMS mutual aid response to an MCI within the REMS Council region.

2) Ensure an effective utilization of the various human and material resources from various localities involved in a regional mutual aid EMS response to a disaster or MCI that affects a part or all of the REMS Council region.

3) Assist in the evacuation and care of a significant number of patients from any health care facility when the care and transportation of those patients exceeds the EMS capabilities of the facility, locality, jurisdiction and/or region.

4) Ensure the largest number of survivors in mass casualty situations or health care facility evacuations.

**Scope**

The Rappahannock EMS Council is defined by a service area made up of Virginia Planning Districts 9 and 16. The regional MCI Plan involves the Virginia counties of Caroline, Culpeper, Fauquier, King George, Orange, Rappahannock, Spotsylvania, and Stafford; the Town of Colonial Beach and the City of Fredericksburg. These localities make up Planning District 9 and Planning District 16 with a total estimated population of 500,000. The EMS population of this area consists of 57 designated emergency response agencies, over 2,300 providers and is made up of volunteer, career and commercial organizations.

The MCI Plan addresses only the EMS mutual aid response of the regional emergency medical services (EMS) system, hospital and pre-hospital, to a Mass Casualty Incident or Health Care Facility Evacuation. This plan is intended to address techniques in field operations that must be employed during multiple or mass casualty incidents when the number of patients exceeds immediately available resources. In addition, this Plan may also serve as the basis for routine operations and pre-planning for mass gathering events and other EMS special operations.

This plan is intended to be an “all hazards” plan to meet the needs of any multiple or mass casualty incident regardless of what caused the incident. If necessary, these procedures can be modified based on the number of patients, the cause or severity of injuries, and special circumstances involved in the incident.

Mass casualty incidents with limited fatalities and those that involve mass fatality incidents within the REMS region will be handled in cooperation with, and under the direction of, the Virginia Office of the Chief Medical Examiner, local law enforcement officials and/or Virginia State Police and the Virginia Department of Emergency Management.

**Relationship to other local emergency plans:**

- It is recognized that each county and locality has an emergency operations plan. Regional EMS mutual aid response should conform to the National Incident Management System (NIMS), this plan, and whenever possible local emergency guidelines in which the incident occurs.
- Regional EMS response planning will be transparent to, and support the health and medical annexes of, jurisdiction emergency operations plans. Planning guidance in this document will be
made available to local Emergency Management Coordinators to assist them in the preparation and maintenance of their plans.

- The REMS Council MCI Plan will be employed in circumstances such as when:
  1. The disaster or MCI is of such magnitude that the locality should institute mutual aid to avoid exhausting its EMS resources.
  2. The disaster or MCI crosses local boundaries to other jurisdictions may need to institute mutual aid to avoid exhausting their EMS resources.
  3. A hospital or other health care facility must evacuate patients on a temporary basis and transportation requirements exceed the EMS capabilities of the facility, locality, and/or region.
  4. The local Emergency Management Coordinator should be made aware as early as possible that the MCI Plan has been activated, or that there is a need for mutual aid.

### Authorities and References

This plan is published by the Rappahannock Emergency Medical Services (EMS) Councils, in cooperation with the emergency medical services agencies, and hospitals within the Rappahannock EMS Council Region.

Authority is granted by the Code of Virginia as outlined below:

**Code of Virginia** - The REMS Council is one of the regional EMS councils established within the Code of Virginia, Section 32.1-113. Created in 1976, the REMS Council is charged by law, “with the development and implementation of an efficient and effective regional emergency medical services delivery system” to include the regional coordination of emergency medical disaster planning and response. The Board of Directors of REMS Council has assigned to its Incident and Threat Mitigation Committee, the responsibility of effectively fulfilling those planning and response functions and with the overall maintenance and oversight of the REMS MCI Plan.

To request a copy of the plan, or to submit questions, comments, or recommendations for improvement, please contact your agency’s respective to EMS Council using the information shown below:

Rappahannock EMS Council, Inc.
435 Hunter Street
Fredericksburg, Virginia 22401
Telephone: 540-373-0249
Facsimile: 540-373-0536
Email: rems@vaems.org

**References**


II. **Department of Homeland Security (DHS) Federal Emergency Management Agency (FEMA)**

General Considerations

- Predetermined guidelines and the proximity and capabilities of appropriate health care facilities will be the primary considerations of MCI Medical Control when designating the health care facilities to which patients are sent during any local or regional emergency situation that results in the activation of the MCI Plan.
- Localities and/or individual pre-hospital EMS agencies will respond with appropriate personnel and equipment as available when the MCI Plan is activated. However, the response will be dispatched by the local Emergency Communications Center and will not reduce any locality’s own EMS response capabilities below established, predetermined levels.
- When considering their responses to activation of the Regional MCI Plan, member localities and/or EMS agencies will be expected to maintain their own emergency medical response capabilities to meet local needs.
- Trigger points for activating the Regional MCI Plan will vary depending on the involved jurisdiction’s available resources, type of incident, time of day, and concurrent responses.
- Predetermined EMS mutual aid responses will be deployed by hospital and pre-hospital members when any of the signatory health care facilities must be evacuated under the MCI Plan.
- The National Incident Management System (NIMS), taught within the REMS Council region, allows EMS personnel from anywhere in the region to quickly and easily become integrated into local and/or regional response efforts. It also provides effective command and control of EMS resources, and provides for integration with other emergency support functions. Under NIMS, position descriptions and roles are clearly defined and supported through this regional MCI Plan. Using the NIMS planning concepts, personnel and EMS agencies should work under the Incident Command System using predetermined system components where applicable.
- Training in the execution of this plan and MCI operations is critical. Hospital and pre-hospital components in the region will participate when possible in annual training exercises of the MCI Plan. These exercises in various localities in the region will be coordinated in cooperation with the locality by REMS Council through the REMS Incident and Threat Mitigation Committee.
- Localities and/or out-of-hospital agencies will respond to all emergency scenes under local dispatch protocols. Units and crews will continue to operate under local protocols until such time as it has been determined that a regional MCI exists and the MCI Plan has been activated.
- Scene safety is always the first consideration in an MCI of any level. Responder safety must be consistently monitored throughout the event. A Safety Officer should be appointed as soon as is practical to ensure that operations are safely carried out.
- In most multiple or mass casualty incidents (MCIs), the following functions ICS functions/positions must be staffed: incident command, staging area, extrication, triage, treatment and transportation.
- Larger agencies may be capable of managing greater numbers of patients without mutual aid whereas other agencies may need mutual aid resources from several jurisdictions to manage an incident of the same magnitude.
- Some incidents may be so large, or the sense of danger so pervasive (such as a terrorist incident), that victims may not wish to remain on the scene and will self-refer to known medical facilities. During such incidents, EMS triage and treatment resources may have to be co-located at hospitals, assembled at multiple locations, and/or situated a great distance away from the initial scene location to ensure the safety of first responders and victims.
- A personnel accountability system must be implemented at MCIs to help ensure the safety of first responders and ensure efficient operations.
- The resources needed to mitigate multiple simultaneous incidents are dependent on the size and complexity of the incidents as well as their location. Expected mutual aid resources may not be
Available or may be significantly delayed. Providers must be prepared to sustain their patients for long
periods of time. Non-traditional modes of transportation and alternate patient transport destinations
will need to be considered.

Potential Hazards
MCIs can occur in varying degrees, at any time, and in practically any conceivable situation. The REMS
Council regional population stands at some 500,000 people. High risks include:

- Heavily traveled highways and interstates between populated areas.
- Freight and passenger rail lines, navigable rivers, and recreational lakes.
- Nuclear power plant and light industrial plants.
- Military installations.
- Regional airports.
- Severe and unusual weather conditions also prevail throughout the region, including tornados,
windstorms, hurricanes and heavy rains, heavy snows usually to the west, sleet and freezing rains and
flooding in the Rappahannock, Rapidan and Potomac rivers.

Based on these numerous components, potential MCIs in the REMS Council region could include:

- Major vehicular accidents with multiple victims.
- Urban, residential and woodland fires.
- Tornados or other severe weather-related events.
- Public transportation mishaps (aircraft, train, bus).
- Construction and/or industrial and farm accidents including hazardous materials, building collapses
with multiple victims.
- River and/or localized flooding, impassable highways, roads and bridges.
- Healthcare facility evacuations.
- Acts of terrorism and/or civil disobedience.
- Military-related incidents and federal disaster responses.
- Large-scale planned events

Scene Safety and Security
Scene safety is always the first consideration in an MCI of any level. Responder safety must be consistently
monitored throughout the event. A Safety Officer should be appointed as soon as is practical to ensure that
operations are safely carried out. Recent history has proven that first responders have become choice targets
for domestic and international terrorists as seen in the Atlanta, Georgia bombings. Due to the potential for the
presence of secondary devices or people targeting first responders, operations should be carried out in such a
way as to assure the security of both first responders and victims. First responders must be alert for the
presence of secondary devices and the presence of people who don’t fit into the scene picture. All suspicious
items, devices, or people must be immediately reported to the Incident Commander via the chain-of-command.
In addition, all first responders should adhere to the prudent safety rule which is, “If you did not bring it into
the scene with you, then don’t touch it!” EMS personnel must also be aware that one or more of the victims
resulting from a suspicious or terrorist incident may actually be the perpetrator of the crime and therefore pose
a threat to first responders, the victims, patients, and the public. EMS personnel must be on alert for the
presence of armed and possibly violent victims or patients.
Responder Safety and Health
Responder occupational safety and health must be considered during an MCI response. On scene safety, occupational health and responder rehabilitation is the responsibility if the Incident Commander/Incident Management Team (IC/IMT) and the Incident Safety Officer (ISO) if one has been designated.

Personal Protective Equipment (PPE)
All EMS personnel involved in a regional response to an MCI or Evacuation will be expected to observe Universal Precautions and other infection control Body Substance Isolation practices as specified by their agency. Suspected or actual exposures to communicable diseases or bio-terror agents will be reported to the appropriate health district as soon as practical. Some communicable diseases are required (under Sections 32.1-36 and 32.1-37 of the Code of Virginia and 12 VAC 5-90-80 and 12 VAC 5-90-90 of the Board of Health Regulations for Disease Reporting and Control) to be reported within 24 hours to public health. In addition, the infectious control officers for the involved public safety agencies and the appropriate hospital and public health infection control personnel should be notified.

Responder Rehabilitation
On scene safety and responder rehabilitation is the responsibility of the IC/IMT and the ISO if one has been designated. In addition the IC/IMT and ISO are responsible for incorporating responder rehabilitation into their Incident Action, Safety and Medical Plans. Guidance for responder rehabilitation are provided in individual EMS Agency/Jurisdictional policies and standard operating procedures.

Chemoprophylaxis and Immunizations
In case of a biological incident, the IC/IMT, after consultation with public health officials, may specify additional occupational health requirements needed to protect the health of potentially exposed responders. A biological incident may require responders to receive prophylaxis with a medication and/or vaccine. The IC/IMT will outline the process/procedure for how such immunizations or medications will be obtained by individual responders.

Critical Incident Stress Management
The IC/IMT should consider making Critical Incident Stress Management (CISM) services available to all first responders. CISM Team services are available from the Rappahannock EMS Council. These services are confidential and free to the emergency services community. The teams provide stress defusing, debriefings, one-on-one sessions, demobilization, family support and educational programs. Any emergency worker in the Rappahannock EMS Council can call for the CISM team.

Rappahannock CISM Team: 24 Hour Dispatch: (540) 752-5883 and ask for CISM.

Personnel Accountability
A personnel accountability system must be implemented at MCIs to help ensure the safety of first responders and ensure efficient operations. The predominant accountability system used in the REMS region is the passport icon system. The jurisdiction in which the incident occurs will have overall responsibility for implementing the personnel accountability system. It will be the responsibility of the Incident Commander to integrate other accountability systems into any accountability system in use at the incident scene. It is the Incident Commander's responsibility to assure that all personnel are accounted for in accordance with the
standard Incident Command System practices.

**Multiple Casualty vs. Mass Casualty Event**
The U.S. Fire Administration defines the difference between a multiple casualty and a mass casualty event as follows:

**Multiple Casualty Incidents**
Multiple casualty incidents are incidents involving multiple victims that can be managed, with heightened response (including mutual aid, if necessary), by a single EMS agency or system. Multi-casualty incidents typically do not overwhelm the hospital capabilities of a jurisdiction and/or region, but may exceed the capabilities of one or more hospitals within a locality. There is usually a short, intense peak demand for health and medical services, unlike the sustained demand for these services typical of mass casualty incidents.

**Mass Casualty Incidents**
Mass casualty incidents are incidents resulting from man-made or natural causes resulting in injuries or illnesses that exceed or overwhelm the EMS and hospital capabilities of a locality, jurisdiction, or region. A mass casualty incident is likely to impose a sustained demand for health and medical services rather than a short, intense peak demand for these services typical of multiple casualty incidents.

This document can be applied to both multiple and mass casualty incidents.

**Multiple Simultaneous Incidents**
The resources needed to mitigate multiple simultaneous incidents are dependent on the size and complexity of the incidents as well as their location. Expected mutual aid resources may not be available or may be significantly delayed. Providers must be prepared to sustain their patients for long periods of time.

**Management of Catastrophic MCIs**
A catastrophic MCI will require assistance from the state and federal government. This level of MCI will also force responders to establish casualty collection points and may also require the establishment of intermediate care facilities. Additional resources may also be needed to assist with patient care at air heads established by the National Disaster Medical System (NDMS).
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Chapter 2 - Concept of MCI Response

Concept of Mass Casualty Incident Levels
Each defined MCI Level provides the Incident Commander with a suggested minimum number and type of resources that should be requested as part of the initial response package. These MCI levels are based upon the number of high acuity (Red Tagged/Immediate) patients, not the total number of victims involved. Ultimately, the type and number of resources requested is dependent on the nature and location of the incident.

Definition of Mass Casualty Incident Levels
The four MCI Levels are defined below. A list of recommend minimum resources is provided for each MCI level. These lists serve as a guideline from which to begin requesting additional resources.

MCI Level 1 (3-10 Immediate/Red Tagged Victims)
Larger agencies may be capable of handling incidents less than 10 Red Tagged/Immediate patients MCI Level I is left to the Incident Commander.

The recommended minimum resources needed to manage this incident are:
- 5 Ambulances (Ambulance Strike Team)
- 2 Engine Companies or minimum of six first responders
- 1 EMS Supervisor/Operational Chief

MCI Level 2 (11-20 Immediate/Red Tagged Victims)
The recommended minimum resources needed to manage this incident are:
- 10 Ambulances (2 Ambulance Strike Teams)
- 5 Engine Companies or fifteen first responder personnel
- 2 EMS Supervisors/Operation Chiefs
- 1 Disaster Support Unit – MCI Trailer/ 1 Medical Ambulance Bus

MCI Level 3 (21-100 Immediate/Red Tagged Victims)
A medical disaster of this magnitude will frequently require the activation of one or more regional and/or state specialty teams. The addition of these teams may require the establishment of a Unified Command and the expansion of the Incident Management Structure to include the Planning, Logistics, and/or Finance and Administration Sections.

The recommended minimum resources needed to manage this incident are:
- 15 Ambulances
- 10 Engine Companies or thirty first responder personnel
- 3 EMS Supervisors/Operation Chiefs
- 2 - 4 Disaster Medical Support Units/MCI Trailers
- 1 – 2 Medical Ambulance Buses

MCI Level 4 (101-1000 Immediate/Red Tagged Victims)
A medical disaster of this magnitude will frequently require the activation of one or more regional, state and/or federal specialty teams. The addition of these teams may require the establishment of a Unified Command and the expansion of the Incident Management Structure to include the Planning, Logistics, and/or Finance and Administration Sections.
The recommended minimum resources needed to manage this incident are:
- 20 ambulances
- 10 Engine Companies or thirty first responder personnel
- 5 EMS Supervisors/Operation Chiefs
- 6 - 8 Mass Casualty Support Units/MCU Trailers
- 3 or more Medical Ambulance Buses
- 1 Communications Trailer and Radio Cashe
- Virginia Disaster Medical Assistance Teams (DMAT)
- Busses

Contaminated Patients
If the victims of the mass casualty incident are contaminated, or potentially contaminated with a chemical, biological or radiological agents or materials consider the activation of the Regional Hazardous Materials (HAZMAT) Team. Regional Hazardous Material Teams are contacted through the Virginia Emergency Operations Center (VA EOC) at 1-800-468-8892.

Requesting Additional Resources
Additional resources must be requested as soon as a potential need for them has been identified. Annex F identifies regional specialty teams and task forces that may be requested to respond to a mass casualty incident. Annex F also identify state and federal teams and task forces that may be requested to respond to a MCI. The annex includes a synopsis of each team or task force’s mission, capabilities, and specific information on how to activate the team or task force.

Incident resources shall be requested using the procedures established by the Incident Commander/Incident Management Team (IC/IMT). The mechanisms commonly employed are:
- The use of existing stocks of host jurisdiction or EMS Agency supplies and equipment
- Activation of existing mutual aid agreements
- The use of the host jurisdiction’s or EMS Agency’s procurement procedures or contracts
- Requesting resources through the host jurisdictions Emergency Operations Center (EOC) at the direction of the IC/IMT.

Each resource request must specify the size, amount of the resource, location where the resource is needed, the type of resource required, and the time the resource is needed (SALTT). Resource requests will be submitted using the processes and ICS forms required by the IC/IMT. Regional mutual aid resources should be requested via the IC/IMT using existing EMS agency or jurisdiction policies and standard operating procedures. State and Federal resources must be requested via your local jurisdiction’s Emergency Operations Center (EOC). The request will then be sent to the Virginia State Emergency Operations Center (VA EOC) by calling 1-800-468-8892.

Resource tracking will be managed by the IC/IMT, or their designee using existing ICS forms (i.e. ICS Form 308, ICS Form 310, ICS Form 312, etc.)

Mass Casualty Incident Plan Activation/Declaration
Effective EMS efforts in a multiple or mass casualty incident should begin with the first arriving unit and expand to meet the needs of the incident. The first arriving unit should establish
Incident Command. In addition to the initial scene size-up the Incident Commander, or his/her
designee, is responsible for declaring a multiple/mass casualty incident thus activating this MCI plan.

**Medical Control**

Once communication has been established with the Coordinating Emergency Department, an Emergency
Department Physician will serve as Medical Control for the incident.

**Regional Medical Protocols/Standing Orders**

Once communication has been established with the Coordinating Emergency Department/Medical
Control ED a request to follow the REMS Regional Medical Protocols, as delineated for the various EMT
skill levels, can be granted by Medical Control. This will allow providers to perform all skills approved
for their level of training and certification (for which physicians orders would normally be required)
without having to contact Medical Control for the duration of the MCI.

**Medical Control for Outside Responders**

Large scale/catastrophic MCIs will require the use of EMS personnel from outside the REMS region.
Outside EMS personnel will be expected to adhere to the patient care protocols of their respective EMS
Agency/region. On-line Medical Control may be waived by the Coordinating Emergency Department via
the IC/IMT. This will allow providers to perform all skills approved for their level of training and
certification without having to contact Medical Control during the MCI.

**Patient Transportation**

Multiple/mass casualty incidents can be expected to create a demand for ambulances that may exceed the
number of ambulances readily available through mutual aid agreements and contracts with private companies.
The use of the Mass Casualty Evacuation and Transportation Units (MCETUs) for patient transportation is
recommended. (MCETUs are described in Annex F.) In addition, the use of non-traditional modes of patient
transportation and alternate patient transport destinations may need to be considered.

**Logistics**

A key difference between a routine incident response and an MCI, or disaster response, is the available
quantity of consumable supplies, equipment and personnel needed to properly manage the incident.
Additional resources must be requested as soon as the potential need for them has been identified. Chapter 2
provides a list of resources that may be needed to manage a specific level of MCI.

**Regional, State and Federal Response Resources**

Annex F identifies regional, state and federal specialty teams, respectively, that may be requested to respond
to a multiple/mass casualty incident. This annex includes a synopsis of each team or task force’s mission,
capabilities, and specific information on how to activate the team or task force.

**Resource Requests and Procurement**

Incident resources will be requested using the procedures established by the Incident Commander/Incident
Management Team (IC/IMT). The mechanisms commonly employed to acquire additional resources are:

- The use of existing stocks of host jurisdiction or EMS Agency supplies and equipment
- Activation of existing mutual aid agreements
- The use of the host jurisdiction’s or EMS Agency’s procurement procedures or contracts
Requesting resources through the host jurisdictions Emergency Operations Center (EOC) at the direction of the IC/IMT. Each resource request must specify the size, amount of the resource, location where the resource is needed, the type of resource required, and the time the resource is needed (SALTT). Resource requests will be submitted using the processes and ICS forms required by the IC/IMT. Regional mutual aid resources should be requested via the IC/IMT using existing EMS Agency/Jurisdiction policies and standard operating procedures. State and Federal resources must be requested via your local jurisdiction’s Emergency Operations Center (EOC). The request will then be sent to the Virginia State Emergency Operations Center (VaEOC) by calling 1-800-468-8892.

Resource Tracking
Resource tracking will be managed by the IC/IMT, or their designee using existing ICS forms (i.e. ICS Form 308, ICS Form 310, ICS Form 312, etc.)

Vehicle Refueling and Maintenance
During large or extended timeframe incidents the need to refuel equipment may be needed. There are many options that could be the appropriate response for the particular circumstances. The Chief/Group Supervisor of Transportation or Logistics Officer shall make the decision to accomplish this task. Some options are included in Annex F.

Vehicle operators are responsible for monitoring and maintaining the fuel level for their respective vehicle. Operators are also responsible for the safe operation, overall mechanical maintenance of their vehicle and reporting mechanical deficiencies to Chief/Group Supervisor of Transportation or Logistics Officer. Some options for maintenance are included in Annex F.

Financial Considerations
Responder, EMS Agency, or jurisdiction financial reimbursement, replacement of equipment, worker’s compensation, and financial dispute resolutions are the responsibility of the respective city or county administrators. In most cases these financial issues have been agreed to in existing local and statewide mutual aid agreements (MAA’s). Questions regarding these issues should be forwarded up the chain-of-command for resolution for all instances not covered under existing agreements and/or local agency/jurisdictional policies and procedures.

Legal Considerations
Responder and agency liability, immunity for responders, worker’s compensation, and dispute resolutions are the responsibility of the respective city or county administrators. In most cases these legal issues have been agreed to in existing local and statewide MAA’s. Questions regarding these issues should be forwarded up the chain-of-command for resolution for all instances not covered under existing agreements and/or local agency/jurisdictional policies and procedures.
Chapter 3 - Basic Principles

Management Goals
The following NIMS management components should be considered:

- Preparedness
- Communication and Information Management
- Resource Management
- Command and Management
- Ongoing Management and Maintenance

Incident Priorities
Priorities of an MCI (or other complex emergency situation):

- Life safety
- Incident stabilization
- Conservation of property and equipment
- Provide safety, accountability and welfare
- Mobilize and track resources on scene and those en route

Participants
The regional EMS mutual aid response to an MCI or Evacuation may involve, as required by the scope of the incident:

- Certified and/or licensed EMS providers at all levels of emergent patient care, from pre-hospital Basic Life Support (BLS) and Advanced Life Support (ALS) to acute medical and surgical treatment nurses and physicians in the hospital in the region, and related healthcare providers, especially those with facilities to care for critically injured or sick patients.
- Healthcare facilities, in particular those with acute-care or emergency facilities to care for critically injured or sick patients.
- Local, state and federal government agencies including, but not limited to:
  1. Virginia Department of Emergency Management
  2. Virginia Department of Health (VDH) including the Office of Emergency Medical Services (OEMS) and Office of the Chief Medical Examiner
  3. Northern Virginia Hospital Alliance NVHA / RHCC
  4. Rappahannock Area and Rappahannock-Rapidan Health Districts (local health districts within VDH)
  5. Virginia Department of State Police
  6. Virginia Department of Transportation
  7. Virginia Department of Military Affairs
  8. U.S. Armed Forces (including the U.S. Coast Guard)
  10. Local Emergency Planning Committees from jurisdictions within the REMS Council region.

- Non-transport and related support components such as the Regional VOAD, American Red Cross, Salvation Army, regular and reserve components of the armed forces, Civil Air Patrol, amateur radio organizations, and any other group that supports EMS operations.
The key to successful EMS mutual aid response to a major disaster or MCI is the close cooperation and coordination of these components and the REMS Council community through effective communications, planning and training.

**Initial Response to an Incident**

This MCI Plan will use the "5-S" approach to an MCI as taught in the Virginia Mass Casualty Incident Management Training Program:

- **Scene Safety Assessment** – Determine providers are safe before entering the scene, while on-scene and en route from scene. Scene safety assessment is ongoing.
- **Survey the Scene** – Determine type of incident, estimate the number of patients and severity of injuries, and determine best access.
- **Send information and requests for assistance** – Contact dispatch with survey information, request resources, activate the MCI Plan.
- **Establish scene management structure utilizing NIMS to include extrication, triage, treatment, and transportation.**
- **Begin Simple Triage and Rapid Treatment of incident victims.** Locate and remove all of the walking wounded into one location away from the incident, if possible. Begin assessing all non-ambulatory victims where they lay, if possible. Each victim should be triaged in 60 seconds or less. Assess respirations, perfusion, and mental status.

**Initial Triage - (Using the START Method)** - Utilize the Triage Ribbons (color coded plastic strips). One should be tied to an upper extremity in a VISIBLE location (wrist if possible). RED – Immediate, YELLOW – Delayed, GREEN – Ambulatory (minor), BLACK – Deceased (non-salvageable).

**Secondary Triage** - Will be performed on all victims during the Treatment Phase. If a victim is identified in the initial triage phase as a RED and transport is available, do not delay transport to perform a secondary assessment. The triage priority determined in the Treatment Phase should be the priority use for transport.
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Chapter 4 - Regional Activation Structure

Authority to Activate Plan
The following individuals can activate the MCI Plan for EMS mutual aid:

- The Incident Commander at the scene of a MCI according to the existing local protocol, usually via the local ECC.
- The local Emergency Management Coordinator, or that person’s representative, of a political subdivision that has authority for the management of the incident.
- The Hospital Incident Commander, or appropriate representative of a health care facility that is required to evacuate or move patients.
- Any health care facility in the REMS Council region when additional resources are necessary to provide appropriate patient care.

Activation of the MCI Plan - Role of the Emergency Communication Center
Upon receiving notification to activate the regional MCI plan, the local affected Emergency Communications Center (ECC) will activate the Pre-hospital Component of the MCI Plan through established mutual aid agreements among pre-hospital volunteer and career EMS agencies. The Emergency Communications Center dispatcher will emphasize that the mutual aid/auto aid request for ambulances and/or equipment is under the activated REMS Council MCI Plan. Localities providing resources by an MCI will be responsible for activating mutual aid through their own Emergency Communications Systems. Use of the available resources of the Virginia Office of EMS, Virginia Department of Emergency Management, the Virginia Association of Volunteer Rescue Squads, or the REMS Council is encouraged.

The Incident Commander, or designee, may direct the local ECC to contact the Regional Healthcare Coordination Center (RHCC) with early initial information. If tasked the ECC shall:

- Should identify herself/himself and request activation of the Rappahannock EMS Council Mass Casualty Plan.
- Give a brief summary of the incident. The information should include time of the incident, type of incident, location, initial number of patients involved, and a callback phone number.

Activation and Role of MCI Medical Control, the Regional Healthcare Coordination Center (RHCC), and Hospitals
In the early stages of the incident a coordinating Emergency Department or Regional Healthcare Coordination Center (RHCC) must be established. For smaller multi-casualty incidents with less than 10 patients (not involving hazardous or biological materials), the Incident Commander (IC) or designee will contact the closest trauma center to advise them of the emergency. The closest hospital should be advised of the situation, number of patients and types of injuries involved. The coordinating ED will decide, based upon capabilities at that time, to accept or decline the role of coordinating ED. The indicated hospital will designate another acute care medical facility to act as primary MCI Medical Control for any appropriate reason including better communications, better or closer geographical location to the MCI site, or because of any other circumstances that would be in the best interest of effective patient care. The indicated hospital will notify the designated hospital, by med com or telecommunication, that it is relinquishing the MCI Medical Control function, and will receive an appropriate sign of acceptance of the MCI Medical Control responsibility from the designated hospital.
For larger mass-casualty incidents with 10 or more patients (or those incidents involving hazardous or biological materials), the Incident Command (IC) or designee will contact the Regional Healthcare Coordination Center (RHCC) (1-888-987-7422). The RHCC will make notification to hospitals throughout the region to coordinate patient placement. The RHCC will communicate with adjoining regional hospitals systems as needed – depending on location and extent of incident. The RHCC will act as the primary placement facility for the event.

The RHCC will activate or alert the appropriate acute care medical facilities and other appropriate health care facilities in those numbers and in those locations that best can accommodate the scope of the MCI and/or Evacuation, and which are in the best interests of effective patient care.

The RHCC will notify Incident Command to assign patients to the medical facilities closest to the site of an MCI or evacuation and which can provide the appropriate levels of emergency care.

The closest regional trauma center will remain responsible for any on-line medical control during patient transport to designated receiving hospitals. On-line medical direction likely will be affected by overload of the HEAR radio system during an MCI. In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with patient care protocols as established by the Medical Directors of Planning Districts 9 and 16.

Hospitals will be responsible for providing definitive patient care to the levels of their capabilities during and after the incident.
The RHCC will be notified to activate in support of EMS agencies in the REMS Council region for incidents meeting any of the following criteria:

- An event which involves (10) or more patients that will require transportation to a hospital; and/or where (3) or more hospitals are to receive patients
- A single HAZMAT event in the REMS region involving (3) or more patients that will be decontaminated in the field by EMS before being transported to a hospital
- An event in REMS region involving a suspected or confirmed Category A biological agent
- A REMS EMS agency has accessed and/or requested a CHEMPACK or MMRS Rx cache

**MCI Declared Under Regional Plan**

**Provide RHCC Staff the Following Information**

- Total number of patients / casualties (actual or estimate)
- Location and jurisdiction of incident
- Type of incident (i.e., explosion, major car accident, chemical fire, etc.)
- A casualty assessment to include number of Red/Immediate, Yellow/Delayed, and Green/Minor patients
- The exact support needed from the RHCC
- The radio channel and/or phone number of Fire/EMS agent on scene to use for ongoing communications during the event

**RHCC Communicates with Hospitals**

- Incident information immediately conveyed to regional hospitals via MedComm. RHCC communicates with adjoining regional hospitals systems as needed – depending on location and extent of incident.
- All NVHA hospitals will be asked to report their immediate casualty capacity information within 10 minutes of activation (i.e., number of red, yellow, green patients they could manage within the next 30 minutes)
- This information will then be relayed to the appropriate EMS field officer on scene to assist with patient disposition and hospital destination decisions by the RHCC

**Appropriate Fire/EMS agent on scene will immediately contact the RHCC by radio or phone 1-888-987-7422**

- Should EMS contact MCI Hospital initially they should be advised to go direct with the RHCC by hospital staff

- Hospital may activate the RHCC if requested as backup to initial EMS direct communications

**Incident page established**

- Hospitals will utilize VHASS/WebEOC for incident and patient tracking to include use of State Triage Tag #s
Activation and Role of Pre-Hospital Agencies and Providers
Transportation of patients under this Plan during an incident or evacuation will be done by licensed pre-hospital EMS agencies in the REMS Council region and from neighboring regions when necessary and available.

Units and personnel involved in mutual aid response to a regional MCI or an evacuation will be dispatched through the local emergency communications and/or dispatching center. Individual providers will report to their respective agencies/stations and will not self-dispatch to the scene of the incident. Providers who so respond in privately owned vehicles (POVs) will be directed to report to their respective agencies or at the discretion of the Incident Commander and if they have appropriate EMS identification and appropriate personal protective equipment, may be directed to the incident Staging Area. No one will be allowed direct access to the MCI site.

All out-of-hospital providers and/or agencies responding to an MCI site within the REMS Council region shall operate under the Virginia Mass Casualty Incident Management System, the Virginia START®/Jump START® Triage System, and the REMS Pre-hospital Patient Care Protocols. On-line medical direction likely will be affected by overload of the HEAR system during an MCI. In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with patient care protocols as established by the Medical Directors of Planning Districts 9 and 16.

Pre-hospital EMS agencies and/or localities agree to respond with personnel and equipment when the MCI Plan is activated, but should not be expected to reduce local emergency response capabilities below acceptable levels.

Crews of pre-hospital EMS units responding to an MCI or Evacuation will be required to carry self-identification and proof of affiliation with their agency.

Crews of pre-hospital EMS units responding to an MCI or Evacuation will be responsible for maintaining all operational documentation, and for making that documentation available to appropriate authorities.

Health Care Facility Roles and Responsibilities
Hospitals that are activated or alerted under the MCI Plan will provide upon request from the Coordinating Hospital/RHCC confirmation or adjusted information on the predetermined numbers of patients they can accommodate in the three START Triage categories: Red, Yellow and Green (Hospital Triage Level), or confirm or adjust the predetermined numbers and categories of patients they can receive from another hospital through Mutual Aid in the event of an Evacuation/Mutual Aid Capability.

The numbers and types of patients which member hospitals will be prepared to receive are suggested in predetermined Hospital Triage Levels and Mutual Aid Capability tables as provided by those facilities.

Hospitals will be responsible for providing definitive patient care to the levels of their capabilities during and after the incident.

When a health care facility must evacuate any number of patients on a temporary basis, or receive patients from another evacuated health care facility, the following shall apply:

- The administrative staff of the evacuating health care facility will be responsible for directing the evacuation and transfer of patients to the designated receiving hospital or health care facility in coordination with the RHCC.
• Physicians whose patients have been evacuated will receive Courtesy Medical privileges from the receiving hospital for the duration of the emergency. These privileges will be stipulated in predetermined and pre-negotiated protocols and/or agreements held between area hospitals.
• Each evacuated patient will be accompanied by his/her medical records.
• The receiving health care facility will use routine admitting procedures for patients from the evacuated facility including, if possible, consent for treatment.

Fatality and Mass Fatality Incident/Medical Examiner and Law Enforcement Roles and Responsibilities
By Virginia State statute, the VDH’s Office of the Chief Medical Examiner is responsible for the medical investigation of sudden, unexpected, and violent deaths throughout the Commonwealth. Persons who die under those circumstances require the expeditious and skilled attention of the Medical Examiner. Under the direction of the Office of the Chief Medical Examiner or designee, the State Funeral Directors MCI Plan may be activated. Depending on the nature of the incident local, state, and federal emergency management agencies, law enforcement officials, and others may also be involved in activities such as morgue operations and suspicious or criminal death investigations.

The Incident Commander is responsible to notify, as early as possible, the Office of the Chief Medical Examiner of any suspected mass casualty incident which involves, or which may involve, fatalities. The Office of the Chief Medical Examiner can be reached by calling 804-786-3174.

Communicable Disease or Bioterrorism Incidents
Suspected or actual exposures to all bioterrorism agents or other reportable diseases will be reported to the appropriate local health district as soon as possible as specified on the Virginia Reportable Disease List (Annex H). The Virginia Department of Health’s 24-hour answering service can be reached at 866-531-3068. Ask for the staff member on call for the appropriate local health district (Rappahannock Area Health District or Rappahannock-Rapidan Health District) or the specific locality involved.

Terrorism Incidents
Terrorism deals specifically with those weapons of mass destruction that generally are categorized as Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE). The initial response will be according to the local emergency plan, followed by the MCI Plan if a regional response is necessary. It is unlikely that emergency responders will immediately be able to determine if an incident is an accident or an act of terrorism. An explosion, the release of chemical or biological agents could be an accidental incident or a planned act of terrorism.

Declared State or Local Emergencies
In a declared state or local emergency, local resources can be supplemented by requesting deployment of state EMS Disaster Task Forces through the Virginia Emergency Operations Center (1-800-468-8892 or 804-674-2400). EMS Task Forces will remain under the command of their Task Force commander and should not be broken up. EMS Task Forces will attempt to arrive supplied for 72 hours, not including water, fuel or expendable supplies.

A Virginia EMS Task Force includes:
• BLS Ambulance
• AMS Ambulance
MCI Plan 2019

- Crash/Rescue Truck
- 12-15 MES Providers lead by a Task Force Commander

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Chapter 5 - MCI Scene Set up

General layout
It is important for responders to establish an orderly flow of patients from the incident scene through the transport area. The uncontaminated patient flow diagram shown below provides a sample diagram of just one way to organize the scene. Ultimately the way a scene is organized will depend on scene security & location, terrain, weather, the number of patients, and other factors.

*Patients, especially green ones, may be transported by means other than ambulance as condition, safety and need dictate.*

Mass Casualty Patient Flow

The Incident Scene
The flow if the incident scene is as follows:
- Ambulatory patients are directed to a safe place as soon as one is identified. (Green Treatment Area).
- Those who are able should be asked to assist with others.
- Self-treatment supplies should be distributed
- All victims are accounted for; trapped victims are rescued or extricated.
- Patients are accounted for and quickly triaged (START)
- Triage ribbons are applied.
- Non-ambulatory patients are removed from the scene to the Treatment Area by porters.
- Patients are decontaminated (as needed) prior to leaving the incident scene, prior to arrival in the Treatment Area.
- Deceased victims are left as they are unless required to access live patients.

The Treatment Area
Treatment area Patients are placed in the Treatment Area and emergency medical care is provided on the basis of the triage priority. The Treatment Area is usually divided into separate areas for the care of Red Tagged/Immediate, Yellow Tagged/Delayed, Yellow Prime/Catastrophically Injured, and Green Tagged/Minimal patients. Personnel, equipment and supplies are allocated to patients based on their triage priority.

Careful consideration should be given to selecting the location of the Treatment Area. If there is inclement weather or temperature extremes consideration should be given to locating the Treatment Area indoors, whereas lighting of the Treatment Area will be a consideration during night operations. In addition, the location of the treatment area should be visible to porters. The Treatment Area should be marked with color coded (red, yellow, green, and black) flags, tarps, and/or colored chemical lights.

The Treatment Area flow is as follows:
- Patients are continuously reevaluated (re-triage).
- Patients arriving from the incident scene are prioritized for treatment using a more in-depth assessment method (Secondary Triage) and a triage tag applied.
- Patients are placed in the Treatment Area and emergency medical care is provided on the basis of the triage priority.
- Separate areas may be created in the Treatment Area for Immediate (Red), Delayed (Yellow), and Minor (Green) injured patients.
- A separate isolated area (Temporary Morgue) is created for victims who die in the Treatment Area. This area should be secured by law enforcement.
- Personnel, equipment and medical care resources are allocated to patients based on the triage priority.

The Transportation Area
The RHCC* should be contacted (early in the incident) to obtain information to assist with the most appropriate patient distribution to medical facilities.

The Transportation Area flow is a follows:
Transportation resources are assigned based on triage priority.

Patients are moved to the Transportation Area to the appropriate vehicle by Porters/Transport Loaders.

Patients are transported to the most appropriate medical facility by the most appropriate means available. On some incidents, the use of vehicles other than ambulances may be an alternative to transport large quantities of casualties to care facilities. A list of these options is included in Annex F.

Transporting units do not make additional contact with the receiving facility. This contact is handled by the onscene Medical Communications Coordinator.

Emergency medical care is continued en route to the hospital. At a minimum all medical care must be documented on the Virginia Triage Tag.

Patient movements are documented.

*For MCIs with < 10 patients the closest Emergency Department ("Coordinating ED") will usually be contacted, which will then notify other emergency departments. Refer to the REMS RHCC Activation guide (page 26).

**Victims with Special Needs and Assistance Animals**

Care must be taken to meet the communication, mobility, cognitive and other needs of victims with special needs. Responders must make certain that assistive devices and equipment are transported with the victim or patient. (e.g., glasses, hearings aids, and mobility devices such as walkers and wheel chairs.) Theses items should be labeled with the patient’s name if known or the patient’s Virginia Triage Tag number.

Patients should not be separated from their assistance animal. Assistance animals are vital to the recovery of these patients and their prompt return to the activities of daily living. If the patient must be transported to a health care facility then arrangements must be made for the housing and care of the assistance animal. Information of the location of the animal must be provided to the patient and/or their family or other care giver. This also applies to working dogs such as canine law enforcement officers (e.g. drug dogs, bomb detection dogs), search and rescue dogs, and cadaver dogs. Care must be taken to meet the communication, mobility, cognitive and other needs of victims with special needs.
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Chapter 6 - Response Overview

First Arriving Unit Responsibilities
It is the responsibility of the first arriving unit to establish command and to perform the initial scene size-up using what is known as the “5-S’s and reporting the information to their dispatcher. The “5-S’s” are:

- Safety Assessment
- Size-up the Scene
- Send Information
- Setup the Scene for Management of Casualties
- START Triage

A job aid check-list is located in annex C of this plan.

EMS Initial Actions by Incident Command
The senior crewmember on the first arriving unit becomes the Incident Commander and reports that they established command to their Communications Center. This person will remain in charge until command is transferred to a higher authority. An Incident Commander (IC) job aid check-list is located in annex C of this plan. In general, the IC should perform the following initial actions:

1) First unit on scene establishes incident command or delegate.
   a) Announce on radio command post location.
   b) Set up command post in a safe location where you can be easily seen and with a clear view of the incident area.
   c) Stay at the command post and in contact by radio.
2) Assess situation and provide size-up to Emergency Communications Center.
   a) Situation and estimated number of victims.
   b) Potential hazards.
   c) Resources on scene and general plan.
   d) Additional resources needed.
3) Develop an initial strategy.
   a) Hazard elimination.
   b) Incident priorities for extricating and treating victims.
   c) Safety steps to prevent additional casualties.
4) Develop Incident Action Plan
5) Assign existing resources to jobs and monitor progress.
6) Appoint as needed:
   a) Operations Section Chief
   b) Air Operations Branch Director
   c) Extrication Group Supervisor
   d) Transportation Group Supervisor
   e) Triage Unit Leader
   f) Air/Ground Ambulance Group Supervisor
   g) Treatment Unit Leader
   h) Planning Section Chief
   i) Logistics Section Chief
j) Medical Group Supervisor  
k) Liaison Officer  
l) Safety Officer  
m) Public Information Officer (PIO)

**Triage**

Field triage of patients will conform to the guidelines described in the Commonwealth of Virginia Emergency Operations Plan which involves the Virginia START/Jump START Triage System as outlined in this MCI Plan Mutual Aid Response Guide. General categories are: Red -- Immediate care required; Yellow – Care can be delayed; Green -- Minor injuries; Black -- Dead or non-salvageable.

Virginia Triage Tags will be used to document patient care during a MCI.

**Initial Triage**

The initial triaging of victims must begin right where the patients lay. The EMS Provider must begin to triage patients where they enter the scene and then progress in a deliberate and methodical pattern to ensure that all of the victims are triaged. When using both the START and JumpSTART triage methods all ambulatory patients are initially directed to a designated Green/Minor treatment area where they will be assessed and further triaged as personnel become available. It is appropriate to provide these patients with self-care kits, if available, so that they may begin treating themselves while awaiting the arrival of EMS providers. For all remaining patients, triage personnel must quickly triage each patient and apply the appropriate color-coded triage ribbons (surveyor's tape).

The initial triage of the victims establishes the order in which non-ambulatory patients will be moved to the treatment area. Red Tagged/Immediate victims should be moved first, Yellow Tagged/Delayed second. All Green Tagged patients should already be in the Green/Minimal Treatment Area as outlined above by moving ambulatory patients first. Deceased victims (Black Tagged/Deceased) are left where they are found unless they must be moved to gain access to living patients or if the remains are in danger of being destroyed.

**Secondary Triage**

Secondary triage includes a more traditional assessment of patients and is based on the clinical experience and judgment of the provider. Secondary triage is performed on the way to the treatment area (entry point), in the patient treatment area, and/or en route to the hospital. The Virginia Triage Tag and work sheets are utilized to document assessment and treatment.

In some cases a patient may be reclassified as red, yellow, or green after secondary triage. Findings from the secondary assessment will further determine priorities. For example a “yellow” abdominal trauma patient will take priority over a “yellow” patient with an ankle injury.

**Patient Care and Transport**

In the absence of on-line or on-scene medical direction, out-of-hospital adult and pediatric patient care will be rendered in accordance with REMS Pre-hospital Patient Care Protocols, as most recently revised. Unless otherwise designated, medical documentation will be done through the use of the Virginia Triage Tag.

**Special considerations during mass fatality incidents:**

- The dead must be treated with respect and dignity in thought and in actions at all times.  
- Delineate a temporary morgue, moving bodies/parts when released by the medical examiner.
MCI Plan 2019

- Preliminary setup for dealing with families, news media and by-standers. Information released through Medical Examiner only.
- Transportation to the hospital morgue for thorough exam and delineation of cause of death will be by the funeral home or other accepted means.
- Identification of the dead and security of the area in which the dead are located are critical issues. Close cooperation with the Office of the Chief Medical Examiner and police authorities, both in MCI preplanning and during the incident, is essential.
Chapter 7 - Special Resources Response

Hazardous Materials (HAZMAT)
The local fire department should be contacted in the event of an incident involving hazardous materials. The local fire department will contact the Virginia Emergency Operations Center at 1-800-468-8892 to request technical assistance or to have the VDEM Regional Hazardous Materials Officer (RHMO) respond to the incident scene. Based on the request and assessment by the RHMO, the RHMO may activate one or more regional hazardous materials response teams and appropriate personnel as required.

Actions of local emergency response organizations are based on local response plans and Virginia's Emergency Operations Plan (COVEOP), including the Oil and Hazardous Materials annex (COVEOP Volume 4), the Terrorism Consequence Management annex (COVEOP Volume 8), as well as local government and hospital emergency operations plans and terrorism management annexes.

While all hospitals are encouraged to have basic decontamination capabilities to treat patients exposed to or contaminated by hazardous materials, it is recommended that Mary Washington Hospital serve as primary receiving facility for victims that have field decontamination at the hazardous materials incidents within the REMS region. Mary Washington Hospital has the ability to provide additional decontamination over an extended period.

The Incident Commander or Decontamination Leader will determine when patients will be released to the first personnel for treatment and/or transportation to a health care facility.

The public safety community, including EMS providers will follow proper decontamination procedures, to include the removal or deactivation of contaminants from people, equipment, or the environment. It protects responders from hazardous substances that may contaminate and permeate their protective clothing, respiratory equipment, tools, vehicles and other equipment used on the scene. By expeditiously removing the contaminant from the victims, first responders may be able to preclude the occurrence of adverse health effects from the materials.

All personnel involved in a Mass Casualty Hazardous Materials incident should meet the appropriate training level in accordance with established guidelines set forth by U.S. Department of Transportation (USDOT), Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), State and Local emergency response procedures. All responders who do not meet these guidelines should stage and stay well outside of the hot and warm zones of the incident.

Health and Medical Emergency Response Team (HMERT)
When requested through the jurisdiction emergency operations center to the State Emergency Operations Center, 1-800-468-8892, Emergency Medical Services personnel and or teams, coordinated through the Office of Emergency Medical Services, can be requested to augment the available capability of local emergency medical services systems. IST Team(s) can be activated and deployed with or without other personnel.

Technical Rescue and Search and Rescue Teams
A technical rescue includes any operation that requires the use of specialized equipment and knowledge to extricate victims from collapsed area, confined spaces, high angle, and search and rescue operations.

Mass Casualty Incidents involving extended technical rescue operations will use the resources available from the local, state, and/or federal system. When the incident overwhelms the abilities and assets of the local jurisdiction and local mutual aid, the locality may request aid from several Virginia jurisdictions that have established technical rescue teams. The Virginia Emergency Operations Center, 1-800-468-8892, is the Search and Rescue Coordination Center for Virginia and can initiate contact with State SAR and Technical Rescue teams for the locality.

Air Operations
Airspace Restrictions
The airspace over any MCI is regulated by the Federal Aviation Administration (FAA) under Federal Aviation Regulation 91.137. Questions or requests concerning the use or restriction of that airspace during an incident should be referred as early as possible to the appropriate air traffic control tower. The Virginia EOC at 804-674-2400 or 1-800-468-8892 has contact information to assist in this function if needed.

Aeromedical Operations
EMS Aeromedical services are available 24 hours a day. This resource will be coordinated through jurisdictions’ local emergency communication centers.

In a large-scale emergency, the Virginia EOC will be contacted to alert the Virginia Army National Guard, Virginia Air National Guard, and the U.S. Coast Guard for possible use of the aviation assets of those organizations.

Fixed-wing and helicopters can be used to evacuate patients from the scene of an MCI with the exception of a hazmat incident. However, other possible uses should be considered:

- Initial disaster scene size-up/access/aerial observation/monitoring of the scene and related conditions
- Weather information
- Scene lighting
- Air-to-air and air-to-ground communications
- Control of airspace over the incident.

Additional possible uses for helicopters include:

- Use of the Flight Paramedic(s) for triage or treatment
- Delivering or shuttling special personnel, equipment or supplies
- Overcoming natural or other physical barriers.

Helicopter Operations - Landing Zones (LZ)
If needed, one or more LZ’s should be designated as early as possible by the Incident Commander or EMS Air Ambulance Group Supervisor.

The LZ should be as near as possible to the MCI scene but should not affect patient care areas. The LZ should be away from power lines, towers, trees, buildings and other potential height hazards. It should be selected with consideration for pedestrian and vehicular traffic control needs. Roads or highways, with proper traffic control, make suitable LZs. However, the LZ should be a minimum of 200 feet away from any traffic.
The overall size of an LZ should not be less than 500 feet by 500 feet. The helicopter touchdown site in daylight should not be less than 75 feet by 75 feet in daylight - 100 feet by 100 feet at and after dusk. The touchdown site should have a wide and clear path of flight approach and departure, preferably with the aircraft’s nose heading into the prevailing wind.

The helicopter pilot is the final judge in selecting an appropriate site to land the aircraft, and on deciding whether or not to land.

The LZ should be staffed, marked and prepared before, during and after landings and takeoffs.

- Minimum staff in daylight should be one person.
- All assigned LZ personnel should wear easy-to-spot clothing, with arms above head and back to the downdraft. LZ personnel should wear effective eye and ear protection and be familiar with dangers of working around helicopters, especially during a “hot” operation, when the aircraft engines and rotors are operating.
- Precise marking of the LZ in bright daylight is not essential as long as the intended area is obvious to the helicopters’ flight crew. The LZ at dusk and in darkness shall not be marked with flares but with lights (lantern, vehicular, etc.). All lighting must be secured against the helicopter’s downdraft. LZ personnel must guard against flashing any lights toward the aircraft. Strobe lights bleed through as white.
- The LZ should be inspected for loose debris, foreign objects and loose dirt. The LZ can be wet down to reduce dust and enhance visibility.

Radio contact from the LZ to the helicopter is extremely important. In the absence of other directives or incident assignments, the EMS Statewide Mutual Aid frequency (155.205) should be used when communicating with the helicopter. Good communications with the flight crew will ensure the prompt and safe landing of the aircraft. Before and during final approach, the flight crew should be advised of potential hazards, wind direction, ground conditions and, if available, the patient’s general status. LZ personnel should check constantly and repeatedly for pedestrian traffic and other hazards in or near the LZ. The helicopter flight crew should be advised immediately to abort the landing if any threat develops to the flight crew or to ground personnel.

**Terrorism Incidents**

First Responders must be aware that a mass casualty incident could be a possible act of terrorism. They must be aware of methods of protecting themselves from becoming victims by avoiding exposure to Chemical, Biological, Radiological, Nuclear, and Explosive or secondary explosions or devices, and of special coordination and operational procedures.

**Program Goals**

- Maximum threat awareness for likely First Responders and hospital staff to include Chemical, Biological, Radiological, Nuclear, and Explosive.
- Maximum utilization of the Virginia MCI Management System
- Seamless interaction of the local, state and federal agencies that respond to an incident by establishing – in advance – specific areas of responsibilities.
- Maximum utilization of human and material resources while minimizing loss of life and suffering among the victims and First Responders.
- Enhance effective interaction, to include communications, between hospitals and out-of-hospital EMS agencies during any act of terrorism, or MCI.
• Encourage the acquisition by appropriate agencies of specialized equipment necessary to counter the effects of terrorism, including caches of medications and mass decontamination facilities.
• Expeditious processing of scene samples by the Virginia Department of Consolidated Laboratory Services to insure accurate identification of substances, proper protection of responders, and ultimate capture and successful prosecution of perpetrators.
• Use practices designed to insure responder and public safety while containing the incident to the fullest extent possible.

**Preparation Process**
Pre-hospital and hospital agencies shall prepare to respond to acts of terrorism through:
• Regular consultations and interactions among participating leaders to review and revise appropriate documents, plans and procedures, including the MCI Plan.
• Regular training programs in terrorism awareness and specific MCI skills. Regular exercises and evaluations of local/regional MCI response.
• Regular review and assessment of the threat(s).
• Regular review and assessment of regional resources and areas of operational responsibility.

**Responding to an incident**
In responding to a potential or actual terrorism incident, some special procedures may apply:
• Give special consideration to protection of first responders and bystanders - a known terrorism tactic is the creation of one incident to draw responders in, then the creation of another incident to injure first responders.
• Include any indicators of terrorism/criminal activity in scene size-ups
• Treat victims as appropriate to their assessed injuries, including all phases of decontamination. Once a victim has been properly decontaminated they should no longer be considered a victim and rather a patient that will be triaged, treated and transported. Follow appropriate hazmat decontamination procedures.
• When possible, assist in the preservation of evidence by including law enforcement in investigations and rehabilitation.
• Enhance seamless interagency and regional interactions using pre-established agreements and procedures.
• The Centers for Disease Control and Prevention (CDC) has partnered with the Virginia Department of Health (VDH) and local agencies for the “forward” placement of nerve agent antidotes in various facilities throughout Virginia so they can be immediately accessible for the treatment of affected persons. One EMS CHEMPACK container is available to Rappahannock area EMS providers in the Rappahannock EMS Region.
Regional EMS Chempack Activation

The Centers for Disease Control and Prevention (CDC) has partnered with the Virginia Department of Health (VDH) and local agencies to place nerve agent antidotes in various facilities throughout Virginia.

Each CHEMPACK container weighs about 700 pounds. Individual boxes may be removed from the container and transported to the field or to another hospital. Pharmaceuticals found in the container include Atropine, Pralidoxime, Diazepam, Atropen and Mark-1 Nerve Agent Antidote Kits. Medications distributed to the EMS field are provided as auto-injectors.

When to Use Regional Chempack

- An event in Rappahannock EMS region involving a suspected or confirmed nerve agent and normally available supplies are of insufficient quantity to provide treatment
- Field or Hospital Competent Authority recognizes need for additional Resources

Competent Authority is defined as:
- Incident Commander, EMS Operations Officer, Hazardous Materials Officer, Hospital ED Senior Physician or Nursing Supervisor, District Health Director, VDH Local Chempack Coordinator, VA State Health Commissioner

YES

Hospital will complete Chempack Delivery Intake form and activate deployment procedures with Chempack Delivery Agency

Provide MWII ED the Following Information

- Caller / Competent Authority’s Name
- Caller Contact Phone Number
- Type of Incident / Number of Casualties
- Chempack Delivery Location / Physical Address of Incident
- Receiving Agency Name / Point of Contact on Scene
- Radio channel and phone number of Fire/EMS agent on scene to use for ongoing communications during the event

Prepare to Receive Chempack from Delivery Agency

- Delivery agency will contact incident scene enroute
- Documentation of Transfer of Chempack Contents / Diazepam Custody required to be signed by receiving agency
  (Chempack Controlled Substance Transfer Form)
- Follow your regional or agency patient treatment protocols for administration
- Field Incident Commander should notify the RHCC of incident and Chempack use. RHCC will support field transport destination decisions for NVTHA Hospitals

Unused Chempack Medications and Completed Chempack Controlled Substance Transfer form returned to Regional VDH Chempack Coordinator (on scene or call 1-866-531-...
Chapter 8 - Communication

Radio communication, as provided by the REMS Council region’s two-channel HEAR (155.340 Mhz) system, will remain the primary method of hospital-to-hospital and hospital-to-field communications during a MCI. The Med Com system provides a dedicated channel for hospital-to-hospital communications.

Due to its location in northern Virginia, REMS EMS may not have radio contact with the Regional Healthcare Coordination Center (RHCC). Telephone will serve as the primary means of field to RHCC contact. The RHCC maintains Med Com communications with the regional hospitals. It also maintains 800Mhz radio talk group capability Alexandria, Arlington, Fairfax, Loudoun, and Prince William localities. REMS agencies may wish to consider utilizing Comm-Link capabilities (through their local emergency communications centers) with these northern VA jurisdictions to establish radio contact with the RHCC.

Other communications tools that can be used during an MCI include the EMS Statewide Mutual Aid Frequency (155.205), and cellular telephones. During an MCI, routine pre-hospital communication procedures are suspended. The TRANSPORTATION GROUP or MEDICAL Branch will communicate directly with the coordinating ED/RHCC and provide instructions to incident personnel.

The EMS Statewide Mutual Aid Frequency (155.205 Mhz) should be monitored to provide updated information and to receive information that will assist in staging ambulances, other EMS vehicles or human an/or material resources in line with the Incident Management System. Incident Commanders may wish to consider requesting state portable radio cashes during extended emergencies. These cashes may be requested through the VA EOC at 804-674-2400.

HEAR radio frequency 155.280 MHz or the established Med Com is the primary channel for communications between the RHCC/Control hospital and other health care facilities involved in the incident.

Unless there is an extreme emergency, pre-hospital ambulance crews should not use the HEAR frequency or EMS Statewide Mutual Aid frequency for communicating when responding to an incident, or when transporting a patient to a designated hospital from the MCI site. If it is absolutely necessary for an ambulance crew to communicate with a hospital or other emergency services agency from the MCI scene, the channels should be used in accordance with established radio protocols.

As required by NIMS, “plain talk” will be used for communications during an MCI or evacuation.

No cellular phone cells dedicated to EMS are available at this time. Therefore, because the cellular system is likely to be very busy during an MCI, once an open cell line has been established by the Incident Commander or other key element of the National Incident Management System (i.e., Transportation Director or Command Post/Communications Center), it should be kept open for the duration of the MCI.

Agency heads should consider seeking eligibility for obtaining Wireless Priority Service (WPS) and Government Emergency Telecommunications Service (GETS). The Government Emergency Telecommunications Service (GETS) is a White House-directed emergency phone service provided by the National Communications System (NCS) in the Office of Cybersecurity and Communications Division, National Protection and Programs Directorate, Department of Homeland Security. GETS supports Federal, State, local, and tribal government, industry, and non-governmental organization (NGO) personnel in performing their National Security and Emergency Preparedness (NS/EP) missions. GETS provides emergency access and priority processing in the local
and long distance segments of the Public Switched Telephone Network (PSTN). It is intended to be used in an emergency or crisis situation when the PSTN is congested and the probability of completing a call over normal or other alternate telecommunication means has significantly decreased. Agency heads should contact their local emergency managers for additional details on this service.

**Multi-Regional Communications**

The RHCC will function as a communications control center in the event of an incident or disaster requiring the coordination of hospital needs for hospitals within the REMS. If multi-regional assistance is required, RHCC will communicate with other Regional Healthcare Coordination Centers or hospitals and coordinate patient distribution.

**Virginia 2-1-1**

The information collected through the use of triage tags establishes a method for tracking patient transport destinations. Virginia 2-1-1, a statewide call system, can be used by hospitals and facilitates family reunification following a mass casualty event.
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Chapter 9 - Demobilization

Demobilization
The Transport Group Supervisor/Unit Leader should notify both the Medical Group Supervisor/Medical Branch Director and the Coordinating Emergency Department/RHCC when all living patients have been transported from the incident scene and all patient care activities have been completed. The Coordinating ED/RHCC will deactivate the MCI Plan among activated hospitals and the local Emergency Communications Centers.

Demobilization of EMS personnel on scene should be accomplished in accordance with the Demobilization Plan developed by the Planning Section/Demobilization Unit. If a Demobilization Plan was not developed then demobilization should precede at the direction of the Incident Commander or his/her designee.

Debriefing/Hot Wash
Immediately following the resolution of the mass casualty incident, the Incident Commander should facilitate an incident debriefing or hot wash with responders representing the various incident assignments. The incident debriefing/hot wash is an opportunity for first responders to voice their opinions regarding the response to the incident and their own performance. All incident command system forms should be completed and turned in before the individual’s responsible for completing the form(s) are demobilized. At this time agency leaders can also seek clarification regarding actions taken during the incident, and what prompted first responders to take those actions. Scribes should be assigned to take notes during the incident debriefing/hot wash. The resulting notes will be used to compile the incident After Action Report.

After Action Report
The After Action Report (AAR) is the culmination of the incident response. It is a written report outlining the strengths and areas for improvement identified by the response. The AAR will include the incident timeline, executive summary, incident description, mission outcomes, and capability analysis. The AAR will be drafted by a core group of individuals from each of the public safety and other agencies involved in the incident response. A copy of the After Action Reports from actual mass casualty incidents should be forwarded to the licensed EMS Agency’s respective and the REMS Council.

Lessons Learned Information Sharing
The improvement process represents the comprehensive, continuing preparedness effort of which the incident response activities are a part. The lessons learned and recommendations from the AAR are incorporated into an Improvement Plan (IP).
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Chapter 10 - Training and Exercise

To maintain the agency’s MCI capability and all hazards MCI training, testing, and exercise program the following procedures will be established.

Training
Pre-hospital agencies in the REMS Council region will participate when possible in annual training exercises of the MCI Plan held in various locations within the council region. Pre-hospital agencies will encourage their providers to participate in on-going regional training for rescue and EMS personnel in the National Incident Management System, Virginia START Triage System, hazardous materials awareness programs and other related MCI skills.

A list of training resources is located in annex J of this plan.

Testing and Exercise
The development and execution of an exercise every two years that tests at least one aspect of the Regional MCI Plan will be coordinated through the REMS Council Incident and Threat Mitigation Committee.

After Action Report and Improvement Plan
An After Action Report (AAR) will be completed after any incident or training exercise and shared through the Regional Incident and Threat Mitigation Committee as a tool to improve local and regional plans. The purpose of the AAR is to analyze the incident to determine “lessons learned.”
Chapter 11 - Plan Maintenance

REMS Incident and Threat Mitigation Committee
The Incident and Threat Mitigation Committee is a working committee of the REMS Council. It is made up of representatives of the hospital and pre-hospital components (career, volunteer, and private services), Health Districts, Law Enforcement, Emergency Management Coordinators, and Red Cross that render emergency medical care in Planning District 9 and 16.

Other members of the Committee include, but are not limited to, representatives of related local, state and federal agencies (including law enforcement, emergency management, and emergency communications), disaster relief organizations, representatives of major industries, transportation and utilities companies, along with local businesses and other individuals whom members of the committee may call upon from time to time for advice and expertise.

Members will be recommended by the committee and appointed by the REMS Council President. Members shall serve in an uncompensated capacity on the Committee.

Plan Maintenance Procedures
The REMS Council Incident and Threat Mitigation Committee is responsible for reviewing this MCI plan each year for proposing revisions and/or amendments to the Mutual Aid Response Guide as necessary to maintain its effectiveness, and for reviewing and evaluating any activation of the MCI Plan.

Proposed revisions, amendments and other changes to the MCI Plan shall be referred to the full Committee for its action. After action reports from any actual MCI incidents or training exercises conducted within the region shall be forwarded to the Committee for its consideration. Revisions and/or amendments will be acted upon by the Committee no sooner than 45 days, and not longer than 60 days, after all signatories have been notified of the proposed changes and have had an opportunity to respond through their representatives or in writing to the Committee Chair.

Revisions and/or amendments to the Plan will require a majority vote of the members present of the REMS Board of Directors to be enacted.

All EMS agencies, local governments, EMS physicians, regional medical control center(s) and hospitals within the REMS service delivery area will receive annually an updated copy of the MCI Plan. A copy of the current plan will be posted to the REMS Council website for regional use.

It is recommended that a copy of this document should be kept in each licensed EMS command, response and transport vehicle in the REMS Council region, in each hospital Emergency Department, and with each licensed EMS agency in the region. Additionally, it is recommended that a copy of this document be kept by the various state agencies that may have a role in response to a mass casualty incident, including but not limited to, the Virginia State Police, the Virginia Department of Emergency Management, and the Virginia Department of Health.
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Chapter 12 - Air Operations
The Incident Commander or Operations Section Chief may establish an Air Operations Branch depending upon the needs of the incident. Air operations at major incidents are complicated. Flight safety is, and must remain, a vital concern of all personnel involved in air operations.

The Air Medical Transport Decision
Aero-medical ambulances should be considered when their use can:

✓ Decrease transport time from the incident scene to the hospital.
✓ Provide advanced critical care not available from ground EMS Units.
✓ When special medical resources must be brought to the scene or moved to an intermediate care facility.
✓ When ground EMS Units cannot access or egress the scene.
✓ Evacuate critical ill patients from the affected disaster area or local hospitals.
✓ Provide the Incident Commander with an aerial scene evaluation.

Requesting Air Ambulance Services
The initial request for air ambulance services will follow normal request procedures from the incident commander, via the jurisdiction’s dispatch center, to the dispatch center of an air ambulance service provider.

Contact the Virginia Emergency Operations Center at 1-800-468-8892 if air ambulance services are needed from providers outside of the jurisdictional/regional area. The Virginia Emergency Operations Center can assist in providing the telephone numbers for other air ambulances service providers such as the Virginia Army National Guard, Virginia Air National Guard, U.S. Coast Guard and the Department of Defense (Air Force, Army, Marine Corp, and Navy).

Airspace Restrictions
Airspace over an MCI is regulated by the Federal Aviation Administration (FAA). Questions or requests concerning the use or restriction of that airspace during an MCI should be directed to the FAA’s Washington Air Route Traffic Control Center (ARTCC) also known as the Washington Center at 703-771-3470. Temporary flight restrictions for disaster areas are designated by the ARTCC which will notify other FAA facilities as appropriate. The Virginia EOC at 1-800-468-8832 has access to additional contact information to assist in this function.

Aircraft Communications
The primary incident Emergency Communications Center / 911 Dispatch Center normally contacts air ambulance services to request medevac services. The scene helispot (landing area) location, coordinates, control and frequency information will be given to the pilots by their agency’s dispatch center when the aircraft is dispatched.

Scene to Aircraft Communications

• **Ground to helicopter communications.** The Virginia Medevac Committee recommends using the VHF Statewide Mutual Aid channel to communicate with air ambulances. Helicopters whose primary base-of-operations are not in Virginia, including those operated by the U.S. Coast Guard and the Department of Defense cannot communicate on 800 MHz channels. However, all of these helicopters can communicate using VHF frequencies. The designated mutual aid VHF frequencies are as follows: 155.205 MHz - Statewide Mutual Aid
Ground to helicopter communications may also be performed on a locally assigned VHF channel that does not interfere with incident communications. Communications may also be established using 800 MHz channels if the responding air ambulances service has that capability.

**Aircraft to Aircraft Communications**
- **Helicopter to helicopter communication** is accomplished using the 123.025 VHF frequency, allowing pilots to communicate flight or scene hazards to each other.

**Communications and Multiple Aircraft Response**
The use of multiple aircraft in an incident response brings with it an increased risk of an aircraft related mishap. The Air Operations Branch Director must establish effective and clear communications with each responding aircraft. During landing area operations, all aircraft-ground communications must occur on an assigned and common incident radio frequency, ideally the VHF 155.205 MHz - Statewide Mutual Aid channel as recommended by the Virginia Medevac Committee. Alternate radio communications between aircraft may be accomplished using VHF 123.025 MHz. Assigned frequencies should be documented on the Air Operations Summary Form (ICS 220).

The following multiple aircraft response communications procedure has been recommended for adoption by all agencies involved in air operations at any incident where more than one air ambulance, or aircraft, is responding. This procedure was designated as a “Best Practice” by the Virginia Medevac Committee in January 2008:

1. The initial request for medevac services should be made to the jurisdictions primary medevac service provider (air ambulance service).
2. If requests were made for additional air ambulances or other aircraft to respond to the scene, the requesting emergency communication center must contact the dispatch center for each air ambulance or other aircraft, and advise them that this is a multiple aircraft response.
3. The medevac service provider/air ambulance service’s dispatch or communications center should take the following actions after they are notified that another aircraft has been requested to the facility or scene.
   - Contact all other responding aircraft communications centers and advise them of the multiple aircraft response.
   - Inform their prospective aircraft that multiple helicopters or aircraft are responding and replay the following information to the individual flight crews:
     - The number of inbound aircraft
     - The assisting aircraft’s name (i.e. LifeEvac, MedFlight, etc.)
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Annexes

A. Glossary of commonly used terms and acronyms

B. Forms and Worksheets
   - Patient Count & Distribution Worksheet (ICS 308)
   - MCI Patient Tracking Form (ICS 306)
   - Air Operations Summary Form (ICS 220)
   - START Flow Chart/JumpSTART Flow Chart

C. Pre-Hospital Job Checklists:
   - First Unit on Scene Unit
   - Incident Commander
   - Medical Branch Supervisor
   - Staging Area Manager
   - Triage Unit Leader
   - Treatment Unit Leader
   - Red, Yellow (Prime), Green Treatment Area Manager
   - Incident Morgue Area Manager
   - Medical Supply Coordinator
   - Transportation Ground Unit Leader
   - Transport Recorder
   - Transport Loader
   - Medical Communications Coordinator
   - Air Operations Group Supervisor

D. Regional Hospitals and Driving Directions

E. REMS Mass Casualty Support Unit Deployment

F. Mass Casualty Resource List

G. REMS Regional Emergency Communications Centers

H. Virginia Reportable Disease List

I. Recommended MCI Equipment and Training Resources

J. Training Resources
HAZARDOUS MATERIALS - Substances or materials, which pose unreasonable risks to health, safety, property or the environment when used, transported, stored or disposed of, which may include materials which are: gases, liquids, or solids. They may include toxic substances, flammable and ignitable materials, explosives, corrosives, and radioactive materials. (Title 44-146.34)

HEALTH CARE FACILITY EVACUATION (Evacuation) – An event resulting in the need to evacuate any number of patients from a health care facility on a temporary basis when the movement of those patients exceeds the EMS capabilities of the facility, locality, jurisdiction and/or region.

HEALTHCARE FACILITY – Any hospital, clinic, infirmary or other healthcare provider that offers emergency services or acute care services.

INCIDENT COMMAND SYSTEM - a standardized, on scene, all-hazard management concept as defined by the Department of Homeland Security. The ICS is flexible and can grow or shrink to meet the needs of the incident. It has a top-down organizational structure which begins when the first responder on the scene becomes the first Incident Commander and expands as necessary.


MASS FATALITY INCIDENT - Any situation where there are more bodies than can be handled using local resources.

MASS CASUALTY INCIDENT (MCI) – Sometimes called a Multiple-Casualty Incident, an MCI is an event resulting from man-made or natural causes, which results in illness and/or injuries which exceed the Emergency Medical Services (EMS) capabilities of a hospital, locality, jurisdiction and/or region.

MULTIPLE CASUALTY INCIDENT - incidents involving multiple victims that can be managed, with heightened response (including mutual aid if necessary), by a single EMS agency or system. Multi-casualty incidents typically do not overwhelm the hospital capabilities of a jurisdiction and/or region, but may exceed the capabilities for one or more hospitals within a locality. There is usually a short, intense peak demand for health and medical services, unlike the sustained demand for these services typical of mass casualty incidents. (FEMA)

MCI MEDICAL CONTROL – That medical facility, designated by the hospital community, which provides remote overall medical direction of the MCI or Evacuation scene according to predetermined guidelines for the distribution of patients throughout the healthcare community. Generally the initial receiving hospital will contact the designated hospital medical control or Regional Healthcare Coordination Center (RHCC) to determine hospital availability and distribution of patients.
NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS) – A management system, adopted and utilized by all participating emergency response agencies, that helps control, direct and coordinate emergency personnel, equipment and other resources, from the scene of an MCI or Evacuation, to the transportation of patients to definitive care, to the conclusion of the incident. (See Incident Command Worksheet - Annex C)

NORTHERN VIRGINIA REGIONAL HOSPITAL COORDINATING CENTER (RHCC) – Designated by the Virginia Department of Health to serve EMS and the Northern Virginia Hospital Alliance region and member hospitals, to include those in the Rappahannock EMS Council region, through timely distribution of patients to the most appropriate hospital resources in response to incidents of significance.

PRE-HOSPITAL EMS AGENCY – Any volunteer, career, private or governmental Emergency Medical Services (EMS) agency or service that is certified by the Commonwealth of Virginia to render pre-hospital emergency care and provide emergency transportation for such and/or injured people as described in the Code of Virginia, Section 32.1-148.

PROVIDER – Any person “responsible for the direct provision of EMS in a given medical emergency” as described in the Code of Virginia, Section 32.1-148.

UNIFIED COMMAND (UC) - An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single Incident Action Plan (IAP).

VIRGINIA S.T.A.R.T. TRIAGE – The Simple Triage And Rapid Treatment method adopted for use in the Commonwealth of Virginia whereby adult patients in an MCI are assessed and evaluated on the basis of the severity of injuries and assigned the following emergency treatment priorities. (See START Triage Flow Chart – see Annex B)
Annex B - Forms and Worksheets

- Patient Count & Distribution Worksheet (ICS 308)
- MCI Patient Tracking Form (ICS 306)
- Air Operations Summary Form (ICS 220)
- START Flow Chart/JumpSTART Flow Chart
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# Patient Count & Distribution Worksheet (ICS 308)

Date: _______________  Incident Name / Location: _______________________________________

<table>
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<th>Number of Patients Reported by Triage Category</th>
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<tr>
<td>On-Scene Location</td>
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## Available Transport Units

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<th>Capacity (R/Y/G)</th>
<th>No. of Pts Sent</th>
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## Patient Distribution

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<th>Capacity (R/Y/G)</th>
<th>No. of Pts Sent</th>
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# MCI Patient Tracking Form (ICS 306)

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<th></th>
<th>Triage Tag No.</th>
<th>Priority (R/Y/G)</th>
<th>Patient’s Primary Injuries</th>
<th>Unit Transporting Pt to ED/Hospital</th>
<th>Time left Scent</th>
<th>Patient Destination</th>
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## MCI Patient Tracking Form (ICS 306)

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<th>Priority (R/Y/G)</th>
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## MCI Patient Tracking Form (ICS 306)

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## Air Operations Summary Form (ICS 220)

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<th>Assignment</th>
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<th>12. Operating Base</th>
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<th>15. Prepared for (Include Date and Time)</th>
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START Triage

S.T.A.R.T
Simple Triage and Rapid Transport

ASSESS RESPIRATIONS
Is Patient Breathing?

YES

>30/Min
RED TAG (IMMEDIATE)

<30/Min
ASSESS PERFUSION

RADIAL PULSE

PULSE ABSENT
CONTROL BLEEDING
RED TAG (IMMEDIATE)

PULSE PRESENT
ASSESS MENTAL STATUS

CAN FOLLOW SIMPLE COMMANDS

NO

YES

RED TAG (IMMEDIATE)

POSITION AIRWAY
Is Patient Breathing?

YES
RED TAG (IMMEDIATE)
BLACK TAG (DECEASED)

NO
YELLOW TAG (DELAYED) or GREEN TAG (MINOR)
JumpStart Pediatric Triage

JUMPSTART
PATIENTS AGED 1 – 8 YEARS

ASSESS RESPIRATIONS
Is Patient Breathing?

YES

<15/min or >40/min or irregular
RED TAG (IMMEDIATE)

15 – 40/min and regular
ASSESS PERFUSION

PERIPHERAL PULSE?

YES

ASSESS MENTAL STATUS (A\P\P\U)

Appropriate (alert, verbal stimuli)
YELLOW TAG (DELAYED) or GREEN TAG (MINOR)

Inappropriate (painful stimuli, unresponsive)
RED TAG (IMMEDIATE)

NO

CONTROL BLEEDING

RED TAG (IMMEDIATE)

NO

POSITION AIRWAY

Is Patient Breathing?

YES

RED TAG (IMMEDIATE)

PERIPHERAL PULSE?

YES

Perform 15 sec. Mouth to mouth

NO

BLACK TAG (DECEASED)

Is Patient Breathing?

YES

RED TAG (IMMEDIATE)

NO

BLACK TAG (DECEASED)
Annex C - Pre-Hospital MCI Job Checklists

This Annex contains position checklists for those positions and functions needed during most multiple or mass casualty incidents. The position checklists are accompanied by incident command system (ICS) or other forms as appropriate.

These checklists do NOT include checklists for the command and general staff positions, (e.g. Public Information Officer, Safety Officer, Operations Section Chief, etc.), with the exception of the Incident Commander. A checklist for the Incident Commander is provided to help guide the initial Incident Commander.

First Unit on Scene Unit
Incident Commander
Medical Branch Supervisor
Staging Area Manager
Triage Unit Leader
Treatment Unit Leader
Red, Yellow (Prime), Green Treatment Area Manager
Incident Morgue Area Manager
Medical Supply Coordinator
Transportation Ground Unit Leader
Transport Recorder
Transport Loader
Medical Communications Coordinator
Air Operations Group Supervisor
Position: First Unit On-Scene

Mission/Tasks: First unit on scene gives visual size-up, assumes and announces command, and confirms incident location, then performs the 5 S’s:

SAFETY assessment. Assess the scene observing for:
- Electrical hazards.
- Flammable liquids.
- Hazardous Materials
- Other life threatening situations.
- Be aware of the potential for secondary explosive devices.

SIZE UP the scene: How big and how bad is it? Survey incident scene for:
- Type and/or cause of incident.
- Approximate number of patients.
- Severity level of injuries (either Major or Minor).
- Area involved, including problems with scene access.

SEND information:
- Contact dispatch with your size-up information and declare a Multiple or Mass Casualty Incident.
- Request additional resources.
- Notify the closest hospital / emergency department of the incident.

SETUP the scene for management of the casualties:
- Establish staging.
- Identify access and egress routes.
- Identify adequate work areas for Triage, Treatment, and Transportation.

START (Simple Triage And Rapid Treatment) and JumpSTART (for pediatric patients).
- Begin where you are.
- Ask anyone who can walk to move to a designated area.
- Use surveyor’s tape to mark patients.
- Move quickly from patient to patient.
- Maintain patient count.
- Provide only minimal treatment.
- Keep moving!
- Remember...Establish COMMAND, SAFETY, SURVEY, SEND, SET-UP AND START/JumpSTART
Position: Incident Commander

Mission: Responsible for the overall management and coordination of personnel and resources responding to the incident.

Tasks:
- Assumes command and announces name and title to the communications center.
- Dress in identifying vest.
- Identify potentially hazardous situations.
- Assess current situation.
- Estimate number of patients.
- Request additional resources as appropriate.
- Notify closest hospital emergency department if < 10 patients. Notify the RHCC if > 10 patients (1-888-987-7422)
- Establish a visible command post.
- Initiate, maintain and control communications.
- Assign ICS functions.
- Assign and direct resources.
- Track current resources committed.
- Develop, evaluate and revise operational plans.
- Coordinate with other agencies.
- Control and facilitate media.
Position: Medical Branch Supervisor Check List

**Mission:** To insure that supervision and coordination is provided for extrication triage, treatment, and transportation of all patients.

**Tasks:**
- □ Report and provide frequent updates to the INCIDENT COMMANDER or Operations Section Chief. The Medical role may be assumed by the Incident Commander on small incidents.
- □ Dress in identifying vest.
- □ Locate in a visible position.
- □ Assume responsibility of MEDICAL GROUP.
- □ Coordinate, direct and manage all MEDICAL GROUP operations.
- □ Account for all personnel assigned to this group.
- □ Monitor safety and welfare of group personnel.
- □ Consider relief crews.
- □ Consider Critical Incident Stress Management (CISM) assistance.
- □ Appoint and assign Medical Group Supervisor / Unit Leaders and support staff.
- □ Verify the location of the staging area if needed.

* On small incidents the Incident Commander may assume responsibility for the Medical Group/Branch.
Position: Staging Area Manager Check List

Mission: To maintain separate stockpiles of manpower, reserve equipment and expended equipment at a staging area away from the incident.

Tasks:
- □ Report to INCIDENT COMMANDER (or OPERATIONS CHIEF if appointed)
- □ Dress in identifying vest.
- □ Locate in a visible position.
- □ Establish STAGING AREA in conjunction with INCIDENT COMMAND or Operations Section Chief as needed.
- □ Provide appropriate staffing, vehicles, equipment, and supplies as requested.
- □ Maintain status of number and types of resources in staging area.
- □ Recommend additional staffing, equipment, and resources when necessary.
- □ Order all personnel to remain with their units until assigned.
- □ Verify the equipment pool location.
- □ Control and document all resources entering and leaving the staging area.
- □ Ensures unimpeded access and egress to and from staging area.
- □ Coordinate security for staging area.

Helpful Hints
- □ Maintain communications with OPERATIONS and TRANSPORT.
- □ Locate and secure buses for use by Transport Group Supervisor/Unit Leader.
- □ Use a mobile radio when possible to communicate with incoming units.
- □ Size of incident may require that a separate ambulance staging area be established.
- □ Direct ambulance crews to leave stretchers in ambulances unless needed for patient movement.
Position: Triage Unit Leader

Mission: To assess and sort casualties to appropriately establish priorities for treatment and transportation.

Tasks:

□ Report and provide updates to INCIDENT COMMANDER (or MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR)

□ Dress in identifying vest.

□ Locate in a visible position between the incident site and the treatment area.

□ If the patients are in imminent danger exists, move all patients out of INCIDENT AREA before establishing TRIAGE.

□ Establish controlled pathway from the incident site to the treatment area.

□ Direct walking wounded to designated treatment area.

□ If START/JumpSTART not yet completed by first arriving crews, appoint triage teams to perform START/JumpSTART using triage ribbons.

□ Obtain a count of accurate count of all victims by triage category (Red/Yellow/Green/Black) & report the count to the MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR.

□ Continue to use START/JumpSTART algorithms, to continually reassess patients.

□ Coordinate the transfer of patients to Treatment Unit Leader.

□ Triage all patients upon entry into the Treatment Area

□ Appoint "porters" to transport patients via backboards to treatment area. At hazardous materials incidents, requiring decontamination, a team must be assigned to move patients from the warm zone decontamination line to the cold zone treatment area.

□ Maintain communications with MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR and other units as needed.
## Treatment Area Patient Count

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<tr>
<th>Victim Location</th>
<th>RED</th>
<th>YELLOW</th>
<th>GREEN</th>
<th>BLACK</th>
<th>Total No. of Patients By Location</th>
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## Helpful Hints
- Continue START/JumpSTART until all patients have been triaged. Have triage teams work in an orderly fashion. Remind Treatment Area Managers to perform secondary triage on all patients in their respective section of the treatment area.
- Move all RED patients to the TREATMENT AREA first, unless tight quarters necessitate moving others first in order to gain access to RED patients.
- Move YELLOW patients next.
- Move GREEN patients to a designated location at the TREATMENT AREA.
- Leave ALL BLACK tagged victims in place unless the remains interfere with the ability to reach the survivors or are in danger of being destroyed.
- Notify that the MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR have Incident Command notify the Medical Examiner if black tags are issued.
- Once a triage tag is applied and color identified the triage ribbons may be removed.
Position: Treatment Unit Leader

**Mission:** Provide patient counts, triage, & treatment to patients awaiting transportation.

**Tasks:**
- Report and provide updates to the INCIDENT COMMANDER (or MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR)
- Dress in identifying vest.
- Locate in a visible position.
- Establish the TREATMENT Area large enough to accommodate all patients allowing for a 3 foot clearance on all sides of each patient.
- Designate an Area Manager for the Red, Yellow & Green patient care areas
- Ensure that all patients upon entry into the Treatment Area are re-triaged.
- Maintain a count of all victims entering the Treatment Area by triage category.
- Ensure that patients are re-triaged using Secondary Triage and that a triage tags is applied to each as patients upon entry to the respective Red, yellow & Green patient care areas.
- Appoint a MEDICAL SUPPLY COORDINATOR (if needed).
- Working with the Area Manager, determine the transportation priority & most appropriate transport method for each patient.
- Maintain contact with the appropriate Area Manager of each patient care area (Red Tagged/Immediate, Yellow Tagged/Delayed and Green/Minor.
- Continually reassess each patient’s condition and triage status.
### Helpful Hints

- Arrange and clearly identify the TREATMENT Area. Identify patient treatment areas for each triage category using colored tarps, flags, tape, chemical lights, etc.

- Have Green/Minor Patients (“Walking Wounded”) move to a supervised & controlled area. Isolate emotionally disturbed patients.


- Consider establishing specialty patient care teams (i.e. IV teams, bandaging teams, etc).

- Maintain contact with the TRANSPORTATION UNIT LEADER & coordinate the movement of patients to the transportation area based on patient priority.

- Establish "cattle shoots" staffed with triage personnel as "gatekeepers" at entrance to and exit from the TREATMENT AREA to control patient flow.
Position: Red, Yellow, or Green Tagged Treatment Area Managers

Mission: Provide patient counts, triage, and treatment to patients awaiting transportation.

Tasks:

- Report and provide updates to the TREATMENT UNIT LEADER
- Dress in identifying vest.
- Establish the TREATMENT Area large enough to accommodate all patients allowing for a 3 foot clearance on all sides of each patient.
- Clearly identify your treatment area with the appropriate colored flag, tarp, and/or chemical light.
- Ensure that patients are re-triaged upon entry to the treatment area using Secondary Triage and ensure a triage tag is applied to each as patient.
- Maintain accountability of all victims in your treatment area.
- Determine the transportation priority & most appropriate transport method for each patient.
- Report the transportation priority of patients and recommended transport method for each patient to the Treatment Unit Leader.
- Continually reassess each patient’s condition and triage status.
- Request the establishment of special patient care teams (e.g. IV team, bandaging team, etc.) as necessary to support the care of your patients.
- Request additional personnel as needed to provide the care for your patients.
- Provide palliative care for catastrophically injured (Yellow Prime) patients until resources allow for their transportation to a hospital.
- Coordinate the relocation of any patient who dies in the treatment area to the Incident Morgue (Black Tagged Treatment Area). Leave all medical devices in place.

Helpful Hints

- Have Green/Minor Patients (“Walking Wounded”) move to a supervised & controlled area.
- Isolate emotionally disturbed patients.
- Remove the triage ribbons once triage tags are applied.
<table>
<thead>
<tr>
<th>Patient Care Area</th>
<th>RED</th>
<th>YELLOW</th>
<th>GREEN</th>
<th>BLACK</th>
<th>Total No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Patients Present</td>
<td></td>
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</tr>
<tr>
<td>No. of Pts Sent to</td>
<td></td>
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<tr>
<td>Transportation Area</td>
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<tr>
<td>Total No. of Patients</td>
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</tbody>
</table>
Position: Incident Morgue Area Managers (Black Tagged Patient Treatment Area)

Mission: To establish and maintain an incident morgue area for deceased persons who die in route to or in the Treatment Area.

Tasks:
- □ Report to the TREATMENT UNIT LEADER.
- □ Dress in identifying vest.
- □ Verify with the TREATMENT UNIT LEADER that the closest Office of the Chief Medical Examiner has been notified of deceased persons:
  - Richmond: (804) 786-3174
- □ Secure the area from all unauthorized personnel and provide security to the morgue area with the assistance of Law Enforcement.
- □ Reassess each patient upon entry to the Incident Morgue / Black Tagged Patient Care Area. Annotate the patient assessment on the triage tag. If the patient does not have a triage tag then attach a completed triage tag to the patient.
- □ Leave all medical interventions in place (i.e. IV’s, bandages, etc.)
- □ Cover patient(s) with sheets or enclose remains in disaster pouches or similar body bags.
- □ Ensure that no human or animal remains are moved from the incident site prior to the arrival and approval of the Medical Examiner/Chief law enforcement officer.
- □ Establish a secure morgue area separate from the TREATMENT AREA, and accessible to vehicles (i.e. emergency vehicles, law enforcement).
- □ With the assistance of Law Enforcement, secure the area from all unauthorized personnel and provide security to the morgue area.
- □ Coordinate activities with the Medical Examiner's Office, funeral directors, and law enforcement as necessary.
- □ Maintain accountability of all victims received in the treatment area using the MCI Patient Tracking Form.

Helpful Hints
- □ The only remains that should be moved to the incident morgue are those whose location is hindering rescue operations, or victims who died in route to, or in the treatment area.
- □ Do NOT allow photographs in the morgue without the medical examiner’s permission.
Position: Medical Supply Coordinator

Mission: Acquire, distribute and maintain the status of medical equipment and supplies.

Tasks:
- □ Report and provide updates to the MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR
- □ Dress in identifying vest.
- □ Locate medical supplies in a central position in the Treatment Area using caution not to block access & egress to and from the Treatment Area.
- □ Maintain an inventory list of equipment, supplies, and Disaster Medical Support Units (DMSUs) received and distributed. Provide receipts upon request.
- □ Continually assess status of medical supplies and equipment. Request additional supplies and equipment through the Medical Group Supervisor / Medical Branch Director as needed.
- □ Distribute medical supplies and equipment to the Patient Care Areas.
- □ Request personnel to assist in the collection and distribution of supplies and equipment. Consider a need to have a vehicles(s) transport supplies and equipment.

Helpful Hints
- □ Do NOT strip ambulance of medical supplies & equipment unless absolutely needed to manage the initial phase of the incident.
- □ Establish a perimeter around the medical supply area to assist in controlling the distribution of supplies and equipment.
- □ Use the SALTT acronym to request resources.

- Size
- Amount
- Location
- Type
- Time
### MEDICAL SUPPLY RECEIPT AND INVENTORY FORM

**INCIDENT NAME:** ____________________________  **INCIDENT #:** __________________

A. **Supplies/Equipment received from:** ____________________________  **DATE:** __/__/____

   **Agency:** __________  **Unit ID #:** __________  **Name:** ______________

   (Whenever possible, use masking tape and markers to identify all equipment)

B. **Supplies/Equipment Received by:**

   **NAME:** ____________________________  **INCIDENT POSITION:** ____________________________

<table>
<thead>
<tr>
<th>No.</th>
<th>Item Description <em>(Print All Entries)</em></th>
<th>Unit*</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>18.</td>
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</table>

*Unit - list a measurable description of the item (gauge, gm, ml, bag, doz., etc.)

**Form distribution:** (Use carbon paper)  
- Original - Medical Supply Coordinator
- Copy - Source of Supply

**INCIDENT RE-IMBURSEMENT OF ANY SUPPLIES/EQUIPMENT WILL BE BASED ONLY UPON ORIGINAL FORM LISTINGS.**

I-MC-312 (1/8/92)
Position: Transportation Ground Supervisor /Unit Leader

**Mission:** Track and distribute patients to medical facilities by assigning the mode of transportation & destination for each patient.

**Tasks:**
- □ Report and provide updates to the INCIDENT COMMANDER (MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR.)
- □ Dress in identifying vest.
- □ Locate in a visible position.
- □ Verify the Staging Area location.
- □ Collaborate with the Treatment Unit Leader to determine patient transportation priorities, Emergency Department bed availability & patient destinations using ICS 308 form.
- □ Communicate transportation resource needs to the MEDICAL GROUP SUPERVISOR / BRANCH DIRECTOR.
- □ Appoint MEDICAL COMMUNICATIONS COORDINATOR and ensure communications link is established with the Coordinating Emergency Department/RHCC.
- □ Appoint TRANSPORT RECORDER for each area of patient egress & ensuring each patient is tracked by triage tag number using the MCI Patient Tracking Form (ICS 306).
- □ Appoint TRANSPORT LOADERS.
- □ Inform transport crews of their destination, remind units to return to the Staging Area unless otherwise directed.
- □ Remind ambulance crews that they do not need to contact receiving facility unless there is significant deterioration in the patient’s condition or if they need physician’s orders.
- □ Document patient and unit movements and destination using the MCI Patient Tracking Form (ICS 306).
- □ Maintain close communications with INCIDENT COMMAND or MEDICAL, TREATMENT, GROUND & AIR OPERATIONS.
- □ Once the last patient has been transported, and before demobilization, work with the Transport Recorder, Transport Loader, Medical Communications Coordinator and the Coordinating ED/RHCC to **account for 100% of the patients/victims.**

**Helpful Hints**
- □ Ensure that transport ambulances are parked to allow easy patient loading and egress without being blocked by other ambulances or require ambulances to back in for patient loading.
Patient Count & Distribution Worksheet (ICS 308)

Date: _______________ Incident Name / Location: _______________________________________

<table>
<thead>
<tr>
<th>Number of Patients Reported by Triage Category</th>
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<tbody>
<tr>
<td>On-Scene Location</td>
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Available Transport Units

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<thead>
<tr>
<th>ED or Hospital Name</th>
<th>Capacity (R/Y/G)</th>
<th>No. of Pts Sent</th>
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</table>

Patient Distribution

<table>
<thead>
<tr>
<th>ED or Hospital Name</th>
<th>Capacity (R/Y/G)</th>
<th>No. of Pts Sent</th>
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</tbody>
</table>
Position: Transport Recorder

Mission: To assist in ensuring proper documentation of victim/patient and unit movements.

Tasks:
- Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER
- Dress in identifying vest.
- Locate at assigned patient egress point in the TRANSPORT area.
- Document patient transport information on triage tag and collect tag stubs.
- Complete an entry on the MCI Patient Tracking Form (ICS 306 Form) for each patient leaving the Transportation Area.
- Deliver triage tag Transportation Record to MEDICAL COMMUNICATIONS/TRANSPORTATION as directed.

Helpful Hints
- Determine whether or not TRANSPORT will be handling the MEDICAL COMMUNICATIONS role or will the function be assigned to a separate individual.
Position: Transport Loader

Mission: Ensure patients are safely loaded into the assigned vehicle or air ambulance, verify & vehicle destination & travel directions.

Tasks:

□ Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.

□ Dress in identifying vest.

□ Ensure patients selected for transportation are:
  o Ready for transport
  o Safely loaded aboard the ambulance or other vehicle designated by TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER

□ Provide the following information to ambulance personnel:
  o Inform crews of the destination hospital/Emergency Department.
  o Provide travel directions to the receiving hospital/Emergency Department
  o Remind ambulance crews that they do not need to contact receiving facility unless there is significant deterioration in the patient’s condition or if they need physician’s orders.
  o Remind crews to return to the Staging Area upon completion of their assignment unless otherwise directed.

□ Ensure all patients being loaded have triage tags attached and the transport stub has been removed.

□ Maintain close communications with TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER and TRANSPORT RECORDER.

Helpful Hints

□ Obtain maps or directions to area hospitals for distribution to ambulance crews.

□ If the TRANSPORT Area is some distance from TREATMENT, consider using a stretcher from a committed ambulance to move patients to the receiving units.
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Position: Medical Communication Coordinator

**Mission:** To maintain and coordinate medical communications at the incident scene between TRANSPORT GROUP SUPERVISOR/UNIT LEADER and the Designated Coordinating Emergency Department/RHCC.

**Tasks:**
- Report to TRANSPORT GROUP SUPERVISOR/UNIT LEADER.
- Dress in identifying vest.
- Remain in close proximity to the TRANSPORT and TREATMENT areas.
- Establish and maintain a dependable communications link with the designated Coordinating Hospital/RHCC. The following minimal information should be provided and updated:
  - Type of incident
  - Number of patients
  - Severity of injuries
- Coordinate patient distribution with the Coordinating ED/RHCC.
- Report individual patient information to Coordinating Emergency Department as relayed by TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
  - Unit transporting
  - Destination hospital
  - Number of patients
  - Triage tag numbers
  - Triage category, major injuries and age of patients
- Assist TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER with documentation.

**Helpful Hints**
- Locate in close physical proximity to the TRANSPORTATION area.
- Maintain contact with designated Coordinating ED/RHCC, relaying triage tag number, patient condition and destination.
- Maintain communications with TRANSPORT GROUP SUPERVISOR/UNIT LEADER.
Position: Air Operations Group Supervisor

Mission: To assume responsibility for the coordination, landing, and communication with air ambulance aircraft.

Tasks:

☐ Report to TRANSPORT GROUP SUPERVISOR/UNIT LEADER.

☐ Dress in identifying vest.

☐ Assign a fire unit and personnel and establish a HELISPOT (a.k.a. landing zone.)

☐ Secure and maintain a helispot of sufficient size on the most firm and level surface available (less than 5° slope) and clear of debris. Night operations and low visibility conditions require a larger helispot! (See the Helicopter Profiles and Helispot Requirements table for landing area space requirements).

☐ Locate helispot at least one mile upwind from HAZMAT incident sites when explosives, gases, vapors, or chemicals are in danger of exploding or burning on sites, or when a plume is present. For radioactive materials incidents with no steam or smoke the helispot can be located ¼ mile upwind from the incident site.

☐ Clearly mark the area with five weighted cones, flares, or beacons.

☐ Maintain helispot/landing zone security. Request law enforcement assistance if needed.

☐ Maintain radio contact with incoming helicopters. (All civilian helicopters stationed in Virginia can communicate on the Statewide Mutual Aid channel, VHF 155.205)

☐ Advise the pilot of the following BEFORE landing:

☐ Obstructions at the landing area, as well as "near-by" (e.g. radio or cell towers, antennas, telephone lines, other wires, cranes, tall buildings, etc).

☐ Wind direction or ground wind gusts.

☐ Location of any HAZMAT incidents, plume location and direction.

☐ Relay patient information from the Medical Communication Coordinator to the air ambulance crew (e.g. patient condition, patient weight, and airway status).

☐ Coordinate loading and transport of patients with TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
Helpful Hints

- Air ambulances will NOT transport contaminated or combative patients.
- Use of white lights should be avoided.
- If landing aircraft repeatedly consider using non-flare lighting to mark the helispot.
- All markers (flashing lights) should be put out and/or cut off before takeoff.
- Assign personnel to secure helispot after landing.
- Have fire equipment wet down the helispot if it is extremely dusty.
- ALWAYS AVOID THE TAIL ROTOR.
- NEVER APPROACH THE CRAFT DURING LANDING OR TAKE OFF.

Helispot Set-up Diagram

Helispot (Landing Area) Requirements and Safety

The following guidelines should be used to select and establish a helispot for rotary wing aircraft:

- **Locate an area that is large enough to land a helicopter safely.** The touchdown or landing area should be 60 X 60 feet during the day and 100 X 100 feet at night for most civilian air ambulances. The area should be on level, firm ground which is free of overhead obstructions, rocks, and other ground debris. If landing more than one helicopter each aircraft must have its own 100’ x 100’ box to land in.

**NOTE:** The size of the landing area varies upon the type of helicopter. U.S. Coast Guard and military helicopters (i.e. JayHawk, SH-60s) require a much larger landing area. Refer to the following table for assistance in determining the appropriate landing area size for U.S. Coast Guard and Department of Defense helicopters.
## Annex D - Area Hospitals and Driving Directions

**Northern Virginia Hospital Alliance Regional Hospital Coordinating Center (RHCC): 888-987-7422**

### Acute Care Hospitals Within the Rappahannock EMS Council Region

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Directions</th>
</tr>
</thead>
</table>
| **Novant Health UVA Culpeper Medical Center** (Culpeper Regional Hospital) | From the southeast, take VA route 3 West / Left on Orange Rd / Right on Sunset Ln
From the north, take I-66 / take exit 43 / merge onto US-29 South/Lee Highway / take LEFT ramp for the US-29 South/Eastern Bypass / take the ramp to US-29 Business North/Madison Rd / turn right onto US-29 Business North/Madison Rd / turn right onto Sunset Ln |
| 501 Sunset Ln. Culpeper VA 22701                                         | **Specialty Resources:** Cardiovascular care, cancer care, Labor and delivery 
540-829-4189 Emergency Dept.  
540-829-5757 Emergency Dept. Fax  
540-829-4300 Administrative Radio Contact  
HEAR 155.340 MHz Dial 174-3522, MED 2, 4, 7, 8, 10 Med Tone 156.7 Coordinates – 38:27:20N 78:00:47W |
| **Fauquier Hospital**                                                     | From the south, take US-17 North / turn right on US-15 N/US-17 N/US-29 N/James Madison Hwy / turn left on US-15 BUS N/US-17 BUS N/US-29 BUS N/James Madison Hwy / turn left on Hospital Dr  
From the north, take I-66 to exit 43 / merge on US-29 South/Lee Highway / Continue onto Broadview Ave / Continue onto W Shirley Ave / turn right onto Hospital Dr |
| 500 Hospital Dr. Warrenton, VA 20186                                     | **Specialty Resources:** Cardiopulmonary and vascular services, Labor and delivery  
540-349-0505 Emergency Dept.  
540-349-0591 Emergency Dept. Fax  
540-347-2550 Administrative Radio Contact  
Medcom 800 MHz (Talk Group 9A in Fairfax County) Coordinates – 38:42:42N 77:48:34W |
| **Mary Washington Hospital**                                             | I-95 to VA route 3 west ramp toward Culpeper / continue on VA 3 west / merge onto US-1/Jefferson Davis Hwy northbound/ turn left on Cowan Blvd / turn right at 2nd light on Hospital Drive onto hospital campus, after stop sign, take second "ER" entrance right uphill to ambulance bays |
| 1001 Sam Perry Blvd, Fredericksburg VA 22401                            | **Specialty Resources:** Level 2 Trauma Center with fly out capabilities, Designated Stroke Center, Cath/Cardiac Center, L&D  
Hear by phone: 540-741-4767  
Hear by Radio: 2345 |
| **Mary Washington Hospital Lee’s Hill Emergency Department**             | 208-Courthouse Rd/Right on US1- Jefferson Davis Hwy / left onto Market St. / Rt onto Spotsylvania Ave / Facility will be on the left - follow lighted signs to Ambulance Entrance. |
| 10401 Spotsylvania Ave, Fredericksburg VA 22408                         | **Specialty Resources:** ideal for minor injuries, cannot admit patients  
Hear by phone: 540-710-0560  
Hear by Radio: 2345 |
## Acute Care Hospitals Outside of the Rappahannock EMS Council Region

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Directions</th>
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</thead>
<tbody>
<tr>
<td>CJW Chippenham Hospital</td>
<td>I-95 South, take exit left onto exit 79 toward Powhite Parkway / keep left and take VA 76 South toward Powhite Parkway / keep left onto Powhite Parkway (toll) / take VA-150 (South Chippenham Pkwy) exit on left / Exit parkway onto VA 686 East Jahnke Rd. / Hospital will be on the right.</td>
</tr>
<tr>
<td>7101 Jahnke Rd., Richmond VA 23225</td>
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</tr>
<tr>
<td>Specialty Resources: Level 3 Trauma Center, Cardiac and Stroke Center</td>
<td></td>
</tr>
<tr>
<td>Hear by phone: 804-323-8900</td>
<td></td>
</tr>
<tr>
<td>Hear by Radio: 172-8522</td>
<td></td>
</tr>
<tr>
<td>CJW Johnston-Willis Hospital</td>
<td>I-95 south / take exit 79 towards Powhite Parkway / keep left and follow signs for Powhite Parkway (toll) / merge onto Midlothian Turnpike West / turn right onto Johnston-Willis Dr.</td>
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<tr>
<td>1401 Johnston-Willis Dr., Richmond VA 23235</td>
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<tr>
<td>Specialty Resources: None</td>
<td></td>
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<tr>
<td>Hear by phone: 804-330-2277</td>
<td></td>
</tr>
<tr>
<td>Hear by Radio: 172-0722</td>
<td></td>
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<tr>
<td>Forest Doctor’s Hospital</td>
<td>I-95 South / take exit 838 onto East Parham Rd. / turn left onto Skipwith Rd. / after about 2 miles, Hospital will be on the right.</td>
</tr>
<tr>
<td>1602 Skipwith Rd., Richmond VA 23225</td>
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<tr>
<td>Specialty Resources: Cardiac and Stroke Center</td>
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<tr>
<td>Hear by phone: 804-289-4605</td>
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<tr>
<td>Hear by Radio: 172-2422</td>
<td></td>
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<tr>
<td>Hanover Emergency Center (Free Standing ER)</td>
<td>I-95 South / Merge onto I-295 South via exit 84A (left) / Take exit 41A-Chamberlayne Rd North. Hospital entrance on the left.</td>
</tr>
<tr>
<td>9275 Chamberlayne Rd, Mechanicsville, VA 23069</td>
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<tr>
<td>Specialty Resources: None</td>
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<tr>
<td>Hear by phone: 804-417-0296</td>
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<tr>
<td>Hear by Radio: Encode N/A – PL-5B used</td>
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<tr>
<td><strong>Heathcote Health Center</strong></td>
<td>From I-66: Take Exit 40 for Rt. 15 toward Haymarket/Leesburg Take Rt. 15 North 0.2 miles Turn Left onto Heathcote Boulevard. The Health Center is on the left side From Rt. 29 (between Gainesville and New Baltimore): Take Rt. 15 North toward Haymarket/Leesburg Cross over I-66 continue about 0.2 miles Turn Left onto Heathcote Boulevard. The Heath Center is on the left side From Waterfall Rd - Sudley Road: Take Rt. 15 South toward Haymarket about 3.5 miles Turn Right onto Heathcote Boulevard (before I-66 interchange). The Health Center is on the left side</td>
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<tr>
<td>15195 Heathcote Blvd.</td>
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<tr>
<td>Haymarket, VA 20169</td>
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<tr>
<td><strong>Specialty Resources:</strong></td>
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<td>571-261-3400</td>
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</tr>
</tbody>
</table>

| **Inova Emergency Care Center – Leesburg** | From Rt. 15/7 Harry Byrd/Leesburg Pkwy. Left onto S. King St and left onto Cornwall St. Facility is on the left on the corner of Cornwall St. and Memorial Dr. NW |
| 224 Cornwall St. |  |
| Leesburg, VA 20176 |  |
| **Specialty Resources:** Pediatric Emergency |  |
| 703-737-7520 |  |

| **Inova Fairfax Hospital** | From 95 north 495 North take Exit 51 Gallows Rd. Hospital on the left. Form 495 south take Exit 51 Gallows Rd. Hospital is located on the left. |
| 3300 Gallows Rd. |  |
| Falls Church, VA 22042 (Fairfax County) |  |
| **Specialty Resources:** Level I Trauma Center |  |
| 703/698-3116 Emergency Dept. |  |
| 703/698-3400 Emergency Dept. Fax |  |
| 703/776-4001 Administrative Radio Contact |  |
| Medcom 800 MHz (Talk Group 9A in FFX County) |  |
| Coordinates – 38:51:30N 77:13:33W |  |

<p>| <strong>Inova Loudoun Hospital</strong> | From Leesburg Pike west right on Lansdowne Blvd. then right onto Riverside Pkwy. Hospital is located on the right. From Leesburg Pike east right off of Leesburg Pike and left onto Lansdowne Blvd., right onto Riverside Pkwy, Hospital is located on the right. |
| 44045 Riverside Pkwy. |  |
| Leesburg, VA 20176 (Loudoun County) |  |
| <strong>Specialty Resources:</strong> N/A |  |
| 703/858-6040 Emergency Dept. |  |
| 703-858-6049 Emergency Dept. Fax |  |
| 703/ 858-6000 Administrative Radio Contact |  |
| Medcom 800 MHz (Talk Group 9A in FFX County) |  |</p>
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memorial Regional Medical Center</strong></td>
<td>8260 Atlee Rd. Mechanicsville, VA 23111</td>
<td>I-95 South / Merge onto I-295 South via exit 84A (left) / Take exit 38B-Meadowbridge Rd. Hospital entrance on the right.</td>
</tr>
<tr>
<td><strong>Parham Doctor's Hospital</strong></td>
<td>7700 East Parham Rd., Richmond VA 23244</td>
<td>I-95 South / Take exit 83B to East Parham Rd. / Hospital will be on the right after approximately 4.5 miles</td>
</tr>
</tbody>
</table>
| **Prince William Hospital**   | 8650 Sudley Rd. Manassas, VA 20110 (City of Manassas) | Traveling from West/Front Royal:  
Take I-66 East to Exit 47 onto Route 234 Business Southbound (Sudley Road). Travel three miles to the hospital, which is located on the right. Turn right into the hospital's main entrance. Parking is free and located in front of the building.  
Traveling from South/Richmond:  
Take I-95 North to Manassas/Dunfries Exit 152. Turn left at the end of the exit ramp onto Dunfries Road (Route 234 North). After approximately 12 miles, turn right onto Route 234 Business (still Dunfries Road). Dunfries Road will become Grant Ave. (Route 234) and Sudley Road. Turn left onto Sudley Road (staying on Route 234), and in a few blocks you will see the hospital on the left. Parking is free and located in front of the building. |
| **Retreat Hospital**          | 2621 Grove Ave, Richmond VA 23220  | I-95 / take exit 78 for Boulevard / keep right at the fork, following signs for VA-161 South / merge onto VA-161 S/N Boulevard / turn left onto Grove Ave |

**Specialty Resources:**
- Cath Lab, Stroke Center, Labor and Delivery
- Cardiac and Stroke Center
- Cardiac, Cancer, and L&D
- 703/369-8337 Emergency Dept.
- 703/369-8052 Emergency Dept. Fax
- 703/369-8000 Administrative
- Northern Virginia Regional Healthcare Coordination Center (Alternate)  
  Radio Contact  
  Medcom 800 MHz (Talk Group 9A in FFX County)  
  Coordinates – 38:46:00N 77:29:10W
- None
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Specialty Resources</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richmond Community Hospital</td>
<td>1500 North 28th St., Richmond VA 23223</td>
<td>None</td>
<td>I-95 south / take exit 75 and merge onto 64 east toward Richmond Airport / take exit 193A Nine Mile Rd. / turn slight left onto North 28th St</td>
</tr>
<tr>
<td>Riverside Tappahannock Hospital</td>
<td>618 Hospital Rd., Tappahannock VA 22560</td>
<td>None</td>
<td>US 17 south (Tidewater Trail) into the town of Tappahannock / slight right onto US 360-West Richmond Hwy / immediately turn right onto hospital drive / hospital will be at the end of the drive.</td>
</tr>
<tr>
<td>St. Francis Hospital</td>
<td>13710 St. Francis Blvd, Midlothian VA 23114</td>
<td>Cardiac Center</td>
<td>I-95 south / take exit 79 towards Powhite Parkway / keep left and remain on Powhite Parkway (toll) / turn right on Charter Colony Parkway / turn left on Bon Secours Dr. / Turn right onto St. Francis Blvd / Hospital will be on the right.</td>
</tr>
<tr>
<td>St. Mary's Hospital</td>
<td>5801 Bremo Rd., Richmond VA 23226</td>
<td>Pediatric Specialty Center</td>
<td>I-95 south / take exit 79 toward Powhite Parkway / immediately merge onto I64 West toward Charlottesville / take exit 185 East Staples Mill Rd. / turn right on W Broad St. / turn left on Libbie Ave / cross Monument Ave / ambulance entrance will be on the right off Libbie Rd.</td>
</tr>
<tr>
<td>University Of Virginia Health System</td>
<td>1215 Lee St.</td>
<td>Level 1 trauma center, pediatric center</td>
<td>From 64 W to Exit 118B onto Monacan Tr. (Us 29) take ramp US-29-BR N, turn right onto Jefferson Park Ave., right onto Lee Street. Hospital is located on your left.</td>
</tr>
<tr>
<td>Virginia Commonwealth University Medical Center (MVC - Medical College of VA)</td>
<td>1250 East Marshall St., Richmond VA 23219</td>
<td>Level 1 trauma center, pediatric trauma center</td>
<td>From Rt. 15, left on to VA 231, take I64 W exit, exit onto 121 (Charlottesville/Scottsville, right onto Journey Through Hallowed Ground Bywy, left onto Elliott Ave., right onto 9th-10th Conn. Left onto Crispell Dr., right onto Lee St. Hospital located on the left.</td>
</tr>
</tbody>
</table>

**EMERGENCY CONTACTS**

**Richmond Community Hospital**
Hear by phone: 804-225-1780
Hear by Radio: 172-5322

**St. Francis Hospital**
Hear by phone: 804-594-7958
Hear by Radio: 172-8531

**St. Mary's Hospital**
Hear by phone: 804-281-8184
Hear by Radio: 172-0822

**University Of Virginia Health System**
Emergency Dept. 434/924-2231
Emergency Dept. Fax 434/924-2011
Adm. 434/924-2231
Radio HEO 155.340 MHz CTCSS 203.5 Dia 174-3122
MED 9, 10 (UVA Medcom)
800 MHz Trunked
Coordinates – 38:01:55N 78:30:00W

**Virginia Commonwealth University Medical Center (MVC - Medical College of VA)**
Hear by phone: 804-828-3989
Hear by Radio: Open (MCI activation only 804-828-8888)
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Address</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Warren Memorial Hospital</strong></td>
<td>1000 N. Shenandoah Ave. Front Royal VA 22630 (Town of Front Royal)</td>
<td>I 66 W, keep left at the fork, take exit 13 toward Linden/Front Royal, left onto VA 79S/Apple Mountain Rd., right on VA 55 W/John Marshall Rd., right onto S. Commerce Ave., left on W 11th St. left on N. Shenandoah Ave. Hospital located on the left. US 522 N, right onto US 211 E/US 522/ N Lee Hwy, left onto US 522/Zachary Taylor Hwy., right onto N Royal Ave., left onto 11th St., left onto N. Shenandoah Ave. Hospital located on the left.</td>
</tr>
</tbody>
</table>
| **Winchester Medical Center**  | 1840 Amherst St. Winchester, VA 22601 (City of Winchester) | From Route 522 south of Winchester  
- Follow Route 522 North to where it intersects with I-81  
- Take I-81 North to Exit 317  
- Turn left at traffic light onto Route 11/Route 37 South  
- Continue on Route 37, getting into the right-hand lane  
- Exit at the Winchester Medical Center access ramp (handy for accessing Shenandoah University School of Pharmacy/Nursing, Diagnostic Center, Valley Health Wellness & Fitness Center, Parking Garage, Medical Office Building II, and other facilities)  
- Follow signs to your destination  
Or, stay on Route 37 to exit at Route 50  
- Turn left at traffic light onto Route 50 East  
- Turn left at second traffic light onto Campus Blvd and the Winchester Medical Center campus (handy access to Surgi-Center, Medical Office Building I, hospital main entrance, conference center, other facilities)  
- Follow signs to your destination  
**Route 7 east of Winchester**  
- Follow Route 7 West to I-81 North  
- Take I-81 North to exit 317  
- Turn left at traffic light onto Route 11/Route 37 South |

**Specialty Resources:**
- **Warren Memorial Hospital:** Cardiology  
540/636-0334 Emergency Dept.  
540/636-0427 Emergency Dept. Fax  
540/636-0300 Administrative  
MED 10 Med Tone 151.4  
Coordinates – 38:55:52N 78:11:56W
- **Winchester Medical Center:** Level 2 trauma center  
540/536-8700 Emergency Dept.  
540/536-8964 Emergency Dept. Fax  
540/536-8000 Administrative  
HEAR 155.340MHz CTCSS (none) Dial  
MED 8,4,1 Med Tone 151.4  
Coordinates – 39:11:42N 78:11:32W
• Continue on Route 37, getting into the right-hand lane
• Exit at the Winchester Medical Center access ramp (handy for accessing Shenandoah University School of Pharmacy/Nursing, Diagnostic Center, Valley Health Wellness & Fitness Center, Parking Garage, Medical Office Building II, and other facilities)
• Follow signs to your destination

From Route 50 east of Winchester

• Take I-81 North to exit 317
• Turn left at traffic light onto Route 11/Route 37 South
• Continue on Route 37, getting into the right-hand lane
• Exit at the Winchester Medical Center access ramp (handy for accessing Shenandoah University School of Pharmacy/Nursing, Diagnostic Center, Valley Health Wellness & Fitness Center, Parking Garage, Medical Office Building II, and other facilities)
• Follow signs to your destination
Annex E - REMS Mass Casualty Support Unit Deployment

1. Definitions
   1.1 Mass Casualty Support Unit (MCSU) - A vehicle designed to carry supplies and equipment for mass casualty incidents. Designated level one (25 patients), level two (50 patients) or level three (100 patients). The minimum inventory is established by the Council of Government agreement.
   1.2 Medical Supply Unit Team Leader - Reports to the Medical Group Supervisor. Acquires and maintains control of appropriate medical equipment from units assigned to the Medical Group.

2. Procedure
   2.1 The MCS unit will be staffed and operated by the personnel from the housed station.
   2.2 In the event the personnel at the housed station is unavailable the next staffed engine will respond and staff MCS unit.
   2.3 The station, engine crew or MCS unit will provide a driver and the units travel together. In the event the housed station provides only a driver, an additional engine will be requested to respond and assist the MCS unit.
   2.4 Minimum staffing will be three, including one EVOC 2 driver and trained crew.
   2.5 The MCS unit radio designation is “Mass Casualty Support Unit XX”.
   2.6 The MCS unit will be dispatched to the appropriate call type:
      Any incident where 10 or more patients are reported.
   2.7 The MCS unit will be dispatched upon request to the following:
      - Incident Commander
      - Mutual Aid
   2.8 The MCS unit crew officer will be designated “Medical Supply Unit Team Leader Coordinator” if required by the Incident Commander and not otherwise assigned and will assume corresponding responsibility.
   2.9 The equipment on the MCS unit will be deployed in green, yellow and red treatment areas when designated. Selection of treatment areas will be guided by proximity to transportation, a safe distance from the impact area, or located in the cold zone. A blue tarp designates the equipment cache.
   2.10 Upon termination of the incident the deployed equipment will be accounted for, reloaded on the MCS unit and returned to quarters for restocking and inventory. The unit officer is responsible for ensuring that all deployed equipment is returned and the unit is returned to service.

3. Responsibilities
   Operations shall maintain, staff, and operate the MCS unit. The host station shall ensure personnel are trained and proficient in MCSU operations and set up of treatment areas. Next due crews shall be capable of deploying the MCS unit when needed.

   Communications shall ensure dispatchers dispatch the MCS unit to incidents identified in 2.7. Dispatch the MCS unit upon request as specified in 2.8.
Annex F - Mass Casualty Resource List

MCI Resources

General
First and foremost the Incident Commander must practice scarce resource management. Single resources will
be requested from the Emergency Communications/911Center and told to report to the designated Staging
Area, where they may be assembled into Strike Teams or Task Forces.

This leaves to the Incident Commander or designated Staging Officer to manage the number of ambulances
assembled. As patients are transported, units should be directed by the Transport Group Supervisor/Unit
Leader Group on whether they should clear then return to staging or clear and return to their stations. The
capacity to assemble Strike Teams will be limited by available resources and by the time needed to assemble
and deploy them.

Medical Supplies & Equipment

Disaster Medical Support Units

<table>
<thead>
<tr>
<th>Resource Description</th>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care Support Unit</td>
<td>Stafford County Fire – Rescue</td>
<td>MCSU (Medical Care Support Unit)</td>
<td>Level 3 MCI unit (100 Patient)</td>
</tr>
</tbody>
</table>

Mass Casualty Trailers
The table below is a list of deployable mass casualty trailers. The size of the trailer and equipment stocked on
each trailer varies.

<table>
<thead>
<tr>
<th>General Service Area</th>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline</td>
<td>Caroline County Department of Fire &amp; Rescue</td>
<td>N/A</td>
<td>3 MCI Trailers (50 BLS patients each)</td>
</tr>
<tr>
<td>Fredericksburg</td>
<td>Fredericksburg Fire Department</td>
<td>N/A</td>
<td>1 MCI Trailer (25 BLS patients)</td>
</tr>
<tr>
<td>Fauquier</td>
<td>Fauquier County Department of Fire Rescue &amp; Emergency Management</td>
<td>N/A</td>
<td>2 MCI Trailers (25 ALS patients each)</td>
</tr>
<tr>
<td>King George</td>
<td>King George Department of Fire, Rescue &amp; Emergency Services</td>
<td>N/A</td>
<td>1 MCI Trailer (25 BLS patients)</td>
</tr>
<tr>
<td>Spotsylvania</td>
<td>Spotsylvania Department of Fire, Rescue &amp; Emergency Management</td>
<td>N/A</td>
<td>1 MCI Trailer (40 BLS patients)</td>
</tr>
</tbody>
</table>
**Medical Transportation Resources**

**Ambulance Services**
Please note that this is not an all-inclusive list.

<table>
<thead>
<tr>
<th>Resource Description</th>
<th>Agency Name</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Ambulance Service</td>
<td>LifeCare Medical Transports, Inc. (Fredericksburg)</td>
<td></td>
<td>540-752-7721</td>
</tr>
<tr>
<td>Private Ambulance Service</td>
<td>Richmond Ambulance Authority (Richmond)</td>
<td></td>
<td>804-254-1150</td>
</tr>
<tr>
<td>Private Ambulance Service</td>
<td>First Med, Inc.</td>
<td></td>
<td>1-888-242-6428</td>
</tr>
<tr>
<td>Private Ambulance Service</td>
<td>Forest Ambulance Service, Inc. (Richmond)</td>
<td></td>
<td>804-358-2595</td>
</tr>
<tr>
<td>Private Ambulance Service</td>
<td>Medical Transport Inc. (MTI)</td>
<td></td>
<td>1-800-322-3451</td>
</tr>
<tr>
<td>Private Ambulance Service</td>
<td>LifeStar Ambulance (Hanover County)</td>
<td></td>
<td>804-262-5105</td>
</tr>
<tr>
<td>Private Ambulance Service</td>
<td>Priority Ambulance (Richmond)</td>
<td></td>
<td>804-639-9112</td>
</tr>
</tbody>
</table>

**NOTE:** This is only a partial listing of private transport companies that provide service in the region. Check your local listings for additional private transport agencies and resources.

**Mass Casualty Evacuation and Transportation Units**
The Mass Casualty Evacuation and Transportation Units (MCETUs) are converted buses that are designed to transport Yellow and Green patients only. Capacity: 18 litter patients and 10 or more seated patients and 2 attendants.

<table>
<thead>
<tr>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stafford Fire and Rescue Department</td>
<td>Medical Ambulance Bus</td>
<td></td>
</tr>
</tbody>
</table>

**Medevac (Air Ambulance) Resources**

<table>
<thead>
<tr>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stafford Fire and Rescue Department</td>
<td>Life Evac 2</td>
<td>ALS Air Ambulance based out of Stafford Airport</td>
</tr>
</tbody>
</table>

**Decontamination Resources**

<table>
<thead>
<tr>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing/Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fredericksburg Fire Department</td>
<td>Decontamination tent &amp; detection equipment</td>
<td>Contact Fredericksburg ECC (540) 373-2234</td>
</tr>
</tbody>
</table>
### Special Operations Resources

#### Dive Teams

<table>
<thead>
<tr>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fredericksburg Fire Department</td>
<td>N/A</td>
<td>Contact Fredericksburg ECC (540) 373-2234</td>
</tr>
<tr>
<td>Stafford Fire and Rescue Department</td>
<td>N/A</td>
<td>Contact Stafford ECC (540) 658-4440</td>
</tr>
</tbody>
</table>

#### All Utility All Terrain Vehicles

<table>
<thead>
<tr>
<th>Resource Description</th>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>One 4-Wheel Drive All Terrain Polaris (w/ EMS Skid / Litter)</td>
<td>Caroline Fire and Rescue</td>
<td>N/A</td>
<td>Contact Caroline ECC (804) 633-5555</td>
</tr>
<tr>
<td>One 4-Wheel Drive All Terrain Gator (1 litter patient)</td>
<td>Fredericksburg Fire Department</td>
<td>N/A</td>
<td>Contact Fredericksburg ECC (540) 373-2234</td>
</tr>
<tr>
<td>Seven All-Terrain Vehicles</td>
<td>Fauquier Fire and Rescue Department</td>
<td>N/A</td>
<td>Contact Fauquier ECC (540) 347-6843</td>
</tr>
<tr>
<td>Two 4-Wheel Drive ALS capable ambulances</td>
<td>Stafford County Fire and Rescue Department</td>
<td>Medic</td>
<td>Contact Stafford ECC (540) 658-4440</td>
</tr>
<tr>
<td>One 4-Wheel Drive All Terrain Gator (1 litter patient)</td>
<td>LifeCare Medical Transports, Inc. (Fredericksburg)</td>
<td>N/A</td>
<td>Contact Lifecare CC (540) 752-7721</td>
</tr>
</tbody>
</table>

#### Search and Rescue Teams

<table>
<thead>
<tr>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated through the VA EOC</td>
<td>N/A</td>
<td>Contact the VA EOC (804) 674-2400</td>
</tr>
</tbody>
</table>

#### Technical Rescue Teams

<table>
<thead>
<tr>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated through the VA EOC</td>
<td>N/A</td>
<td>Contact the VA EOC (804) 674-2400</td>
</tr>
</tbody>
</table>

#### Responder Rehabilitation Units

<table>
<thead>
<tr>
<th>Jurisdiction/Agency</th>
<th>NIMS Typing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stafford Fire and Rescue Department</td>
<td>Rehab 4</td>
<td>Rehabilitation bus with air conditioning</td>
</tr>
</tbody>
</table>

#### Regional Specialty Teams

**Regional Hazardous Materials (HAZMAT) Team**
Mission
The Fredericksburg Regional Hazardous Materials Team are prepared to provide highly trained and equipped personnel who will respond to HAZMAT incidents that exceed the capabilities of local fire departments. Further, the Team will perform offensive mitigation procedures to rapidly protect citizens, critical infrastructure and the environment.

Capabilities
The Fredericksburg Regional Hazardous Materials Team has the training and equipment to respond to any Hazardous Materials incident. The Team also has the capability to respond incidents involving CBRNE.

Emergency Team Activation
The Fredericksburg Regional Hazardous Materials Team is available on a 24-hour basis. Activation is initiated by calling the Virginia Emergency Operations Center at (800) 468-8892 or (804) 674-2400.

Base of Operations Footprint
The team's footprint will vary depending upon the size of the responding apparatus and associated equipment.

Cost of Operations
Any costs for a response by the Fredericksburg Regional Hazardous Materials Team shall be the responsibility of the Responsible Party, after an investigation has determined who that Party is.

Mass Transit Transports Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Company</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Schools Buses</td>
<td>Managed by each locality</td>
<td>Contact the local ECC(s) as needed</td>
</tr>
<tr>
<td>Public Transportation, Accessible (20/30 Ambulatory)</td>
<td>FRED Transit</td>
<td>Fredericksburg ECC (540) 373-2234</td>
</tr>
</tbody>
</table>

The region’s mass transportation resources include the FRED Transit bus system, private school buses and locality school systems’ buses. Additional sources of mass transit include faith-based and other non-profit organization buses. Because none of these buses are dedicated to emergency response, limitations do exist. School and non-profit buses may be in use at the time they would be needed as a resource, so there may be some delay. The FRED Transit operates only in the City of Fredericksburg but could potentially be re-routed and used for mass transport throughout the region if requested.

Emergency Fuel Resources

<table>
<thead>
<tr>
<th>Company</th>
<th>Jurisdiction</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Fuel</td>
<td>Fredericksburg</td>
<td>(540) 898-2151</td>
</tr>
<tr>
<td>Quarles</td>
<td>Fredericksburg</td>
<td>(540) 322-2804 (877) 529-2680</td>
</tr>
<tr>
<td>Watchcard Fleet Fuel System</td>
<td>Surrounding Localities</td>
<td>(540) 898-2151 (800) 805-3835</td>
</tr>
<tr>
<td>EM Gray and Sons, Inc.</td>
<td>Caroline</td>
<td>(804) 633-6800</td>
</tr>
</tbody>
</table>
Emergency Maintenance Resources

<table>
<thead>
<tr>
<th>Company</th>
<th>Services</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Public Works</td>
<td>Vehicle Maintenance</td>
<td>Fredericksburg ECC (540) 373-2234</td>
</tr>
<tr>
<td>Coleman Towing and Motor Company</td>
<td>Vehicle Towing</td>
<td>(540) 785-1500</td>
</tr>
<tr>
<td>Merryman Service Center</td>
<td>Vehicle Towing</td>
<td>(540) 371-6990</td>
</tr>
<tr>
<td></td>
<td>Vehicle Maintenance</td>
<td></td>
</tr>
<tr>
<td>Tire Tread Service</td>
<td>Road Tire Service Retail</td>
<td>(540) 373-3131</td>
</tr>
</tbody>
</table>

State MCI Resources

During emergency and large scale non-emergency events, the Health and Medical Emergency Response Teams (HMERT) are available to provide trained emergency medical services personnel to assist the Virginia Department of Health, Office of Emergency Medical Services in state health and medical disaster response. Task Forces, Incident Support Teams, and specialized Strike Teams provide services to meet a locality’s needs. HMERT members train in the entire scope of disaster management, including all areas of emergency operations.

Health and Medical Emergency Response Teams

Mission
HMERTs are capable of providing emergency medical services to the affected jurisdiction upon exhaustion of local and mutual aid resources.

Capabilities
The Office of Emergency Medical Services, in cooperation with EMS agencies around the state, has established the Health and Medical Emergency Response Teams (HMERT) to provide trained emergency medical services personnel to assist the OEMS in responding to a health and medical disaster response.

EMS Disaster Task Forces

Mission
EMS Disaster Task Forces are designed to be used as units to either undertake specific tasks or to supplement the needs of the requesting jurisdiction. EMS Task Forces will remain under the command of their Task Force Commander and should not be broken up.

Capabilities
The OEMS can deploy either the task force personnel, or the task force personnel and their vehicles depending upon the needs of the jurisdiction. In most cases a task force deployment will include both personnel and vehicles. These Task Forces are made up of:
1 Basic Life Support Ambulance with crew
1 Advanced Life Support Ambulance with crew
1 Rescue (Squad) Truck with crew
1 Quick Response Vehicle (QRV) or Chief's Car (optional)
1 Disaster Truck or Trailer (optional)
1 Specialty Unit (technical rescue, water rescue, etc.) or Trailer (optional)
1 Task Force Commander

EMS Task Forces will attempt to come supplied for 72 hours, not including water, fuel or expendable supplies.

Task Force Configurations
EMS Disaster Task Forces can be deployed in three configurations: standard task force, augmentation package, incident support team. The requesting jurisdiction should identify the specific configuration needed.

Standard Task Force: Composed of one Basic Life Support (BLS) ambulance, one Advanced Life Support (ALS) ambulance, one heavy-duty or medium-duty rescue truck, and a disaster truck or trailer if available, with a Task Force Commander and minimum of eight (8) EMS providers.

Augmentation Package: A standard Task Force with vehicles and personnel tailored to meet the needs of the requesting jurisdiction.

Incident Support Team: As described below.

Incident Support Teams

Mission
The Incident Support Team (IST) coordinates Task Force actions in the impact area, ensures that Task Forces have the necessary logistical support and collect current situation and activity reports for OEMS. An IST will always deploy with a Task Force. In a major event of any type, ISTs can be requested as a separate asset.

Capabilities
This IST works with local government and EMS agencies. These team members are trained as experts in the Incident Command System, to work with other state government response agencies and to operate in the EOC if needed to augment HMERT.

HMERT, EMS Disaster Task Forces and IST Emergency Activation
HMERT resources must be requested via your local jurisdiction’s Emergency Operations Center and from the Virginia State Emergency Operations Center (VaEOC). The VaEOCs telephone number is 1-800-468-8892.
Federal MCI Resources

National Disaster Medical System
The National Disaster Medical System (NDMS) is a federally coordinated system that augments the Nation’s medical response capability. The overall purpose of the NDMS is to establish a single integrated National medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts. The National Response Plan utilizes the National Disaster Medical System (NDMS), as part of the Department of Health and Human Services, Office of Preparedness and Response, under Emergency Support Function #8 (ESF #8), Health and Medical Care, to support Federal agencies in the management and coordination of the federal medical response to major emergencies and federally declared disasters including: natural disasters, technological disasters, major transportation disasters, and acts of terrorism including weapons of mass destruction events.

Mission
It is the mission of the National Disaster Medical System to design, develop, and maintain a national capability to deliver quality medical care to the victims of - and responders to – a domestic disaster. NDMS provides state-of-the-art medical care under any conditions at a disaster site, in transit from the impacted area, and into participating definitive care facilities.

Components of the National Disaster Medical System
- Medical response to a disaster area in the form of teams, supplies, and equipment.
- Patient movement from a disaster site to unaffected areas of the nation.
- Definitive medical care at participating hospitals in unaffected areas.

NDMS Teams
NDMS Operations are partially supported by the various teams that comprise the NDMS:

Disaster Medical Assistance Team (DMAT)
DMAT is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved. DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site. To supplement the standard DMATs, there are highly specialized DMATs that deal with specific medical conditions such as crush injury, burn, and mental health emergencies. In mass casualty incidents, their responsibilities may include triaging patients, providing high-quality medical care despite the adverse and austere environment often found at a disaster site, and preparing patients for evacuation. DMATs are designed to be a rapid response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved.

Disaster Mortuary Operational Response Teams (DMORT)
DMORTs provide victim identification and mortuary services. These responsibilities include: temporary morgue facilities; victim identification, forensic dental pathology, forensic anthropology methods, processing preparation, and disposition of remains.
DMORTs are composed of funeral directors, medical examiners, coroners, pathologists, forensic anthropologists, medical records technicians and scribes, fingerprint specialists, forensic odontologists, dental assistants, x-ray technicians, mental health specialists, computer professionals, administrative support staff, and security and investigative personnel.

**Disaster Portable Morgue Units (DPMU) Team**

The DMORT DPMU promotes the most dignified handling and positive identification of fatalities in federally declared emergencies by supporting all DMORT teams through the efficient and effective management of federal mortuary assets throughout the planning, preparation and response phases. The DPMU is responsible for pre-deployment equipment activities including maintenance, equipment purchases, upgrades and resupply after missions. The DMORT DPMU Team consists of members from throughout the country who possess advanced skills in logistics management and all areas of mortuary operations.

**Veterinary Medical Assistance Teams (VMATs)**

VMATs provide assistance in assessing the extent of disruption, and the need for veterinary services following major disasters or emergencies. These responsibilities include: assessing the medical needs of animals, medical treatment and stabilization of animals, animal disease surveillance, zoonotic disease surveillance and public health assessments, technical assistance to assure food and water quality, hazard mitigation, and animal decontamination. VMATs are composed of clinical veterinarians, veterinary pathologists, animal health technicians (veterinary technicians), microbiologist/virologists, epidemiologists, toxicologists and various scientific and support personnel.

**National Nurse Response Team (NNRT)**

The NNRT is a specialty team used in any scenario requiring hundreds of nurses to assist in chemoprophylaxis, a mass vaccination program, or a scenario that overwhelms the nation’s supply of nurses in responding to a weapon of mass destruction event. The NNRTs are composed of approximately 200 civilian nurses.

**National Pharmacy Response Teams (NPRTs)**

NPRTs assist in chemoprophylaxis or the vaccination of hundreds of thousands, or even millions of Americans, or perhaps in another scenario requiring hundreds of pharmacists, pharmacy technicians, and students of pharmacy.

**NDMS Activation**

The NDMS cannot be activated by local emergency management authorities. The state must request NDMS activation as a component of the Federal response package.

**Strategic National Stockpile**

The Centers for Disease Control and Prevention (CDC) maintains the Strategic National Stockpile (SNS). The SNS is a national repository of antibiotics, chemical antidotes, antitoxins, life-support medications, IV administration, airway maintenance supplies, and medical/surgical items.

The SNS is organized for flexible response. The first line of support lies within the immediate response 12-hour Push Packages. These are caches of pharmaceuticals, antidotes, and medical supplies designed to provide rapid delivery of a broad spectrum of assets for an ill-defined threat in the early hours of an event. These Push Packages are positioned in strategically located, secure warehouses ready for immediate deployment to a designated site within 12 hours of the federal decision to deploy SNS assets.
If the incident requires additional pharmaceuticals and/or medical supplies, follow-on vendor managed inventory (VMI) supplies will be shipped to arrive within 24 to 36 hours. If the agent is well defined, VMI can be tailored to provide pharmaceuticals, supplies and/or products specific to the suspected or confirmed agent(s). In this case, the VMI could act as the first option for immediate response from the SNS Program.

**Requesting the SNS**

The decision to deploy the SNS will be a collaborative effort between local, State, and Federal officials. It will start at the local level when health officials identify a potential or actual problem that they believe will threaten the health of the community. Local health officials will notify and coordinate with state officials through the VDH Central Office or State EOC.

When health officials, in coordination with emergency management officials, confirm the incident is anticipated to deplete existing resources, a request for the SNS will be channeled through the Governor to the CDC. CDC will make the decision to activate the SNS after discussions with State and Federal officials. When CDC confirms that local and State resources will be insufficient to respond to the incident, the SNS will be deployed. The Virginia Department of Health (VDH) has plans in place to receive and distribute SNS medicine and medical supplies to local communities as quickly as possible.

**FEMA Urban Search and Rescue Task Forces**

If a disaster event warrants national US&R support, the Federal Emergency Management Agency (FEMA) will deploy the three closest task forces within six hours of notification, and additional teams as necessary. The role of these task forces is to support state and local emergency responders’ efforts to locate victims and manage recovery operations. Each task force consists of two 31-person teams, four canines, and a comprehensive equipment cache. US&R task force members work in four areas of specialization: search, to find victims trapped after a disaster; rescue, which includes safely digging victims out of tons of collapsed concrete and metal; technical, made up of structural specialists who make rescues safe for the rescuers; and medical, which cares for the victims before and after a rescue. In addition to search-and-rescue support, FEMA provides hands-on training in search-and-rescue techniques and equipment, technical assistance to local communities, and in some cases federal grants to help communities better prepare for urban search-and-rescue operations.
Annex G - REMS Regional Emergency Communications Centers

**Caroline County** 804-633-4357
Caroline 911 Center
108-B Courthouse Lane
Bowling Green, Virginia 22427

**Culpeper County** 540-727-7900
Culpeper Joint Dispatch Center
14022 Public Safety Court
Culpeper, Virginia 22701

**City of Fredericksburg** 540-373-3122
Fredericksburg Emergency Communications Center
2200 Cowan Boulevard
Fredericksburg, VA 22401
Fredericksburg, Virginia 22404

**Fauquier County** 540-347-6843
78 W. Lee Street, #102
Warrenton, Virginia 20186

**King George County** 540-775-2049
King George Sheriff’s Department
9483 Kings Hwy.
King George, Virginia 22485

**Orange County** 540-672-1515
Orange County Emergency
112 West Main Street
Orange, Virginia 22960

**Rappahannock County** 540-675-5300
Rappahannock Communications
383 Porter Street
Washington, Virginia 22747

**Spotsylvania County** 540-582-7115
Spotsylvania Communications
9101 Courthouse Road
Spotsylvania, Virginia 22553

**Stafford County** 540-658-4440
Stafford Dispatch
1300 Courthouse Road
Stafford, Virginia 22554

**LifeCare Medical Transports Dispatch Center** 540-752-5883
1170 International Parkway
Fredericksburg, Virginia 22406
Annex H - Virginia Reportable Disease List

Virginia Reportable Disease List

Any reporting of the following diseases is required by state law (32.2-136 and 32.2-137) of the Code of Virginia and 12VAC5-90-80 and 12VAC5-90-80 of the Board of Health Regulations for Disease Reporting and Control, [http://www.vdh.virginia.gov/epidemiology/regulations.htm](http://www.vdh.virginia.gov/epidemiology/regulations.htm). Report all conditions when suspected or confirmed to your local health department within three days on an Epi-1 form, except those listed in **RED** must be reported immediately by the most rapid means available.

<table>
<thead>
<tr>
<th>Acquired immunodeficiency syndrome (AIDS)</th>
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<tbody>
<tr>
<td>Anthrax</td>
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<tr>
<td>Arboviral infection (e.g., dengue, EEE, LAC, SLE, WNV)</td>
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<tr>
<td>Botulism</td>
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<tr>
<td>BRUCELLOSIS</td>
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<tr>
<td>Campylobacteriosis</td>
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<tr>
<td>Chancroid</td>
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<tr>
<td>Chickenpox (Varicella)</td>
</tr>
<tr>
<td>Clamydial Pachonma infection</td>
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<tr>
<td>Cholera</td>
</tr>
<tr>
<td>Creutzfeldt-Jakob disease if &lt;55 years of age</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
</tr>
<tr>
<td>Cyclosporiasis</td>
</tr>
<tr>
<td>Diphtheria</td>
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<tr>
<td>Disease caused by an agent that may have been used as a weapon</td>
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<tr>
<td>Ehrlichia/Anaplasmosis</td>
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<tr>
<td>Escherichia coli infection, Shiga toxin-producing</td>
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<tr>
<td>Escherichia</td>
</tr>
<tr>
<td>Gonorrhea</td>
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<tr>
<td>Granuloma inguinale</td>
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<tr>
<td>Hemophilus influenza infection, invasive</td>
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<tr>
<td>Hemolytic uremic syndrome (HUS)</td>
</tr>
<tr>
<td>Hepatitis A</td>
</tr>
<tr>
<td>Hepatitis B (acute and chronic)</td>
</tr>
<tr>
<td>Hepatitis C (acute and chronic)</td>
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<tr>
<td>Hepatitis, other acute viral</td>
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<tr>
<td>Human immunodeficiency virus (HIV) infection</td>
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<tr>
<td>Influenza</td>
</tr>
<tr>
<td>Influenza-associated deaths in children &lt;18 years of age</td>
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<tr>
<td>Influenza-associated deaths in children</td>
</tr>
<tr>
<td>Lead, elevated blood levels</td>
</tr>
<tr>
<td>Legionellosis</td>
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<tr>
<td>Leprosy (Hansen disease)</td>
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<tr>
<td>Listeriosis</td>
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<tr>
<td>Lyme disease</td>
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<tr>
<td>Lymphgranuloma venereum</td>
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<tr>
<td>Malaria</td>
</tr>
<tr>
<td>Measles (Rubella)</td>
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<tr>
<td>Meningococcal disease</td>
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<tr>
<td>Monkeypox</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Mycobacterial diseases (including AFB), identification of organism and drug susceptibility</td>
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<tr>
<td>Pertussis</td>
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<tr>
<td>Plague</td>
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<tr>
<td>Poliovirus infection, including poliomyelitis</td>
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<tr>
<td>Psittacosis</td>
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<tr>
<td>Q Fever</td>
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<tr>
<td>Rabies, human and animal</td>
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<tr>
<td>Rabies treatment, post-exposure</td>
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<tr>
<td>Rubella, including congenital rubella syndrome</td>
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<tr>
<td>Salmonellosis</td>
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<tr>
<td>Severe acute respiratory syndrome (SARS)</td>
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<tr>
<td>Sigmoidias</td>
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<tr>
<td>Smallpox (Varicella)</td>
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<tr>
<td>Spotted fever rickettsiosis</td>
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<tr>
<td>Streptococcus aureus infection, invasive</td>
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<tr>
<td>Streptococcus pneumonia infection, invasive, in children &lt;5 years of age</td>
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<tr>
<td>Syphilis (report PRIMARY and SECONDARY immediately)</td>
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<tr>
<td>Tetanus</td>
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<tr>
<td>Toxic substance-related illness</td>
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<tr>
<td>Trichinosis</td>
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<tr>
<td>Tuberculosis, active disease</td>
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<tr>
<td>Tuberculosis infection in children &lt;4 years of age</td>
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<tr>
<td>Tularemia</td>
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<tr>
<td>Typhoid/paratyphoid fever, unusual occurrence of disease of public health concern</td>
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<tr>
<td>Vaccinia, disease or adverse event</td>
</tr>
<tr>
<td>Vibrio infection</td>
</tr>
<tr>
<td>Viral hemorrhagic fever</td>
</tr>
<tr>
<td>Yellow fever</td>
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<tr>
<td>Yersiniosis</td>
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</table>

These conditions are reportable by directors of laboratories. In addition, these and all other conditions except meticillin-resistant Staphylococcus aureus (MRSA), invasive and mycobacterial diseases are reportable by physicians and directors of medical care facilities. Laboratory reports may be by computer-generated printout, Epi-1 form, CDC surveillance form, or upon agreement with VDH, by means of secure electronic transmission.

A laboratory identifying evidence of these conditions shall notify the local health department of the positive culture and submit the initial isolate to the Virginia Division of Consolidated Laboratory Services (DCLS) or, for tuberculosis, to another lab designated by the Board.

Laboratories that use a Shiga toxin EIA methodology without a simultaneous culture should forward all positive stool specimens or positive broth cultures to DCLS for further characterization.

Physicians and directors of medical care facilities should report influenza by number of cases only (report total number per week and by type of influenza, if known); however, individual cases of influenza A novel virus should be reported immediately by rapid means.

Note:
1. Central line-associated bloodstream infections in adult intensive care units are reportable. Contact the VDH Healthcare-Associated Infections Program at (804) 864-8141 or see 12VAC5-90-370 for more information.
2. Cancers are also reportable. Contact the VDH Virginia Cancer Registry at (804) 864-7868 or see 12VAC5-90-150-180 for more information.

Effective March 26, 2011

VDH VIRGINIA DEPARTMENT OF HEALTH
Annex I - Recommended MCI Equipment and Training

A) Required Training (Course materials are available through online independent course study at http://training.fema.gov/is/crslist.asp
- IS-100.b Course Name: Introduction to Incident Command System, ICS-100 – (10/12/2010)
- IS-200.b Course Name: ICS for Single Resources and Initial Action Incidents – (10/12/2010)
  ICS 300 for mid-level managers and above is not available online (classroom only)
- IS-700.a Course Name: National Incident Management System (NIMS) An Introduction
- IS-800.b Course Name: National Response Framework, An Introduction

B) Recommended Training - (Course materials or resources are available through REMS Council)
- Mass Casualty Incident Training Module I and II
- Incident Command System *
- National Incident Management System Course (NIMS) *
- START Triage
- Hazardous Materials Awareness *
- Emergency (Public Safety) Response to Terrorism *

C) Recommended Personnel Protective Equipment
- Standard PPE (gloves, eye protection, paper gowns, vionex)
- N95 Respirators
- Escape Hoods, Butyl Gloves, Chemical Tape and Overboots
- Chemical Resistant Splash Coverall

D) Recommended Ambulance Equipment
- START Triage Cards
- Red, Yellow, Green and Black Survey Tape with Dispenser of Choice
- Laminated START Triage Cards
- Vests – Triage, Treatment, Staging, Transport, and EMS Sector
- Five Clipboards; Four Small Notepads and Pens
- Flashlights, Headlamps or Glow Sticks
- Laminated Quick Reference Cards for Each Sector Officer Position
- Colored Boundary Tape or Triage Tarps

E) Recommended Non-Transport Vehicle Equipment
- START Triage Cards
- Red, Yellow, Green and Black Survey Tape with Dispenser of Choice
- Laminated START Triage Cards
- Four Small Notepads and Pens
- Flashlights, Headlamps or Glow Sticks

List Approved By REMS Board of Directors: 12/15/04; Updated 06/18/08; Updated 12/10/10
Annex J - Training Resources

Training resources are available through a number of local, state, and federal opportunities. These include, but are not limited to:

**Mass Casualty Incident Management – Module I Course**
This course is designed by the Virginia Office of Emergency Medical Services and taught by an OEMS certified Emergency Operations Instructor.

This awareness-level course addresses basic concepts of mass casualty incidents. The course recognizes key on-scene indicators of a mass casualty event as well as appropriate notification measures. The course also covers the command and control structure associated with on-scene activities.

Contact your local EMS Council or the Virginia Office of Emergency Medical Services for information on upcoming courses.

**Mass Casualty Incident Management – Module II Course**
This course is designed by the Virginia Office of Emergency Medical Services and taught by an OEMS certified Emergency Operations Instructor.

This operations-level course prepares students who would assume staff positions and direct effective actions within the Medical Group/Branch during a mass casualty incident response. This course provides the student with in depth information on managing mass casualties, including creating the medical command structure. A table top exercise helps practice the skills taught in the class.

Contact your local EMS Council or the Virginia Office of Emergency Medical Services for information on upcoming courses.

**Mass Casualty Incident Management (Module I & II) Instructor Course**
This course is designed and taught by the Virginia Office of Emergency Medical Services staff. Successful completion of this course of instruction certifies the student as an Emergency Operation Instructor. Emergency Operations Instructors may teach both the Mass Casualty Incident management – Module I and Module II courses. To be eligible to take this course students must have successfully completed both the Mass Casualty Incident Management Module I & II within the previous 12 months.

Contact your local EMS Council or the Virginia Office of Emergency Medical Services for information on upcoming courses.

**EMS Operations at Multi-Casualty Incidents Course (Q157)**
This is an on-line course offered by the National Fire Academy. The course is designed to help EMS providers respond more effectively to multiple and mass casualty incidents, including MCIs resulting from a chemical, biological, radiological, nuclear, or explosive agent or device.

Students must complete all lessons and pass the final examination to receive course credit.

Students may register to take this and other courses at: [http://www.nfaonline.dhs.gov/index.shtm](http://www.nfaonline.dhs.gov/index.shtm).
EMS: Special Operations Course (R152)
The purpose of this course is to enable EMS System Managers to prepare their organizations for major operations by identifying potential hazards, determining potential resource needs, determining how those resources may be acquired, and developing a plan that enables the effective control of these events. Events such as mass-casualty incidents, storms, earthquakes, or technological emergencies, mass gatherings, dignitary visits, and terrorism can place an unusual demand upon our ability to provide continued EMS response to our anticipated daily call volume. It is only through effective planning and preparation for these unique events that we can continue to respond effectively to our customers. This program discusses many of these special operations and the burdens they place upon our communities, EMS systems, and the responders within our systems. This course meets NIMS requirements for ICS 300.

Prerequisites: ICS 100 level and ICS 200 level training. Preferred courses are Q462 and Q463 available through NFA Online at www.nfaonline.dhs.gov. Chief’s signature on the application attests that the applicant has completed this required training.

This is a 10-day on-campus course delivered at the National Fire Academy resident facility in Emmitsburg, Maryland. On the Emmitsburg campus, the Academy conducts specialized training courses and advanced management programs of national impact. NFA offers these courses and programs in a concentrated, residential setting that is most conducive to intensive learning. On-campus programs target middle- and top-level fire officers, fire service instructors, technical professionals, and representatives from allied professions. Any person with substantial involvement in fire prevention and control, emergency medical services, or fire-related emergency management activities is eligible to apply for Academy courses.

Future students must apply to the National Fire Academy to attend this course. The Academy employs a competitive application process. Application procedures vary with the different courses and programs. Each course or program has specific application requirements listed. Applicants should carefully read the course descriptions and requirements and follow the procedures listed; this will save time and speed up the application process. To apply go to: http://www.usfa.dhs.gov/nfa/

Trauma Triage Tag Days
The Incident and Threat Mitigation Committee has partnered with area hospitals for a Triage Tag Day program. Historically, this program has been conducted on the third Saturday of each month from 0700-1900. This program is meant to familiarize providers with appropriate use of triage tags. Contact hospital EMS Coordinators if you are interested in participation. Mary Washington Hospital, Stafford Hospital, and Spotsylvania Regional Medical Center have agreed to review collected tags for quality while Novant Health UVA Culpeper Medical Center and Fauquier Hospital have agreed to retain the tags for thirty days. Please see the next two pages for a tag that may be duplicated for practice use.
Annex K – Example Disaster Tag
### MCI Plan 2019

**REMS - Regional Mass Casualty Incident (MCI) Plan**

#### DISASTER TAG

<table>
<thead>
<tr>
<th>TIME</th>
<th>PULSE</th>
<th>BP</th>
<th>RESP</th>
<th>LOC</th>
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**MEDICAL HISTORY**

**ALLERGIES**

<table>
<thead>
<tr>
<th>TIME</th>
<th>TREATMENT RECORD</th>
<th>INITIALS</th>
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- SYM
- CT
- EVA
- FTL
- Oxygen by al
- Imm
- Bleeding Control
- Tourniquet
- Splint
- Immobilization
- Extremity Splint
- IF Started at:
- MAST
- Inflated at:
- Groove Decom
- Final Decom
- Chest Decompression
- HI L
- MECS: osseous

**DISASTER TAG**
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