RAPPAHANNOCK EMS COUNCIL

EMS COUNCIL INC.

Regional Mass Casualty Incident (MCI) Plan

Rappahannock Emergency Medical Services Council, Inc.
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Fredericksburg, VA 22401
(540) 373-0249

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.

I. 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.

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, transportation, and safety officer. 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.

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.

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. 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.

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 have 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 the 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

I. **Peninsulas Emergency Medical Services Council, Inc. and Tidewater Emergency Medical Services Council, Inc.,** *Hampton Roads Mass Casualty Incident Response Guide*, June 2013

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

III. **Virginia Office of EMS**, *EMS Surge Planning Template and Toolbox for Mass Casualty Incidents in Virginia*, August, 2007

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.
- 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.
- 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.

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. 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. EMS personnel must be on alert for the presence of armed and possibly violent victims or patients.

Responder Safety, Health, and Rehabilitation

Responder occupational safety, health, and rehabilitation 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. In addition, the IC/IMT and ISO are responsible for incorporating responder rehabilitation into their Incident Action, Safety and Medical Plans.

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 (Lifecare)** 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. Non-traditional modes of transportation and alternate patient transport destinations will need to be considered.

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).

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 Medial 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. 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. In addition, the use of non-traditional modes of patient transportation and alternate patient transport destinations may need to be considered.

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

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:

- **Safety** – Determine providers are safe before entering the scene, while on-scene and en route from scene. Scene safety assessment is ongoing.
- **Size Up** – Determine type of incident, estimate the number of patients and severity of injuries, and determine best access.
- **Send** – Contact dispatch with survey information, request resources, activate the MCI Plan.
- **Set Up** – Establish scene management structure utilizing NIMS to include extrication, triage, treatment, and transportation.
- **START or JumpSTART** – 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.

Chapter 4 - Regional Activation Structure

Authority to Activate Plan

The following individuals can active 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.

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 to an MCI will be responsible for activating mutual aid through their own Emergency Communications Systems.

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:

- 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.

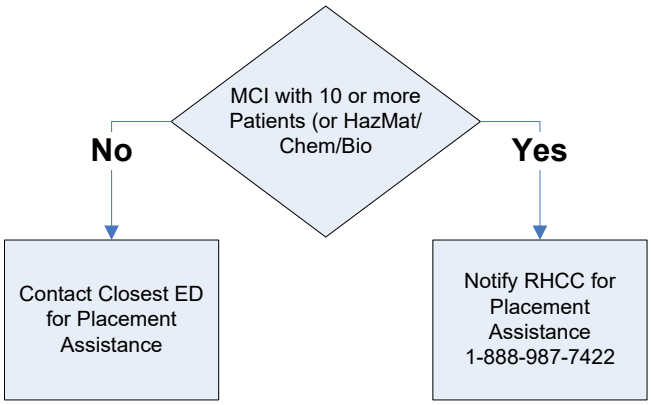
Role of MCI Medical Control, the Regional Healthcare Coordination Center (RHCC), and Hospitals

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 may 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) at 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.

Coordinating Hospital Notification



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.

Rappahannock EMS Council
Regional Hospital Coordination Center Activation (RHCC)

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:

MCI Declared Under Regional Plan

- [] 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

YES → 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

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

Incident page established → Hospitals will utilize VHASS/WebEOC for incident and patient tracking to include use of State Triage Tag #s

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. 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.

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; they also 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.

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.
- 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 E). 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.

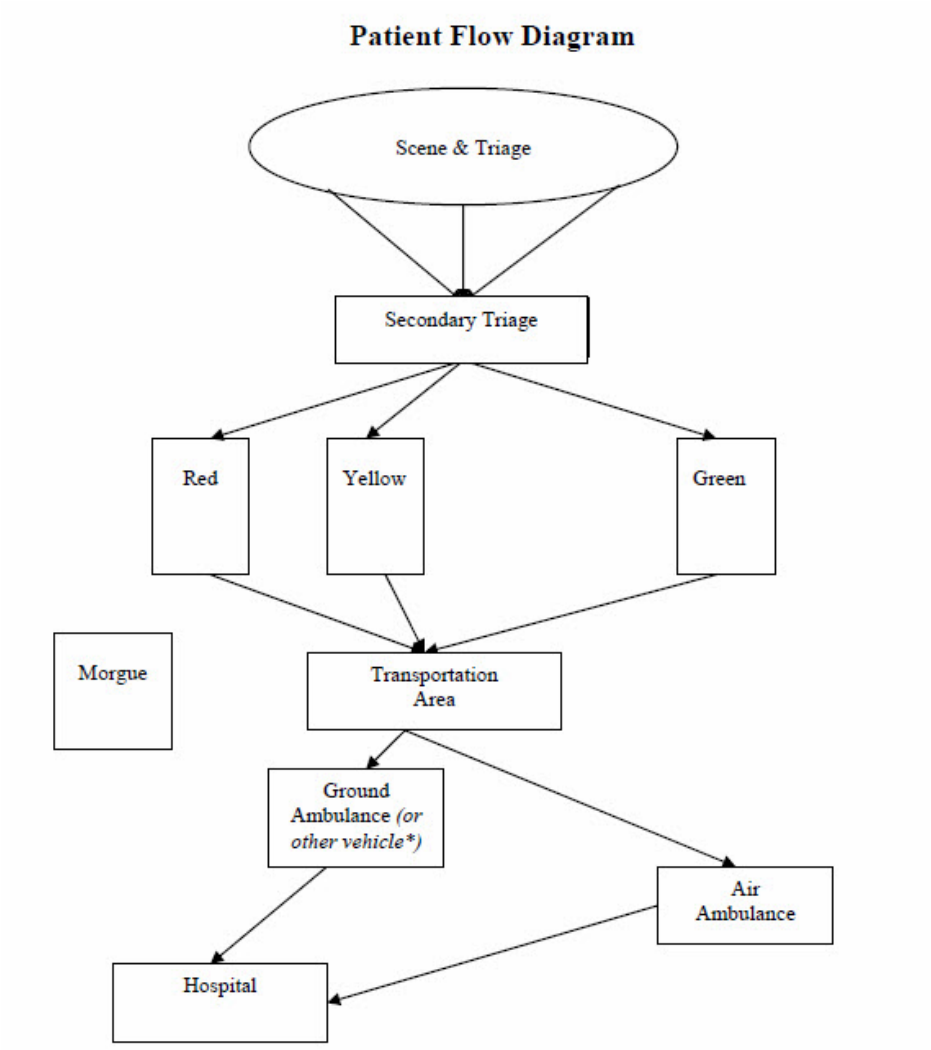
A Virginia EMS Task Force includes:

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

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.

(Hampton Roads Mass Casualty Incident Response Guide, April 2007)

Mass Casualty Patient Flow

The Incident Scene

The flow of 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, 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-triaged).
- 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 as 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.
- Transporting units do not make additional contact with the receiving facility. This contact is handled by the on scene 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 18).*

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.

Chapter 6 - Response Overview

All job aid check-lists are located in annex C of this plan.

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.
- 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

If an agency requires additional resources beyond its capabilities (e.g.: Technical Rescue Operations, Hazardous Materials, Health and Medical Emergency Response Team (HMERT) or Air Medical Operations, etc.), contact the Virginia Department of Emergency Management Emergency Operations Center at **1-800-468-8892 or 804-674-2400** to request assistance.

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 when supervised by a hazmat authority.

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.

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 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.

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.

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 →

Competent Authority makes request to Mary Washington Hospital ED by HEAR radio or phone (540) 373-0348

Provide MWH 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

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

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 NVHA 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

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. 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 and/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**. 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.

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.

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 procede 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 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." It is a written report outlining the strengths and areas for improvement identified by the response. The AAR will include the incident/training timeline, executive summary, incident/training 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 or trainings 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).

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.

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. 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." It is a written report outlining the strengths and areas for improvement identified by the response. The AAR will include the incident/training timeline, executive summary, incident/training 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 or trainings should be forwarded to the licensed EMS Agency's respective and the REMS Council.

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 may 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 to the Plan will require a majority vote of the members present of the REMS Board of Directors to be enacted. 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.

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. REMS Mass Casualty Support Unit Deployment

E. Virginia Reportable Disease List

F. Hostile Incident Response Guide

Annex A - Glossary

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.

JUMP START TRIAGE – Jump Simple Triage and Rapid Treatment. A pediatric triage method modeled on the START triage method and adopted for use in the Commonwealth of Virginia.

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.

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 **S**imple **T**riage **A**nd **R**apid **T**reatment 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

Patient Count & Distribution Worksheet (ICS 308)

Date: _____ Incident Name / Location: _____

Number of Patients Reported by Triage Category					
On-Scene Location	**Red (Immediate)**	**Yellow (Delayed)**	**Green (Minimal)**	**Black (Deceased)**	**Total Number of Victims**

Available Transport Units					

Patient Distribution															
ED or Hospital Name															
Capacity (R/Y/G)															
No. of Pts Sent															
ED or Hospital Name															
Capacity (R/Y/G)															
No. of Pts Sent															

MCI Patient Tracking Form (ICS 306)

#	Triage Tag No.	Priority (R/Y/G)	Patient's Primary Injuries	Unit Transporting Pt to ED/Hospital	Time left Scent	Patient Destination
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
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17						
18						
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21						
22						
23						
24						
25						

MCI Patient Tracking Form (ICS 306)

#	Triage Tag No.	Priority (R/Y/G)	Patient's Primary Injuries	Unit Transporting Pt to ED/Hospital	Time left Scent	Patient Destination
26						
27						
28						
29						
30						
31						
32						
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MCI Patient Tracking Form (ICS 306)

#	Triage Tag No.	Priority (R/Y/G)	Patient's Primary Injuries	Unit Transporting Pt to ED/Hospital	Time left Scent	Patient Destination
51						
52						
53						
54						
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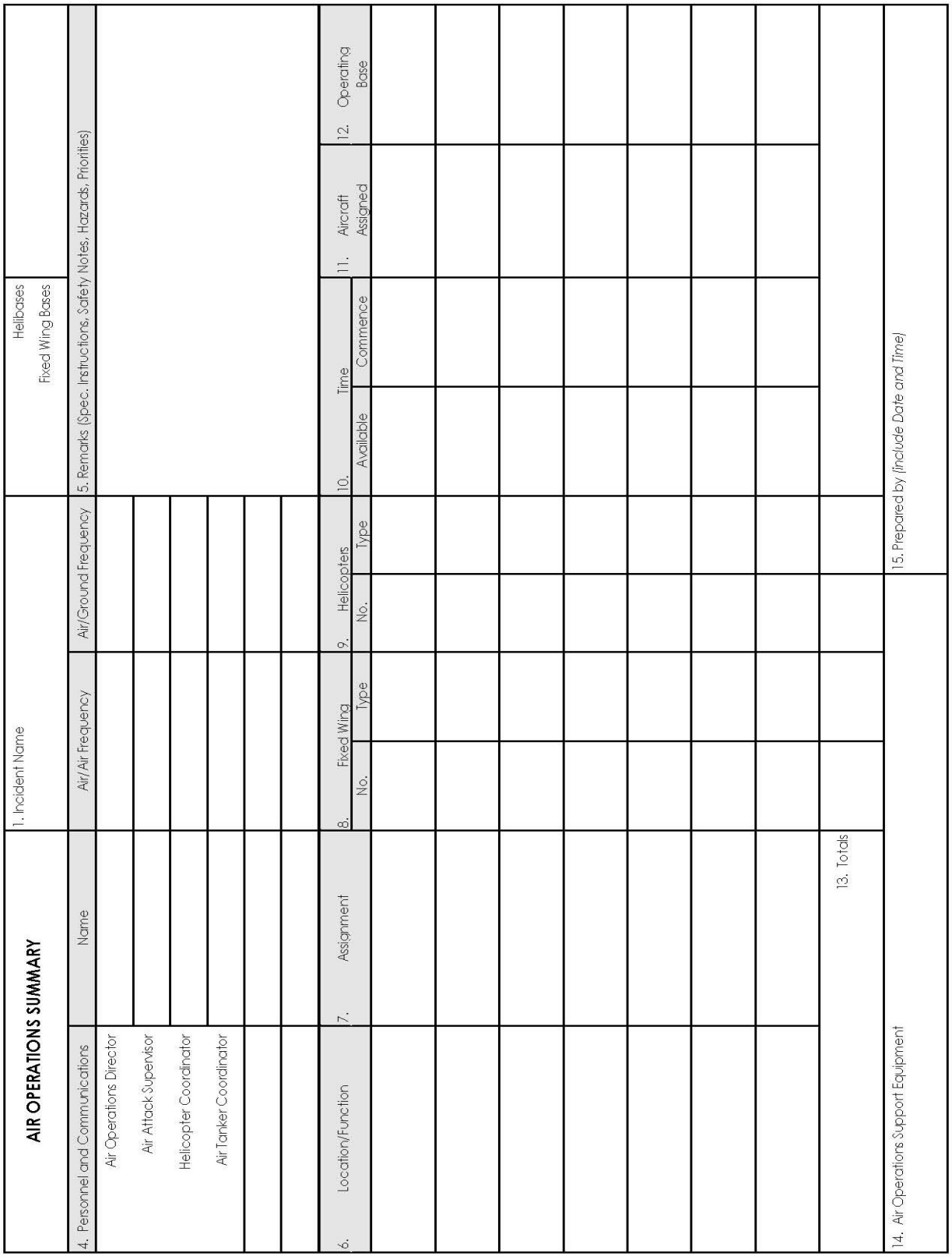
Air Operations Summary Form (ICS 220)



AIR OPERATIONS SUMMARY

1. Incident Name

Helibases
Fixed Wing Bases

4. Personnel and Communications

	Name	Air/Air Frequency	Air/Ground Frequency
Air Operations Director			
Air Attack Supervisor			
Helicopter Coordinator			
Air Tanker Coordinator			

5. Remarks (Spec. Instructions, Safety Notes, Hazards, Priorities)

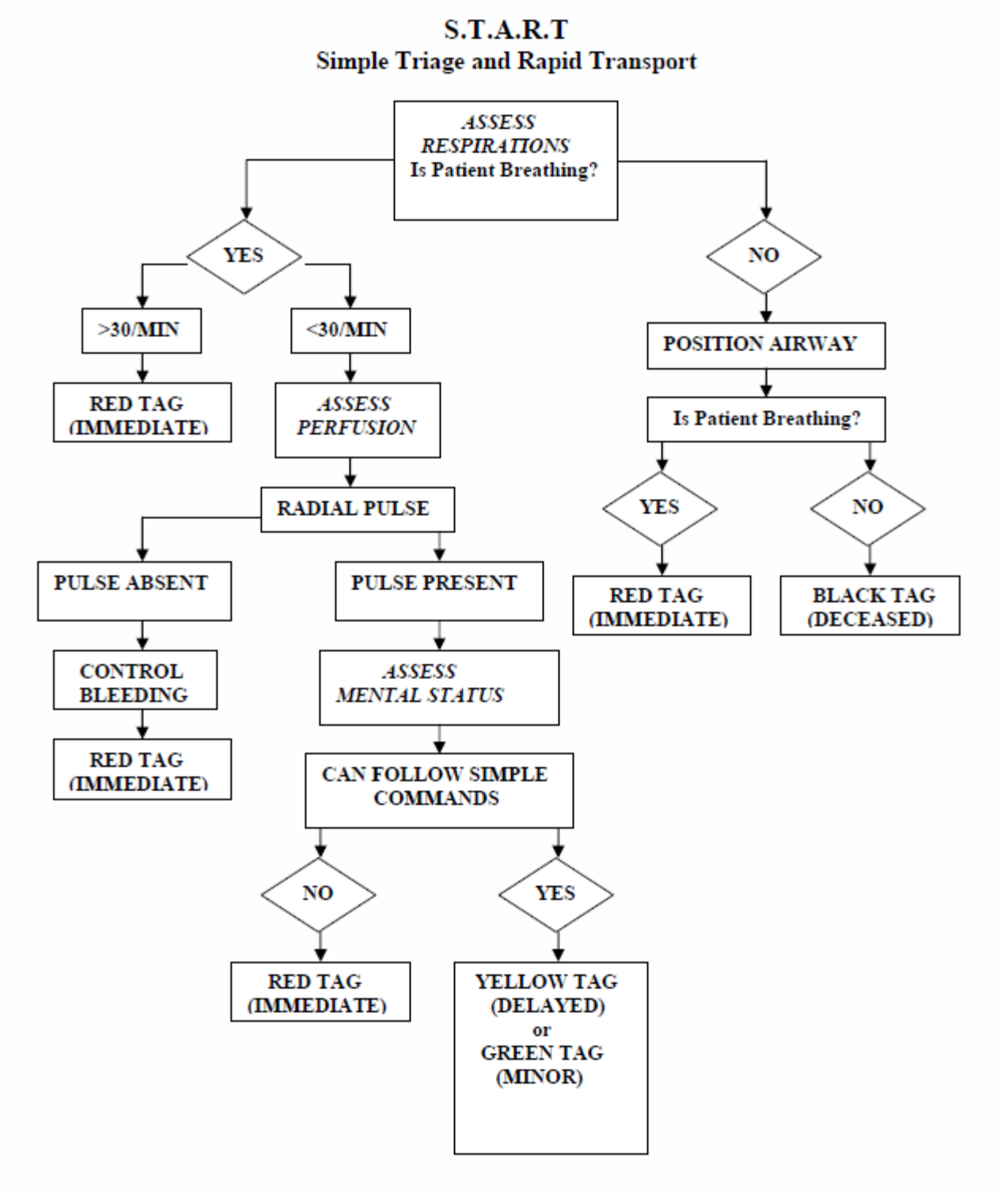
6. Location/Function | 7. Assignment | 8. Fixed Wing (No. / Type) | 9. Helicopters (No. / Type) | 10. Time (Available / Commence) | 11. Aircraft Assigned | 12. Operating Base

13. Totals

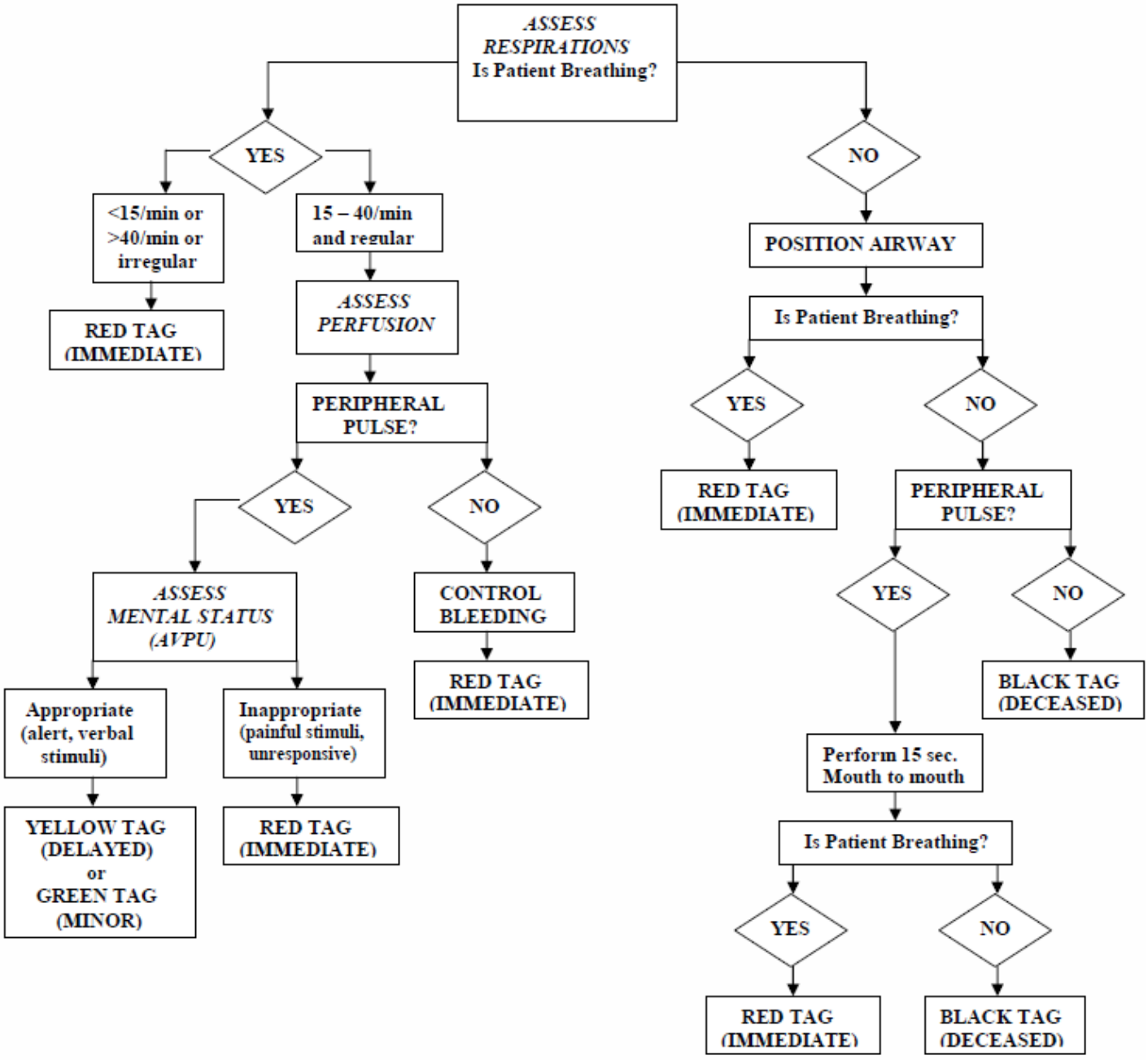
14. Air Operations Support Equipment

15. Prepared by *(include Date and Time)*

START Triage



JumpStart Pediatric Triage



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 **T**riage **A**nd **R**apid **T**reatment) 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, **S**AFETY, **S**URVEY, **S**END, **S**ET-UP AND **S**TART/JumpSTART

Position: Incident Commander

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

Tasks:

□ Assumes command, establishes a visible command post, and announces name and title on radio.

□ Stay in the command post and in contact by radio.

□ Dress in identifying vest.

□ Identify potentially hazardous situations.

□ Assess current situation and provide size-up to Emergency Communications Center.

□ 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)**

□ Initiate, maintain and control communications.

□ Develop an initial strategy (life safety, incident stabilization, and property conservation).

□ Assign ICS functions; assign and direct resources.

□ Track current resources committed.

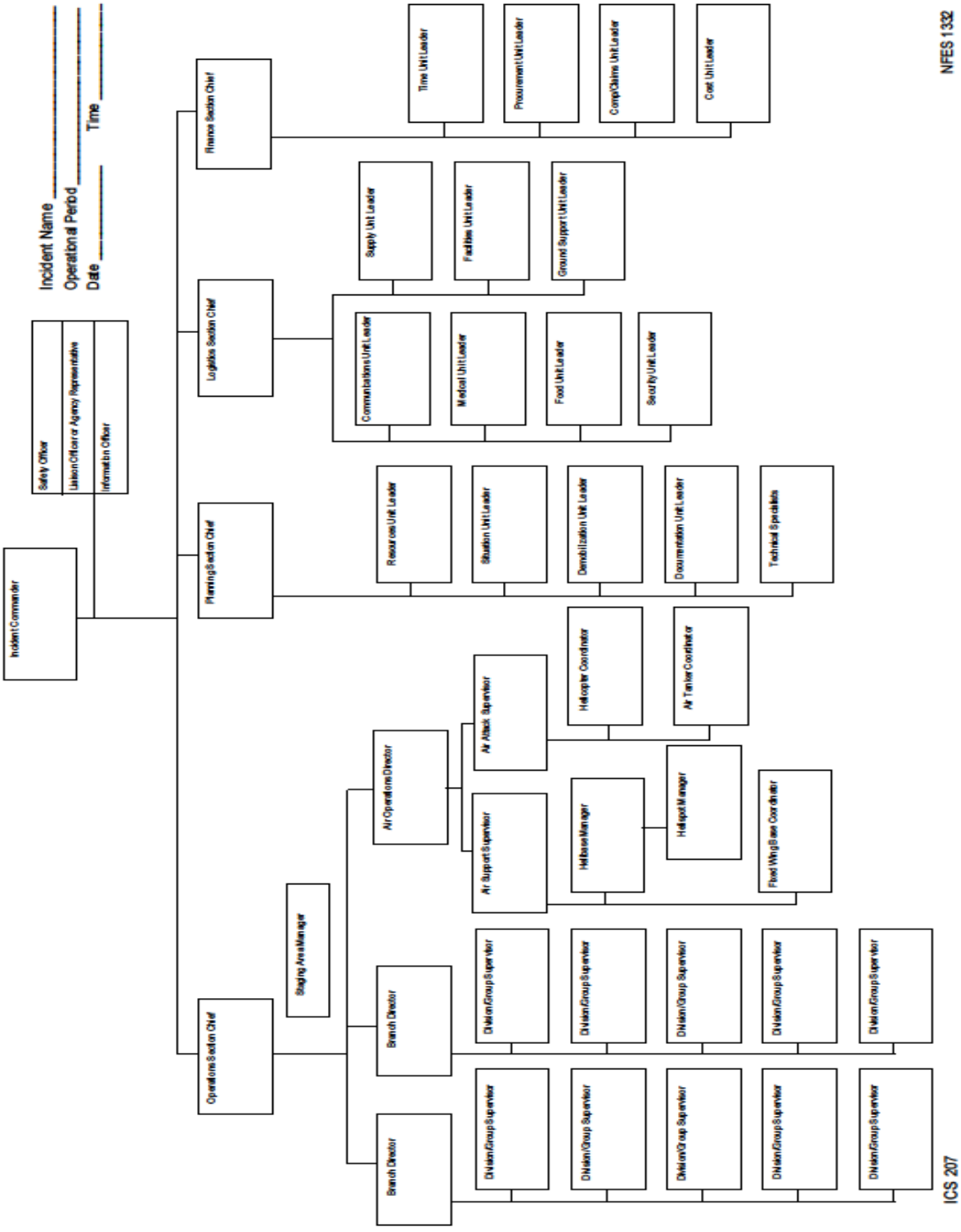
□ Develop, evaluate and revise Incident Action Plan.

□ Coordinate with other agencies.

□ Control and facilitate media.

□ Appoint as needed:

- Operations Section Chief
- Air Operations Branch Director
- Extrication Group Supervisor
- Transportation Group Supervisor
- Triage Unit Leader
- Air/Ground Ambulance Group Supervisor
- Treatment Unit Leader
- Planning Section Chief
- Logistics Section Chief
- Medical Group Supervisor
- Liaison Officer
- Safety Officer
- Public Information Officer


Incident Name
Operational Period
Date
Time
Incident Commander
Safety Officer
Liaison Officer or Agency Representative
Information Officer
Planning Section Chief
Resources Unit Leader
Situation Unit Leader
Demobilization Unit Leader
Documentation Unit Leader
Technical Specialists
Logistics Section Chief
Supply Unit Leader
Facilities Unit Leader
Ground Support Unit Leader
Communications Unit Leader
Medical Unit Leader
Food Unit Leader
Security Unit Leader
Finance Section Chief
Time Unit Leader
Procurement Unit Leader
Comp/Claims Unit Leader
Cost Unit Leader
Operations Section Chief
Staging Area Manager
Air Operations Director
Air Attack Supervisor
Air Support Supervisor
Helicopter Coordinator
Air Tanker Coordinator
Helibase Manager
Helispot Manager
Fixed Wing Base Coordinator
Branch Director
Division/Group Supervisor
Division/Group Supervisor
Division/Group Supervisor
Division/Group Supervisor
Division/Group Supervisor
Branch Director
Division/Group Supervisor
Division/Group Supervisor
Division/Group Supervisor
Division/Group Supervisor
Division/Group Supervisor
NFES 1332
ICS 207

Position: Medical Branch Supervisor Check List

Mission: To ensure 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.

MULTI-CASUALTY BRANCH WORKSHEET

INCIDENT NAME	DATE	TIME
INCIDENT COMMANDER	MULTI-CASUALTY BRANCH DIRECTOR	

MEDICAL GROUP/DIVISION SUPERVISOR

- TREATMENT UNIT LEADER
  - IMMEDIATE TREATMENT MANAGER
    - HOSPITAL TEAM
  - DELAYED TREATMENT MANAGER
    - HOSPITAL TEAM
  - MINOR TREATMENT MANAGER
  - TREATMENT DISPATCH MANAGER
- TRIAGE UNIT LEADER
  - TRIAGE PERSONNEL
  - MORGUE MANAGER
- MEDICAL SUPPLY COORDINATOR

PATIENT TRANSPORTATION GROUP SUPERVISOR

- MEDICAL COMMUNICATIONS COORDINATOR
- AIR AMBULANCE COORDINATOR
- GROUND AMBULANCE COORDINATOR

OTHER

- MEDICAL CACHES
- AIR AMBULANCES
- LAW ENFORCEMENT
- RADIO FREQUENCIES
- CORONER
- RED CROSS
- CHAPLAIN
- BUSES
- MENTAL HEALTH

ICS-MC-305

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.

INCIDENT CHECK-IN LIST	1. Incident Name	2. Check-in Location (complete all that apply)					3. Date/Time
Check one: ☐ Personnel ☐ Engines ☐ Helicopters ☐ Handcrew ☐ Dozers ☐ Aircraft ☐ All ☐ _____ ☐ _____		☐ Base	☐ Camp	☐ Staging Area	☐ ICP Restat	☐ Helibase	

Check-in Information

4. List Personnel (overhead) by Agency & Name - OR - List equipment by the following format: Agency	Single	Kind	Type	I.D. No./Name	5. Order/Request Number	6. Date/Time Check-in	7. Leader's Name	8. Total No. Personnel	9. Manifest Yes	9. Manifest No	10. Crew or Individual's Weight	11. Home Base	12. Departure Point	13. Method of Travel	14. Incident Assignment	15. Other Qualifications	16. Sent to RESTAT Time/Init

Page 1 of	17. Prepared by (Name and Position) *Use back for remarks or comments*

ICS 211 3/2007

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 where the patients lay.

□ 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.

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

□ 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					
Victim Location	**RED**	**YELLOW**	**GREEN**	**BLACK**	**Total No. of Patients By Location**
Total No. of Patients By Triage Category					

Helpful Hints

- Continue START/JumpSTART until all patients have been triaged. Have triage teams work in an orderly fashion. Remind Treatment Area Mangers to perform secondary triage on all patients in their respective section of the treatment areas and to utilize/update the Virginia Triage Tags.
- 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 tag 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.

Treatment Area Patient Count					
Patient Care Area	**RED**	**YELLOW**	**GREEN**	**BLACK**	**Total No. of Patients**
No. of Patients Present					
No. of Pts Sent to Transportation Area					
Total No. of Patients					

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.
□ Continuously triage ALL patients. Remove the triage ribbons once triage tags area applied. *Refer to Secondary Triage Decisions.
□ 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 Mangers

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 are 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 area applied.

Treatment Area Patient Count					
Patient Care Area	**RED**	**YELLOW**	**GREEN**	**BLACK**	**Total No. of Patients**
No. of Patients Present					
No. of Pts Sent to Transportation Area					
Total No. of Patients					

Position: Incident Morgue Area Mangers (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.

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:**_____

No.	Item Description *(Print All Entries)*	Unit*	Amount
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			

*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: _____

Number of Patients Reported by Triage Category					
On-Scene Location	**Red (Immediate)**	**Yellow (Delayed)**	**Green (Minimal)**	**Black (Deceased)**	**Total Number of Victims**

Available Transport Units					

Patient Distribution															
ED or Hospital Name															
Capacity (R/Y/G)															
No. of Pts Sent															
ED or Hospital Name															
Capacity (R/Y/G)															
No. of Pts Sent															

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:

- Inform crews of the destination hospital/Emergency Department.
- Provide travel directions to the receiving hospital/Emergency Department
- 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.
- 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.

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:

- o Type of incident
- o Number of patients
- o 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.

- o Unit transporting
- o Destination hospital
- o Number of patients
- o Triage tag numbers
- o 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 fire unit and personnel and establish a HELISPOT (a.k.a. landing zone.)

□ Secure and maintain a helispot of sufficient size on the firmest 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.

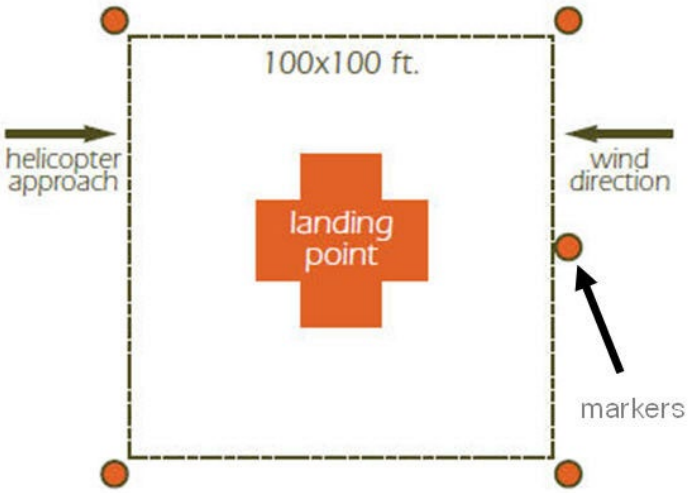
□ Location of any HAZMAT incidents, plume location and direction.

□ 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 - 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 E - Virginia Reportable Disease List

Virginia Reportable Disease List

Reporting of the following diseases is required by state law (§32.1-36 and §32.1-37 of the *Code of Virginia* and 12VAC5-90-80 and 12VAC5-90-90 of the Board of Health *Regulations for Disease Reporting and Control*, 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.

Acquired immunodeficiency syndrome (AIDS)
Amebiasis
I **ANTHRAX**
Arboviral infection (e.g., dengue, EEE, LAC, SLE, WNV)
BOTULISM
I **BRUCELLOSIS**
Campylobacteriosis
Chancroid
Chickenpox (Varicella)
Chlamydia trachomatis infection
I **CHOLERA**
Creutzfeldt-Jakob disease if <55 years of age
Cryptosporidiosis
Cyclosporiasis
I **DIPHTHERIA**
DISEASE CAUSED BY AN AGENT THAT MAY HAVE BEEN USED AS A WEAPON
Ehrlichiosis/Anaplasmosis
^ I *Escherichia coli* infection, Shiga toxin-producing
Giardiasis
Gonorrhea
Granuloma inguinale
I ***HAEMOPHILUS INFLUENZAE* INFECTION, INVASIVE**
Hantavirus pulmonary syndrome
Hemolytic uremic syndrome (HUS)
HEPATITIS A
Hepatitis B (acute and chronic)
Hepatitis C (acute and chronic)
Hepatitis, other acute viral
Human immunodeficiency virus (HIV) infection
Influenza
I (report **INFLUENZA A, NOVEL VIRUS** immediately)
INFLUENZA-ASSOCIATED DEATHS IN CHILDREN <18 YEARS OF AGE
Lead, elevated blood levels
Legionellosis
Leprosy (Hansen disease)
I Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
MEASLES (RUBEOLA)
I **MENINGOCOCCAL DISEASE**
MONKEYPOX
Mumps
MYCOBACTERIAL DISEASES (INCLUDING AFB),
I **(IDENTIFICATION OF ORGANISM) AND DRUG SUSCEPTIBILITY**
Ophthalmia neonatorum
OUTBREAKS, ALL (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, and waterborne)
I **PERTUSSIS**
I **PLAGUE**
I **POLIOVIRUS INFECTION, INCLUDING POLIOMYELITIS**
PSITTACOSIS
I **Q FEVER**
RABIES, HUMAN AND ANIMAL
Rabies treatment, post-exposure
RUBELLA, INCLUDING CONGENITAL RUBELLA SYNDROME
I Salmonellosis
SEVERE ACUTE RESPIRATORY SYNDROME (SARS)
I Shigellosis
SMALLPOX (VARIOLA)
Spotted fever rickettsiosis
Staphylococcus aureus infection,
(invasive methicillin-resistant) and
I (vancomycin-intermediate or vancomycin-resistant)
I Streptococcal disease, Group A, invasive or toxic shock
Streptococcus pneumoniae infection, invasive, in children <5 years of age
Syphilis (report **PRIMARY** and **SECONDARY** immediately)
Tetanus
Toxic substance-related illness
Trichinosis (Trichinellosis)
I **TUBERCULOSIS, ACTIVE DISEASE**
Tuberculosis infection in children <4 years of age
TULAREMIA
I **TYPHOID/PARATYPHOID FEVER**
UNUSUAL OCCURRENCE OF DISEASE OF PUBLIC HEALTH CONCERN
VACCINIA, DISEASE OR ADVERSE EVENT
***VIBRIO* INFECTION**
VIRAL HEMORRHAGIC FEVER
YELLOW FEVER
I Yersiniosis

These conditions are reportable by directors of laboratories. In addition, these and all other conditions except methicillin-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.

I 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) 864-7866 or see 12VAC5-90-150-180 for more information.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
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Annex F – REMS Council Hostile Incident Response Guide

PURPOSE:

Law Enforcement (LE) and Fire & Rescue Departments (FR) must work in a coordinated manner on major incidents to avoid duplication of efforts, ensure mission accomplishment, and provide rapid medical treatment to casualties; which could include our own. Through cooperation and teamwork, we can accomplish these goals. The purpose of this Hostile Incident Guide is to provide emergency responders with a strategic framework during incidents of violence. The framework will assist responding agencies to bridge the gaps in both Law Enforcement terminology and tactical decision making. This document is a GUIDE for first responders and does not supersede local protocols as each jurisdiction within the REMS Council has a different leadership thought on responding to hostile incidents.

TERMINOLOGY:

Hot Zone: An operational area consisting of the immediate incident location with a DIRECT AND IMMEDIATE THREAT TO PERSONAL SAFETY OR HEALTH. All Active Shooter incidents are considered HOT until Law Enforcement determines otherwise. ONLY Law Enforcement operates in the HOT Zone.

Warm Zone: An operational area with a POTENTIAL (indirect) threat to personal safety or health. ONLY life-saving patient treatment will be performed in the WARM Zone with a focus on patient removal.

Cold Zone: An operational are where first responders can operate with MINIMAL threat to personal safety or health. Routine EMS care is provided in the COLD Zone.

Casualty Collection Point (CCP): A forward location where victims can be assembled for movement from areas of risk. Based upon incident dynamics (number and location of patients), multiple CCP's may be required. An ideal location is one with reduced risk to FR and greater access to transportation units. Not all incidents will require a CCP.

Evacuation Corridor: A pathway secured by Law Enforcement for the purpose of accessing and removing patients.

Rescue Task Force (RTF): A team consisting of a minimum of two Fire/EMS personnel in ballistic gear paired with two assigned Law Enforcement Officers. FR personnel are tasked with initial life threating treatments and triage of patients. LE personnel assigned to the RTF are the protection of this team and MAY NOT separate from FR personnel. Due to the size and location of the incident, multiple RTF's maybe assembled. RTF's may operate in the WARM zone and always aware that the WARM zone may turn into a HOT zone. Once treatment and triage is complete, the RTF assists with patient removal or movement.

Extraction Task Force (ETF): A large team of FR personnel pair with a minimum of two LE personnel tasked with rapidly moving patients from a threat area to medical treatment; ideally to ambulances for immediate transport. LE are assigned as ETF force protection and MAY NOT separate from the ETF. FR personnel should wear reflective vests or turnout gear for easy LE identification. This team typically will not have ballistic protection as they only operate in areas that have been already cleared by LE and the RTF. ETFs may operate in the WARM zone for patient movement only. If a CCP has been established, the ETF may take patients there.

Force Protection: Law Enforcement resources assigned to escort, protect, and support FR operations. This will include the RTF and ETF and may include the staging area, CCP, perimeter, etc.

Unified Command: A structure that brings together the "Incident Commanders" of all major organizations involved in the incident in order to coordinate an effective response while at the same time carrying out their own jurisdictional duties and responsibilities. Unified Command may include other agency representatives such as Law Enforcement, Fire Department, Office of Emergency Management, VDOT, FBI, Military, Etc.

RHCC: Regional Healthcare Coordination Center. This facility has contact with all hospitals within the region and works to coordinate availability to ensure patients are distributed rather than overloading one medical facility. FR should handle all communication with RHCC. Keep in mind that victims often will self-transport via POV to nearby emergency facilities. In the past, many hostile incidents involved Law Enforcement transporting patients in their patrol cars.

INCIDENT ACTIONS:

NON-VIOLENT INCIDENTS (Overdose, MVC, Fire)

Many of these incident types involve Law Enforcement response. There may be a need to coordinate an effective response. Unified Command should NOT be established for these types of incidents.

LAW ENFORCEMENT ACTION	FIRE & RESCUE ACTION
• Identify scene supervisor/lead LE Officer • Identify FR Counterpart	• Identify scene supervisor/AIC/Command • Identify LE Counterpart
JOINT ACTION Both agencies meet, exchange information, relay potential hazards, and determine needs for mitigation. Examples: traffic concerns, relay patient life or non-life threat, transport destination.	

EXPLOSION/WEAPONS OF MASS DESTRUCTION INCIDENT

Explosions happen for a variety of reasons, most often NOT from terrorist activity (FBI). However, all responding personnel need to be aware of the possibility of secondary devices and potential for "dirty bombs". Take appropriate precautions, but coordinate to treat injured persons and gain scene/incident control.

LAW ENFORCEMENT ACTION	FIRE & RESCUE ACTION
• Establish perimeter/traffic control • Maintain access route in and out of the scene for emergency vehicles. • Make contact, best if face-to-face, with FR command. • Check for secondary devices. • Perform initial crime scene preservation (as needed).	• FR should NOT stage for LE unless there is an active/known additional threats. Units should respond and take actions based on the situation. • Establish incident command and announce command location. • Establish HOT, WARM, COLD Zones. • Contact Fire Investigator or additional resources as needed.
JOINT ACTION Based on the scale of the incident of belief of criminal involvement, establish Unified Command. In this case, the lead agency will shift based on the greatest incident need (patient care or scene preservation). Anticipate that other Federal agencies maybe involved if this is deemed criminal or terrorist involvement. If non-criminal, FR should remain in command with LE support.	

VIOLENT INCIDENTS EXCLUDING SHOOTINGS (Stabbing, Assault, Riots, etc)

LAW ENFORCEMENT ACTION	FIRE & RESCUE ACTION
• Respond and take appropriate action to address threat. • Remove patients from the HOT zone if direct threat remains. • Determine scene status for responding personnel (HOT, WARM, COLD). • Identify entry point or CCP. • Identify FR contact/ LE OIC.	• STAGE until LE determine scene status. • Establish command. • FR command to report to LE command. • Monitor both LE and FR radios if possible. • Assemble RTF in staging. • WARM scene will deploy an RTF. • COLD scene deploy all routine equipment. • ALL FR personnel should be in reflective vests for easy LE identification.
JOINT ACTION LE and FR command should meet face-to-face when possible to exchange information and determine needs, to include patient condition and transport destination. LE retains command and FR assumes FIRE/EMS Branch.	

HOSTAGE/BARRICADE/SUSPICIOUS DEVICE

LAW ENFORCEMENT ACTION	FIRE & RESCUE ACTION
• Respond and take appropriate action to address threat. • Remove patients from the HOT zone if direct threat remains. • Determine scene status for responding personnel (HOT, WARM, COLD). • Initiate call out	• Stage until LE determines scene status. • Establish Command. • FR IC to report to LE Command Post. • Monitor both LE and LE Radios. • Assemble RTF. • FR personnel in reflective vests.
JOINT ACTIONS Develop a contingency plan to address scene access for EMS/FR if needed, to include LE evacuation, RTF force protection/deployment, and potential need for LZ/Aircraft. LE retains command. FR assumes FIRE/EMS Branches.	

SHOOTING (1-2 victims, no repot of active shooting)

LAW ENFORCEMENT ACTION	FIRE & RESCUE ACTION
• Respond and take appropriate action to address threat. • Remove patients from HOT zone if direct threat remains. • Determine scene status (HOT, WARM, COLD) and identify number of patients and injuries. • Identify entry point or CCP for FR. • Identify FR contact. • Identify if a LE Supervisor is needed.	• Stage until LE determines scene status. • Monitor LE and FR radios. • Establish Command. • If needed, establish RTF in staging. • FR personnel in reflective vests. • Limit crime scene contamination.
JOINT ACTIONS LE and FR should meet face-to-face when possible and exchange information and determine needs, to include patient condition and transport destination. LE retains command. FR assumes FIRE/EMS Branch.	

ACTIVE SHOOTER

Indicators of an active shooting are typically multiple calls to 9-1-1 with consistent details of shooting in progress, multiple victims, and 9-1-1 call takers hearing gunshots. Hoax calls typically involve only one call to 9-1-1 and steps should be taken to confirm the validity of the call, such as callbacks to the location. Schools are beginning to staff School Resource Officers and some Virginia Jurisdictions are allowing teachers to carry firearms in schools.

LAW ENFORCEMENT ACTION	FIRE & RESCUE ACTION
• Primary task- Respond and take appropriate action to address threat. • Establish/secure a safety corridor. • Remove patients from HOT zone if direct threat remains. Establish command and announce command location. • Establish perimeter control and maintain incoming access for emergency personnel. • Determine zones (HOT, WARM, COLD). • Provide current intelligence as to shooter status, patient locations, and estimated number of patients. • Identify FR entry point/CCP. • Identify LE officers to serve as members of the RTF and ETF. • Officers may use TECC kits to render medical care, however the PRIMARY task is to stop the violence.	• Request MCI Alarm. • Notify RHCC • Stage until LE determines scene status. • Establish Command. • Monitor both FR and LE radios. • Fire Command will report to LE command. • Assemble RTFs and ETFs as needed based on patient estimate. • All FR personnel in reflective gear. • RTFs enter WARM zone after command direction. • ETFs enter WARM zone after RTF has completed task and coordinated with command. • Once the scene is COLD, apply MCI procedures.
JOINT ACTIONS Unified Command must be established with commanders co-located. LE should coordinate with LE Command and FR should coordinate with FR Command. LE is lead agency.	