

ANNEX **XX**

Regional Mass Casualty Incident Plan

OF THE

**Western Virginia EMS Council
Blue Ridge EMS Council
Near Southwest Preparedness Alliance**

APPROVAL & IMPLEMENTATION

Annex **XX**

Regional Mass Casualty Incident Plan

This plan is hereby approved for implementation and supersedes all previous editions.

WVEMS Executive Director

Date

WVEMS Board Chair

Date

BREMS Executive Director

Date

BREMS Board Chair

Date

NSPA Executive Director

Date

NSPA Coalition Chair

Date

Regional MCI Plan Committee Chair

Date

RECORD OF CHANGES

Annex **XX**

Regional MCI Plan

Change #	Date of Change	Entered By	Date Entered

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ANNEX XX

REGIONAL MCI PLAN

I. AUTHORITY

A. Regional

The Western Virginia and Blue Ridge EMS Councils represent two of eleven Regional EMS Councils established within the State Code of Virginia, § 32.1-111.11. Created in 1975 and 1976 respectively, WVEMS and BREMS are charged by the code of Virginia "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.

Working in tandem with the Near Southwest Preparedness Alliance, the designated regional healthcare preparedness program coalition comprising both WVEMS and BREMS regions, the three agencies have joined to realize this plan's region wide implementation and ongoing maintenance.

The Board of Directors of these three agencies have assigned this plan to a committee referred to as "The Regional MCI planning committee", hereinafter referred to as the (MCIPC). Furthermore, the respective boards have endorsed the MCIPC to create and fill positions on relevant sub-groups. It is the responsibility of the MCIPC to produce and maintain on an annual basis the regional MCI Plan.

Each Jurisdiction shall develop and implement, as part of their state-mandated Emergency Operations Plan, as Outlined in § 44-146.19, Letter E, a local and/or regional MCI plan to address each type of MCI. This plan should include:

- √ List of local target hazards
- √ Incident/Event hazard analysis for their jurisdiction
- √ Mutual aid agreements and matrix of agency response
- √ The jurisdiction's Emergency Operations Center activation
- √ A list traditional and non-traditional resources
- √ A reference to THIS Regional MCI Plan and the integration and adoption of this plan's concepts when the capabilities of the local plan are exceeded.

The intention of this plan is to serve as a means to draw together localities and community based organizations, namely, Healthcare, to enhance the local MCI plan based on a regional accepted standard.

B. Local

1. Interlocal Agreements and Contracts.

2. Adoption of Plan & Memorandum of Understanding

- a. Participation in the plan shall be through the adoption by the appropriate governing body and signing by an authorized representative of the municipality or agency to the Regional Memorandum of Understanding/Mutual Aid, as most recently revised.
- b. Copies of the Regional MCI Plan shall be provided to each locality and hospital either through WVEMS, BREMS or NSPA. A copy of the plan should be maintained within each Hospital and all licensed EMS commander vehicles. The field guide is maintained and reproduced by WVEMS and BREMS. This field guide is available thru the respective EMS Offices. The MCIPC encourages that all licensed EMS Responders in the regions maintain a copy of the field guide.

Copies of the plan shall be filed by WVEMS and BREMS with the Virginia Office of Emergency Medical Services. NSPA will file a copy of the plan with the Virginia Department of Health and Virginia Hospital & Healthcare Association.

In the case of a hospital, a resolution of adoption shall include an attachment that provides for appropriate adjunctive or emergency privileges to be accorded to attending physicians during an MCI. Required of Joint Commission accredited hospitals – JC Std: EM.02.02.13 EP1-2

II. PURPOSE and SCOPE

A. Purpose

The purpose of this plan is to outline our approach to Mass Casualty Incident Management. It provides general guidance for MCI Management activities and an overview of our methods of mitigation, preparedness, response, and recovery.

The need for regional coordination and a common framework for addressing mass or multi casualty incidents is imperative. In the interest of capitalizing on synergies known to the Blue Ridge EMS Council, Western Virginia EMS Council and Near Southwest Preparedness Alliance, this plan will provide guidance for regional healthcare activities in a mass or multi casualty incident.

This plan, in design, is aimed to ensure an effective utilization of the various human and material resources from various jurisdictions and healthcare agencies involved in a regional mutual aid EMS and Healthcare agency response to a disaster or MCI that affects a part of, or the entire region. This plan aims to support each municipalities Mass casualty plan by providing

for next-level support for incidents in scope and significance that surpass the capabilities addressed in a local plan.

B. Scope

The Blue Ridge EMS Council, Western Virginia EMS Council, and Near Southwest Preparedness Alliance Regional MCI Plan will address the regional response to a mass or multi casualty incident within our region. This plan, in scope, will cover operations for the first two consecutive 12 hour operational periods. This plan will accomplish standard MCI incident levels with common actions and triggering points for each level. It is understood that each hospital and EMS agency has varying capabilities. Each agency will implement this plan at the appropriate level based on the agency's current capabilities. This plan is intended to be an 'All hazards' guide to meet the incidents needs regardless of cause.

This document will provide an overarching framework that will identify resources and guide response. Response guidance will be supported with an operational focused field guide and resource document accessible to field staff. Due to the unique and complex nature of pandemic, non Bio-terrorism events, this plan will not address the EMS Response to pandemics.

III. EXPLANATION OF TERMS

A. Acronyms

BREMS	Blue Ridge EMS Council, Inc.
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive
C-SALTT	Size, Amount, Location, Type, and Time
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOC	Emergency Operations or Operating Center
HazMat	Hazardous Materials
ICP	Incident Command Post
ICS	Incident Command System
MCI	Mass or Multi Casualty Incident
MCIPC	Mass Casualty Incident Planning Committee
MOU	Memorandum of Understanding
NIMS	National Incident Management System
NRF	National Response Framework
NSPA	Near Southwest Preparedness Alliance
OCME	Office of the Chief Medical Examiner
OEMS	The Virginia Office of Emergency Medical Services
PIO	Public Information Officer
RHCC	Regional Healthcare Coordination Center
SOGs	Standard Operating Guidelines
VDH	Virginia Department of Health
VHHA	Virginia Hospital & Healthcare Association
WVEMS	Western Virginia EMS Council, Inc.

B. Definitions

1. Blue Ridge EMS Council. One of 11 non-profit EMS Councils serving the Cities of Lynchburg and Bedford and the Counties of Amherst, Appomattox, Bedford and Campbell
2. C-SALTT. Capability – Size - Amount - Location - Type - Time.
3. Hazardous Materials. Define here.
4. Inter local agreements. Define here.
5. Mass Casualty Incident. 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.
6. 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
7. Near Southwest Preparedness Alliance. Referred to as “NSPA”, this is a consortium of healthcare emergency managers and counterparts working to further prepare the BREMS and WVEMS Regions for healthcare disasters.
8. National Incident Management System: a structured framework used nationwide for both governmental and non-governmental agencies to respond to natural disasters and or terrorist attacks at the local, state, and federal levels of government
9. Regional Healthcare Coordination Center. The Regional Healthcare Coordination Center, or RHCC, is a coordinating entity that is tasked with surveillance and coordinating a defined geographic regions response to a healthcare emergency. The RHCC is a central answering point for healthcare needs and should possess the capabilities to communicate and collaborate with entities in its region and abroad.
10. START & JumpSTART. Define here.
11. VHASS. Virginia Healthcare Alerting and Status System
12. WebEOC. A web based tool that holds “boards” and other methods of messaging and is used broadly in the Emergency Management community to communicate between EOCs, RHCCs, Hospitals, and other entities.

13. Western Virginia EMS Council. One of eleven non-profit EMS Councils supporting the counties of Alleghany, Craig, Botetourt, Floyd, Franklin, Giles, Henry, Montgomery, Roanoke, Patrick, Pittsylvania, and Pulaski; and the cities of Covington, Danville, Martinsville, Radford, Roanoke, and Salem.

IV. SITUATION & ASSUMPTIONS

A. Situation

1. All disasters are considered local. All Virginia jurisdictions are required by the Code of Virginia to have an Emergency Operations Plan (EOP). The EOP for each jurisdiction will delineate the Scope, Jurisdiction and Authority of each entity in their plan. This planning tool is not meant to take the place of the jurisdiction's Emergency Operations Plan. This document is intended to be a supplement to planning already taking place and should be integrated into those efforts. The Regional Mass Casualty Incident Planning Committee, hereinafter referred to as the MCIPC encourages EMS response agencies and hospitals to stay involved with their locality in developing and enhancing the jurisdictional Emergency Operation Plans. The committee also requests EMS response agencies and hospital's staff, to include the emergency department, stay current in the National Incident Management System training.
2. Our area is vulnerable to a number of hazards. These hazards could result in a mass or multiple casualty incidents.
3. Medical and health care facilities that remain in operation after a mass casualty incident and have the necessary utilities and staff could be overwhelmed by the "walking wounded" and seriously injured victims transported to facilities in the aftermath of a disaster.
4. Use of nuclear, chemical, or biological weapons of mass destruction could produce a large number of injuries requiring specialized treatment that could overwhelm the local health and medical system.

B. Assumptions

1. All agencies and other entities and/or jurisdictions will operate during an Incident or Evacuation under the National Incident Management System (NIMS) as endorsed by the MCIPC and taught within the WVEMS, BREMS and NSPA region.
2. In most multiple or mass casualty incidents (MCIs), the following ICS functions/positions should be staffed: incident command, staging area, extrication, triage, treatment and transportation. In a small scale incident, one person may assume more than one function, (i.e., triage and treatment may be done by the same person or transportation and staging may 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. The RHCC and the hospitals involved will interact with and support the Medical Branch as requested by the Unified Command. In multi area events or widespread disaster situations, the RHCC may serve as the Medical branch if requested by Unified Command.

3. The incident command structure will expand or contract as necessary 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.
4. START and JumpSTART Triage criteria will be utilized by pre-hospital EMS and hospital agencies.
5. Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital agencies, state, regional and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning district(s) and related jurisdictions which comprise the region.
6. 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.
7. Jurisdictions and/or other agencies will respond to a mutual aid request from the host locality 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 (ECC) and will not reduce any locality's own EMS response capabilities below established, predetermined levels. Each Locality should outline the acceptable resource allocation in a mutual aid event and maintain that with the ECC.
8. Hospital and pre-hospital components in the region should participate in annual training exercises of the MCI Plan. Inclusion of other healthcare entities, such as LTCs, Behavioral Health, and coordinating entities like the RHCC and VDH is encouraged.
9. 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. When the RHCC is activated, Hospitals affected will report self referring patients, as well as EMS transported patients received, to the RHCC in an effort to create and maintain situational awareness. The Affected hospitals bed capacity should be updated on VHASS as self referrals are received.
10. 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. The coordinating Emergency room will interact with the RHCC to verify bed availability and transport destinations.
11. Predetermined EMS mutual aid responses will be employed by hospital and pre-hospital members when any of the signatory health care facilities must be evacuated under the MCI Plan. Facility evacuations will be coordinated between the jurisdiction having the

authority's Emergency Operations Center, the RHCC, and the affected facility. There are specific considerations that should be accounted for when evacuating a healthcare facility.

12. 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).

V. CONCEPT OF OPERATIONS

A. Objective

The objective of our mass casualty incident plan is to provide resources to the MCI response that will support life safety, incident stabilization, and incident mitigation while doing the greatest amount of good for the greatest number of people.

B. General

- 1) It is our responsibility to protect public health and safety and preserve property by preparing for Mass or Multiple casualty events. We have the primary role in identifying and mitigating hazards, preparing for and responding to, and managing the recovery from a Mass Casualty Incident that affects our community.
- 2) Local government is responsible for organizing, training, and equipping local emergency responders, Healthcare workers and emergency management personnel, providing appropriate emergency facilities, providing suitable warning and communications systems. WVEMS, BREMS, and NSPA, along with the state and federal governments offer programs that provide some assistance with portions of these responsibilities.
- 3) To achieve our objectives, we have adopted this Regional Mass Casualty Incident plan that is both integrated (employs the resources of government, organized volunteer groups, and businesses) and comprehensive (addresses mitigation, preparedness, response, and recovery). This plan is one element of our preparedness activities.
- 4) This plan is based on an all-hazard approach to emergency planning. It addresses general functions that may need to be performed during any Mass Casualty Incident situation and is not a collection of plans for specific types of incidents.
- 5) Managing MCIs can produce significant stressors for responders and the community. CISM Teams comprised of volunteers within the region are available and are encouraged to be used to by agencies for post-incident stress management. These services are free and confidential and free to the emergency services community. Teams for each EMS Council have their own activation

procedures. WVEMS 24/7 Dispatch: 1-888-377-7628; BREMS CISM Team: 434 947 5934 or by email: **Janet Blankenship** [j.blankenship@bedfordcountyva.gov]; **Meg Cosby** [MCosby@depaulfamilyservices.org]-or- [MCosby@depaulcr.org]

- 6) 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, hearing aids, and mobility devices such as walkers and wheel chairs.) These 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.

7) Mass Casualty Incident Management Goals

Manage scarce resources. In a resource limited environment heroic resuscitative efforts are not appropriate. These heroic efforts take too much time, require too many people to perform, and require the use of supplies and equipment that should be used for salvageable patients. In normal day-to-day circumstances four or more providers may work on a single patient. In mass casualty incidents this provider to patient ratio is reversed. Scarce resources management recognizes that you do not have enough providers, equipment, vehicles, or time to provide the normal level of prehospital care. Providers must focus their efforts on salvaging as many patients as possible while waiting for the arrival of additional resources.

Do not relocate the disaster. Do not relocate the incident by transporting all of the patients to one hospital. Providers must use triage to determine patient prioritization for treatment and transport. The first arriving EMS units may never transport a single patient, often it is better to conduct triage, establish the treatment area and wait for more units to arrive and provide patient transportation. In large events, some victims are likely to leave the scene and seek shelter and/or treatment at medical facilities nearby the scene. This is likely to occur before first responders are able to complete the triage process and establish control of the scene. The unexpected patient influx may overwhelm the closest emergency department or affected medical facilities (such as urgent cares and physician offices). It is essential that communications be established with the one or two Emergency Departments closest to the incident scene and the RHCC as quickly as possible. Effective scene to hospital and scene to RHCC communications, combined with triage will ensure that patients will be distributed to the appropriate receiving hospital, in the correct order and quantity.

- 8) Departments and agencies tasked in this plan are expected to develop and keep current standard operating procedures that describe how emergency tasks will be performed. Departments and agencies are charged with ensuring the training and equipment necessary for an appropriate response are in place. WVEMS, BREMS,

and NSPA will support regional training activities and as able, equipment purchases in support of this plan.

- 9) This plan is based upon the concept that the emergency functions that must be performed by many departments or agencies generally parallel some of their normal day-to-day functions. To the extent possible, the same personnel and material resources used for day-to-day activities will be employed during emergency situations. Because personnel and equipment resources are limited, agencies may suspend select routine functions.
- 10) We have adopted the National Incident Management System (NIMS) in accordance with the President's Homeland Security Directive (HSPD)-5.

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C. Operational Guidance

There will be four levels that classify Mass or Multiple casualty incidents within the WVEMS, BREMS and NSPA regions. In utilizing the NIMS typing matrix, the levels move from the most significant and demanding of resources ("Level 1") to the least significant ("Level 4").

1. Levels for MCI Response

MCI Level 4 (up to 15 Ill/Injured Victims) (4-10 HazMat Patients requiring Gross Decon)

Larger agencies may be capable of handling incidents with less than 15 ill or injured patients without implementing the MCI Plan or requesting mutual aid resources. The decision to declare an MCI Level I is left to the Incident Commander. The RHCC should be considered if Patients cannot be accommodated by local hospital.

Resources:

MCI Level 3 (16-30 Ill/Injured Victims) (11-20 HazMat Patients requiring Gross Decon)

An incident producing this number of patients may require additional resources beyond what traditional mutual aid agreements can provide. Additionally, patients in these numbers will tax the healthcare system receiving these patients.

Resources:

MCI Level 2 (31-100 Ill/Injured Victims) (21-40 HazMat Patients requiring Gross Decon)

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 RHCC will be contacted and work collaboratively with Emergency Department MedComs to provide patient placement support for this level.

Resources: Plan activation strongly recommended

MCI Level 1 (101 or more Ill/Injured Victims) (40 or more HazMat Patients requiring Gross Decon)

A medical disaster of this magnitude is considered catastrophic and will require broad support from multiple entities.

The RHCC will be contacted and work collaboratively with Emergency Department MedComs to provide patient placement support for this level.

Resources: Plan activation strongly recommended

2. Initial Response. Our Emergency Medical Services and Fire Services are likely to be the first on the scene of a mass casualty situation. These EMS and Fire officials will initiate Incident command per local protocol. Through a locally defined incident command structure, they will normally take charge and remain in charge of the incident until it is resolved or others who have legal authority to do so assume responsibility. They will seek guidance and direction from our local and regional officials and seek technical assistance from state and federal agencies and industry where appropriate.

3. Implementation of ICS and Triage

- a. The first local emergency responder to arrive at the scene of a potential Mass Casualty Incident will implement the incident command system and serve as the incident commander until relieved by a more senior or more qualified individual.
- b. The State of Virginia, and the WVEMS and BREMS Regions have adopted and trained on the 'START' triage system of patient assessment and scene management. When the incident is deemed a MCI or Multiple Casualty event, START or JumpSTART triage will be initiated by the first arriving, appropriately medically trained units.
- c. The incident commander will establish an incident command post (ICP) and provide an assessment of the situation to local officials, identify response resources required, and direct the on-scene response from the ICP. In most MCIs, a MAC is the most common and acceptable type of Incident Command structure, given the number of agencies involved in mitigation.
- d. Prompt communication of assessment of the MCI and communicating needs is essential. The Incident commander or a designee will assess the situation, and based on the current known or estimated patient count, notify hospitals proximate to the Scene, and if indicated per section 1 "Levels of MCI Response", the RHCC.
- e. Requesting resources and communicating an assessment of the scene will be done through a communications plan (see Attachment 11).
- f. For some types of emergency situations, a specific incident scene may not exist in the initial response phase and the EOC may accomplish initial response actions, such as mobilizing personnel and equipment and issuing precautionary warning to the public. As the potential threat becomes clearer and a specific impact site or sites identified, an incident command post may be established, and direction and control of the response transitioned to the Incident Commander.

4. Source and Use of Resources.

- a. Each agency will use its own resources, all of which meet the requirements for resource management in accordance with the NIMS, to respond to emergency situations. Purchasing supplies and equipment, if necessary, and/or request assistance if the lead agencies resources are insufficient or inappropriate will be requested as follows:

- 1) Summon those resources available to us pursuant to inter-local agreements. See Attachment 10 to this plan, which summarizes the inter-local agreements and identifies the officials authorized to request those resources.
 - 2) Summon emergency service resources that we have contracted for. See Attachment 7.
 - 3) Request Regionally controlled assets through the appropriate entity
 - a) NSPA RHCC may be used to request assets that are owned or known (regional hospital, and other entities). (Attachment 7)
 - b) VDH Medial Reserve Corps can be requested thru the RHCC, or by contacting the VDH Emergency Planner directly for each district (Attachment 1 contact list).
 - c) Chempacks locate at regional hospitals may be requested. Attachment 12 details the request process for each chempack.
 - 4) Request State controlled assets through VDEM (1-800-468-8892)
 - a) VDEM May be use to request assistance from volunteer groups active in disasters.
 - 5) Request assistance from industry or individuals who have resources needed to deal with the emergency situation.
- b. 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.
 - c. Regional mutual aid resources should be requested via the IC/IMT using existing EMS agency, hospital, 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 (VaEOC) by calling 1-800-468-8892.
 - d. When external agencies respond to a MCI in any jurisdiction, they are expected to conform to the guidance and direction provided by the incident commander, which will be in accordance with the NIMS.
 - e. Tracking Resources will be managed by the IMT/IC, or their designee using existing ICS forms (i.e. ICS form 308, ICS form 310, ICS form 312, etc.)
 - f. When indicated, the IC/IMT will establish refueling and emergency vehicle maintenance locations and procedures. Vehicle refueling and emergency maintenance/repairs should be requested using the procedures established by the IC/IMT
 - g. 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. *HOW*

5. Activating the Plan

1. The determination to activate the plan will be made by the on scene designated Incident Commander or designee (i.e. Emergency Communications Center), affected Hospital/Healthcare facility and/or locality EOC.
2. Activation of the plan should occur once the local area has exceeded its capabilities
3. The decision to activate the plan will engage the NSPA RHCC and Regional Healthcare entities, including Hospitals, Long Term Care, Behavioral health, OCME, EMS agencies, etc. Activation of the plan will provide for mutual aid ambulances (and other resources), initiate a bed status update for all 16 NSPA region hospitals, allow for readiness steps to be taken by receiving hospitals, and provide for regional situational awareness.
4. The emergency room(s) closest to the scene will be contacted by EMS and bed availability will be assessed and provided in the Start Triage Categories of Red/Yellow/Green. Once the closest 1 or 2 hospitals have been contacted, EMS and the contacted hospital(s) should weigh the need for contacting the RHCC and the activation of the MCI PLAN. The Hospital, or the EMS Agency may contact the RHCC. The RHCC will alert regional contacts of an MCI. *The RHCC Dispatch center may assist EMS in contacting ERs close to the scene if requested by EMS.*
 - a. SUGGESTED ACTIVATION GUIDANCE: The plan should be activated (By EMS or by Hospital) and the RHCC should be consulted and assist as the regional guide for patient capacity and placement for EMS when any of the below conditions are met:
 - 1) The number of patients requiring transport and definitive medical care requires more than two hospitals be involved
 - 2) Patients will be taken to hospitals out of the state (due to a disaster response only)
 - 3) For any Level 2 or Level 1 (highest acuity) MCI
 - 4) A large portion of the patients exceed the capabilities or the scope of the hospital proximate to the scene (such as complex Trauma, Pediatrics, etc).
 - 5) The scene requires RHCC assistance with resources
 - 6) When multiple, simultaneous incidents are producing patient surge that taxes EMS and local Hospital resources.
 - 7) When a Healthcare facility is evacuating patients
5. Decision to activate: Activation should be accompanied with the assessed level (Section V, Letter C, Bullitt 1.) and an assessment of resources needed. The NSPA RHCC should be notified when the plan is activated by calling 1-866-679-7422, regardless of the need for patient placement support. When Calling, You will be asked the following questions:
 - a. Entity (Locality, Agency, EOC) requesting MCI Plan activation
 - b. Call Back Number
 - c. Radio channel being utilized (Channel Name)
 - d. Tier and if possible, number of Red/Yellow/Green patients
 - e. Needs (Such as patient placement or resources)

- o Please specify to the Dispatcher whether or not you will need patient placement support and the Emergency Room(s) that have already been contacted
 - f. Actions you've taken so far (Such as calling a local Emergency Room, Deploying a MCI trailer, or notifying a neighboring Jurisdiction)
 - g. A brief summary of the incident to include "What happened"
6. *Smaller Level MCI's, such as Level 4 and 3, may not require the activation of this plan or require the support of the RHCC.*

D. Incident Command System (ICS)

1. We intend to employ ICS, an integral part of the NIMS, in managing emergencies. ICS is both a strategy and a set of organizational arrangements for directing and controlling field operations
2. The incident commander is responsible for carrying out the ICS function of command -- managing the incident. The four other major management activities that form the basis of ICS are operations, planning, logistics, and finance/administration. For small-scale incidents, the incident commander and one or two individuals may perform all of these functions. For larger incidents, a number of individuals from different departments or agencies may be assigned to separate staff sections charged with those functions.
3. An incident commander using response resources from one or two departments or agencies can handle the majority of emergency situations. Departments or agencies participating in this type of incident response will normally obtain support through their own department or agency.
4. In emergency situations where other jurisdictions or the region, state or federal government are providing significant response resources or technical assistance, it is generally desirable to transition from the normal ICS structure to a MAC model or Area Command structure. This arrangement helps to ensure that all participating agencies are involved in developing objectives and strategies to deal with the emergency.

E. ICS – EOC - Hospital(s) - RHCC Interface

1. For major emergencies and disasters, the on scene Incident Command, Local Emergency Operations Center (EOC), Affected Hospital EOCs, and the RHCC will be activated. When these entities activate, it is essential to establish a division of responsibilities between these groups, as outlined below. It is essential that a precise division of responsibilities be determined for specific emergency operations.
2. The incident commander is generally responsible for field operations, including:
 - a. Isolating the scene.
 - b. Directing and controlling the on-scene response to the emergency situation and managing the emergency resources committed there.
 - c. Warning the population in the area of the incident and providing emergency instructions to them.

- d. Determining and implementing protective measures (evacuation or in-place sheltering) for the population in the immediate area of the incident and for emergency responders at the scene.
 - e. Implementing traffic control arrangements in and around the incident scene.
 - f. Requesting additional resources from the EOC.
3. The Municipal EOC is generally responsible for:
- a. Providing resource support for the incident command operations.
 - b. Issuing community-wide warning.
 - c. Sharing information with the RHCC and the Hospital EOC(s) involved and providing for a coordinated response.
 - d. Issuing instructions and providing information to the general public.
 - e. Organizing and implementing large-scale evacuation.
 - f. Organizing and implementing shelter and mass arrangements for evacuees.
 - g. Coordinating traffic control for large-scale evacuations.
 - h. Requesting assistance from the State and other external sources.
4. The Hospital(s) involved in a MCI is generally responsible for:
- a. Providing a coordinated response and sharing information with the RHCC, the On Scene Incident Command post, and the EOC(s) involved.
 - b. Communicating information on patient dispositions and transfers for the purposes of family reunification
 - c. Collaborating with the RHCC, On Scene EMS, and the local EOC to assure equal distribution of resources.
 - d. Posting and/or making available Inpatient and ED Bed capacity in a timely manner
 - 1. The Goal is for hospitals to post within 15 minutes of a request
 - 2. The ED may be called by phone in the initial phases of a MCI and it is requested that staff members maintain an awareness of current ED capacity to accept patients.
 - b. Collaborating with the RHCC and On Scene EMS to assure equal distribution of Patients.
 - c. Collaboration with the municipal EOC and the RHCC on facility status and needs
5. The RHCC is generally responsible for:
- a. Serving as the Regional ESF-8 entity for activated EOCs within the NSPA Region.
 - b. Serving as the regional monitor for ESF-8 activities and a conduit for reporting needs and current activities to the State.
 - c. Alerting Regional Contacts affiliated in the VHASS (VHHA-MCI.org) System.
Generally by SMS Text message and Email
 - 1) Regional Contacts include key individuals with Emergency management at each of the 16 regional Hospitals, Municipal EMS and Emergency Management, Long Term Care facilities, and other affiliated agencies.
 - d. *AS REQUESTED* Obtain Bed count (***Immediately***) for the three closest Emergency Rooms proximate to the MCI Scene and best fitting Patient needs / acuity.

- e. Request thru Text Message/Email to Primary Hospital Emergency Management contacts that a status of ED and Inpatient beds be updated for all 16 hospitals in the region.
 - 1) If the incident falls at or near a regional boundary, adjacent region hospitals will be alerted through the RHCC and a bed count obtained.
 - f. Collaborating with involved hospitals, On Scene EMS, and the local EOC to assure equal distribution of patients and resources. The RHCC will support involved hospitals and On Scene EMS in the distribution of patients when requested by hospitals involved or On Scene EMS, and specifically when patients will be distributed beyond the “Local” area hospitals. A good point of reference is when **more than two** hospitals are needed to absorb patients from the scene. There is a list of suggested criteria regarding the involvement of the RHCC in patient placement in (Section V, Letter C, Bullitt 5.)
 - g. If the incident produces large populations of patients with unique or special needs, such as Pediatric, or Burn patients, the RHCC will obtain specialty bed counts for medical centers outside the region and in other states (as needed).
 - h. Respond to requests for assistance as the incident matures.
 - i. Support large-scale evacuation and mass healthcare operations
 - j. Deploy, as available, resources managed by NSPA to competent and approved entities. A list of resources is available in the Resource attachment 7
 - k. Support the activities of the Office of the Chief Medical Examiner, and the needs of Hospitals with expanded morgue capacity thru the use of Mobile Morgue assets.
 - l. As Needed, Support interoperable communications thru the creation of radio patches and message relay from response entities thru maintained communications systems
6. In some large-scale emergencies or disasters, emergency operations with different objectives may be conducted at geographically separated scenes. In such situations, more than one incident command operation may be established. If this situation occurs, a transition to an Area Command or a Unified Area Command is desirable, and the allocation of resources to specific field operations will be coordinated through the EOC. The RHCC will be the Area commands point of contact for Health and Medical incidents until such time as more than two RHCCs have been involved in the incident. At that time, the State ESF-8 Desk and State HCC will be integrated in the response. The first contacted RHCC will remain the point of contact for escalation and support from other RHCCs and the state HCC.

F. State Assistance

- 1. State Assistance
 - a. If local and regional resources are inadequate to deal with an emergency situation, the municipality leading the response will request assistance from the State. State assistance furnished to local governments is intended to supplement local resources

and not substitute for such resources, including mutual aid resources, equipment purchases or leases, or resources covered by emergency service contracts.

G. Emergency Authorities

1. Key federal, state, and local legal authorities pertaining to emergency management are listed in Section I of this plan.
2. Virginia statutes and the Executive Order of the Governor Relating to Emergency Management provide local government, principally the chief elected official, with a number of powers to control emergency situations. If necessary, the locality involved shall use these powers during emergency situations. These powers include:
 - a. Disaster Declaration. When an emergency situation has caused severe damage, injury, or loss of life or it appears likely to do so, the [County administrator] may by executive order or proclamation declare a local state of disaster.

H. Actions by Phases of Emergency Management

1. This plan addresses emergency actions that are conducted during all four phases of emergency management.

a. Mitigation

While it is virtually impossible to identify and mitigate all of the causes of MCI events, participants will participate in training activities, such as Drills and full scale exercises. Training is an integral part in a successful MCI response. Mitigation should be a pre-disaster activity, although mitigation may also occur in the aftermath of an emergency situation with the intent of avoiding repetition of the situation.

b. Preparedness

We will conduct preparedness activities to develop the response capabilities needed in the event an emergency. Among the preparedness activities included in our emergency management program are:

- 1) Providing emergency equipment and facilities.
- 2) Emergency planning, including maintaining this plan, its annexes, and appropriate SOPs.
- 3) Conducting or arranging appropriate training for emergency responders, emergency management personnel, other local officials, and volunteer groups who assist us during emergencies.
- 4) Conducting periodic drills and exercises to test our plans and training.

c. Response

We will respond to emergency situations effectively and efficiently. The focus of most of this plan and its annexes is on planning for the response to emergencies. Response operations are intended to resolve an emergency situation while minimizing casualties. Response activities specific to MCIs can include the

following: warning, emergency medical services, firefighting, law enforcement operations, evacuation, shelter and mass care, emergency public information, search and rescue, as well as other associated functions.

d. Recovery

If a disaster occurs, we will carry out a recovery program that involves both short-term and long-term efforts. Short-term operations seek to restore vital services to the community and provide for the basic needs of the public, like ensuring the restoration of EMS capability to respond to calls. Long-term recovery focuses on restoring the community to its normal state.

VI. ORGANIZATION & ASSIGNMENT RESPONSIBILITIES

A. Organization

1. Most departments and agencies of local government have emergency functions in addition to their normal day-to-day duties. During emergency situations, our normal organizational arrangements are modified to facilitate emergency operations

B. Assignment of Responsibilities

1. General

For most emergency functions, successful operations require a coordinated effort from a number of departments, agencies, and groups. The municipality where the MCI takes place will be the lead responder and incident command entity. To facilitate a coordinated effort the municipality will provide clear guidelines regarding emergency authority on MCI incidents. Usually, this authority is clearly outlined in the Municipalities emergency operations plan. Generally, primary responsibility for an emergency function will be assigned to an individual from the department or agency that has legal responsibility for that function or possesses the most appropriate knowledge and skills. Other officials, departments, and agencies may be assigned support responsibilities for specific emergency functions. Attachment 4 summarizes the general emergency responsibilities of local officials, department and agency heads, and other personnel.

All agencies/organizations assigned to provide health and medical services support are responsible for the following:

- a. Designating and training representatives of their agency, to include NIMS and ICS training.
- b. Ensuring that appropriate SOPs are developed and maintained.
- c. Maintaining current notification procedures to insure trained personnel are available for extended emergency duty in the EOC and in the field.

2. EMS, Hospital, RHCC, Locality Responsibilities

A. EMS Initial Actions and responsibilities:

- a. First Arriving Unit Responsibilities: It is the responsibility of the first arriving unit to establish command and to perform the initial scene size-up using what is known as the “5-S’s and reporting the information to their dispatcher. The “5-S’s” are:
 - i. SAFETY assessment: Assess the scene for safety by looking for:
 - ✓ Electrical hazards.
 - ✓ Flammable liquids.
 - ✓ Hazardous Materials
 - ✓ Other life threatening situations.
 - ✓ The potential for secondary explosive devices or other security threats.
 - ii. SIZE UP the scene: How big and how bad is it? Survey the 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.
 - iii. SEND information:
 - ✓ Contact dispatch with your size-up information.
 - ✓ Request additional resources.
 - ✓ Notify the closest hospital.
 - iv. SETUP the scene for management of the casualties:
 - ✓ Establish the staging area.
 - ✓ Identify access and egress routes.
 - ✓ Identify adequate work areas for Triage, Treatment, and Transportation.
 - v. START Triage: Triage all patients using Simple Triage and Rapid Treatment (START) and Jump START triage methods as appropriate. (The triage algorithms may be found in Chapter 4 of this document.)
 - ✓ Begin where you are standing.
 - ✓ 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 including a record of casualties and transport destinations
 - ✓ Provide only minimal treatment.
 - ✓ Keep moving!
- b. The First Unit On-Scene size-up position check list is located in attachment x of this document.
- c. All ambulances and emergency rescue vehicles serving in our region will be equipped with Virginia Field Triage Tags and shall contain at all times, those essential items as specified by the VDH/WVEMS/BREMS Councils.

- d. Emergency Department/Hospital and RHCC Notification. It is vital that the First Arriving contact the closest one or two Emergency Departments and inform the facility that there is a MCI in progress. The EDs contacted will report Capacity utilizing the START Triage Categories “Red, Yellow, and Green”. EMS or the Hospital will then notify the RHCC if it is necessary.
 - i. Each of these notifications should include the nature or apparent cause of the event, the estimated number of victims, and whether or not the victims may be contaminated.
- e. Establishing Incident Command. The senior crewmember on the first arriving unit becomes the Incident Commander and reports that they established command to their dispatcher. This person will remain in charge until command is transferred to a higher authority.
- f. Once capacity numbers have been obtained for the closest one or two Emergency Departments, EMS can start making transports to said hospitals.
- g. When activated, the RHCC or the RHCC Dispatch center will update EMS on additional facilities bed capacity and make transport recommendations when more than two EDs are needed to absorb the patients generated from the MCI
- h. Upon the establishment of a Triage / Transport Officer, all ambulance service personnel will place themselves at his/her disposal and will follow their directions in regard to casualty movement.
- i. The Triage / Transport Officer, during the course of the disaster, will provide the ambulance personnel with information relative to situation and/or existing capabilities at the various medical treatment facilities.
- j. Request Additional Resources. If the emergency situation warrants, the Operations Chief (or another appropriate designee) will request, through the Incident Commander, additional ambulances. The Incident Commander’s request for additional resources should be accompanied by the identification of the incident Staging Area(s).

B. Hospitals/Healthcare Facilities

- a. Initiate assessment of Emergency Room and Inpatient bed capacity and report that capacity to requesting On Scene EMS and to the RHCC via VHASS.
- b. Implement internal and/or external disaster plans.
- c. Provide for the security of facility and monitor for self-presenting patients
- d. Report patient arrivals to incident command or, if activated, to the RHCC
- e. Continually re-assess bed capacity and evaluation for ability to continue to accept patients.
 - i. Notify the RHCC and On Scene incident command if you are no longer able to accept patients (EMS DIVERSION). If you require diversion declaration assistance, tell the RHCC when notifying.

- f. Monitor status and count of critical medical supplies necessary for sustained operations. Consider requesting additional supplies to be deployed as needed (RHCC or local EOC).
- g. Consider requesting police / security support thru the local EOC
- h. Establish and staff a reception and support center at each hospital for relatives and friends of disaster victims searching for their loved ones.
- i. Report names of received victims to the FAC if activated. This may be done thru the RHCC. If a FAC is not activated (or an RHCC not activated) Share this information with local emergency management PIO, the EOC, or Command (depending on accessibility)
- j. Coordinate with local emergency responders to isolate and decontaminate incoming patients, if needed, to avoid the spread of chemical or bacterial agents to other patients and staff.
- k.

C. Regional healthcare Coordination Center (RHCC) Dispatch Center

- a. Receive call for assistance
- b. Ask standard questions (Section V, Letter E, Bullitt 5.)
- c. Clarify if bed status for upto three closest hospitals is needed
- d. Send SMS text alert to RHCC ICT
 - i. Monitor for Incident commander call back and initiate a phone tree if no response within 5 minutes
- e. Upon IC call back, provide a brief report of known incident, immediate needs, actions taken, and overall status of regional assets.
- f. Carry out actions per direction of IC
- g. Prepare Main RHCC (physical space) for occupancy if instructed per IC
- h. Maintain contact with RHCC ICT thru Radio, phone, or WebEOC

D. Regional healthcare Coordination Center (RHCC) Incident Command team

- a. Receive notification of incident (or potential incident)
- b. Assess situation based on information available and determine Tier for RHCC Response
- c. Alerting Regional Contacts affiliated in the VHASS (VHHA-MCI.org) System. *Generally by SMS Text message and Email*
 - 1) Regional Contacts include key individuals with Emergency management at each of the 16 regional Hospitals, Municipal EMS and Emergency Management, Long Term Care facilities, and other affiliated agencies.
- d. Initiate Tier specific actions per protocol
- e. Obtain a Bed count for regional hospitals via SMS Text Message alert sent to regional contacts in VHASS
- f. Place follow-up phone calls to facilities who have not posted status.
- g. Establish a WebEOC Event and post a SitREP based on known information
- h. Monitor radio channels and email for updates from response entities
- i. For MCI Level Two and One, transmit a SitRep to the state including known Injured and fatality count.
- j. Collaborating with involved hospitals, On Scene EMS, and the local EOC to assure equal distribution of patients and resources. Ensure check-back to hospitals proximate to the Scene to verify status.
- k. Escalate incident to additional RHCCs when the incident occurs on or near a geographic boundary. Request specific hospital status updates.

- l. Request bed count for specialty centers (Burn, Pediatric, Neuro, Trauma, hyperbaric chamber, etc) when the nature of the incident mechanism can produce patients of a specialty nature.
- m. Respond to requests for assistance as the incident matures.
- n. Support large-scale evacuation and mass healthcare operations
- o. Deploy NSPA Resources as available and as requested
- o. Create radio patches to support inter-operable communication as requested.
- p. Coordinate efforts of local health and medical organizations activated for an emergency assessing their needs, obtain additional resources, and ensure that necessary services are provided.

E. The Mental Health Authority will:

Ensure appropriate mental health services are available for disaster victims, survivors, bystanders, responders and their families, and other community caregivers during response and recovery operations. The request to deploy Mental Health services will come from the:

- Local EOC
- Hospital(s) involved
- RHCC (on behalf of an aforementioned entity)

F. Law Enforcement will:

- a. Upon request, provide security for medical facilities.
- b. Conduct investigations of deaths not due to natural causes.
- c. Locate and notify next of kin.

G. Public Information.

- a. Primary responsibility for this function is assigned to the locality leading the response. A common message is essential, and Annex I (Public Information) provides guidance on the collaboration between PIOs.
- b. Emergency tasks to be performed include:
 - (1) Establish a Joint Information Center (JIC) when indicated by the scope of the incident.
 - (2) Pursuant to the Joint Information System (JIS), compile and release information and instructions for the public during emergency situations and respond to questions relating to emergency operations.
 - (3) Utilize WebEOC or Email distribution groups to share and collaborate on common message between PIOs involved in the incident.
 - (4) Provide information to the media and the public during emergency situations.
 - (5) Arrange for media briefings.
 - (6) Compiles print and photo documentation of emergency situations.

3. Recovery / Post-Incident

- 1) Primary responsibility for this function is assigned to the Locality leading the response.
- 2) Emergency tasks to be performed include:

- a) Evaluate the need for Counseling and bereavement coordination.
- b) Enact a Family Assistance Center
- c) Assess and compile information on damage to public and private property and needs of disaster victims.

4. The Health Regional District of the Virginia Department of Health will coordinate:

- c. Public health and medical activities as requested by the local EOC
- d. Rapid assessments of health and medical needs in collaboration with the RHCC.
- e. Support ESAR VHP activities as requested.
- f. Monitor situation for public health concerns and communicate identified issues to local EOC
- g. Collaborate with the lead PIO on casualties and instructions to the public on dealing with public health problems.
- h. The provision of laboratory services required in support of emergency health and medical services.
- i. Immunization campaigns or quarantines, if required.
- j. As applicable Inspections of foodstuffs, water, drugs, and other consumables that were exposed to the hazard.
- k. Implementation of measures to prevent or control disease vectors such as flies, mosquitoes, and rodents.
- l. Preventive health services, including the control of communicable diseases such as influenza, particularly in shelters.
- m. Food handling and sanitation monitoring in emergency facilities.

5. Mortuary Services, Regional/State/Federal Teams

A. Mortuary Services

- 1) Law enforcement is responsible for investigating deaths that are not due to natural causes or that do not occur in the presence of an attending physician. The office of the chief medical examiner and the local Medical Examiner are responsible for determining cause of death, authorization of autopsies to determine the cause of death, forensic investigations to identify unidentified bodies, and removal of bodies from incident sites.
- 2) When it appears an incident involves fatalities, the Incident Commander shall request the Emergency communications Center make notifications to the Medical Examiner and law enforcement requesting a response to the scene.
- 3) Law enforcement or and the Medical Examiner shall arrange for the transportation of bodies requiring autopsy or identification to morgues or suitable examination facilities. When mass fatalities have occurred, it may be necessary to establish a temporary morgue and holding facilities. Additional mortuary service assistance may be required.

B. Medical and Mortuary Assistance

- 1) Virginia Department of Health (VDH). When requested by local officials, the VDH can provide health and medical advice and assistance during emergency situations from its various regional offices.

C. Disaster Medical Assistance Team (DMAT)

DMAT is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved. DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site. To supplement the standard DMATs, there are highly specialized DMATs that deal with specific medical conditions such as crush injury, burn, and mental health emergencies.

In mass casualty incidents, their responsibilities may include triaging patients, providing high-quality medical care despite the adverse and austere environment often found at a disaster site, and preparing patients for evacuation. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved.

D. Disaster Mortuary Operational Response Teams (DMORT)

DMORTs provide victim identification and mortuary services. These responsibilities include: temporary morgue facilities; victim identification, forensic dental pathology, forensic anthropology methods, processing preparation, and disposition of remains.

DMORTs are composed of funeral directors, medical examiners, coroners, pathologists, forensic anthropologists, medical records technicians and scribes, finger print specialists, forensic odontologists, dental assistants, x-ray technicians, mental health specialists, computer professionals, administrative support staff, and security and investigative personnel.

The DMORT provides mortuary and victim identification services following major or catastrophic disasters. The team is comprised of volunteer professionals from the mortuary and funeral industries.

5. Volunteer and Other Services

This group includes organized volunteer groups and businesses that have agreed to provide certain support for emergency operations. *The Medical Reserve corps is considered a state supported agency and is listed in Section 4.

VII. DIRECTION & CONTROL

A. General

1. The localities Public Safety entity shall direct and coordinate the efforts of local emergency medical services and agencies, and other response organizations during the field response portion of major emergencies and disasters requiring.
2. Hospitals and LTC facilities will maintain an EOC and internal command structures based on incident needs.
3. Command and coordination entities (EOCs, On Scene Command, RHCCs, Etc) will work together in mitigating the incident.
4. Each participating entity will work under the immediate control of their own supervisors. Supervisors will conform to the incident command system for the location they are working under.

VIII. READINESS LEVELS

Readiness levels have no correlation to MCI Levels or RHCC Tiers. These levels simply provide guidance to localities and regional entities on preparedness steps that can be taken in advance of known events, such as mass gatherings, as well as weather related warnings.

A. Level IV: Normal Conditions

1. Review and update plans and related SOPs.
2. Review assignment of all personnel.
3. Coordinate with local private industries on related activities.
4. Maintain a list of health & medical resources
5. Maintain and periodically test equipment.
6. Conduct appropriate training, drills, and exercises.
7. Develop tentative task assignments and identify potential resource shortfalls.
8. Establish a liaison with all private health & medical facilities.

B. Level III: Increased Readiness:

1. Check readiness of health and medical equipment, supplies, and facilities.
2. Correct any deficiencies in equipment and facilities.
3. Check readiness of equipment, supplies, and facilities.
4. Correct shortages of essential supplies and equipment.
5. Update incident notification and staff recall rosters.
6. Notify key personnel of possible emergency operations.
7. Review procedures for relocating patients and determine the availability of required specialized equipment if evacuation of health & medical facilities may be required.

C. Level II: High Readiness:

1. Alert personnel to the possibility of emergency duty.
2. Place selected personnel and equipment on standby.
3. Identify personnel to staff the EOC and ICP if those facilities are activated.

D. Level I: Maximum Readiness:

1. Mobilize health and medical resources to include personnel and equipment.
2. Dispatch health and medical representative(s) to the EOC when activated.

IX. ADMINISTRATION & SUPPORT

A. Reporting

1. In addition to reports that may be required by their parent organizations, health & medical elements participating in emergency operations should provide appropriate situation reports to the Incident Commander, or if an incident command operation has not been established, to the Health Officer in the EOC. The Incident Commander will forward periodic reports to the EOC.
2. Pertinent information from all sources will be incorporated into the Initial Emergency Report and the periodic Situation Report that is prepared and disseminated to key officials, other affected jurisdictions, and state agencies during major emergency operations.

B. Maintenance and Preservation of Records

1. Maintenance of Records. Health and medical operational records generated during an emergency will be collected and filed in an orderly manner. A record of events must be preserved for use in determining the possible recovery of emergency operations expenses, response costs, settling claims, assessing the effectiveness of operations, and updating emergency plans and procedures.
2. Documentation of Costs. Expenses incurred in carrying out health and medical services for certain hazards, such as radiological accidents or hazardous materials incidents, may be recoverable from the responsible party. Hence, all departments and agencies will maintain records of personnel and equipment used and supplies consumed during large-scale health and medical operations.
3. Preservation of Records. Vital health & medical records should be protected from the effects of a disaster to the maximum extent possible. Should records be damaged during an emergency situation, professional assistance for preserving and restoring those records should be obtained as soon as possible.

C. Post Incident Review

For large-scale emergencies and disasters, the locality emergency manager, in cooperation with designees from WVEMS, BREMS, and NSPA shall organize and conduct a review of

emergency operations. The purpose of this review is to identify needed improvements in this annex, procedures, facilities, and equipment. Health and medical services that participated in the emergency operations being reviewed should participate in the post-incident review.

D. Exercises

Local drills, tabletop exercises, functional exercises, and full-scale exercises based on the hazards faced by our [county/city] will periodically include health and medical services operations. Additional drills and exercises may be conducted by various agencies and services for the purpose of developing and testing abilities to make effective health and medical response to various types of emergencies.

E. Resources

1. A list of local health & medical facilities is provided in Attachment 1.
2. A list of deployable health and medical response resources is provided in Annex M, Resource Management.

X. ANNEX DEVELOPMENT & MAINTENANCE

A. Plan Development

The WVEMS, BREMS, and NSPA is responsible for approving and promulgating this MCI Annex.

B. Distribution of Planning Documents

1. The MCIPC shall determine the distribution of this plan and its attachments. In general, copies of plans and attachments should be distributed to those individuals, departments, agencies, and organizations tasked in this document. Copies should also be set-aside for the EOC and other emergency facilities.

C. Review

This MCI Annex shall be reviewed annually by the Regional MCI Planning team. The Regional MCI Planning Team will establish a schedule for annual review of planning documents by those tasked in them. The schedule for annual review will be approved by WVEMS, BREMS, and NSPA

D. Update

1. This plan will be updated based upon deficiencies identified during actual emergency situations and exercises and when changes in threat hazards, resources and capabilities, or government structure occur.
2. This MCI annex must be revised or updated by a formal change at least once every year. Responsibility for revising or updating this MCI annex is assigned to the MCIPC. Responsibility for revising or updating the annexes to this plan is outlined in Section VI.B, Assignment of Responsibilities, as well as in each attachment.

- 3. Revised or updated planning documents will be provided to all departments, agencies, and individuals tasked in those documents.

XI. REFERENCES

A.

XI. ATTACHMENTS

- Attachment 1 Local Health & Medical Facilities contact page
- Attachment 2 START and JUMP Start Triage Algorithms
- Attachment 3 Field Triage Guide
- Attachment 4 Scene setup guide for MCI Incidents
- Attachment 5 MCI Tactical Worksheets
- Attachment 6 VHHA-MCI.org Guidelines for accounts
- Attachment 7 Resource Guide
- Attachment 8 Hospital Direction and Information page
- Attachment 9 Municipal Information page
- Attachment 10 Field Guide for MCIs
- Attachment 11 Communications Plan
- Attachment 12 Chempack Information Guide

ATTACHMENT 1

LOCAL HEALTH & MEDICAL FACILITIES LISTING

1. Hospitals

Organization Name	Address 1	City	Zipcode	Main Phone	24H Phone	Trauma Designation
Near Southwest						
Southern Virginia Mental Health Institute	382 Taylor Drive	Danville	24541	(434) 799-6220	(434) 773-4250	None
Veterans Affairs Medical Center -- Salem	1970 Roanoke Blvd.	Salem	24153	(540) 982-2463 2173	(540) 982-2463 2667	None
Virginia Baptist Hospital	Virginia Baptist Hospital	Lynchburg	24503	(434) 200-4000 3135	(434) 200-3211 3156	None
Catawba Hospital	5525 Catawba Hospital Dr.	Catawba	24070	(540) 375-4200	(540) 375-4711	None
Bedford Memorial Hospital	1613 Oakwood Street	Bedford	24523	(540) 586-2441	(540) 586-2441	None
Memorial Hospital of Martinsville & Henry Co	320 Hospital Dr	Martinsville	24112	(276) 666-7200	(276) 666-7200	None
LewisGale Hospital - Montgomery	3700 South Main Street	Blacksburg	24060	(540) 951-1111	(540) 953-5112	Level 3
LewisGale Hospital - Pulaski	2400 Lee Highway	Pulaski	24382	(540) 994-8100	(540) 994-8100	None
Pioneer Community Hospital	18688 Jeb Stuart Highway	Stuart	24171	(276) 694-8600	(276) 694-8600	None
Danville Regional Medical Center	142 South Main Street	Danville	24541	(434) 799-2100	(434) 799-2100	None
LewisGale Medical Center	1900 Electric Rd.	Salem	24153	(540) 776-4000	(540) 776-4000	None
Lynchburg General Hospital	Lynchburg General Hospital	Lynchburg	24501	(434) 200-3000	(434) 200-3000 3135	Level 2
LewisGale Hospital - Alleghany	One ARH Lane	Low Moor	24457	(540) 862-6011	(540) 862-6011	None
Carilion Franklin Memorial Hospital	180 Floyd Avenue	Rocky Mount	24151	(540) 483-5277	(540) 483-5277	None
Carilion Giles Community Hospital	159 Hartley Way	Pearisburg	24134	(540) 921-6000	(540) 921-6000	None
Carilion New River Valley Medical Center	2900 Tyler Road	Christianburg	24073	(540) 731-2000	(540) 731-2000	Level 3
Carilion Medical Center (CRMH and CRCH)	1906 Belleview Ave	Roanoke	24014	(540) 981-7000	(540) 981-7140	Level 1

2. Clinics

3. Nursing Homes

Facility	Phone	Address	City	Zip
Abingdon Place of Danville	(434) 799-1930	149 Executive Court,	Danville	24541
Autumn Care of Altavista	(804) 369-6651	1317 Lola Avenue,	Altavista	24517
Avante at Lynchburg	(434) 846-8437	2081 Langhorne Road	Lynchburg	24501
Avante at Roanoke	(540) 345-8139	324 King George Avenue, Southwest	Roanoke	24016
B&B Adult svc., Inc. DBA Covington Manor I	(540) 962-4967	4401 Midland Trail,	Covington	24426
Bedford County Nursing Home	(540) 586-7658	1229 County Farm Road	Bedford	24523
Bentley Commons at Lynchburg	(434) 316-0207	1604 Graves Mill Road,	Lynchburg	24501
Berkshire Healthcare Center, The	(540) 982-6691	705 Clearview Drive	Vinton	24179
Bethel Ridge, Inc.	(540) 992-6226	10535 Lee Highway, North,	Fincastle	24090
Blue Ridge Manor	(276) 638-8701	400 Blue Ridge Street,	Martinsville	24112
Blue Ridge Nursing Center	(276) 694-7161	105 Landmark Drive, PO 549	Stuart	24171
Blue Ridge Rehab	(276) 638-8701	300 Blue Ridge Street PO4904	Martinsville	24112
Branches of Hope, LLC	(276) 656-2181	337 East Church Street,	Martinsville	24112
Brandon Oaks	(540) 776-2600	3804 Brandon Avenue SW,	Roanoke	24018
Brandon Oaks Nursing and Rehabilitation ct	(540) 776-2616	3837 Brandon Avenue, Southwest	Roanoke	24018
Brian Center Nursing Care/Fincastle	(540) 473-2288	188 Old Fincastle Road	Fincastle	24090
Brian Center Rehabilitation and Nursing	(540) 862-3610	100 Alleghany Regional Hospital Lane	Low Moor	24457
Campbell Rest Home	(540) 586-0825	1350 Longwood Ave.,	Bedford	24523
Cana Adult Home	(276) 755-4981	2004 Wards Gap Road,	Cana	24317
Candis Adult Care, Inc	(540) 343-8640	1619 Hanover Ave,	Roanoke	24017
Carriage Hill	(540) 586-5982	1203 Roundtree Drive,	Bedford	24523
Carrington Place at Botetourt Commons	(540) 966-0056	290 Commons Parkway	Daleville	24083
Carrington, The	(434) 846-3200	2406 Atherholt Road	Lynchburg	24501
Cave Creek ALF	5409924599	8088 Lee Highway,	Troutville	24175
Central Va. Training Center (MR)	(434) 947-6000	521 Colony Road	Lynchburg	24572
Central Va. Training Center (SNF/NF)	(434) 947-6960	521 Colony Road	Lynchburg	24505
Eastwood Assisted Living, Inc.	(540) 265-2244	320 Hershberger Road,	Roanoke	24012
Elkridge ALF (Central VA CSB)	(434) 213-2471	109 Elkridge Drive,	Forest	24551
Elks National Home	(540) 586-8232	931 Ashland Avenue,	Bedford	24523
Emeritus at Cave Spring	(540) 772-7181	3585 Brambleton Avenue,	Roanoke	24018
Emeritus at Danville	(434) 791-3180	432 Hermitage Drive,	Danville	24541
Emeritus at Ridgewood Gardens	(540) 387-4945	2001 Ridgewood Drive,	Salem	24153
Emeritus at Roanoke	(540) 343-4900	1127 Persinger Road, S.W.	Roanoke	24015
English Meadows Senior Living Facility	540-3824919	1140 West Main Street	Christiansburg	24073
Fairmont Crossing	(434) 946-2850	173 Brockman Park Drive	Amherst	24521
Fairview Home	(540) 674-5260	5140 Hatcher Road,	Dublin	24084
Fairview Home Assisted Living Facility	540-674-5260	5140 Hatcher Road	Dublin	24084
Forest Hill ICF/MR	(434) 386-4449	3018 Forest Hill Circle	Lynchburg	24501
Fork Mountain Adult Home	(540) 483-8800	2925 Fork Mountain Road,	Rocky Mount	24151
Franklin Healthcare Center	(540) 489-3467	720 Orchard Avenue	Rocky Mount	24151
Friendship Health and Rehab Center	(540) 265-2100	327 Hershberger Road, Northwest	Roanoke	24012
Glebe, The	(540) 591-2100	250 Glebe Road	Daleville	24083
Golden LivingCenter - Allegheny	(540) 862-5791	1725 Main Street	Clifton Forge	24422
Golden LivingCenter - Martinsville	(276) 632-7146	1607 Spruce Street Extension	Martinsville	24112
Grace Lodge	(434) 528-0969	1503 Grace Street,	Lynchburg	24504
Guggenheimer Nursing Home	(434) 947-5100	1902 Grace Street	Lynchburg	24504
Hairston Home for Adults	(276) 638-5121	601 Armstead Ave,	Martinsville	24112
Hamilton Haven of Roanoke	(540) 366-5355	2720 Cove Road NW,	Roanoke	24017
Harmony Hall Assisted Living Facility	(276) 629-3533	PO Box 1614,	Bassett	24055
Heritage Green Daybreak	(434) 385-5102	200 Lillian Lane,	Lynchburg	24502
Heritage Hall	540-951-7000	3610 South Main Street	Blacksburg	24060
Heritage Hall - Brookneal	(434) 376-3717	633 Cook Avenue	Brookneal	24528
Highland House	(540) 862-4271	3501 Longdale Furnace Road,	Clifton Forge	24422
Highland Ridge Rehab Center	540-674-4193	5872 Hanks Ave	Dublin	24084
Hollins Manor	(540) 563-1212	7610 Williamson Road,	Roanoke	24019
Jeanne's Elderly Care	(540) 563-1262	1682 Monterey Road,	Roanoke	24019
Johnson's Senior Center, Inc.	(434) 964-2770	108 & 112 Senior Street,	Amherst	24521
Joseph C. Thomas Center	(540) 380-6527	3939 Daugherty Road,	Salem	24153
Kings Grant Retirement Community	(276) 634-1000	350 Kings Way Rd.,	Martinsville	24112-6631
Kroontjie Health Care Center	540-953-3200	1000 Litton Lane	Blacksburg	24060
Lea's Home For Adults	(434) 792-5865	157 Broad Street,	Danville	24541
Lynchburg Health & Rehabilitation Center	434 239-2657	5615 Seminole Avenue	Lynchburg	24502
Magnolia Ridge ALF	5403428861	1007 Amherst Street, SW,	Roanoke	24015

Facility	Phone	Address	City	Zip
Medical Care Center	804 740-2900	2200 Landover Place	Lynchburg	24501
Milam's Home for Adults	(434) 799-9482	1111 N Main St,	Danville	24540
North Roanoke Assisted Living Facility	(540) 265-2173	6910 Williamson Road,	Roanoke	24019
Oak Grove Lodge Residential Care	(434) 432-0513	220 Oak Grove Lane,	Chatham	24531
Oaks of Lynchburg	4348466611	2249 Murrell Road,	Lynchburg	24501
Oakwood Manor (Bedford Mem Hosp LTC)	(540) 586-2441	1613 Oakwood Street	Bedford	24523
Odd Fellows Home of Virginia	(434) 845-1261	600 Elmwood Avenue,	Lynchburg	24503
Our Lady of the Valley	(540) 345-5111	650 N. Jefferson St,	Roanoke	24016
Pheasant Ridge Nursing and Rehab Ctr	540 725-8210	4355 Pheasant Ridge Road	Roanoke	24014
Pheasant Ridge Senior Living	(540) 725-1120	4435 Pheasant Ridge Road SW,	Roanoke	24014
Pinecrest Adult Home	(434) 685-1620	709 River Ridge Road,	Danville	24541
Pineview Estate	(434) 352-8282	4471 Salem Road,	Spout Spring	24593
Pulaski Health and Rehab	540-980-3111	2401 Lee Highway	Pulaski	24301
Pulaski Retirement Community	(540) 980-8535	2421 Lee Highway,	Pulaski	24301
Radford Health and Rehab	540-633-6533	700 Randolph Street	Radford	24141
Raleigh Court Health and Rehab Center	540 342-9525	1527 Grandin Road	Roanoke	24015
Red Oak Manor	(540) 482-0982	18360 Virgil Goode Highway,	Rocky Mount	24151
Restin South	(540) 774-9255	6347 Crowell Gap Road,	Roanoke	24014
Richfield Recovery and Care Center	540 380-4500	3615 West Main Street	Salem	24153
Riverview Nursing Home	540-726-2328	120 Old Virginia Ave. PO Box 327	Rich Creek	24147
Roanoke United Methodist Home	(540) 344-6248	1009 Old Country Club Road, N.W.,	Roanoke	24017
Runk & Pratt of Forest Inc.	(434) 385-6678	208 Gristmill Drive,	Forest	24551
Runk & Pratt Residential Adult Care	4342377809	20212 Leesville Road,	Lynchburg	24502
Salem Health and Rehabilitation Center	540 345-3894	1945 Roanoke Boulevard	Salem	24153
Salem Terrace at Harrogate	5404440343	1851 Harrogate Drive,	Salem	24153
Showalter Center	(540) 443-3427	1060 Showalter Drive,	Blacksburg	24060
Skyline Nursing and Rehab	540-745-2016	2378 Franklin Pike Road	Floyd	24091
Slagle Home	(434) 845-1636	3209 Memorial Avenue,	Lynchburg	24501
Smith Mountain Lake Retirement Village	5407191300	115 Retirement Drive,	Hardy	24101
Smith's Adult Care Facility	(434) 685-1778	16069 Martinsville Highway,	Axton	24054
Snyder Nursing Home	540 389-0160	11 North Broad Street	Salem	24153
South Roanoke Nursing Home	540 344-4325	3823 Franklin Road, Southwest	Roanoke	24014
Springtree Health & Rehabilitation Center	540 981-2790	3433 Springtree Drive	Roanoke	24012
Stanleytown Healthcare Center	276 629-1772	240 Riverside Drive PO538	Stanleytown	24055
Stratford House	(434)799-2266	1111 Main Street,	Danville	24541
Summit Assisted Living	(434) 845-6045	1320 Enterprise Drive,	Lynchburg	24502
Summit Health & Rehabilitation Center	434 845-6045	1300 Enterprise Drive	Lynchburg	24502
The Brian Center	(540) 862-3610	100 ARH Lane, Robert (Bob) McClintic	Low Moor	24457
The Fields of Heritage Green	(434) 385-5102	201 Lillian Lane,	Lynchburg	24502
The Glebe	(540) 591-2100	200 Glebe Boulevard,	Daleville	24083
The Landmark Center	(276) 694-3050	227 Landmark Drive,	Stuart	24171
The Oaks at Richfield	(540) 380-4500	3706 Knollridge Rd,	Salem	24153
The Park-Oak Grove Retirement Community	(540) 989-9501	4920 Woodmar Drive, SW,	Roanoke	24018
The Village on Pheasant Ridge	(540) 400-6482	4428 Pheasant Ridge Road,	Roanoke	24014
The Wybe & Marietje Krootje Health Care	(540) 953-3200	1000 Litton Lane,	Blacksburg	24060
Timothy and Bethany House	(804) 239-0722	3011 Roundelay Road	Lynchburg	24502
TLC Adult Home	(276) 629-4884	880 Lillian Naff Drive,	Henry	24102
Trinity Mission Health & Rehab of Rocky	540 483-9261	300 Hatcher Street	Rocky Mount	24151
Valley Retirement Home	(540) 563-9153	1418 10TH Street NW,	Roanoke	24012
Valley View Retirement Community	(434) 237-3009	1213 Long Meadows Drive,	Lynchburg	24502
Virginia Baptist Hospital LTC	(434) 947-4000	3300 Rivermont Avenue	Lynchburg	24503
Virginia Veterans Care Center	(540) 982-2860	4550 Shenandoah Ave.,	Roanoke	24017
Virginia Veterans Care Center	540/982 2860	4550 Shenandoah Avenue, Northwest	Roanoke	24017
Virginia's Assisted Living Facility	(540) 343-3330	1205 Moorman Rd. NW,	Roanoke	24017
Westminster Canterbury of Lynchburg	(434) 386-3500	501 Ves Road,	Lynchburg	24503
Wheatland Hills-Christiansburg	(540) 382-5200	201 Wheatland Court,	Christiansburg	24073
Wheatland Hills-Radford	(540) 639-2411	7486 Lee Highway,	Radford	24141
Williams Home Incorporated	4343848282	1201 Langhorne Road,	Lynchburg	24503
Woodhaven Nursing Home	540/947-2207	13055 West Lynchburg/Salem Turnpike	Montvale	24122-0168
Woodlands Health & Rehab Ctr, The	540/863-4096	1000 Fairview Avenue	Clifton Forge	24422

4. EMS Agencies

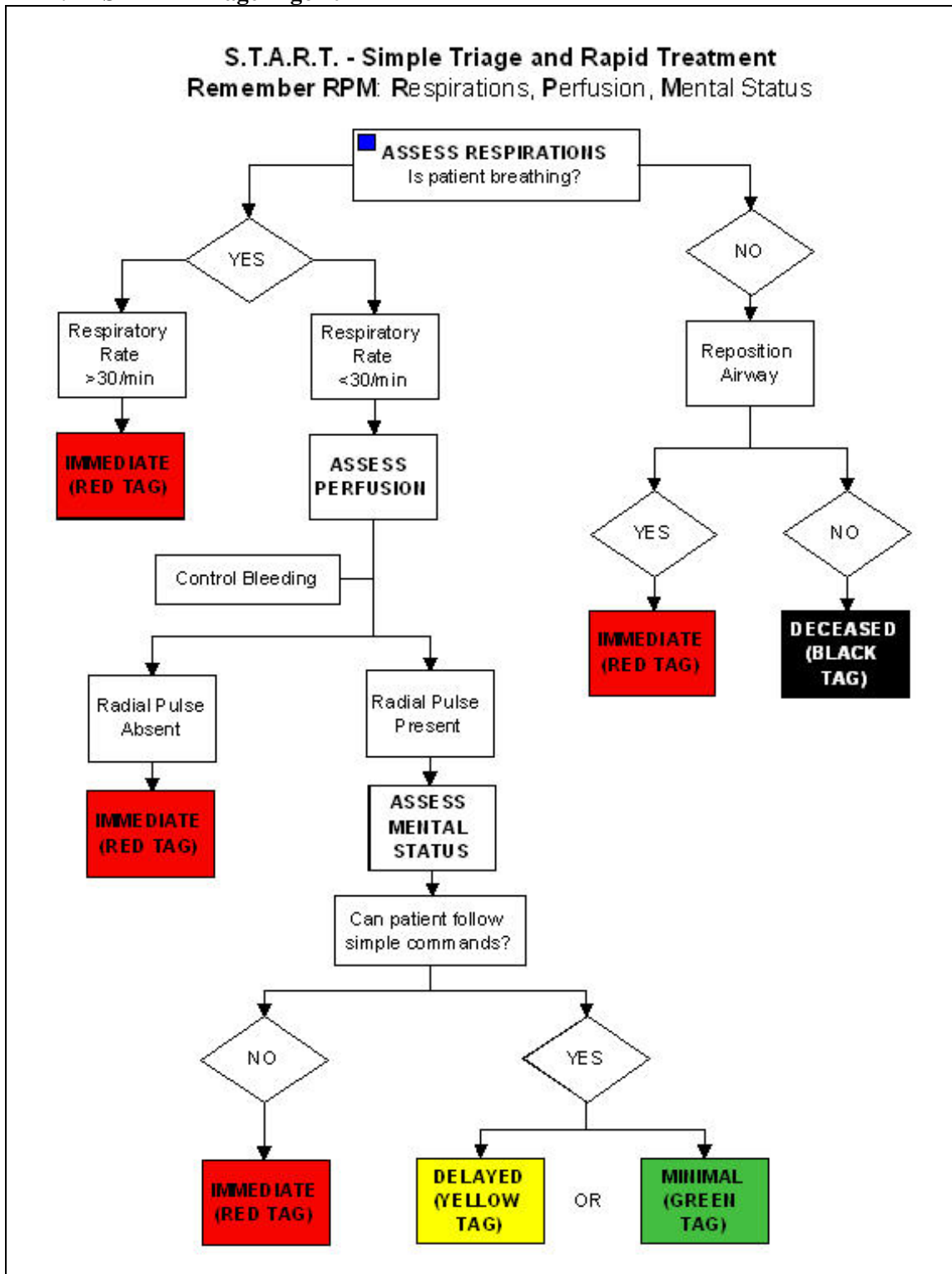
5. Health Districts and Emergency Planners

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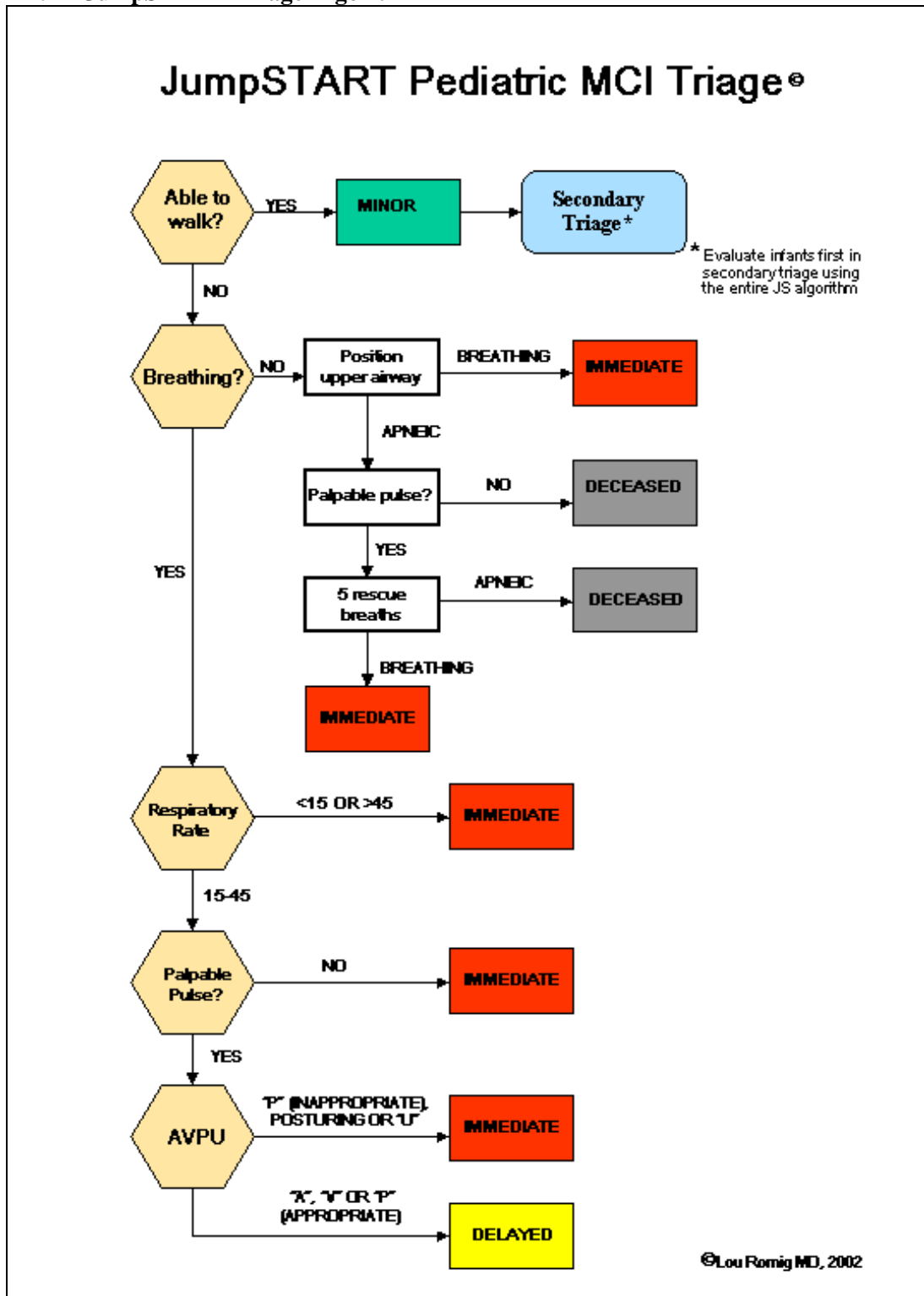
ATTACHMENT 2
Start and JumpStart Triage Algorithm

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A. START Triage Algorithm



B. JumpSTART Triage Algorithm

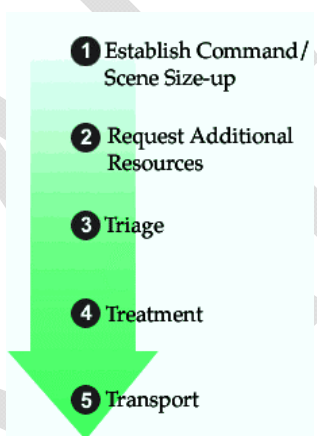


ATTACHMENT 3 Standard Trauma Triage Methods

The purpose of triage is to assign treatment and transportation priorities to patients by separating the victims into easily identifiable groups. The method of initial field triage to be utilized is the Simple Triage and Rapid Treatment (START) method for adult patients. Pediatric patients, ages 8 and under, will be better served by using the JumpSTART triage method. The START and Jump START algorithms are found on pages 4-2 and 4-3.

There are some incidents where START Triage may not be the most appropriate tool to sort patients. Patients who have been exposed to various HAZMAT or CBRNE may need to be triaged using guidelines that are specific to the agent to which they have been exposed. Patients who have been exposed to certain CBRNE weapons may have different triage needs than trauma patients. **START Triage is the preferred tool for sorting trauma patients.**

Initial Triage



Provisions must be made for the following:

- 1) Establishment of a medical command post at the disaster site.
- 2) Coordinating health & medical response efforts.
- 3) Triage of the injured, if appropriate.
- 4) Medical care and transport for the injured.
- 5) Identification, transportation, and disposition of the deceased.
- 6) Holding and treatment areas for the injured.
- 7) Isolating, decontaminating, and treating victims of hazardous materials

The initial triaging of victims must begin right where the patients lay. The EMS Provider must begin to triage patients where they enter the scene and then progress in a deliberate and methodical pattern to ensure that all of the victims are triaged. When using both the START and JumpSTART triage methods all ambulatory patients are initially directed to a designated Green/Minor treatment area where they will be assessed and further triaged as personnel

become available. For all remaining patients, triage personnel must quickly triage each patient and apply the appropriate color-coded triage ribbons (surveyor's tape).

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

Secondary Triage

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

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

Catastrophically injured patients who still have signs of life may be classified as "yellow prime" and designated with a "P" or "///" on the yellow tape or triage tag. These patients have a low probability of survival even with immediate treatment and transport and should be placed in a separate in the delayed / yellow prime treatment area.

Ongoing triage is then performed continually as a part of the patient assessment until the patient arrives at an Emergency Department/hospital.

Triage and Mass Patient Care

Today's EMS providers can expect to face a non-traditional multiple or mass casualty incident resulting from a man-made biological event (e.g. anthrax attack), a natural occurring pandemic disease event (e.g. influenza), natural disaster or other event resulting in a large number of victims becoming ill, or where patients with preexisting conditions become increasing ill due to the exacerbation of their illness or condition.

Massive region wide infrastructure damage may result from these types of incidents and may also result in the loss of hospitals, physicians offices, dialysis centers, other healthcare facilities and home healthcare services. Patients who live with controlled chronic illnesses and conditions may suddenly find themselves separated from their existing family members/care givers, and/or their normal healthcare system. Many of these patients may be unable to obtain needed medications, oxygen, dialysis, cancer treatments, etc. due to the destruction or disruption in the healthcare system. This situation will exacerbate their medical conditions forcing many of these patients to turn to the EMS system for care. The principles of triage still apply during these incidents and serve to assist providers by prioritizing patient care and transportation.

ATTACHMENT 4

Scene Setup and Patient Management

First Arriving Unit Actions

The first arriving unit on a potential MCI must restrain themselves from rushing into the scene. The first arriving unit should use the “5-S’s” to properly assess the scene and report the information to their dispatch center. This step is vital to initiate a response appropriate to the size and complexity of the MCI.

The Emergency Department closest to the scene MUST be notified immediately that an MCI has been declared. Ask the hospital if they want to retain the role of Coordinating Emergency Department or hand it off to another facility.

The Incident Scene

Initial triage must be conducted at the incident scene if it is safe to do so.

- All injured victims must be rapidly triaged.
- Make certain that triage ribbons are applied.
- Ambulatory (Green Tagged/Minimal) patients must be directed to a safe place as soon as one is identified.
- Green Tagged/Minimal patients should be asked to assist other patients if they are able to do so.
- Non-ambulatory patients are removed from the scene to the Treatment Area by porters in the following order: Red Tagged/Immediate, Yellow Tagged/Delayed, Yellow Prime/Catastrophically Injured.
- Deceased victims (Black Tagged/Deceased) are left where they are found, unless they must be moved to gain access to living patients or if the remains are in danger of being destroyed.
- All incident victims must be accounted for. This includes victims who may be uninjured, trapped, or who have been rescued or extricated.

Continual Evaluation

Patients in the treatment area must be continuously reevaluated (re-triaged) throughout their stay in the treatment area.

Designating and Marking the Treatment Area

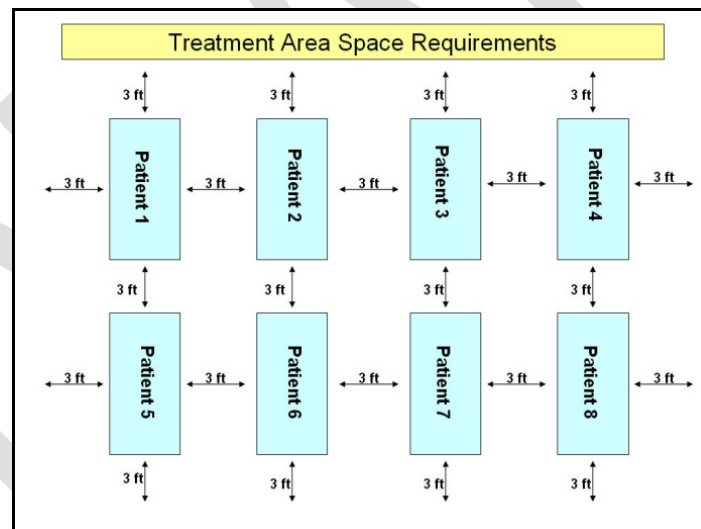
Patients are placed in the Treatment Area and emergency medical care is provided on the basis of the triage priority. The Treatment Area is usually divided into separate areas for the care of Red Tagged/Immediate, Yellow Tagged/Delayed, Yellow Prime/Catastrophically Injured, and Green Tagged/Minimal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

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

Designate a separate, secure and isolated area for the Incident Morgue. The incident morgue is for the placement of victims who die en route to, or in the Treatment Area. An EMS provider must be assigned to this area to confirm death and track patients transported to and from this area. The Incident Morgue/Black Tagged Area should be secured by Law Enforcement Officers, not EMS providers.

Treatment Area Space Requirements

It is important to provide enough space between patients to allow providers room to place, treat, and move safely between patients. Each patient should have three feet of open space on all four sides of the patient as shown in the following figure. Many agencies stock colored tarps for use in designating treatment areas. Be aware that the treatment area required will easily exceed the size of the tarps. Responders must expand and/or relocate the treatment area during an incident to accommodate increasing space requirements.



The Transportation Area

The Transport Group Supervisor/Unit Leader or Medical Communications Coordinator must be in contact with the Emergency Departments initially contacted, as well as the RHCC when activated. The distribution of patients is dependent on these entities..

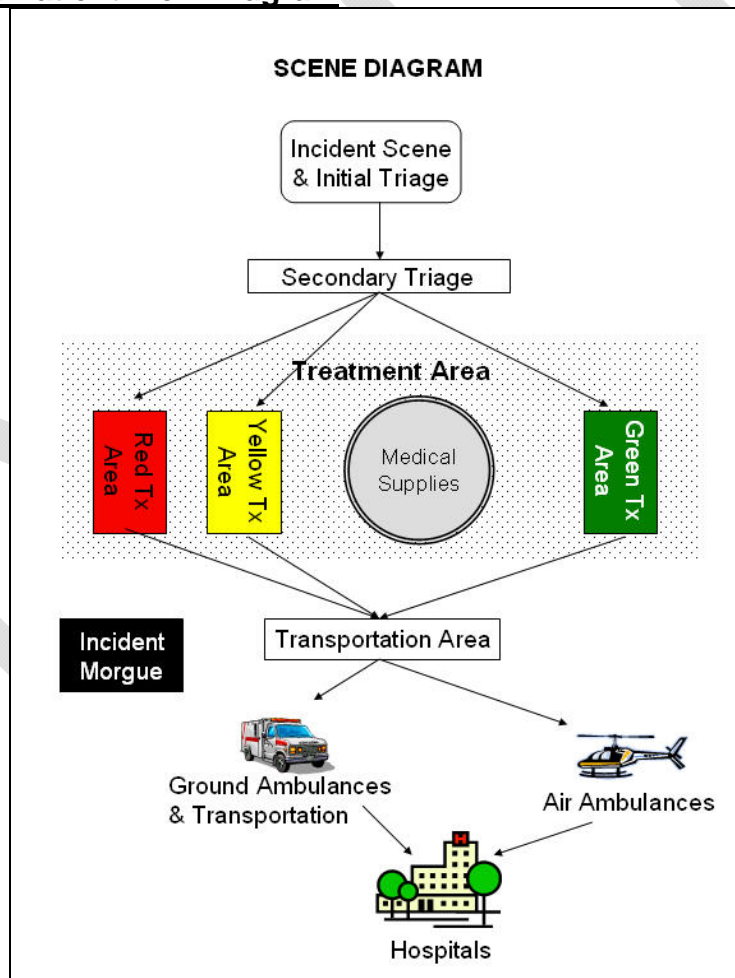
Transportation resources are assigned based on triage priority. Patients are moved to the Transportation Area, and then loaded into the appropriate vehicle by Porters/Transport Loaders.

Patients are transported to the appropriate medical facility by the most appropriate means available. 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 transports to receiving Emergency Departments are documented on the Virginia Triage Tag and the MCI Patient Tracking Form located in **Annex B** of this document. If time and resources allow medical care should also be documented on the Pre-hospital Patient Care Report (PPCR).

Scene 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.

Uncontaminated Patient Flow Diagram



Scene Setup and Patient Management

HAZ MAT PATIENTS

First Arriving Unit Actions

The first arriving unit on a potential HAZMAT or CBRNE incident must restrain themselves from rushing into the scene and remain uphill and upwind of the incident.

The successful initial management of a HAZMAT or CBRNE incident is based upon the first arriving unit using the “5-S’s” to properly assess the hazard and report the information to their dispatch center. This step is vital to the safety of all first responders, victims, and the community alike.

Request the Regional HAZMAT Team to respond. The first arriving unit should also make an effort to control the scene by designating a “danger zone” and a “safe zone”. Consult the Emergency Response Guide (ERG) for initial isolation distances.

Weapons of Mass Destruction, CHEMPACKS

If WMD antidotes are needed, coordinate with local hospital based Emergency Departments to obtain additional pharmaceuticals and supplies from the Strategic National Stockpile Emergency Medical Services CHEMPACKS. For more information on the Strategic National Stockpile and CHEMPACKS refer to Annex J of this document.

Designation of the Hot, Warm, and Cold Zones

Upon arrival the HAZMAT Team will assess the incident scene and designate a “Hot Zone, “Warm Zone” and a “Cold Zone”.

I. Hot Zone

The hot zone is the area that immediately surrounds a hazardous materials incident. The hot zone normally extends out in a 360 degree radius around the incident scene. The hot zone is also referred to as the exclusion zone, or restricted zone, in other documents. Patients may receive antidotes and other life saving treatments in the hot zone.

II. Warm Zone

The warm zone is the area where personnel and equipment decontamination and hot zone support takes place. The designation of access control points reduces the spread of contamination. This is also referred to as the decontamination, contamination reduction, or limited access zone in other documents. The warm zone is the first place that patients will be decontaminated. Patients may receive antidotes and other life saving treatments in the warm zone. Once patients have been decontaminated, they will be transferred into the care of EMS Providers in the cold zone.

Note: The administration of life saving treatments takes precedence over decontamination for radiologically contaminated patients and the safety of the responder is within a reasonable level of risk.

III. Cold Zone

The cold zone serves as the control zone for a hazardous materials incident. The cold zone contains the Incident Command Post and other incident support facilities. This zone is also referred to as the clean zone or support zone.

In some cases victims may remove themselves from the contaminated area. It is important to channel these victims into a hasty decontamination corridor consisting of the strip, flush, and cover activities. This action may be necessary to save lives and protect first responders before a more formal contamination reduction corridor can be established.

IV. Decontamination

Patient decontamination, if required, should be carried out in the warm zone by properly trained personnel wearing appropriate chemical-protective clothing and respiratory equipment. (i.e. Regional HAZMAT Team, etc.)

Refer to established protocols to:

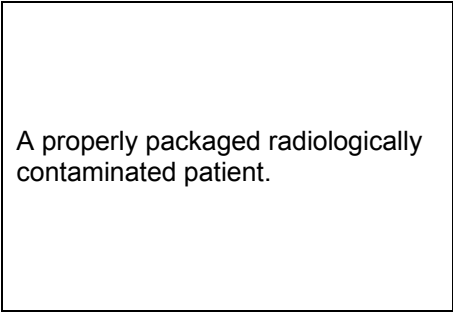
- Determine the potential for secondary contamination, the necessity for and extent of decontamination.
- Select appropriate personal protective equipment for wear by personnel in the warm zone.
- Decontaminate patients when the exposure is to an unidentified gas, liquid, or solid material.
- Provide emergency decontamination for patients with critical injuries and illness requiring immediate patient care or transport.
- Identify and consider crime scene related issues such as the preservation of evidence, chain of custody, etc.

V. Packaging Radiologically Contaminated Patients for Transport

Do not withhold lifesaving treatment from a patient solely because they are contaminated with radioactive material. In this instance the rendering of life saving treatment takes precedence over decontamination. Unstable ALS patients requiring immediate transport can be “packaged” to reduce the likelihood of spreading contamination to providers, the ambulance or the hospital.

Follow these steps to wrap the patient for transfer or transport:

- Cover ground or floor up to location of patient.
- Place two sheets on a clean (uncontaminated) ambulance cot/stretcher.
- Bring in the clean ambulance cot/stretcher.
- Transfer the patient to the clean ambulance cot or stretcher.



A properly packaged radiologically contaminated patient.

MCI-45

- Wrap one sheet around patient, then the other.
- Perform radiological monitoring of the ambulance cot/stretcher and wheels to reduce the spread of contamination.



VI. Transportation Considerations

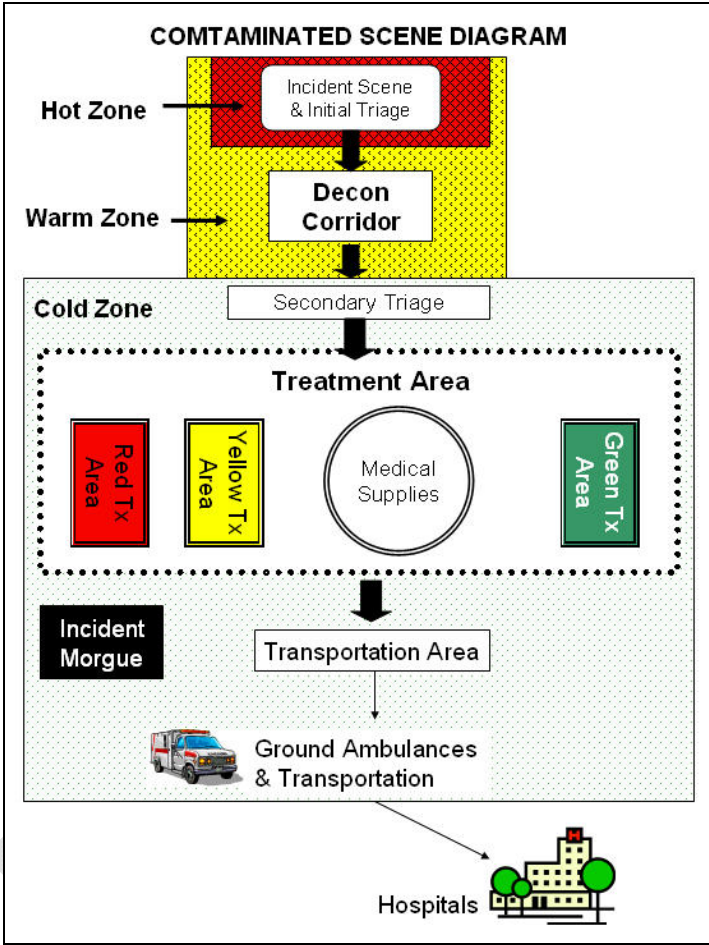
Clinically unstable, radiologically contaminated patients must be transported via ground ambulance to an Emergency Department. These patients should be packaged as outlined above and the receiving Emergency Department must be notified that they will be receiving a contaminated patient.

Air ambulances will **NOT** transport contaminated patients of any kind. If there are any questions as to whether or not a patient is safe to fly, consult with the pilot of the responding air ambulance. The pilot has the final authority as to whether or not the patient will be accepted.

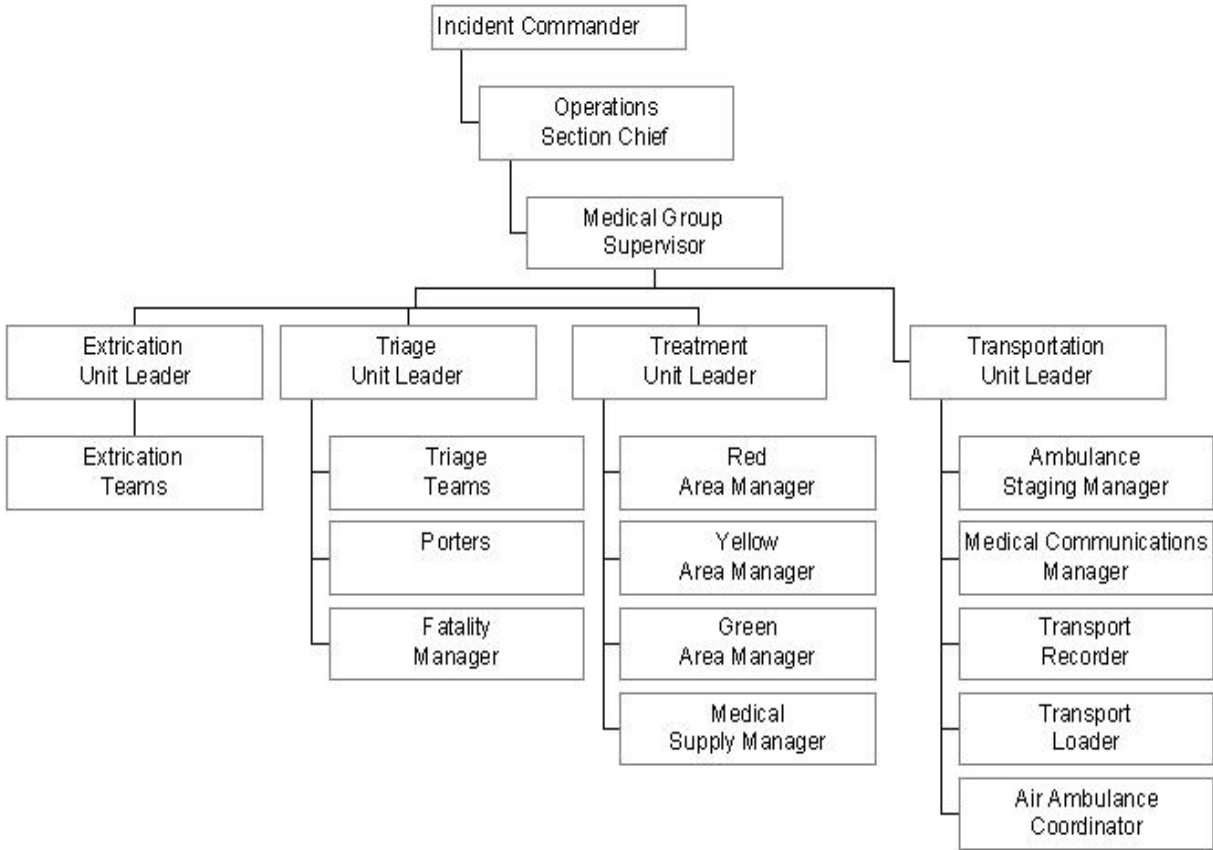
VII. Scene Layout

It is important for responders to establish an orderly flow of patients from the incident scene in the hot zone, through the warm zone, and then through the cold zone to the transport area. The contaminated 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, presence and type of hazardous materials, the number of patients, and other factors.

VIII. Contaminated Patient Flow Diagram



Attachment 5: MCI Tactical Worksheets and Response Guide



MASS CASUALTY PATIENT FLOW

1. INCIDENT SCENE

- First actions done at close to the same time.
 - Direct walking patients to a supervised area.
 - Locate all victims.
 - Quickly triage patients using START and apply triage ribbons.
 - Start extrication of trapped victims.
- Complete initial patient count.
- Decontaminate patients if needed prior to leaving the incident scene.
- Move walking GREEN patients with escort to TREATMENT.
- Move RED and YELLOW patients by porter to TREATMENT.
- Leave BLACK victims where they lie.

2. TREATMENT AREA

- Retriage arriving patients (secondary triage) and apply triage tags.
- Put patients in RED, YELLOW, or GREEN areas.
- Give stabilizing or definitive care based on Triage priority (RED then YELLOW then GREEN).
- Assign Providers, equipment, and supplies to patients based on Triage priority.
- Continuously retriage patients.
- Move patients who die to separate BLACK area.
- Select patients to move from scene to hospitals based on severity (RED first, then YELLOW).

3. TRANSPORTATION AREA

- Contact Command Hospital to start patient distribution decisions.
- Assign patients to ambulances or air medical helicopters based on severity and most appropriate vehicles available.
- Move GREENs early on vehicles such as buses if available.
- Porters move patients from TREATMENT through TRANSPORTATION to ambulances.
- Advise hospitals of patient movement before departure.
- Ambulance crews provide emergency care and reassessment on way to hospital.

IX. FIRST EMERGENCY MEDICAL UNIT ON SCENE

OBJECTIVE: Safely initiate patient assessment and start operations for the Medical Group.

- _____ 1. **SAFETY** Assessment - observe for hazards.
 - a. Fire.
 - b. Electrical hazards.
 - c. Flammable liquids.
 - d. Hazardous materials.
 - e. Other situations threatening lives of rescuers and patients.
- _____ 2. **SURVEY** the scene - determine how many injured and how bad.
 - a. Type or cause of the incident.
 - b. Approximate number and location of patients.
 - c. Severity of injuries (Major or Minor).
- _____ 3. **SEND** information and request help and resources.
 - a. Contact dispatch with SURVEY information.
 - b. Declare mass casualty incident.
 - c. Request resources and mutual aid as needed.
 - d. Advise COMMAND HOSPITAL.
- _____ 4. **SET-UP** scene to handle patients.
 - a. Identify COMMAND on scene and brief on actions.
 - b. Unless otherwise instructed, assume MEDICAL GROUP role until relieved. Announce on radio.
 - c. Identify best location for STAGING and direct incoming resources to it.
- _____ 5. Begin **START** triage.

SECOND EMERGENCY MEDICAL UNIT ON SCENE

OBJECTIVE: Expand incident management, continue initial patient assessment and treatment.

- _____ 1. Second unit reports to first unit on scene for briefing and assignment. If appropriate, relieve as MEDICAL GROUP Supervisor.
- _____ 2. MEDICAL GROUP Supervisor assigns Ambulance STAGING Officer and directs establishment of STAGING Area.
 - a. Coordinate with COMMAND or Incident STAGING to locate away from scene with easy access.
- _____ 3. MEDICAL GROUP Supervisor assigns key functions as required:
 - a. EXTRICATION. Coordinate with agency providing extrication if not an EMS function.
 - b. TRIAGE.
 - c. TREATMENT.
 - d. TRANSPORTATION.
 - e. MEDICAL COMMUNICATIONS.
 - f. AMBULANCE STAGING
 - g. Others as required.
- _____ 4. Each function puts on vest and starts to carry out their checklist.

INCIDENT COMMAND (COMMAND)

NOTE: EMS will not usually command a major incident. However, as first-in resource you are in command until relieved. Use this checklist and FIRST and SECOND EMERGENCY MEDICAL UNIT ON SCENE checklists to guide your actions.

OBJECTIVE: Coordinate incident response to save lives, stabilize the incident, save property, and keep the rescuers safe.

- _____ 1. As first unit on scene, assume command.
 - a. Announce on radio with your location.
 - b. Put on INCIDENT COMMANDER vest.

- _____ 2. Set up command post in a safe location where you can easily be seen and with a clear view of the incident area. Stay at the command post and use the vehicle mobile radio.

- _____ 3. Assess situation and provide size-up to dispatch.
 - a. What has happened and number of victims.
 - b. Potential hazards.
 - c. What resources are on scene and what are they doing.
 - d. What help you need.

- _____ 4. Develop initial strategy of:
 - a. What has to be done to make area safe to work in.
 - b. What priorities are for rescuing and caring for injured.
 - c. What has to be done to reduce chances of more casualties.

- _____ 5. Assign existing resources to jobs and monitor the work in progress. Appoint as soon as possible:
 - a. STAGING Area Manager.
 - b. SAFETY Officer.
 - c. GROUP, DIVISION, SECTOR Supervisors.
 - d. PUBLIC INFORMATION Officer.

- _____ 6. Account for all personnel assigned to the incident.

- _____ 7. Make a clean hand-off to your successor. Brief on what you know about the incident. Brief on resources committed, available, responding. Brief on strategy and tasks in progress.

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MEDICAL GROUP SUPERVISOR (MEDICAL GROUP)

OBJECTIVE: Manage all Medical Group functions to safely and quickly extricate, triage, treat, and transport all patients according to the incident medical objectives.

WORKS FOR: OPERATIONS Section Chief or COMMAND (if no OPERATIONS).

- _____ 1. Put on the MEDICAL GROUP vest.
- _____ 2. Set up MEDICAL GROUP in a location where you are visible and you have a clear view of the working area.
- _____ 3. Coordinate with COMMAND on incident objectives and plans. Set MEDICAL GROUP objectives and make sure all unit leaders know them.
- _____ 4. Start using Tactical Worksheets to record key information and help manage the response.
- _____ 5. Ensure STAGING and traffic flow established for arriving resources. Coordinate with OPERATIONS or COMMAND.
- _____ 6. Assign personnel to jobs based on available people and time the function will be needed. Consider following order for assignments.
 - a. STAGING, EXTRICATION (if done by EMS), TRIAGE
 - b. TREATMENT
 - c. TRANSPORTATION
 - d. MEDICAL COMMUNICATIONS
- _____ 7. Request added resources as needed and assign new resources to tasks quickly. Keep any resources with no assignment in STAGING.
- _____ 8. Monitor work and progress toward incident objectives.

- _____ 9. Monitor condition of assigned personnel. Request relief crews as needed to keep people safe and reduce incident stress and to keep moving toward MEDICAL GROUP objectives.
- _____ 10. Account for all assigned personnel.
- _____ 11. Keep OPERATIONS Section Chief or COMMAND informed.

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TRIAGE UNIT LEADER (TRIAGE)

OBJECTIVE: Locate, initially assess, and sort patients to establish priorities for TREATMENT, move patients to TREATMENT, and safeguard the dead. **WORKS FOR:** MEDICAL GROUP Supervisor.

- _____ 1. Put on TRIAGE vest.
- _____ 2. Set up TRIAGE on site or at closest safe area if site is too dangerous. Locate where you can be seen and have a clear view of the incident.
- _____ 3. Identify a safe place to have GREEN patients walk to. Order them to start walking toward that place.
- _____ 4. Identify TRIAGE Teams and dispatch them to begin START.
 - a. Have them work through the site in a systematic way.
 - b. If necessary, subdivide site and assign teams to each division.
 - c. Use START algorithm and tag patients with surveyor=s tape.
- _____ 5. Establish PORTER Teams. Obtain backboards and straps from STAGING or MEDICAL SUPPLY for the PORTER Teams.
- _____ 6. PORTER Teams follow TRIAGE teams and start moving patients to TREATMENT on backboards with C-Spine precautions.
 - a. If area permits, move REDs first, then YELLOWs.
 - b. Do not have porters wait for REDs to be tagged if there are YELLOWs waiting.
- _____ 7. Designate FATALITY MANAGER.
 - a. Have FATALITY MANAGER log BLACK patient locations.
 - b. Do not authorize movement of BLACK patients prior to MEDICAL EXAMINER approval unless to protect remains.
- _____ 8. Monitor condition of assigned personnel. Request relief crews as needed to keep people safe, reduce incident stress and maintain progress toward TRIAGE objectives.
- _____ 9. Account for all personnel assigned.
- _____ 10. Keep MEDICAL GROUP, EXTRICATION, and TREATMENT informed.

MCI-55

FATALITY MANAGER (FATALITY MANAGER)

OBJECTIVE: To locate and safeguard remains of the deceased and personal effects pending arrival of the MEDICAL EXAMINER. **WORKS FOR:** TRIAGE Unit Leader.

- _____ 1. Put on FATALITY MANAGER vest.
- _____ 2. Locate and tag remains of incident casualties in the incident area. Plot approximate positions on Tactical Worksheet and record description of the remains.
- _____ 3. Establish a BLACK casualty area separate from TREATMENT. BLACK area should be accessible with 2-wheel-drive vehicles.
- _____ 4. Coordinate with TREATMENT and TRIAGE for porters to move to the BLACK area any patients who die in TREATMENT.
- _____ 5. Maintain records of patients dieing in TREATMENT, including identify (if known), triage tag number, situation and time of death, and description of clothing and personal effects.
- _____ 6. Safeguard remains and personal effects. Do not leave remains unattended or unobserved. Request assistance of law enforcement if necessary.
- _____ 7. Where appropriate to preserve privacy or to protect the remains, cover remains with disposable non-absorbent or fluid barrier sheets.
- _____ 8. Keep TRIAGE and TREATMENT informed.
- _____ 9. Turn over responsibility for remains to the MEDICAL EXAMINER.

TREATMENT UNIT LEADER (TREATMENT)

OBJECTIVE: Continually assess patients, stabilize patients and begin definitive treatment based on priorities and resources, and determine priority for transport to medical facilities. **WORKS FOR:** MEDICAL GROUP Supervisor.

- _____ 1. Put on TREATMENT vest.
- _____ 2. Set up Treatment area. Consider: (1) safety, (2) portering distance, (3) space, (4) weather, (5) lighting, (6) TRANSPORTATION access.
- _____ 3. Inform TRIAGE and MEDICAL GROUP of Treatment location.
- _____ 4. Determine how to do secondary triage - assign a Secondary Triage Officer and funnel patients through Secondary Triage.
- _____ 5. Arrange Treatment Area for parallel rows of patients.
 - a. Allow room for RED and YELLOW areas to grow outward.
 - b. Consider separate location for GREEN area.
- _____ 6. Assign Treatment Teams with RED, YELLOW, GREEN Managers.
- _____ 7. Set up MEDICAL SUPPLY. Assign MEDICAL SUPPLY Officer.
- _____ 8. Consider use of Special Procedures Teams for common treatments (Airway, IV, Splinting, etc.) if needed and resources available.
- _____ 9. Supervise prehospital patient care per approved protocol. Supervise regular reassessment of patient conditions and priorities.
- _____ 10. Isolate emotionally disturbed patients if possible.
- _____ 11. Determine patient transport order and best means.
- _____ 12. Monitor condition of assigned personnel. Request relief crews as needed to keep people safe and reduce incident stress and to maintain progress toward TREATMENT incident objectives.
- _____ 13. Account for all assigned personnel.
- _____ 14. Keep MEDICAL GROUP and TRANSPORTATION informed.

MEDICAL SUPPLY MANAGER (SUPPLY)

OBJECTIVE: Provide Porters and Treatment Area supplies and equipment needed to move and treat the injured. **WORKS FOR:** TREATMENT Unit Leader.

- _____ 1. Put on MEDICAL SUPPLY vest.
- _____ 2. Set up within easy reach of the TREATMENT Unit.
- _____ 3. Coordinate with Ambulance STAGING Officer to have crews bring extra supplies from vehicles to the MEDICAL SUPPLY area (keep essential equipment on vehicles). Request:
 - Backboards and rescue baskets and straps
 - Splints
 - Oxygen and airway kits
 - IV sets
 - Bleeding control supplies
 - Prepacked disaster kits
- _____ 4. Sort supplies and arrange for easy access. Determine points in inventory at which more supplies will have to be ordered.
- _____ 5. For night time operations, coordinate with MEDICAL GROUP Supervisor and Ambulance STAGING Officer to have portable lighting brought to TREATMENT Unit.
- _____ 6. Issue supplies as needed within the TREATMENT Unit.
- _____ 7. Contact TRANSPORTATION to arrange for returning vehicles to bring additional supplies when order points are reached.
- _____ 8. On completion of operations collect unused supplies and equipment and attempt to return to owning agency (if marked). Make arrangements for distribution or return of unmarked supplies and equipment.

TRANSPORTATION UNIT LEADER (TRANSPORTATION)

OBJECTIVE: Coordinate all patient transportation and maintain all records of patient and unit movement. **WORKS FOR:** MEDICAL GROUP Supervisor.

- _____ 1. Put on TRANSPORTATION vest.
- _____ 2. Set up TRANSPORTATION Unit at exit from TREATMENT Unit.
- _____ 3. As needed appoint AMBULANCE STAGING MANAGER, MEDICAL COMMUNICATIONS MGR, TRANSPORT RECORDER(s), TRANSPORT LOADER(s), AIR AMBULANCE COORDINATOR.
- _____ 4. Set up vehicle flow from STAGING to Transportation to Hospitals.
- _____ 5. Contact COMMAND HOSPITAL through COMMUNICATIONS to determine hospital capabilities to accept patients in each category.
- _____ 6. Select mode of transportation based on patient needs and available air and ground ambulance resources.
- _____ 7. Order ambulances from STAGING for patients TREATMENT selects.
 - a. Load RED patients first, then YELLOW, then GREEN.
 - b. Depending on hospital capacity load mixed patients.
 - c. If non-ambulance transport is available early move GREENs.
- _____ 8. Ensure ambulances are parked parallel to each other. Avoid end-to-end. If end-to-end must be used, load first in the line first.
- _____ 9. Request porter teams from TRIAGE to move patients from TREATMENT and assist in loading.
- _____ 10. Coordinate with COMMAND HOSPITAL for destination for each ambulance dispatched to hospitals.

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- _____ 11. Brief ambulance crews on destination hospital and route (if needed).
- _____ 12. Record patient and unit movements on tactical worksheet.
- _____ 13. Keep MEDICAL GROUP and TREATMENT informed.

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AMBULANCE STAGING MANAGER (STAGING)

OBJECTIVE: Maintain EMS manpower and ground vehicle resources ready for dispatch at a location separated from the incident (may be collocated with incident STAGING). **WORKS FOR:** TRANSPORTATION Unit Leader.

- _____ 1. Put on STAGING vest.
- _____ 2. Establish ambulance STAGING in coordination with OPERATIONS Section Chief or incident STAGING. Site is away from scene and should:
 - a. Be large enough to hold the needed number of units.
 - b. Have easy road access from major transportation routes.
 - c. Have easy access to TRANSPORTATION Unit.
- _____ 3. Direct arriving vehicles to stage for easy departure. Parallel staging for pull through should be used unless space does not permit.
- _____ 4. Ensure personnel on staged vehicles remain with their unit.
- _____ 5. Park vehicles used to transport scene staff out of traffic flow.
- _____ 6. Update TRANSPORTATION on available vehicles and personnel.
- _____ 7. Ensure ambulance cots are not removed from units.
- _____ 8. As needed, remove medical supplies from ambulances for relocation to MEDICAL SUPPLY:
 - Backboards and straps
 - Splints and bandages
 - Blankets
 - Portable oxygen equipment and supplies
 - Airway equipment
 - IV sets
- _____ 9. Coordinate for REHABILITATION (food, drink) for staged crews.

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- _____ 10. As ordered dispatch vehicles to the TRANSPORTATION Unit.
- _____ 11. Track the status, number, and types of ambulances in STAGING. Use the Tactical Worksheet.

MEDICAL COMMUNICATIONS MANAGER (COMMUNICATIONS)

OBJECTIVE: Establish, maintain, and coordinate medical communications at the incident scene between TRANSPORTATION, the COMMAND HOSPITAL, and the MEDICAL GROUP. **WORKS FOR:** TRANSPORTATION Unit Leader.

- _____ 1. Put on COMMUNICATIONS vest.
- _____ 2. Set up close to TRANSPORTATION Unit. Check for good radio contact with repeater or other simplex users.
- _____ 3. Establish initial communications with the COMMAND HOSPITAL or nearest receiving hospital using public safety radio, cellular telephone, or amateur radio (if available).
- _____ 4. Break out tactical worksheets and use to track information.
- _____ 5. Get initial information from MEDICAL GROUP. Give hospital initial report. Be accurate. Identify estimates. Do not speculate.
 - a. CATEGORY or level of Mass Casualty Incident.
 - b. CAUSE of incident.
 - c. NUMBER of patients.
 - d. SEVERITY of injuries.
- _____ 6. Get hospital emergency capacity information. Provide to

TRANSPORTATION and MEDICAL GROUP.
- _____ 7. Coordinate with COMMAND HOSPITAL to determine to which facility ambulances should be dispatched. Provide transport reports to COMMAND HOSPITAL on departure. Include:

- a. UNIT transporting.
- b. DESTINATION hospital.
- c. NUMBER of patients.
- d. PATIENT INFORMATION (triage category, chief complaint, age, sex)

_____ 8. Monitor equipment status - replace batteries as needed.

TRANSPORT RECORDER (RECORDER)

OBJECTIVE: Ensure proper documentation of patient and vehicle movements.

WORKS FOR: TRANSPORTATION Unit Leader.

_____ 1. Put on TRANSPORT RECORDER vest.

_____ 2. Set up at patient loading point in the TRANSPORTATION Area.

_____ 3. Record patient movement information on tactical worksheet.

_____ 4. Give COMMUNICATIONS following information on every patient leaving TREATMENT.

UNIT transporting

DESTINATION hospital

NUMBER of patients

PATIENT INFORMATION (triage category, age, sex, chief complaint)

ETA at destination

_____ 5. Give other information to COMMUNICATIONS for relay to hospital.

TRANSPORTATION LOADER (LOADER)

OBJECTIVE: Ensure proper loading of patients on ground vehicles and provide directions to receiving hospitals. **WORKS FOR:** TRANSPORTATION Unit Leader.

- _____ 1. Put on TRANSPORTATION LOADER vest.
- _____ 2. Get local area maps and directions to receiving hospitals.
- _____ 3. Set up at the patient loading point in TRANSPORTATION Unit.
- _____ 4. Make sure patients selected for ground transportation by TRANSPORTATION are:
 - a. Ready for movement.
 - b. Loaded on the correct ambulance - cross check numbers with RECORDER.
- _____ 5. Provide instructions to vehicle drivers:
 - a. Directions to the designated hospital.
 - b. Actions to take (Return to Staging or Return to Home) after delivering patients.
- _____ 6. Keep TRANSPORTATION and RECORDER informed.

AIR AMBULANCE COORDINATOR (AIR)

OBJECTIVE: Establish helicopter landing zone and coordinate helicopter operations into and out of the landing zone. **WORKS FOR:** TRANSPORTATION Unit Leader.

- _____ 1. Put on AIR AMBULANCE COORDINATOR vest.
- _____ 2. Select Landing Zone site.
 - a. Select area large enough for safe operations:

	DAY	NIGHT
small helicopter	60' x 60'	100' x 100'
medium helicopter	75' x 75'	125' x 125'
large helicopter	125' x 125'	200' x 200'
 - b. Landing surface is flat and firm and free of debris.
 - c. Landing zone not close to TREATMENT.
 - d. Clear approach path.
 - e. Upwind of hazardous materials scenes.
- _____ 3. Assign people to assist in establishing the Landing Zone.
- _____ 4. Mark the Landing Zone.
 - a. Other light sources are preferred to flares (source of ignition).
 - b. At night, make sure spotlights, floodlights, vehicle headlights, and other white lights are not pointed toward the helicopter.
- _____ 5. Advise flight crew before their landing approach of:
OBSTRUCTIONS (towers, power lines, buildings, etc.)
WIND DIRECTION and any gusting
SPECIAL HAZARDS
- _____ 6. Coordinate patient loading and movement with TRANSPORTATION.
- _____ 7. Keep operations safe and secure. Do not allow anyone to approach the aircraft who is not accompanied by a flight crew member.
- _____ 8. Keep TRANSPORTATION and HELICOPTER CREWS informed.

TACTICAL WORKSHEET BOOK

TACTICAL WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management										MCI 1
											Rev 1
Incident										Date	Time
Time	Task		Scene Sketch:								
	Scene Safe										
	Survey/Size-Up										
	Send Help										
	Contact IC										
	Set-up Medical										
	Staging										
	Extrication										
	Porter Teams										
	Treatment	UNIT	Assignment	UNIT	Assignment						
	Medical Supply										
	Brief Hospital										
	Transportation										
	Landing Zone										
	REDs First										
	Move GREENs										
	Manage BLACKs										
	Release Units										
CASUALTIES						HOSPITAL CAPABILITIES					
Time	RD	YE	GN	BK	Trans	Facility	RD	YE		GN	Trans
Totals											

EMS INCIDENT ACTION PLAN		Commonwealth of Virginia Mass Casualty Incident Management		MCI 10
Incident		Date		Time
For Operational Period From:		To:		
INCIDENT COMMANDER GOALS:				
INCIDENT COMMANDER STRATEGY:				
Scene Sketch				
TACTICAL PRIORITIES:	(1)			By:
	(2)			By:
	(3)			By:
	(4)			By:
	(5)			By:
HAZARDS AND LIMFACS:				
ASSIGNMENTS:	(1)			(4)
	(2)			(5)
	(3)			Other:

STAFFING WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management		Rev 1	MCI 11
Incident		Date	Time	
Position		Agency:	Person:	
INCIDENT COMMAND				
OPERATIONS SECTION CHIEF				
	MEDICAL GROUP SUPV			
	EXTRICATION UNID LDR			
	Extrication Team Ldr			
	Extrication Team Ldr			
TRIAGE UNIT LEADERS				
	Triage Team Leader			
	Triage Team Leader			
	Triage Team Leader			
	Fatality Manager			
TREATMENT UNIT LEADER				
	Red Area Manager			
	Yellow Area Manager			
	Green Area Manager			
	Medical Supply Manager			
TRANSPORTATION UNIT LDR.				
	Ambulance Staging Mgr			
	Medical Communications			
	Transport Recorder			
	Transport Loader			
	Air Ambulance Coord			

EXTRICATION WORKSHEET		Commonwealth of Virginia Mass Casualty Incident Management				MCI 2
Incident			Date		Time	
Scene Sketch:						
No.	Patients	Problem	Unit	Start	Complete	
Notes:				Special Resources		
Time	Task	Time	Task			
	Set Up		Treatment			
	Assign Resources		Monitor Personnel			
	Locate Victims		Account for personnel			
	Triage		Complete			

FATALITY WORKSHEET		Commonwealth of Virginia Mass Casualty Incident Management		MCI 31
Incident			Date	Time
Scene Sketch:				
DRAFT				
Number	Sex	Description	Condition	
Individual Completing:			Agency:	

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TRANSPORTATION WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management rev 1			MCI 5
Incident		Date	Time	
Hospital (Optional Use):				
Patient	Status	Hospital	Unit	Time
Name				
Name				
Name				
Name				

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LANDING ZONE WORKSHEET		Commonwealth of Virginia Mass Casualty Incident Management		MCI 52
Incident			Date	Time
LZ Sketch			AIRCREW BRIEFING	
			LZ Lat:	
			LZ Lon:	
			Landmark:	
			Approach From:	
			Size:	
			Hazards:	
			Lighting:	
Aircraft	Type	Patients	Operational	Winds:
				Visibility:
				Precip:
				Other:
				AIRSPACE RESTRICTION
HOSPITALS RECEIVING PATIENTS BY AIR				Time From:
Facility		From Scene:		Time To:
				By:
				Contact:
				Altitudes:
				Area:
Notes:				

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Attachment 6: Registration on VHHA-MCI.org

How do I register a user account?

Register Now

Open your browser and go to the VHHA-MCI Website (<http://www.vhha-mci.org>). You may need to type the full web address out in the address bar the first time you go to the site.

o NOTE: You may not logon to VHHA-MCI until your account has been approved by either a VHHA-MCI Administrator or your organization's designated Organization Contact or Alternate Organization Contact.

o NOTE: You may want to create a bookmark of the homepage to quickly access the logon screen. Hold down the CTRL key and press the D Key (CTRL+D) to create a bookmark.

The VHHA-MCI Homepage will be displayed as shown below: Under the "Are you a Healthcare Provider" heading, click the green "Register Now" button

The screenshot shows the VHHA-MCI website homepage. At the top, there is a navigation bar with links for "VHHA Web Site", "Contact Us", and "Home". The main content area is divided into several sections:

- Member Login:** Includes fields for "Username:" and "Password:", a "Login to VHHA-MCI" button, a red "EMERGENCY OPERATIONS PAGE" button, and a "Forgot your password?" link.
- Welcome to VHHA-MCI.org:** A central heading.
- Are you a Healthcare Provider?:** A yellow box with the text "Obtain access to VHHA-MCI site." and a green "Register Now" button.
- Need Help?:** A black box with the text "Click [here](#) if you were unable to successfully register as a Healthcare Provider." and a link to "Instructions for registering on this site (updated 8/21/2008)".
- Virginia Fusion Center:** A yellow box containing the mission statement: "Mission: Gather, classify, and disseminate information to better defend the Commonwealth against terrorist threats and/or attack." It also lists contact information: Toll Free #: 1-877-4VA-TIPS, General #: (804) 674-2196, Fax #: (804) 674-2983, E-mail: vfc@vsp.virginia.gov, and Website: VA Fusion Center. A link for "Recognizing & Reporting Potential Terrorist Activities" is also present.

At the bottom of the page, there is a footer with "Developed by SiteVision, Inc." on the left and "Version 2.08.06.27.1 - Copyright © 2008, Virginia Hospital & Healthcare Association. All rights reserved." on the right.

Select Hospital/Organization

Select your organization from the dropdown menu and click the “Continue” button under “Select Your Organization”

VHHA-MCI >> User >> Add User >> Choose Organization - Windows Internet Explorer

http://dev2.vhha-mci.org/index.cfm?fuseaction=user.orgSelectForm&fromHome=1

VHHA-MCI >> User >> Add User >> Choose Organiz...

VHHA-MCI

VHHA Web Site | Contact Us | Home

Select Hospital/Organization

Select Your Organization

The first step in creating a new user account is selecting your Hospital/Employer/Organization. Use the following select box to see if your organization is currently registered in our system. If your organization is listed, please select your organization and click “Continue” to create your account.

1st Medical Group Hospital

Add New Organization

If your hospital/employer/organization is not listed, please click the button below to add your organization/employer. After adding your organization/employer, you will then be able to create an account.

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Internet 100%

Account Information

Fill in the information on this page. The required fields are:

- o Username
- o Password (and Confirm Password)
- o First Name
- o Last Name
- o Email Address
- o Business Address
- o Business Telephone

NOTE: The username and password must contain a minimum of 4 letters, numbers, or a combination of both.

You can select a job category from the dropdown menu and click the check boxes beside any professional groups you are a member of.

You will be able to communicate with members of your professional groups and committees through the state using the post office.

Click the “Continue” button at the bottom of the page.
Review the information on the confirmation page and click the “Continue” button to submit your information and complete the registration process.

VHHA-MCI >> User >> Add User >> Contact Information - Windows Internet Explorer

http://dev2.vhha-mci.org/index.cfm?fuseaction=user.contactInfoForm

VHHA-MCI

VHHA Web Site | Contact Us | Home

Account Information

General Information

Username:

Password:

Confirm Password:

First Name:

Middle Initial:

Last Name:

Job Title:

Contact Information

Email Address:

Business Address:

address 1:

address 2:

city: state: zip:

Business Telephone: () - ext.

Business Fax: () -

Cell Phone: () -

Done Internet 100%

Registration Complete

Upon completing the registration process, you will be sent a confirmation email notifying you that your information has been received.

Your user account will now be sent to your organization’s designated organization contact.

Once your account has been approved, you may then login to VHHA-MCI and begin using the system.