

Western Virginia EMS Council

Mass Casualty Incident Plan

EMS Mutual Aid Response Guide

May 2004

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1. PREFACE

The goal of the Western Virginia EMS Council Mass Casualty Incident Plan is to prepare on a regional basis for a unified, coordinated and immediate emergency medical services (EMS) mutual aid response by prehospital and hospital agencies to, and the effective emergency medical management of, the victims of any type of Mass Casualty Incident (MCI). It includes patients who are involved in any emergency evacuation of any health care facility in the Western Virginia Emergency Medical Services (WVEMS) Region and/or any such facility outside the region that is a participant in a WVEMS MCI response effort. **Whenever possible, regional EMS mutual aid response should conform to the local emergency operations guidelines.** This guide **does not** supersede existing local emergency operations plans and procedures, but complements them.

This Response Guide will serve as the basis for hospital and out-of-hospital response under the Western Virginia MCI Plan (hereafter referred to as the MCI Plan) in the WVEMS region, Planning Districts 4, 5, and 12.

Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning districts which comprise the WVEMS region as provided in the Code of Virginia, Section 32.1-111.11.

2. BASIC DEFINITIONS

2.1. For purposes of the MCI Plan and this Operational Guide, the following definitions will apply:

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

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

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

- 2.1.4. **M.C.I. MEDICAL CONTROL** -- That medical facility, designated by the hospital community, which provides remote overall medical direction of the MCI or Evacuation scene according to predetermined guidelines for the distribution of patients throughout the healthcare community.
- 2.1.5. **PREHOSPITAL E.M.S. AGENCY** -- Any volunteer, career, private or governmental Emergency Medical Services agency or service that is certified by the Commonwealth of Virginia to render prehospital emergency care and provide emergency transportation for sick and/or injured people as described in the Code of Virginia, Section 32.1-148.
- 2.1.6. **E.M.S. PROVIDER** -- Any person "responsible for the direct provision of EMS in a given medical emergency" as described in the Code of Virginia, Section 32.1-148.
- 2.1.7. **NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS-ICS)** -- A written plan, adopted and utilized by all participating emergency response agencies, that helps control, direct and coordinate emergency personnel, equipment and other resources, from the scene of an MCI or Evacuation, to the transportation of patients to definitive care, to the conclusion of the incident.
- 2.1.8. **VIRGINIA S.T.A.R.T. TRIAGE** -- The Virginia Simple Triage and Rapid Treatment method whereby patients in an MCI are assessed and evaluated on the basis of the severity of injuries and assigned the following emergency treatment priorities.
- 2.1.9. **REGIONAL HEALTHCARE COORDINATING CENTER (RHCC)**—The fixed coordination center for the Near Southwest Preparedness Alliance region currently located at Carilion Clinic Patient Transportation office in Roanoke and/or the mobile RHCC Communication Trailer.

3. GENERAL AGREEMENT

3.1. The Western Virginia MCI Plan calls for the following general provisions:

- 3.1.1. Predetermined guidelines and the proximity and capabilities of appropriate health care facilities will be the primary considerations of MCI Medical Control when designating the health care facilities to which patients are sent during any local or regional emergency situation that results in the activation of the MCI Plan.
- 3.1.2. Localities and/or individual prehospital EMS agencies will respond with appropriate personnel and equipment as available when the MCI Plan is activated. However, the response will be dispatched by the local Emergency Communications Center and will not reduce any locality's own EMS response capabilities below established, predetermined levels.
- 3.1.3. When considering their responses to activation of the MCI Plan, member localities and/or EMS agencies will be expected to maintain their own emergency medical response capabilities to meet local needs.
- 3.1.3. Predetermined EMS mutual aid responses will be employed by hospital and prehospital members when any of the signatory health care facilities must be evacuated under the MCI Plan.
- 3.1.4. Personnel affiliated with all participating EMS agencies and/or jurisdictions will operate during an Incident or Evacuation under a standard National Incident Management System (NIMS-ICS).
- 3.1.5. Hospital and prehospital components in the region will participate when possible in training exercises of the MCI Plan. These exercises in various localities in the region will be coordinated in cooperation with the locality.

4. AUTHORITY

- 4.1. The Western Virginia EMS Council is one of eleven regional EMS councils established within the Code of Virginia, Section 32.1-111.11. Created in 1975, WVEMS is charged by law "with the development and implementation of an efficient and effective regional emergency medical services delivery system" to include the regional coordination of emergency medical disaster planning and response.

5. SCOPE OF THE M.C.I. PLAN

- 5.1. The Western Virginia EMS Council is defined as the region made up of Virginia Planning Districts 4, 5 and 12. The regional MCI Plan involves the counties of: Alleghany, Botetourt, Craig, Franklin, Floyd, Roanoke, Montgomery, Pulaski, Giles, Henry, Patrick, Pittsylvania; and the cities of Roanoke, Salem, Covington, Radford, Martinsville and Danville.
- 5.2. The MCI Plan addresses only the EMS mutual aid response of the regional emergency medical services (EMS) system, hospital and prehospital, to a Mass Casualty Incident or Health Care Facility Evacuation.
- 5.3. Mass Casualty Incidents with limited fatalities and those that involve mass fatality incidents within the WVEMS region will be handled in cooperation with, and under the direction of, the Virginia Office of the Chief Medical Examiner, local law enforcement officials and/or Virginia State Police and the Virginia Department of Emergency Services (See Section 19).

6. M.C. I. OPERATIONAL GUIDE

- 6.1. The purposes of the MCI Plan's Mutual Aid Response Guide are to:
 - 6.1.1. Provide a standardized action plan that will assist in the coordination and/or management of any regional EMS mutual aid response to an MCI within the WVEMS region.
 - 6.1.2. Ensure an effective utilization of the various human and material resources from various localities involved in a regional mutual aid EMS response to a disaster or MCI that affects a part or the entire WVEMS region to include Planning Districts 4, 5 and 12.
 - 6.1.3. Assist in the evacuation and care of a significant number of patients from any health care facility when the care and transportation of those patients exceeds the EMS capabilities of the facility, locality, jurisdiction and/or region.
 - 6.1.4. Ultimately, to ensure the largest number of survivors in mass casualty situations or health care facility evacuations.
- 6.2. A copy of the Western Virginia Mutual Aid Response Guide will be provided for each licensed EMS response vehicle in the WVEMS region, to each hospital Emergency Department, and to each licensed EMS agency in the region.
- 6.3. The Response Guide will be reviewed each year by the Council. Proposed revisions, amendments and other changes will be referred to the appropriate Committee for approval or modification. Updated copies will be provided by WVEMS (See Section 31).

7. LEVELS AND TRIGGERS

7.1. MCIs within the WVEMS region will be classified by levels, following assessment by EMS providers using the Virginia START Triage system:

- 7.1.1 **Level 1** Multiple-casualty situation resulting in less than 10 surviving victims.
- 7.1.2 **Level 2** Multiple-casualty situation resulting in 10 to 25 surviving victims.
- 7.1.3 **Level 3** Mass casualty situation resulting in more than 25 surviving victims.

Number of Ambulances =
$$\frac{\text{(Total \# of Patients) (Time Required for Round Trip)}}{\text{(Total Time to Complete Operation) (\# of Patients per Ambulance)}}$$
Required

8. POTENTIAL INCIDENTS

8.1. MCIs can occur in varying degrees, at anytime, and in practically any conceivable situation. Western Virginia's population stands at some 1.3 million people. These residents live in areas ranging from densely-populated urban such as Roanoke and Danville, to suburban locations, to largely rural areas with farms, forests and recreational areas. High risks include:

- 8.1.1. Two major Interstate highways (81 and 64), numerous highly-traveled primary highways (U.S. 460, 57, 58, etc.) between major population areas.
- 8.1.2. Freight and passenger rail lines, a regional airport and a number of smaller airports that serve high-speed, multi-passenger aircraft.
- 8.1.3. Industrial plants ranging from chemical manufacturing, to petroleum fuels storage, to light industry.
- 8.1.4. Severe and usual weather conditions also prevail throughout the region, including tornadoes, windstorms, hurricanes and heavy rains, heavy snows sleet and freezing rains, and flooding.

8.2. Based on these components, potential MCIs in the region could include:

- 8.2.1. Major vehicular accidents with multiple victims.
- 8.2.2. Urban, residential and woodland fires.
- 8.2.3. Tornadoes or other severe weather-related situations.

- 8.2.4. Public transportation accidents (aircraft, train, bus).
- 8.2.5. Construction and/or industrial and farm accidents including hazardous materials, building collapses with multiple victims.
- 8.2.6. River and/or localized flooding, impassable highways, roads and bridges.
- 8.2.7. Healthcare facility evacuations.
- 8.2.8. Acts of terrorism and/or civil disobedience.
- 8.2.9. Military-related incidents and federal disaster responses.

9. MANAGEMENT GOALS

- 9.1. The goals of MCI management are:
 - 9.1.1. Do the greatest good for the greatest number of people.
 - 9.1.2. Make the best possible use of resources.
 - 9.1.3. Avoid relocating the MCI, especially to any receiving hospitals.

10. INCIDENT PRIORITIES

- 10.1. The top priorities of an MCI (or other complex emergency situation) are:
 - 10.1.1. Provider safety, accountability and welfare.
 - 10.1.2. Life safety.
 - 10.1.3. Incident stabilization.
 - 10.1.4. Conservation of property and equipment.

11. PARTICIPANTS

- 11.1. The regional EMS mutual aid response to an MCI or Evacuation may involve, as required by the scope of the incident:
 - 11.1.1. Certified EMS providers from both the out-of-hospital arena (career services and volunteer rescue squads and emergency crews) and trained medical staff from critical care hospitals, especially trauma centers, to provide on-scene care for the critically injured or sick.
 - 11.1.2. Healthcare facilities, in particular trauma centers and hospitals with acute-care or other emergency or special facilities, to receive and treat critically injured or sick patients.

- 11.1.3. Certified and/or licensed healthcare providers at all levels of emergent patient care, from prehospital Basic Life Support (BLS) and Advanced Life Support (ALS) to acute medical and surgical treatment nurses and physicians in hospitals, local health department personnel, and other related healthcare professionals.
- 11.1.4. Trained First Responders and specially trained emergency services personnel to include firefighters, hazardous materials specialists and individuals trained in technical/tactical rescue skills, search and rescue procedures and dive rescue.
- 11.1.5. Local, state and federal government agencies including, but not limited to: Local Emergency Planning Committees (LEPCs) of jurisdictions within the WVEMS region; Virginia Department of Emergency Management; Virginia Department of Health (VDH) including the Office of Emergency Medical Services, Office of the Chief Medical Examiner and local public health departments; Virginia Department of State Police; local police and sheriffs' offices; Virginia Commission of Game and Inland Fisheries; Virginia Department of Transportation; Virginia Department of Corrections; Virginia Department of Military Affairs; Federal Emergency Management Agency (FEMA); Federal Bureau of Investigation (FBI); and U.S. Armed Forces (including the U.S. Coast Guard).
- 11.1.6 Non-traditional transport vehicles such as school buses, commercial bus services, and commercial airlines.
- 11.1.7 Non-transport and/or related support components such as the American Red Cross, Salvation Army, public utilities (gas, power, water), airlines, regular and reserve components of the armed forces, Civil Air Patrol, amateur radio organizations, and any other group that supports EMS operations.
- 11.2. The key to successful EMS mutual aid response to a major disaster or MCI is the close cooperation and coordination of these components and the Western Virginia EMS Community through effective communications, planning and training.

12. LOCAL EMERGENCY OPERATIONS PLANS

- 12.1. It is recognized that each Virginia county and locality has an emergency operations plan. **Whenever possible, regional EMS mutual aid response should conform to the local emergency operations guidelines.** This guide **does not** supersede existing local emergency operations plans and procedures, but complements them.
- 12.2. Regional EMS response planning will be transparent to, and support the health and medical annexes of, local jurisdiction emergency operations plans. Planning guidance in this document will be made available to local Emergency Services Coordinators to assist them in the preparation and maintenance of their plans. The WVEMS MCI Plan will be employed in circumstances such as when:
 - 12.2.1. The disaster or MCI is of such magnitude that it completely exhausts the EMS resources of one locality.
 - 12.2.2. The disaster or MCI crosses local boundaries and exhausts the EMS resources of one or more of those localities.
 - 12.2.3. A hospital or other health care facility must evacuate patients on a temporary basis and transportation requirements exceed the EMS capabilities of the facility, locality, and/or region.
- 12.3. The local Emergency Services Coordinator should be contacted as soon as possible that the MCI Plan is activated, or of a possible need for mutual aid.

13. INITIAL RESPONSE TO AN INCIDENT

- 13.1 The MCI Plan calls for the 5-S approach to an MCI as taught in the Virginia Mass Casualty Incident Management training program:
 - 13.1.1. Assess scene for Safety -- Determine if providers will be safe.
 - 13.1.2. Survey the Scene -- Determine type of incident, number of patients, severity of injuries, and best access.
 - 13.1.3. Send information and requests for assistance – Early contact local Emergency Communications Center (ECC) with survey information, request resources, and to activate the MCI Plan.
 - 13.1.4 Set up scene management structure -- include extrication, triage, treatment and transportation.
 - 13.1.5 Begin START Triage of incident victims.

14. ACTIVATING THE M.C.I. PLAN

- 14.1. The MCI Plan for EMS mutual aid can be activated by the following individuals:
 - 14.1.1. The Incident Manager at the scene of an MCI according to the existing local protocol, usually through the local ECC.
 - 14.1.2. The EMS or Emergency Services Coordinator, or that person's representative, of a political subdivision who has authority for the management of the incident.
 - 14.1.3. The Chief Executive Officer, or that person's representative, of a health care facility that is required to evacuate or move patients.
 - 14.1.4. Any health care facility in the WVEMS region when additional resources are necessary to provide appropriate patient care.
- 14.2. It is strongly recommended that the MCI Plan be activated through the local Emergency Communications Center which will communicate directly with MCI Medical Control and with localities whose prehospital resources may be used within the WVEMS region.
- 14.3. The MCI Medical Control component of the MCI Plan is activated by contacting the medical facility (hospital) that is in closest proximity to the incident, and that hospital will then use the MCI function of WebEOC to involve other facilities as needed.
 - 14.3.1. The person authorized to request activation should identify herself/himself, ask to activate the MCI Plan.
 - 14.3.2. The person should give a brief summary of the incident. The information should include time of the incident, location, initial number of patients involved, and a callback phone number.
- 14.4. Depending on local protocol and the scope of the incident, the local Emergency Communications Center will activate the Prehospital Component of the MCI Plan through established mutual aid agreements among prehospital volunteer and career EMS agencies in the region as provided for in this document.
 - 14.4.1. The Emergency Communications Center dispatcher should emphasize that the mutual aid request for ambulances and/or equipment is under the activated Western Virginia MCI Plan.

15. RESPONSIBILITIES--HOSPITAL

- 15.1. Alleghany Regional Hospital, Carilion (CMC) Medcom, Danville Regional Medical Center, Memorial Hospital of Martinsville, Carilion New River Valley Medical Center and Patrick County Memorial Hospital will serve as primary MCI Medical Control facilities for the WVEMS region in the event of an incident that requires activation of the MCI Plan.
 - 15.1.1. MCI Medical Control may designate another acute care medical facility to act as primary MCI Medical Control for any appropriate reason including better communications, better or closer geographical location to the MCI site, or because of any other circumstances that would be in the best interest of effective patient care.
 - 15.1.2. MCI Medical Control will notify the designated hospital, by WebEOC messaging, radio or other telecommunication, that it is relinquishing the MCI Medical Control function, and will receive an appropriate sign of acceptance of the MCI Medical Control responsibility from the designated hospital.
- 15.2. Representatives of participating hospitals will establish Hospital Triage Level and Mutual Aid Capability tables. These tables will be reviewed each six months and which will be confirmed or adjusted at the time of the incident.
- 15.3. MCI Medical Control will activate or alert the Regional Healthcare Coordinating Center by contacting the Near Southwest Preparedness Alliance. The RHCC will then notify the appropriate acute care medical facilities and other appropriate health care facilities in those numbers and in those locations that best can accommodate the scope of the MCI and/or Evacuation, and which are in the best interests of effective patient care.
- 15.4. Hospitals that are activated or alerted under the MCI Plan will provide upon request from the RHCC confirmation or adjusted information on the predetermined numbers of patients they can accommodate in the three START Triage categories: Red, Yellow and Green (Hospital Triage Level), or confirm or adjust the predetermined numbers and categories of patients they can receive from another hospital through Mutual Aid in the event of an Evacuation (Mutual Aid Capability).
- 15.5. The RHCC will assign patients to the medical facilities closest to the site of an MCI or evacuation and which can provide the appropriate levels of emergency care. The levels will be contained in the suggested Hospital Triage Level and Mutual Aid Capability tables that are agreed to in advance by hospital officials (See Section 15.4.).
- 15.6. MCI Medical Control also will be responsible for any on-line medical control during patient transport to designated receiving hospitals. On-line medical direction likely will be affected by limited access to the HEAR radio system during an MCI.

- 15.7. In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with WVEMS's Prehospital Patient Care Protocols, as most recently amended and approved by the WVEMS Medical Control Committee.
- 15.8. Hospitals will be responsible for providing definitive patient care to the levels of their capabilities during and after the incident.

16. RESPONSIBILITIES--PREHOSPITAL

- 16.1. Transportation of patients under the MCI Plan during an incident or evacuation will be done by licensed prehospital EMS agencies in the WVEMS region and from neighboring regions when necessary and available.
- 16.2. Units and personnel involved in mutual aid response to a regional MCI or Evacuation will be dispatched through the local emergency communications and/or dispatching center. Each communication center will track those resources in route from their respective localities and be ready to report these numbers to Incident Command on request.
- 16.3. Individual providers will report to their respective agencies and will not self-dispatch to the scene of the incident. Providers who so respond in privately-owned vehicles (POVs) will be directed to report to their respective agencies or, at the discretion of the Incident Manager and if they have appropriate EMS identification, may be directed to the incident Staging Area. **They will not be allowed direct access to the MCI site.**
- 16.4. All out-of-hospital providers and/or agencies responding to an MCI site in the WVEMS region agree to operate under the Virginia Mass Casualty National Incident Management System, the Virginia START Triage system and the WVEMS Regional Operational Protocols, as most recently revised.
- 16.5. Localities affected by an MCI will be responsible for activating mutual aid in the region through their own Emergency Communications Systems. Use of the available resources of the Virginia Office of EMS, Virginia Department of Emergency Management, the Virginia Association of Volunteer Rescue Squads, or WVEMS is encouraged.
- 16.6. Prehospital EMS agencies and/or localities agree to respond with personnel and equipment when the MCI Plan is activated, but should not be expected to reduce local emergency response capabilities below acceptable levels. When considering their responses to requests for assistance under the MCI Plan, localities and/or individual prehospital EMS agencies will be expected to maintain their emergency response capabilities to meet local needs. (See Sections 3.1.2. and 3.1.3.)
- 16.7. The crews of prehospital EMS units responding to an MCI or Evacuation will be required to carry self-identification and proof of affiliation with their agency.

- 16.8. The crews of prehospital EMS units responding to an MCI or Evacuation will be responsible for maintaining all medical and operational documentation, and for making that documentation available to IMS officials.
- 16.9. Prehospital agencies in the WVEMS region will participate when possible in annual training exercises of the MCI Plan held in various locations within Planning Districts 4, 5 and 12. (See Section 3.1.5).
- 16.10 Prehospital agencies will encourage their providers to participate in on-going regional training for rescue and EMS personnel in the National Incident Management System, Virginia START Triage System, hazard awareness programs and other related MCI skills.

17. MEDICAL DIRECTION, PROTOCOLS AND TRIAGE

- 17.1. In the absence of on-line or on-scene medical direction, out-of-hospital adult and pediatric patient care will be rendered in accordance with WVEMS' Regional Operational Protocols, as most recently revised. Unless otherwise designated, final medical documentation will be done on Virginia Prehospital Patient Care Reports (PPCRs) and/or the Virginia Triage Tag.
- 17.2. Field triage of patients will conform to the guidelines described in the Commonwealth of Virginia Emergency Operations Plan which involves the Virginia START Triage System as outlined in this MCI Plan Mutual Aid Response Guide. General categories are: Red -- Immediate care required; Yellow -- Care can be delayed; Green -- Minor injuries; Black -- Dead or non-salvageable.
- 17.3. The numbers and types of patients which member hospitals will be prepared to receive are suggested in predetermined Hospital Triage Levels and Mutual Aid Capability tables. (See Sections 15.2 through 15.5.)

18. SPECIAL CONSIDERATIONS FOR HEALTH CARE FACILITY EVACUATIONS

- 18.1. When a hospital must evacuate any number of patients on a temporary basis, the following shall apply:
 - 18.1.1. The administrative staff of the evacuating hospital will be responsible for directing the evacuation and transfer of patients to the designated receiving hospital in coordination with MCI Medical Control.
 - 18.1.2. Physicians whose patients have been evacuated will receive Courtesy Medical Privileges from the receiving hospital for the duration of the emergency. These privileges will be stipulated in predetermined and pre-negotiated protocols and/or agreements which may be added to this document as an appendix.
 - 18.1.3. Each evacuated patient will be accompanied by his/her medical records.

- 18.1.4. Receiving hospitals will use routine admitting procedures for patients from the evacuated hospital including, if possible, consent for treatment.
- 18.1.5. Other admitting and billing procedures will be predetermined by the participating hospitals in pre-negotiated protocols and/or agreements which may be an appendix to this document.

19. FATALITIES AND MASS FATALITIES INCIDENTS

- 19.1. By Virginia State Statute, the Chief Medical Examiner is responsible for the medical investigation of sudden, unexpected and violent deaths throughout the Commonwealth. Persons who die under those circumstances require the expeditious and skilled attention of the Medical Examiner.
- 19.2. It is critical that the Medical Examiner's Office be notified as early as possible in any mass casualty incident which involves, or which may involve, fatalities.
- 19.3. The Office of the Chief Medical Examiner can be reached at 804-786-3174.
- 19.4. The dead must be treated with respect and dignity in thought and in actions at all times.
- 19.5. An MCI also may be a Mass Fatalities Incident.
 - 19.5.1. A Mass Fatalities Incident is any situation where there are more bodies than can be handled using local resources.
 - 19.5.2. In a disaster situation, identification of the dead is a critical issue. Therefore, security of the area in which the dead are located is critical. Close cooperation with the Medical Examiner and police authorities, both in MCI preplanning and during the incident, is essential.
 - 19.5.3. During a mass fatalities incident, extreme stress and grief are natural and expected reactions by emergency responders and EMS providers, as well as survivors. In these events, Critical Incident Stress Management is highly recommended (See Section 25).

20. SAFETY AND STANDARD PRECAUTIONS

- 20.1. The safety of all EMS personnel involved is the first priority.
- 20.2. The scene should be deemed safe to operate in via the use of air monitoring devices under the use of trained hazardous materials personnel.
- 20.3. Appropriate protective equipment should be utilized at all times. Different situations will require different equipment.
- 20.4. EMS personnel will operate under incident command and will be placed in the “Cold Zone”. This is an area that has been deemed safe to occupy with no protective equipment. This area designation must come from Incident Command.
- 20.5. All EMS personnel involved in a regional response to an MCI or Evacuation will be expected to observe Standard Precautions (aka Universal Precautions) and other infection control Body Substance Isolation practices as specified by the Center for Disease Control, OSHA and the NFPA Infection Control Standard 1581, and other applicable state and local infection control regulations.
- 20.6. The use of S.T.A.R.T. and triage tags is recommended once patients have been decontaminated and moved to an area that is safe for EMS providers to render care.

21. EMERGENCY COMMUNICATIONS

- 21.1. Radio communication will remain the primary method of hospital-to-field communications during a MCI. The NSPA mobile communications command trailer may be requested to provide on (or near) site interoperable communications.
- 21.2. Other communications tools that can be used during an MCI include the WebEOC web-based information program, the statewide Rescue Mutual Aid Frequency (155.205), the UHF MED channels, and cellular telephones.
- 21.3. If it is absolutely necessary for an ambulance crew to communicate with a hospital or other emergency services agency en route from the MCI scene, the UHF MED channels, if available, should be used in accordance with established radio protocols.
- 21.5. Because 10-Codes can vary among localities, their use is NOT recommended during an MCI or Evacuation.
- 21.6. In the case of cellular phones, no cells exclusively dedicated to EMS are available at this time. Therefore, because the cellular system is likely to be very busy during an MCI, once an open cell line has been established by the Incident Manager or other key element of the National Incident Management System (i.e. Transportation Officer or Command Post/Communications Center), it should be kept open for the duration of the MCI.

22. EMERGENCY MEDICAL RESPONSE

- 22.1. The MCI Plan assumes that localities and/or out-of-hospital agencies will respond to all emergency scenes under local dispatch protocols. Units and crews will continue to operate under local protocols until such time as it has been determined that a regional MCI exists and the MCI Plan has been activated by the MCI Medical Control.
- 22.2. In the interest of safety, efficiency and accountability, response to the scene of an MCI by individual providers in their privately-owned vehicles (POVs) is strongly discouraged. Providers who so respond will be directed to report to their respective agencies or, at the discretion of the Incident Manager and if they have appropriate EMS identification, may be directed to the incident Staging Area. They will not be allowed direct access to the MCI site. (See Article 16.3)
- 22.3. The MCI Plan stipulates the use of the Virginia Simple Triage and Rapid Treatment (START) system within standardized National Incident Management System that is used by Virginia Emergency Services and Emergency Medical Services agencies. The MCI Plan also calls for the use of the Virginia Triage/MCI Patient Information Tags during any response.
- 22.4. A standardized National Incident Management System (NIMS-ICS), as developed and taught within the WVEMS region, allows EMS personnel from anywhere in the region to quickly and easily become integrated into local and/or regional response efforts. It also provides effective command and control of EMS resources, and provides for cooperative integration with other emergency support functions.

23. TECHNICAL RESCUE OPERATIONS

- 23.1. MCIs involving extended technical rescue operations (i.e. large transportation extrications, confined spaces, collapsed man-made or natural structures, search and rescue operations, etc.) should use the resources of the local jurisdiction.
- 23.2. When needs exceed local capabilities or resources, utilize existing methods to locate specialized resources. Several local teams exist in Virginia which have technical rescue capabilities. Local dispatch centers should keep team contact phone numbers available for use during an incident.
- 23.3. The Virginia EOC, 1-800-468-8892, is the Search and Rescue Coordination Center for Virginia and can contact SAR teams for local jurisdictions.
- 23.4. All personnel involved in the technical rescue aspects of an MCI regional response must have appropriate training and maintain compliance with local, state and federal OSHA standards.

24. HAZARDOUS MATERIALS

- 24.1. Hazardous materials, as defined in Section 44-146.34 of the Code of Virginia, means substances or materials which may pose unreasonable risks to health, safety, property or the environment when used, transported, stored or disposed of, which may include materials which are solid, liquid or gas. Hazardous materials may include toxic substances, flammable and ignitable materials, explosives, corrosive materials, and radioactive materials and include: those substances or materials in a form or quantity which may pose an unreasonable risk to health, safety or property when transported and which the U.S. Secretary of Transportation has so designated by regulation or order; hazardous substances as defined or designated by law or regulation of the Commonwealth or law or regulation of the U.S. government; and hazardous waste as defined or designated by law or regulation of the Commonwealth.
- 24.2. The local fire department should be contacted for incidents involving hazardous materials. The local fire department will contact Virginia EOC at 1-800-468-8892 for technical assistance or to have a Virginia Department of Emergency Management (VDEM) Regional Hazardous Materials Officer respond to the incident site. The VDEM Hazardous Materials Office can activate one or more regional hazardous materials response teams if required.
- 24.3. Actions of local emergency response organizations are based on local response plans and Virginia's Emergency Operations Plan (COVEOP), including the Oil and Hazardous Materials annex (COVEOP Volume 4), the Terrorism Consequence Management annex (COVEOP Volume 8), as well as local government and hospital emergency operations plans and terrorism management annexes.
- 24.4. Decontamination is the process of removing or neutralizing contaminants that have accumulated on personnel and equipment that is critical to health and safety at the scene of any hazardous materials incident, including a terrorism incident. **Whenever possible, decontamination should be accomplished at the incident site.** The process is designed to protect emergency care providers, to prevent mixing of incompatible substances, and to protect the community by preventing uncontrolled transportation of contaminants from the incident site.
- 24.5. While all hospitals are encouraged to have basic decontamination capabilities to treat patients exposed to hazardous materials, specific hospitals in the region have advanced decontamination capabilities.
- 24.6. Decontamination of hazmat patients and/or hospital and prehospital EMS providers will be in accordance with established national guidelines by the U.S. Department of Transportation, the Occupational Safety and Health Administration (OSHA), and the National Fire Protection Association (NFPA), as well as local and regional emergency operations plans, including the regional Domestic Terrorism and Hazmat plans that are annexes to this Response Guide.

25. CRITICAL INCIDENT STRESS MANAGEMENT

25.1. Critical Incident Stress Management (CISM) has been determined to be an integral part of any emergency medical response to an MCI or Evacuation. Regional and local teams of mental health and peer debriefers have been trained and are available throughout the WVEMS region.

25.1.1. The WVEMS Regional CISM Team can be activated by calling 1-800-377-7628.

26. AIRSPACE RESTRICTIONS

26.1. Airspace over an MCI is regulated by the Federal Aviation Administration (FAA).

26.1.1. Questions or requests concerning the use or restriction of that airspace during an MCI should be referred as early as possible to the FAA's Washington Air Route Traffic Control Center (ARTCC) also known as the Washington Center, at 703-771-3470.

26.1.2. Temporary flight restrictions for disaster areas are designated by the ARTCC which will notify other appropriate FAA facilities.

26.1.3. NOTE: The Virginia EOC, at 804-674-2400 or 1-800-468-8892, has contact information to assist in this function.

27. MED-EVAC OPERATIONS

27.1. Medflight 3 (based in Lynchburg) is available 24 hours a day through the Virginia Emergency Operations Center (Virginia EOC) at 804-674-2400 or 1-800-468-8892. To assist in landing zone location, the caller must provide Virginia EOC with precise identification of the intersection of highways/roads nearest to the chosen LZ.

27.2. Life Guard 10 (based in Roanoke) is available 24 hours a day through the Carilion Clinic Patient Transport dispatch center (1-800-377-7628).

27.3. In a large-scale emergency, the Virginia EOC can assist with phone numbers to contact the Virginia Army National Guard and Virginia Air National Guard and the U.S. Coast Guard for possible use of the aviation assets of those organizations.

27.4. Fixed-wing and rotorcraft (helicopters) can be used to evacuate patients from the scene of an MCI. However, given their limited space, other possible uses should be considered. These uses for both types of aircraft include:

27.4.1 Initial disaster scene size-up/access; aerial observation/monitoring of the scene and related conditions; weather information; scene lighting; air-to-air and air-to-ground communications; and control of airspace over the incident.

27.4.2 Movement of essential medical or public safety personnel and/or medical supplies to or from the MCI site.

27.5. Specific uses for rotorcraft may include:

27.5.1. Use of Flight Nurses or Flight Paramedics for triage or treatment; use of the helicopter to overcome natural or other physical barriers.

28. HELICOPTER OPERATIONS

28.1. A helicopter landing zone (LZ), if needed, should be designated as early as possible by the Incident Manager or the Manager's designed EMS Air Ambulance Coordinator.

28.1.1. The LZ should be as near as possible to the MCI scene but should not affect patient care areas.

28.1.2. The LZ should be away from power lines, towers, trees, buildings and other potential height hazards. It should be selected with consideration for pedestrian and vehicular traffic control needs. The LZ should be a minimum of 200 feet away from any traffic.

28.1.3. Roads or highways, with proper traffic control, make suitable LZs. However, safety considerations must include nearby power lines.

28.2. The overall size of an LZ should be not less than 500 feet by 500 feet.

28.2.1. The helicopter touchdown site in daylight should be not less than 75 feet by 75 feet.

28.2.2. The helicopter touchdown site at and after dusk should be not less than 100 feet by 100 feet.

28.2.3. The touchdown site should have a wide and clear path of flight approach and departure. Helicopter pilots prefer to land and take off with the aircraft's nose into the prevailing wind.

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

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

28.2.5.1. Minimum staff in daylight should be a person with easy-to-spot clothing, with arms above head and back to the down-draft. LZ personnel should wear effective eye and ear protection and be familiar with dangers of working around helicopters, especially during a "hot" operation, when the aircraft engines and rotors are not shut down.

28.2.6. Precise marking of the LZ in bright daylight is not essential as long as the intended area is obvious to the helicopter flight crew.

28.2.7. The LZ at dusk and in darkness should be marked with lights (lantern, vehicular, etc.), but not flares. All lighting must be secured against the helicopter's down-draft.

28.2.8. LZ personnel must guard against flashing any lights toward the aircraft. Strobe lights bleed through as white.

28.2.9. The LZ should be inspected for loose debris, foreign objects and loose dirt. The LZ can be wet down if necessary to reduce dust and enhance visibility.

28.3. Radio contact from the LZ to the helicopter is extremely important.

28.3.1. In the absence of other directives, the Statewide Mutual Aid radio frequency (155.205) should be used when communicating with the helicopter. Good communications with the flight crew will ensure the prompt and safe landing the aircraft.

28.3.2. Before and during final approach, the flight crew should be advised of potential hazards, wind direction, ground conditions and, if available, the patient's general status. LZ personnel should check constantly and repeatedly for pedestrian traffic and other hazards in or near the LZ.

28.3.3. The helicopter flight crew should be advised immediately to abort the landing if any threat develops to the flight crew or to ground personnel.

29. VIRGINIA E.M.S. DISASTER TASK FORCES

29.1. In a declared state of emergency, local resources can be supplemented by requesting deployment of state EMS Disaster Task Forces through the EMS Desk in the Virginia Emergency Operations Center (1800-468-8892 or 804-674-2400).

29.2. EMS Disaster Task Forces can be deployed in three configurations. The requesting jurisdiction should identify the specific configuration needed.

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

29.2.2. **Personnel Package:** Composed of standard Task Force staffing with appropriate transportation. No equipment other than personal kits is carried by providers.

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

29.3. EMS Disaster Task Forces are designed to be used as units to either undertake specific tasks or to supplement the needs of the requesting jurisdiction.

29.4. EMS Task Forces will remain under the command of their Task Force commander and should not be broken up.

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

30. MOVEMENT OF PATIENTS INTO OR OUT OF THE REGION

30.1 During a major MCI or a national emergency, it may become necessary to move large numbers of patients into or out of the WVEMS region. Such movements will be done in accordance with the Western Virginia National Disaster Medical System (NDMS) Operations Plan. Copies of both are included as appendices of this document.

31. DEACTIVATING THE M.C.I. PLAN

- 31.1. The Medical Incident Manager will be responsible for notifying MCI Medical Control that all patients have been assigned to transport units and that all on-scene patient care activities have been completed and ended at the MCI or Evacuation site or sites.
- 31.2. The on-scene Medical Incident Manager should confer with the appropriate official (e.g. Incident Manager, Emergency Services Coordinator, healthcare facility CEO) to determine any additional patient care need for EMS prior to contacting the MCI Medical Control.
- 31.3. If appropriate and possible, on-scene contact to MCI Medical Control should be made by phone (804-828-8888 if the MCI Medical Control hospital is VCU Medical Center). Otherwise, radio communication should be used.
- 31.4. MCI Medical Control will deactivate the MCI Plan among activated hospitals when the designated MCI Medical Control hospital is notified by the on-scene Medical Incident Manager that EMS activities are completed at the MCI or Evacuation site or sites, and when it determined that all other patient care issues have been resolved.

32. THE M.C.I. COMMITTEE

- 32.1. The Western Virginia MCI Committee is a working Committee of WVEMS, and it operates in conjunction with the Near Southwest Preparedness Alliance. It is made up of representatives of the hospital and prehospital components career and volunteer, that render emergency medical care in Planning Districts 4, 5 and 12. Other members include representatives of health care facilities outside the region as appropriate
- 32.2. Other members of the Committee include, but are not limited to, representatives of related local, state and federal agencies (including law enforcement and emergency communications), disaster relief organizations, representatives of major industries, transportation and utilities companies, along with local businesses and other individuals whom members of the committee may call upon from time to time for advice and expertise.
- 32.3. Members will be recommended by the Committee and endorsed by the WVEMS Board of Directors. Members shall serve in an uncompensated capacity on the Committee for as long as they are willing and able to render service to the cause of regional disaster preparedness.

33. ADOPTION OF THE M.C.I. PLAN MEMORANDUM OF UNDERSTANDING

- 33.1. Participation in the plan **may** be through the execution of memoranda of understanding among all governments, hospitals and other entities affected by the Plan. Should these memoranda be implemented, the following guidelines will apply:
- 33.1.1. Copies of the Memorandum of Understanding and this Mutual Aid Response Guide shall be provided to each locality and hospital by WVEMS.
 - 33.1.2. WVEMS shall be responsible for providing the signatory agencies with copies of the most recent updated Memorandum and Mutual Aid Response Guide, and not more than 60 days following any revision(s).
 - 33.1.3. Copies of the Memorandum and one copy of the Mutual Aid Response Guide shall be filed by WVEMS with the Virginia Office of Emergency Medical Services.
 - 33.1.4. In the case of a hospital, a resolution of adoption shall include an appendix that provides for appropriate adjunctive or emergency privileges to be accorded to attending physicians during an MCI (See Section 18).

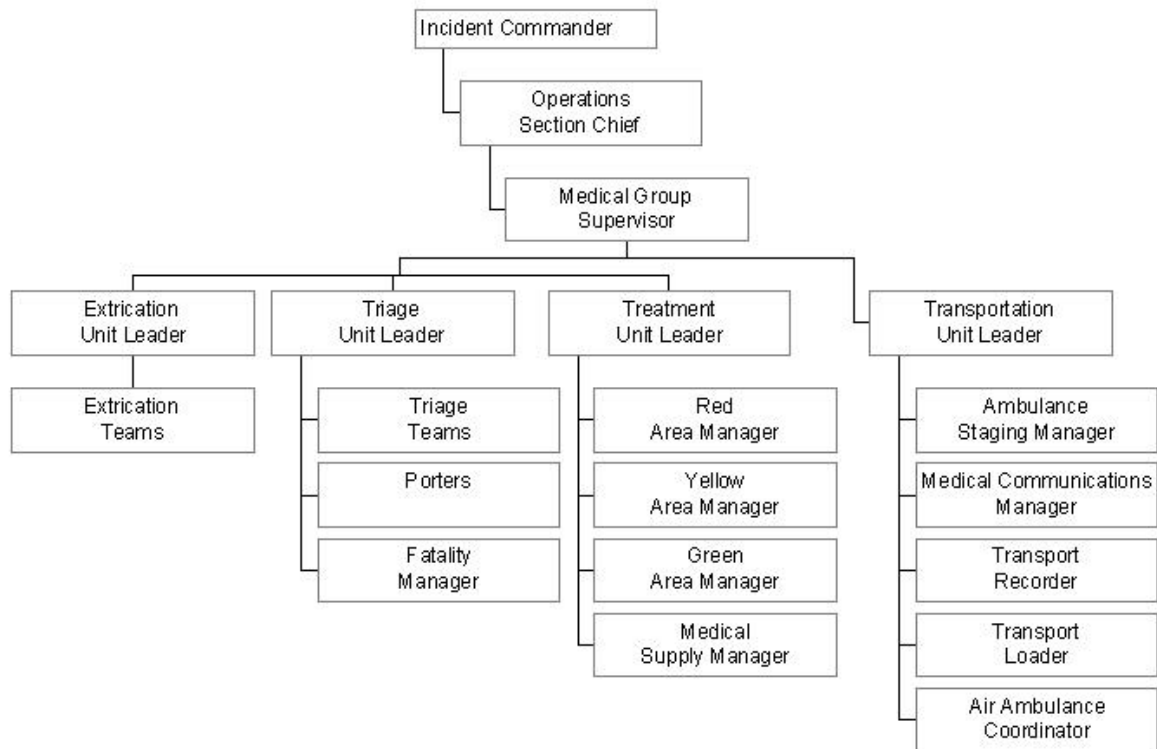
34. REVISIONS AND AMENDMENTS TO THE M.C.I. PLAN

- 34.1. The Western Virginia MCI Committee is responsible for reviewing each year the MCI Plan in line with the Western Virginia MCI Plan Memorandum of Understanding, for proposing revisions and/or amendments to the Mutual Aid Response Guide as necessary to maintain its effectiveness, for reviewing and evaluating any activation of the MCI Plan, and for planning annual MCI exercises in the region.
- 34.2. Revisions and/or amendments will be acted upon by the Committee no sooner than 45 days, and not longer than 60 days, after all signatories have been notified of the proposed changes and have had an opportunity to respond through their representatives or in writing to the Committee Chair.
- 34.3. Revisions and/or amendments to the Plan will require a two-thirds majority of the members present in a quorum to be enacted

Original signed MOUs for the Western Virginia Mass Casualty Incident Plan are on file at the Offices of WVEMS, 1944 Peters Creek Road NW, Roanoke VA 24017. Please direct inquiries to the attention of the Executive Director at 540-562-3482 or by e-mail to logan@vaems.org. A copy of this document can be downloaded from WVEMS's web site, www.wvems.org.

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Appendices



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.

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.
 - a. Brief on what you know about the incident.
 - b. Brief on resources committed, available, responding.
 - c. Brief on strategy and tasks in progress.

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.

EXTRICATION UNIT LEADER (EXTRICATION)

OBJECTIVE: Locate, physically extricate, and remove trapped victims to safe area. **WORKS FOR:** MEDICAL GROUP Supervisor.

- _____ 1. Put on EXTRICATION vest.
- _____ 2. Set up where you can be seen and reached by arriving resources, with a clear view of the area in which EXTRICATION will be done.
- _____ 3. Assign resources to specific area or group of victims.
- _____ 4. Position heavy equipment (technical and heavy tactical rescue units, ladder trucks, and specialized equipment) as close to the site as possible without blocking access.
- _____ 5. Coordinate with TRIAGE for triage either in the EXTRICATION area (if safe) or after victim removal to safe area.
- _____ 6. Locate and remove trapped victims and deliver them to a safe area for pickup by PORTERS. Non-ambulatory patients move on backboards with C-spine precautions.
- _____ 7. Determine need for medical treatment for victims during extrication. Coordinate with TREATMENT for support.
- _____ 8. Monitor condition of assigned personnel. Request relief crews as needed to keep people safe, reduce incident stress, and maintain progress toward EXTRICATION incident objectives.
- _____ 9. Supervise site safety and keep EXTRICATION operations safe.
- _____ 10. Record actions using Tactical Worksheet.
- _____ 11. Keep MEDICAL GROUP and TRIAGE informed.
- _____ 12. Account for all personnel assigned to EXTRICATION.

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.

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.
- _____ 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.

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.
- _____ 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.

STAFFING CHART - TREATMENT AND PORTERS

PURPOSE: Quick reference chart of desired numbers of providers for mass casualty incidents. Total column gives number by Treatment Area and an overall total.

PATIENTS		ALS	BLS	PORTERS	TOTAL
10	2 RED	2	2		4 area
	2 YELLOW	1	2		3 area
	6 GREEN	0	2		2 area
		3	6	8	17
20	4 RED	4	4		8 area
	4 YELLOW	1	4		5 area
	12 GREEN	0	4		4 area
		5	12	8	25
50	10 RED	10	10		20 area
	10 YELLOW	3	10		13 area
	30 GREEN	0	10		10 area
		13	30	20	63
100	20 RED	20	20		40 area
	20 YELLOW	6	20		26 area
	60 GREEN	0	20		20 area
		26	60	40	126

BASIC STAFFING RATIOS:

RED TREATMENT AREA 1 ALS Provider and 1 BLS Provider per patient.

YELLOW TREATMENT AREA 1 BLS Provider per patient.
 1 ALS Provider per 3 patients.

GREEN TREATMENT AREA 1 BLS Provider per 3 patients

PORTERS 1 per RED or YELLOW patient

SIMPLE TRIAGE AND RAPID TREATMENT

ALGORITHM

- Tell all who can WALK to move to a easily identified location. Assign a rescuer to supervise these patients. Tape as **GREEN**.
- Begin where you stand and move through the remaining victims. Quickly assess each victim and tag with surveyor's tape. Wrap the tape around an extremity and tie with a knot.

COLOR CODE	PRIORITY
RED	1 Immediate
YELLOW	2 Delayed
BLACK	3 Deceased or Not Salvageable

- Evaluate each patient as follows:

RESPIRATION

Not breathing and does not breath when airway opened - **BLACK**.
Not breathing - breathes when airway opened - **RED**.
More than 30 breaths a minute - **RED**.
Less than 30 breaths a minute - go to next check.

PERFUSION

Stop obvious life threatening bleeding.
No radial pulse - **RED**.
Radial pulse - go to next check.

MENTAL STATUS

Altered level of consciousness - **RED**.
Does not follow simple commands - **RED**.
Follows commands - **YELLOW**.

- Keep a patient count - use a strip of tape on your leg and mark each patient with a tick mark by color code.

SECONDARY TRIAGE

- Secondary triage decisions are based on clinical experience and judgment. Consider the following guidelines for mass casualty incidents.
- **RED** Priority 1 IMMEDIATE
 - life threatening injuries or illness.
 - shock or risk of asphyxiation is present or imminent.
 - high probability of survival if treated and transported immediately.
- can be stabilized without requiring constant care or elaborate treatment.
- **YELLOW** Priority 2 DELAYED
 - potentially life threatening injuries or illnesses.
 - severely debilitating injuries or illnesses.
- can stand a delay in treatment and transportation.
- **CATASTROPHICALLY INJURED**
 - not yet deceased.
 - low probability of survival even with immediate treatment and transport.
 - placed separately in the **YELLOW** area.
 - TREATMENT and TRANSPORTATION determine when to transport.
- **GREEN** Priority 3 MINOR
 - non-life threatening injuries or illnesses.
 - require a minimum of care with minimal risk of deterioration.
- **BLACK** DECEASED
 - NOT SALVAGEABLE
 - deceased on way to TREATMENT or on arrival.
 - unresponsive with no circulation; cardiac arrest.

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												

MCI-1 TACTICAL WORKSHEET

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time that this particular worksheet page was initiated.

SCENE SKETCH – Make a rough sketch of the scene, indicating major elements. Draw in and label areas of responsibility assigned to the teams, locations of command, staging, treatment, landing zone, and other key areas, and other information that will help you manage the incident.

TIME AND TASK – Record times key tasks are started.

UNIT – List all responding EMS units.

ASSIGNMENT – Note current assignment of each unit.

CASUALTIES:

TIME – Note time of report.

RD, YE, GN, BK - Record number of RED, YELLOW, GREEN and BLACK patients.

TRANS – Record total number transported so far.

HOSPITAL CAPABILITIES:

FACILITY – Note names of operational hospitals.

RD, YE, GN – Record totals of RED, YELLOW, GREEN patients each can accept.

TRANS – Note current number transported to each hospital.

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:

MCI-10 EMS INCIDENT ACTION PLAN

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date

TIME – The time in 24-hour clock time that this particular worksheet page was initiated.

FOR OPERATIONAL PERIOD – Write in the start and end time of the period covered by the Plan. These may be time, day and time, or specific events that serve as response benchmarks.

INCIDENT COMMANDER GOALS – Note the goals established by the Incident Commander.

INCIDENT COMMANDER STRATEGY – Note the strategy set by the Incident Commander as it applies to the EMS response.

SCENE SKETCH – Make a simple scene sketch noting the key elements. Use this sketch to note tactical priorities, hazards, and assignments.

TACTICAL PRIORITIES – Write down key events that must happen to meet goals and strategy. List in priority order or in the order in which they must be done (if different from priority). Examples are: "extricate patients from railroad car 2," "do a scene perimeter check for patients," or as simple as "initial triage."

BY – Set a measure to define success for each priority. It may be a specific time (most common) or some other measure of effectiveness (for example, "all alive" for "extricate patients" if we know some patients are in very poor condition).

HAZARDS AND LIMFACS – Note specific hazards (either normal to the site, resulting from the emergency, or resulting from the response) that affect operations. Note any limiting factors that will make the response more difficult (for example, "radio repeater down – use simplex").

ASSIGNMENTS – Assign EMS resources to each Tactical Priority.

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			

Accountability Worksheet		Commonwealth of Virginia Mass Casualty Incident Management						MCI 12	
Incident				Date		Time			
Unit	Assignment	Released	Accountability Checks						
			1	2	3	4	5	6	
Action Taken:									

MCI-12 ACCOUNTABILITY WORKSHEET

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time that this particular worksheet page was initiated.

UNIT – List each EMS response unit on scene by agency and unit number.

ASSIGNMENT – List first assignment on the first line. If reassigned, note the new assignment on the second line or third line, as needed.

RELEASED – Enter the time the unit is released for return to quarters or normal service.

ACCOUNTABILITY CHECKS – Blocks are provided for up to six accountability checks. Based on your standard operating procedures you may either enter the number of personnel reported or the time of the check in the block. If time is not entered here, the time each check process is completed for all units should be noted in the ACTION TAKEN section.

ACTION TAKEN – Note any action taken to account for units that do not reply or in the event of persons identified as missing with the time the action is taken.

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	

MCI-2 EXTRICATION WORKSHEET

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time that this particular worksheet page was initiated.

SCENE SKETCH – Make a rough sketch of the scene, indicating major elements. Draw in and label areas of responsibility assigned to teams for extrication and the locations of ongoing operations. Note any special hazards that affect the extrication operations. Key each operation location with a number.

NO. – Enter the operation number from the scene sketch.

PATIENTS – Note the number of patients and triage category, if available.

PROBLEM – Note a brief description of the extrication problem.

UNIT – Note the unit assigned to the problem.

START – Record time of start of extrication.

COMPLETE – Record time extrication is complete.

NOTES – Use for any additional information you need to record.

TIME AND TASK – Record times key tasks are started.

SPECIAL RECOURCES – Record the time in and the identification of any special units called.

TRIAGE WORKSHEET		Commonwealth of Virginia Mass Casualty Incident Management				MCI 3	
Incident				Date		Time	
Scene Sketch:							
TRIAGE TEAM REPORTS							
Team	RED	YELLOW	GREEN	BLACK	Total	Notes	
TOTALS							
Time	Task		Time	Task			
	Assign Triage Teams			Safeguard BLACKS			
	START			Personnel Count			
	Assign Porter Teams			Patient Count			
	Clear Scene						

MCI-3 TRIAGE WORKSHEET

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time that this particular worksheet page was initiated.

SCENE SKETCH – Make a rough sketch of the scene, indicating major elements. Draw in and label areas of responsibility assigned to the Triage Teams or individuals.

TEAM – Identify the units assigned to triage. If individuals are assigned to areas, identify individuals.

RED, YELLOW, GREEN, BLACK – Record number of patients reported in each category by each Team.

TOTAL – Total up the number of patients reported by each Team, and the totals by color code. Cross check your arithmetic.

NOTES – Note additional information as needed.

TIME AND TASK – Record times key tasks are started.

MCI-31 FATALITY WORKSHEET

SPECIAL INSTRUCTIONS – Do not move remains unless necessary to preserve them from destruction. All observations on this sheet should be made as the remains lie in place. Remember: the Office of the Chief Medical Examiner is responsible for the dead. Assistance from the Chief Medical Examiner may be requested.

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time this particular worksheet page was initiated.

SCENE SKETCH – Make a rough sketch of the scene, indicating major elements. Label identifying elements such as roads, buildings, runaway number, etc. clearly. For each remains located place a circled number on the worksheet with approximate distance and direction from a feature that will be there when the Medical Examiner arrives (such as a large piece of wreckage, a building, etc.)

NUMBER – Enter each remains number that you place on the sketch.

SEX – If the sex of the remains is obvious note M FOR male, F for FEMALE. If unknown write in UNK. Do not guess – if in any doubt at all mark as UNK.

DESCRIPTION – Write in a description of what the remains are as you see them, such as “severed hand” or torso, missing one leg, head, both arms.” Do not guess about the status of parts of the remains that are not visible.

CONDITION – Note other information that would help the Medical Examiner's staff account for the remains, such as “badly charred” or “no obvious wounds, wearing a brown suit.” Use general descriptions and avoid valuation – for example, a wedding band is a “yellow metal band” not “gold”, stones are “clear stones” not “diamonds.”

INDIVIDUAL COMPLETING – Enter your name.

AGENCY – Enter your agency.

TREATMENT WORKSHEET		Commonwealth of Virginia Mass Casualty Incident Management						MCI 4	
Incident					Date		Time		
RED TEAM		YELLOW TEAM		GREEN TEAM		MEDICAL SUPPLY			
Patients	Time	Patients	Time	Patients	Time				
Staff	Time	Staff	Time	Staff	Time				
Notes:									
Time	Task		Time	Task					
	Set up area			Move to Transport					
	Secondary triage			Monitor staff					
	Assign Teams			Personnel count					

MCI-4 TREATMENT WORKSHEET

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time that this particular worksheet page was initiated.

RED TEAM, YELLOW TEAM, GREEN TEAM:

Write in the number of PATIENTS and TIME when reported to you by the Team Leaders or as needed to monitor flow of patients for each patient treatment team. Set up a regular schedule of making these checks so you will know what the current patient loading is – every 15 minutes is a starting point. Report these figures to MEDICAL GROUP.

Write in the number of STAFF and the TIME at the same time you check the patient flow.

MEDICAL SUPPLY – Record key supply needs reported by the Medical supply Manager. As they are ordered check them off.

NOTES – Use this area to record any other information needed to help manage your unit.

TIME AND TASK – Record times key tasks are started.

TREATMENT LOG	Commonwealth of Virginia Mass Casualty Incident Management		MCI 41		
Incident		Date	Time		
Unit (Optional Use):					
Patient	Status	Priority	Notes	To Transport	
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					
Name: Bar Code:					

MCI-41 TREATMENT LOG

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time that this particular worksheet pages was initiated.

UNIT – This worksheet can be used in the individual treatment teams within the Treatment Unit. If used this way, enter the color code of the Treatment Team in this block (Red Team, Yellow Team, or Green Team).

PATIENT – Enter the patient triage tag number. If a tag with a numbered pull off is used, peel and stick the numbered pull off here.

STATUS – Enter patient triage color code (Red, Yellow, Green). If the UNIT block was used to identify a Treatment Team, color code does not need to be entered unless it represents a color change and a transfer to another team.

PRIORITY – Use this block to further rank patients within a triage color code.

NOTES – Enter additional information when needed.

TO TRANSPORT – Enter the time in 24-hour clock time when the patient is transferred to the Transportation Unit.

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				

MCI-5 TRANSPORTATION WORKSHEET

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today’s date.

TIME – The time in 24-hour clock time that this particular worksheet page was initiated.

HOSPITAL – This is an optional line. If there are a large number of patients going to several hospitals, a separate page can be used for each hospital. In this case, write in the name of the hospital on this line and use the sheet for all patients going to this facility. Do not use the hospital block below.

PATIENT – Enter the patient triage tag number. If a tag with a numbered pull off is used, peel and stick the numbered pull off here.

NAME – Space is provided in the patient block to write in the name of the patient if you track names in the field.

STATUS – Enter patient color code.

HOSPITAL – Enter the hospital to which the patient is being dispatched.

UNIT – Enter number and agency identifier for the ambulance on which the patient is loaded.

TIME – Enter the time the ambulance departs in 24-hour clock time.

Number of Ambulances = $\frac{\text{(Total \# of Patients) (Time Required for Round Trip)}}{\text{(Total Time to Complete Operation) (\# of Patients per Ambulance)}}$
Required

MCI-51 COMMUNICATIONS LOG

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today’s date.

FREQUENCIES OR MEANS – Enter either the actual radio frequency or standard designator for each frequency, one to a lettered block (for example, A: MED 10). This form can also be used to make a record of telephone conversations, faxes sent, etc. In this case enter either PHONE or FAX as appropriate in a lettered block.

TIME – Enter the time in 24-hour clock time for each communication.

STATION CALLED – Enter the designator of the station that was called.

Note that this section is set up for a transmission protocol that leads with the station called and ends with the station doing the calling (for example, “MEDICAL GROUP this is COMMUNITY HOSPITAL”).

STATION CALLING – Enter the designator of the station making the call.

FREQ – Enter the frequency letter from the bar above. If only one frequency is in use, this column can be left blank.

MESSAGE – In general make a record of every set of radio transmissions or phone conversation that involves the medical communicator and that gives directions, reports resource or situation status, or otherwise passes information of value in resolving the incident. Do not attempt to run a log of every transmission. Make a brief note of the information passed in the transmission. Include the key data, but do not try to use complete sentences or standard punctuation. Normally record only messages that are for your station or that you originate. However, if key information that you need (such as hospital loadings) is passed on the frequency by other stations, use the log to note this.

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:						

MCI-52 LANDING ZONE WORKSHEET

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time that this worksheet page was initiated.

LZ SKETCH – Make a simple sketch of the location of the landing zone, relation to the incident area, and the location of key landmarks (from the air) and hazards.

AIRCRAFT – Enter aircraft identification (normally by service, such as PEGASUS or NIGHTINGALE) of each available helicopter.

TYPE – Enter the aircraft model.

PATIENTS – Enter the number of patients the helicopter can normally carry.

OPERATIONAL – Enter the time the aircraft became available. If there are any limitations on performance (altitude, number of lifts, range, etc.) note these.

HOSPITALS RECEIVING PATIENTS BY AIR – Note the name of the **FACILITY** and the distance and direction the facility is **FROM SCENE**.

AIRCREW BRIEFING – Note information to brief inbound helicopters on radio contact. Include the **LZ LATitude** and **LONGitude** and distance and direction from an easily recognized **LANDMARK**. Determine best direction to **APPROACH FROM** and the **SIZE** of the LZ. **HAZARDS** (type and height) can be briefed from the LZ sketch. At night, brief what type of **LIGHTING** is in use. Provide current weather information, **WINDS** (direction from), **VISIBILITY**, and **PRECIPitation**.

AIRSPACE RESTRICTION – If airspace has been restricted note the **TIME FROM** and **TIME TO** and **BY** which air traffic control facility restriction was issued. Note the phone number of the contact to release the airspace or negotiate problems. Record the **ALTITUDES** and **AREA** covered by restriction.

NOTES – Enter any additional information needed.

MCI-53 STAGING WORKSHEET

INCIDENT – The name or number of the Incident as currently being used. This may be a facility name, a location, a sequential number, or other identifier.

DATE – Today's date.

TIME – The time in 24-hour clock time that this particular worksheet page was initiated.

IN – Enter the time the resource arrives in Staging in 24 hour time.

AGENCY/UNIT – Enter the agency and unit number of the resource.

CREW – Enter the number of personnel in the resource crew.

CLASS – Enter the classification of the resource (i.e., ALS, BLS, HR, etc.).

ASSIGNMENT – Enter the assignment given the unit while in Staging.

OUT – Enter the time the resource leaves Staging in 24-hour time.

NOTES AND SPECIAL INSTRUCTIONS – Record any special instructions received from the Medical Group Supervisor.

SUPPLIES TO SCENE – Circle supplies that needed to be carried forward to the Medical Supply Manager. Add any in the open boxes.

Number of Ambulances = $\frac{\text{(Total \# of Patients) (Time Required for Round Trip)}}{\text{(Total Time to Complete Operation) (\# of Patients per Ambulance)}}$
Required