FIRE AND RESCUE DEPARTMENTS OF NORTHERN VIRGINIA
FIREFIGHTING AND EMERGENCY OPERATIONS MANUAL

EMS Multiple Casualty Incident Manual
Second Edition

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PREFACE

The Northern Virginia region has significant potential for multiple casualty incidents and relies on mutual aid from jurisdictional partners to manage these types of incidents. They are low frequency, high demand incidents with the tendency to strain local, regional, and, sometimes, state resources. It is imperative that cooperating jurisdictions have standard operating procedures to identify and establish best practices for multiple casualty incidents.

A number of sources were used in the production of this manual, including the:

- Virginia Mass Casualty Incident Management Curriculum,
- Model Procedures Guide for Emergency Medical Incidents,
- NOVA Command Officer Operations Manual,
- COG Chapter 16, and
- National Incident Management System.

The following are key changes that are found in this second edition of the *EMS Multiple Casualty Incident Manual*.

1. Prioritization of the creation of the Transportation Group above the Treatment Group to meet the goal of moving the red tag patients off the scene in the most rapid manner possible.
2. Includes information about patient tracking technology.
3. The response algorithm relies more heavily on units reporting to a staging location prior to committing to the scene.
4. Formalization of two naturally occurring patient transit points – Patient Intake Point and Patient Exit Point – to require a higher degree of victim accountability.
5. Minor adjustments to the number of units assigned to the EMS Task Force and MCI Alarm have been adjusted.
6. Consideration is given to unusual MCI events, such as active shooter, medical facility evacuation and pandemic flu events.
7. Establishes the Transport Supervisor using the officer on the first arriving EMS transport unit.
8. Updates to charts and graphs to include changes to content described herein.
9. Editorial changes to the position roles and responsibilities for readability. Also, the Treatment Dispatch Manager role was rewritten and is now titled the Treatment/Transport Liaison.
10. The Emergency Communications Center section was simplified.
11. Includes information on Virginia’s new 2-1-1 hospital based family/patient information phone number.
OVERVIEW

The EMS Multiple Casualty Incident Manual outlines the response policies and procedures to be utilized by NOVA jurisdictions in the event of a multiple casualty incident. It establishes consistency throughout the Northern Virginia region on many levels including resource deployment, organization, communications, accountability, and patient flow.

The goals of managing a Multiple Casualty Incident are to:

- Establish a NIMS compliant multiple casualty incident plan that is effective for the Northern Virginia region.
- Establish multiple casualty incident response packages based on casualty numbers with predetermined assignments and a central resource control point.
- Do the greatest good for the greatest number.
- Prioritize movement of the most critically injured patients (Red Tags) from the scene, to appropriate, definitive care as rapidly and efficiently as possible.
- Effectively use personnel, equipment, and resources.
- Avoid relocating the incident.
MULTIPLE/MASS CASUALTY INCIDENT COMMAND

The Incident Commander (IC) will follow the NOVA Command Officer Operations Manual Guidelines. Key points for success include:

- Early reconnaissance and staging when multiple casualty incident conditions are recognized.
- Announce the Staging Area location and Incident Entry Point.
- Requesting additional or return resources as required.
- Establishing appropriate Branches, Groups, and Divisions.
- Determining the need for Unified or Area Command.

Management Priorities – EMS Branch

- Establish Triage Operations
- Establish Transport Operations
- Establish Treatment Area

Incident Descriptions

Multiple casualty incidents can be described using the following terminology:

- **EMS Taskforce Incident** – Low-impact incident with conventional response characteristics that can be handled with readily available resources. Patients are assigned directly to EMS units and the incident should not require establishment of Treatment and Transportation areas.

- **Multiple Casualty Incident** – High-impact incident which reduces the effectiveness of traditional fire/EMS response because of number of patients, special hazards, or difficult rescue. Will require the full development of the EMS Branch.

MCI Organization Development

The EMS Task Force and MCI Alarm were developed for the NOVA jurisdiction to quickly gain specific scalable resources for a multiple casualty incident. The units within the packages are dispatched in a predetermined order to identify their assignment without distracting the Incident Commander. If the Incident Commander feels that a change of incident resource priority is required, this may be accomplished by reassigning unit(s) to desired positions.

The Multiple Casualty Incident EMS Task Force and MCI Alarm have been established to give MCI command staff a predetermined allotment of resources to establish the EMS Branch and transport a given number of patients.

The patient counts used to build each response package are based on only patients to be transported and has been set up for 30% red, 30% yellow, and 40% green. Resources may need to be manipulated and redistributed if patient counts vary significantly from this distribution.
MCI Response Components

EMS Taskforce (up to 10 patients maximum) – The EMS Taskforce may be used when the number of available transport units matches the number of victims. A transport unit loading area should be established to maintain incident organization. A Treatment Area may not be required.

MCI Alarm (more than 10 patients) – Dispatch one MCI Alarm per 25 patients. For the purpose of supporting the regional electronic patient tracking devices and EMS Branch operations, a Mobile Communications Unit should be added as a specialized resource during an MCI where one or more MCI Alarm assignments are dispatched.

EMS Task Force and MCI Alarm Resources

The first box below summarizes the resources needed for an EMS taskforce and the EMS Task Force assignments. The second box summarizes the resources needed for an MCI Alarm.

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**EMS TASKFORCE**

**Dispatched Units:**
- 5 EMS Transport Units
- 1 Battalion Chief
- 2 EMS Supervisors
- 2 Suppression Units
- Air Transport Units (Upon request)

**EMS Taskforce Assignments:**
- 5 EMS Transport Units
  - Patient Treatment / Transport
- Battalion Chief & 2 EMS Supervisors
  - Battalion Chief: Assume role of Incident Commander or IC Aide
  - 1st due EMS Supervisor: Medical Group Supervisor
  - 2nd due EMS Supervisor: Medical Communications Coordinator
- 2 Suppression Units
  - 1st due Suppression Unit: Triage Unit Leader
  - 2nd due Suppression Unit: Porters / Loaders
- Specialty Units Available Upon Request
  - Air Medical
  - MCSU
  - MAB

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**MCI Alarm**

**Dispatched Units:**
- 10 Suppression Units
- 10 EMS Transport Units (Minimum 5 ALS)
- 3 EMS Supervisors
- 1 Battalion Chief
- 1 Mobile Communications Unit
- 1 Green (Civilian) Transport Bus
- Air Transportation Units (Upon request)
- 1 Multiple Casualty Support Unit (MCSU)
- 1 Medical Ambulance Bus (MAB)

See Quick Reference Guide for initial suggested assignments. All other units go to Staging.

**Specialized Resources**

- **ALS and BLS Strike Teams** – Strike teams consist of five like resources with comparable treatment/transport capabilities used to augment the Task Force levels.
- **Special Response** – Consists of resource(s) with capabilities used to augment the Task Force/Alarm levels and/or incidents. For example: MCSU, MAB, Canteen, MCU, MAU, CSU, Engine, Truck/Tower, Rescue, Medic, etc.
- **Medical Strike Team** – A team of medical personnel used to perform life-saving measures to critical patients within an Impact Area. This team initially reports to the Medical Group Supervisor. This resource would not be used when there are a significant number of critical patients that would overwhelm the team response. The need for this resource will be determined by the Triage Unit Leader and the appointed hazard mitigation officer. This resource option is to be used when critical patient numbers will not impact overall incident goals and objectives and is subject to resource availability.
- **Engine/Truck Strike Teams** – Strike teams consist of five like resources with comparable capabilities used to augment the Task Force levels.
MCI INITIAL COMPANY-LEVEL OPERATIONS

The first arriving suppression unit is to recon the situation and will establish command as per the NOVA Command Officer Operations Manual.

The first arriving unit initiates the five S’s. (Note: It is possible that the first arriving unit may not be a suppression unit.)

The Five S’s of the Multiple Casualty Incident

The Five S’s of a multiple casualty incident are safety, size-up, send, set up, and START/Jump START triage (START=Simple Triage and Rapid Treatment).

Safety

- The first arriving unit’s priority is scene safety.
- Declare MCI and stage incoming units until scene is secure.
- Mitigate IDLH if appropriate and warn incoming units of hazards.

Size-Up

- Ascertain type of incident.
- Determine approximate number of patients.
- Determine severity and type of injuries or illness.
- Determine best scene access.

Send

- Give a situation report to communications.
- Request the appropriate MCI Task Force level.
- Request additional resources as needed.
- Have Communications notify Northern Virginia Regional Hospital Coordination Center (RHCC) and provide a situation report.
  o RHCC will immediately notify all affected facilities.

Set Up

- Establish and maintain command until relieved.
- Establish a unit staging area, as per the current Command Officer Operations Manual. (Reference the NOVA Quick Reference Guide for initial EMS operations assignments.)
- Establish EMS Incident Operations, assigning the following priority:
  o Establish Triage operations as appropriate utilizing the first available suppression unit.
  o Establish Transport operations using the first available EMS transport unit.
    - Announce the Patient Exit Point (PEP).
    - Augment Transport with additional suppression units
      - Transport has priority over Treatment for additional resources.
      - Transport of Red patients is the priority.
  o Set up scene access and egress.
  o Establish the Treatment Area.
- Announce the Patient Intake Point(s) (PIP).
- Set up a perimeter using fire line tape or other means.
SPECIAL CONSIDERATIONS

This section describes special considerations in multiple casualty incidents.

**Crisis Standard of Care**

In the case of a mass casualty incident, in which EMS personnel, medical and transport equipment, and hospital beds are scarce, local EMS personnel will be forced to modify their care from conventional to crisis care. This means moving from usual standards of care, in which the goal is to save everyone, to Crisis Standard of Care (CSC), in which as many lives as possible are saved with the resources that are available. Resource shortages may include limited staff/supplies/equipment, a lack of fuel or medicines, limited mutual aid, or disruption of coordination and communication functions.

Fundamental changes in pre-hospital care may result during a disaster. EMS personnel may be asked to alter the staffing levels for an ambulance (using a driver and one medical attendant), use other modes of transportation (i.e., vans and buses), or not transport at all by treating and releasing patients. Extraordinary circumstances may require EMS personnel to assist in the evacuation of patients at a healthcare facility to alternate care sites. This, in turn, may require them to provide care to patients for longer than is usual for EMS providers, who normally care for patients only through the duration of transport and transfer.

**EMS Physician On Scene**

When an EMS physician arrives on an emergency scene, they must immediately report to the Command Post for guidance, direction, and integration into the ICS, unless specifically directed to report to another area (i.e., Medical Branch or Staging) during their response to the incident scene. Properly trained medical directors can be of great value on the scene when they are fully integrated into the ICS.

On-scene physicians often function as part of the Medical Branch or as a technical advisors to the IC. As resources arrive on the emergency scene, they are assigned to work in functional groups or geographic divisions and will report up the assigned chain of command.

**Virginia Regulations Governing EMS - Exemptions**

The [Virginia Regulations Governing Emergency Medical Services](http://www.iom.edu/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx) has a specific section that deals with situations where exemptions for the regulations are granted. In that section, §12VAC5-31-190, *General exemptions from these regulations*, the following exception is stated:

“A person or vehicle assisting with the rendering of emergency medical services or medical transportation in the case of a major medical emergency as reasonably necessary.

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when the EMS agencies, vehicles, and personnel based in or near the location of such major emergency are insufficient to render the services required.”

**Pandemic Medical Scenarios**

Pandemic events can be characterized as a slow developing MCI. Early activation of the local and regional pandemic plans and integration with Emergency Management and Health Department resource are keys to long-term management. (See Appendix M for Regional Pandemic Plan.)

**Hazard Mitigation**

It is conceivable that other hazardous situations are present and remain a top priority during multiple casualty incidents. Refer to the appropriate operations manual for specific hazard mitigation.
TRIAGE CONSIDERATIONS

The following section describes specific triage considerations during hazard mitigation incidents. Consult the Appendices for links to various specialized plans and manuals.

Hazardous Materials, CBRNE, WMD, and Active Shooter Incidents

For incidents involving hazardous materials, CBRNE\(^2\), WMD, and/or an Active Shooter, the Triage Unit Leader coordinates through Unified Incident Command or a designee to establish a safe triage operation. The Hazardous Materials/WMD Entry Team performs initial triage of patients in the impact area if possible and porters patients to decontamination.

All patients must go through appropriate decontamination, be moved to the Casualty Collection Point, triaged, and then ported to a treatment area. The Casualty Collection Point will be established at the transition point between the warm zone and the cold zone. In this scenario, patients will not be accepted to a treatment area directly from an impact area.

A Mobile Treatment, Hazardous Materials, or Active Shooter Team Member may be used to provide patient care for patients who cannot be quickly moved to the treatment area. The specialized team leader and Triage Unit Leader should confer to ensure that conditions warrant this response.

Evacuation of a Medical Facility

It is important to establish a safe Casualty Collection Point early in the incident; this can be accomplished by using the resources of the RHCC and local emergency management resources to develop appropriate destinations that can include hospitals, nursing facilities, or emergency shelters.

Collapse and Extrication Incidents

For incidents involving collapse or extrication, the Triage Unit Leader coordinates through Incident Command or a designee to establish a safe triage operation. Extrication units may perform initial triage on trapped patients or patients in the impact area if possible.

Move patients to the Casualty Collection Point after extrication. Triage and then porter patients to the appropriate Treatment Area. The Casualty Collection Point will be established at the transition from the warm zone to the cold zone.

A Medical Strike Team may be used to provide care to patients requiring a prolonged extrication with life threatening injuries. The Extrication Officer (Group Leader/ Unit Leader, etc.) and Triage Unit Leader should confer to ensure that conditions warrant this response.

\(^2\) Acronym that stands for Chemical, Biological, Radiological, Nuclear, and/or Explosive.
Fire Incidents

For incidents involving fires, the Triage Unit Leader coordinates through the Incident Command or a designee to establish a safe triage operation. The Casualty Collection Point will be established at the transition from the warm zone to the cold zone.
EMS BRANCH POSITIONS

This section details the roles and responsibilities of the various EMS Branch positions.

Figure 1: EMS Branch Positions
MCI assignments are based on the ability of the IC to assign apparatus to EMS Branch based on incident priorities. In the absence of direction from the IC, units responding on the MCI Alarm will assume these roles.

Figure 2: EMS Branch MCI Alarm Roles
EMS Branch Director

This position is established by the first due EMS Supervisor on the MCI Alarm, then assumed by the first due Battalion Chief on the MCI. The EMS Branch Director is responsible for the implementation of the Incident Action Plan within the EMS Branch. This includes the direction and execution of Branch planning for the assignment of the resources within the Branch. The EMS Branch Director reports to the Operations Section Chief and manages the Medical Group and Transportation Group Supervisors.

Responsibilities are:
- Report to the ICP and receive information and assignment.
- Establish position, announce location, and don appropriate vest.
- Obtain Command Board #5 EMS Branch.
- Request and verify dedicated tactical EMS operations channels (i.e., Medical and Transportation Groups).
- Ensure effectiveness of current EMS Branch operations to meet the needs of each specified operational period.
- Provide input to Operations Section Chief to update the Incident Action Plan.
- Ensure adequate safety measures and accountability procedures are followed for both providers and victims.
- Ensure non-disrupted, on-scene communication is maintained with the RHCC throughout the incident.
- Evaluate and reassess needed and available incident EMS resources.
- Fill EMS specific tactical unit and group positions as incident needs dictate.
- Maintain log of unit activity.

Medical Group Supervisor

The Medical Group Supervisor reports to the EMS Branch Director and supervises the Triage Unit Leader, Treatment Unit Leader, and Medical Supply Coordinator. The Medical Group Supervisor establishes command and controls the activities within a Medical Group, in order to assure the best possible emergency medical care to patients during a multiple casualty incident.

Responsibilities are:
- Establish position, announce location, and don appropriate vest.
  - Consider requesting a dedicated tactical channel for Medical Group.
  - Obtain Command Board #3 Medical Group Supervisor and maintain as needed.
  - Maintain log of unit activity.
- Ensure RHCC activation.
- Communicate with Triage and Treatment Unit Leaders to determine situational status and resource needs.
  - Determine Casualty Collection Point (CCP).
  - Ensure that pre-designated positions of Treatment and Triage are filled.
  - Ensure each Treatment Area has been established and announced.
  - Verify Treatment Area Managers are appointed.
Verify communications between Treatment/Transportation Liaison and Transport Group.

- Ensure PIP and PEP have been established and announced.

- Participate in EMS Branch/Operations Section planning activities.
- Establish communications and coordination with Transportation Group.
  - Ensure that RHCC has been activated.
  - Delegate communication with Transport Group with Treatment/Transport Liaison when position is established.

- Anticipate needs of the uninjured.
- Monitor operations within the Group, evaluate progress, make resource requests, and report as necessary to EMS Branch Director.
- Establish Medical Supply Cache(s) and announce location.
- Anticipate/request porters.
- Complete par checks.
- Appropriately manage Medical Group resources (i.e., personnel accountability, Rehab, reassignment, and resource replenishment).
- Ensure proper security, traffic control, and access for the Medical Group area.
- Demobilize Triage and Treatment Areas when finished.
  - Ensure proper documentation is completed.

**Treatment/Transport Liaison (formerly Treatment Dispatch Manager)**

The Treatment/Transport Liaison position is established during incidents where more than one Treatment Unit exists. This position is an aide to the Medical Group Supervisor responsible for coordinating the movement of patients out of each Treatment Area for transport from the scene.

Responsibilities are:

- Establish position and don appropriate vest.
- Receive information from the Treatment Unit Leader(s) as to when patients are ready for transport.
- Communicate with the Medical Communications Coordinator to relay the number and severity of patients ready for transport.
  - Relay specific patient information such as pediatrics, burns, or information that would necessitate transport to a specialty care facility other than a trauma center.

**Medical Supply Coordinator**

The Medical Supply Coordinator reports to the Medical Group Supervisor and acquires and maintains control of medical equipment and supplies from and for units assigned to the Medical Group. The suppression unit officer (three or four crew members) assigned to respond with the Medical Care Support Unit (MCSU) should assume this role.

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Determine the best location to set up the MCSU.
- Distribute supplies as requested to the Treatment Area(s).
- Maintain an accurate accounting of supplies distributed and still available.
- Maintain a log of unit activity.
- Request and secure additional medical supplies as necessary (if Logistics Section is established, work with the Supply Unit Leader).

**Triage Unit Leader**

The Triage Unit Leader position is filled by the first arriving suppression unit after hazards are addressed. The Triage Unit Leader reports to the Medical Group Supervisor (when established) and supervises Triage Crew/Porters and the Morgue Manager. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the Triage Area. When triage has been completed, the Unit Leader may be reassigned as needed.

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Obtain Command Board #1 Triage Unit Leader.
- Implement the 5 S’s of MCI.
  - **Scene safety.**
    - Anticipate WMD or CBRNE agents (including secondary devices).
    - Establish a perimeter for security and scene control.
    - Determine evacuation distances around impact area.
    - Assess appropriate level(s) of PPE.
  - **Size-up** incident.
    - Estimate extent of impact area.
    - Approximate number and severity of victims.
    - Determine resources required.
  - **Send** situation report and request appropriate specialty resources (i.e., EMS Task Force and/or MCI Alarm, medevac, metro/school buses, search and rescue resources) if not already done.
    - Request resources and personnel via Command.
    - Activate the RHCC.
      - RHCC will immediately notify all affected facilities.
  - **Set-up** incident command and establish staging area, if not already done.
    - Designate the Casualty Collection Point (CCP) if needed.
    - Establish and coordinate Triage Units and Porter Units.
      - Triage Units are more efficient when grouped in teams of two or three.
        - One person managing the Unit while the other person(s) performs.
    - Establish and request adequate resources for Porter Units.
      - Establish Porter Units of two to four people each.
      - Under optimal conditions: One four-person Porter Unit can effectively make four patient trips prior to rotating Unit to Rehab. Consider incident and environmental extremes when making resource requests.
      - Triage Units may become Porters.
- Initiate and complete the START/JumpSTART triage process.
  - Obtain and communicate an accurate patient count from the Triage Units.
  - Maintain the rule of less than a minute of patient contact time.
  - Move the ambulatory Green Patients to a defined location.
    - Assign a Triage Unit to relocate and count walking wounded to a safe location.
  - Ensure all patients leave impact area with a triage ribbon.
- Communicate resource needs to Incident Command via the established ICS.
- Coordinate movement of patients from the triage area to the CCP or into the appropriate treatment area via the Patient Intake Point (PIP).
  - Ensure scene is clear of all patients.
- Maintain personnel accountability using the Triage Unit Leader Board #1.
- As necessary, call for establishment of an incident Morgue Area.
  - Assign a Morgue Manager. (Using a law enforcement officer to fill this position will allow you to better utilize your EMS personnel.)
  - Safeguard the deceased and coordinate with law enforcement.
- Advise Medical Group Supervisor (or Incident Command via the established ICS) of total patient count (Red/Yellow/Green) upon completion of triage.
- Assess mental and physical well-being of personnel.
- Maintain security and control of the triage area.
- Request reassignment or Rehab based on personnel needs and demobilize Triage Unit.
  - Reconcile proper documentation.

**Triage Units**

Triage Unit(s) reports to the Triage Unit Leader. They triage patients and attach the appropriate color ribbon to each triaged patient.

Responsibilities are:

- Break crews up to begin START/JumpSTART.
  - Teams of two or three – One person maintaining accurate patient count while the other person (s) completes START/JumpSTART.
- Report to assigned triage location.
- Triage and attach colored ribbon to all injured patients (if <10 patients, it may be appropriate to attach a COG Disaster Tag during primary triage).
  - Classify patients according to treatment priority while noting injuries that require special resources (i.e., entrapment, burns, amputations, infants/children).
  - The recommended site of the triage ribbon is usually the arm/wrist.
- Provide treatment during triage based ONLY on the START/JumpSTART triage model – spending no more than 30 - 60 seconds per patient, stopping triage only for the time needed to open the airway and control severe bleeding.
- Communicate accurate triage count (Red/Yellow/Green) as well as any injuries that require special resources to Triage Unit Leader.
- Evaluate and report crew readiness for rehab or reassignment.
Porters

Porters report to the Triage Unit Leader. Position is established when non-ambulatory patients need to be moved from the impact area or Casualty Collection Point (CCP) to the Treatment Area.

Responsibilities are:

- Coordinate with Triage Unit Leader to determine location of triaged patients.
- Move patients to appropriate Treatment Areas based on initial triage priority.
- Move patients within Treatment Area after re-triage, if necessary.
- Report to the Triage Unit Leader to determine location of prioritized patients.
- Obtain necessary equipment of porter patients (i.e., stretchers, litters, skeds).
- Remove patients in order of priority to the designated CCP or Treatment Area depending on direction from the triage Unit Leader. Depending on the needs of an incident, patients may be moved directly from the impact area to the Treatment Area. This information will be communicated by the Triage Unit Leader.

Morgue Manager

This is not an urgent position to be filled by fire/EMS personnel. The Morgue Manager reports to the Triage Unit Leader and assumes responsibility for Morgue Area activities until relieved by the appropriate Coroner’s Office. Initial morgue activities are usually for patients expiring in the Treatment Area.

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Review common responsibilities.
- Assess resource/supply needs and order as needed.
- Coordinate all Morgue Area activities.
- Keep area off limits to all but authorized personnel.
- Request position to be filled by law enforcement and assist the coroner as necessary.
- Ensure that identity of deceased persons is kept confidential.
- Establish a temporary morgue away from viable patients.
- Be ready to accept deceased patients from the Treatment Area.
- Once law enforcement arrives on scene, turn temporary morgue over.

Transportation Group Supervisor

The first due transport unit AIC/OIC establishes the Transportation Group and assumes the role of Transportation Group Supervisor. Once relieved by the second due EMS Supervisor (assigned to the EMS Branch), the unit AIC/OIC then becomes the Medical Communications Coordinator (MCC). The unit operator shall assume and maintain the role of Air/Ground Ambulance Coordinator (to include the role of Patient Transport Recorder) until relieved.
Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Obtain the Command Board #4 - Transportation Group Supervisor and maintain as needed.
- Communicate with receiving facilities through the RHCC.
- Announce Loading Area and PEP.
  - Reinforce the Transport loading area with a suppression unit.
- Determine total patient count and transport needs.
- Coordinate the air and ground transportation of all patients.
  - Verify location for air ambulance loading.
  - Verify loaders are assigned as needed.
- Establish and maintain communications with Staging Manager.
- Ensure that patient information and destination is recorded for all patients prior to departure from the scene.
- Monitor operations within the Group; make requests and report to the EMS Branch Director.
- Monitor personnel/rehab.
- Maintain log of unit activity.
- Demobilize Transportation when finished.
- Reconcile all patient transport records through the Medical Communications Coordinator, the Air/Ground Ambulance Coordinator(s), and the RHCC.

Patient Transport Operations:

- Confirm initial (and follow-up) communication with the RHCC has occurred.
- Request and announce dedicated radio channel for Transportation Group.
- Identify and establish the patient transport corridor(s).
  - Establish and announce the Patient Exit Point (PEP).
  - Transport unit deployment from Staging.
  - Loading area(s).
  - Ambulance Entrance/Exit path(s).
  - Ensure best access and egress to the patient loading area to facilitate rapid loading and transport of priority patients early in the incident.
- Establish contact with the Treatment Unit Leader.
  - Acquire an accurate triage count.
- Assume communication with the RHCC (ordinarily the responsibility of the MCC).
  - Relay most current triage count to the RHCC.
  - Receive updated hospital bed count.
- Establish and maintain communications with the Staging Area.
  - Request appropriate air and ground resources needed to transport all patients to definitive care.
- Determine and announce the landing zone(s) for arriving air transport units.
- Designate patient loading area(s) with best access and egress.
- Assign Patient Loaders.
Patient Accountability:

- The Transportation Group Supervisor is ultimately responsible for ensuring total patient accountability (from incident scene to a hospital receiving facility).
- In a rapidly evolving incident, critical Red Tag patients may bypass the Treatment Area and be taken directly to transport. This can be accomplished by utilizing one or more of the following procedures:
  - Place a COG disaster tag on the patient.
    - Scan the disaster tag with a Patient Tracking Device (PTD) if available.
    - Complete as much of the front side of the disaster tag as possible with emphasis on the PATIENT INFORMATION section at the top and the TRANSPORT RECORD at the bottom of the tag.
    - Remove the large TRANSPORT RECORD sticker from the bottom of the disaster tag, placing it on the Transport Recorder Worksheet corresponding to the destination receiving facility.
    - Scan the TRANSPORT RECORD sticker with a PTD if available and update the information that the patient was transported and to which receiving facility.

Air/Ground Ambulance Coordinator

Each Air/Ground Ambulance Coordinator reports to the Transportation Group Supervisor and manages their respective areas.

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Establish and maintain communications with the Transportation Group Supervisor to facilitate transport of patients.
- Establish appropriate loading area for ground or air ambulances.
- Designate points and paths of entry and exit for all transport units.
- Supervise the Transportation Recorder.
- Ensure all patients leaving scene have a COG disaster tag.
- Request additional transportation resources as appropriate through the Staging Area Manager.
- Request additional patient transfer resources as needed (Transport Loaders, cots, litters etc.)
- Provide any needed receiving facility directions to ground transport units.
- Effectively manage all transport resources within assigned area.
- Obtain Air/Ground Ambulance Coordinator Worksheet and Transport Recorder Worksheet, ensuring all appropriate documentation is completed.
- Reconcile all patient transport records through the Transportation Group Supervisor.
**Patient Transportation Recorder**

The Patient Transportation Recorder reports to their assigned Air/Ground Ambulance Coordinator; when the scope of the incident requires expanded patient transport operations. A Patient Transportation Recorder must be assigned to each established patient loading area (i.e., multiple LZ/ground ambulance transportation corridors).

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Alert Air/Ground Ambulance Coordinator of any patient within the loading area who does not have a COG disaster tag, or whose tag does not have an assigned receiving facility destination. Request instructions from Air/Ground Ambulance Coordinator.
- Obtain Patient Transport Recorder Worksheet.
- Maintain records of all patients departing the scene.
- Maintain appropriate incident documentation relevant to the patients transported from the scene, to include:
  - COG disaster tag and unique identifying number (UIN).
  - Ensure disaster tag is attached to each patient and scanned with PTD, if available.
  - Record the transporting unit number.
  - Record destination receiving facility.
  - Record total number of patients (per unit).
  - Triage status, age, sex, and chief complaint of patient when transported off scene.

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**Figure 3: Patient Transportation Recorder Flow Chart**

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Transport Loader

Transport Loader(s) report to the Air/Ground Ambulance Coordinator as directed and work in the transportation loading area. Position is established when demands of the incident require and the transport functions are needed. Transport Loaders may be the crew from the assigned transporting unit. May be assigned to assist transport EMS personnel in loading patients.

Responsibilities are:

- Cooperate with Transport Recorder in maintaining transport records.
- Ensure patients selected for transportation are:
  - Ready for movement.
  - Loaded on the correct transport unit.
- Report to Air/Ground Ambulance Coordinator to receive assigned patient information (color code, transporting unit and hospital destination).
- Keep Air/Ground Ambulance Coordinator informed as directed.
- Obtain necessary equipment to accomplish task.
- Remove and load patients as directed.
- Monitor crew for rehab needs.

Medical Communications Coordinator

The Medical Communications Coordinator (MCC) reports to the Transportation Group Supervisor and maintains a real-time patient destination bed count via communications with RHCC. In the EMS Branch, there shall only be one MCC per incident – regardless of size or scope of the incident.

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Establish and maintain communications with the RHCC.
- Obtain and maintain Hospital Availability Tracking Board Worksheet.
- Determine and maintain current status of receiving facility availability and capability.
- Coordinate patient receiving facility destination with RHCC based on prevailing criteria with the current RHCC Protocol (Appendix L).
- Request additional resources as needed.
- Coordinate information through the Transportation Group Supervisor.
- Reconcile all patient transport records through the Transportation Group Supervisor, the Air/Ground Ambulance Coordinator(s), and the RHCC.
- Maintain log of unit activity.

Treatment Unit Leader

The Treatment Unit Leader reports to the Medical Group Supervisor and oversees the Treatment Area Managers and the Treatment/Transport Liaison. The Treatment Unit Leader assumes
Responsibility for establishing the treatment areas, initiating treatment for all patients, coordinating patient movement within the Treatment Area(s) and directing patient movement to the transport loading location(s).

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
  - Identify and announce the location of all designated Treatment Areas. Considerations should include:
    - Large open area with safe, appropriate access to the incident scene and identified transport loading area(s).
  - Identify and announce the Patient Intake Point (PIP).
    - Ensure every patient is assigned a COG disaster tag.
      - Assign personnel necessary to ensure each patient receives a disaster tag (utilizing PTD to scan each tag, if available).
  - Obtain Command Board #2 Treatment Unit Leader.
  - Designate Treatment Area Managers.
  - Establish communications and coordinate patient movement with the Transportation Group.
    - The Medical Group Supervisor may assign this responsibility to a Treatment/Transport Liaison, as dictated by size & scope of the incident.
  - Maintain a real-time count of all patients within the Treatment Areas.
  - Assess needs for additional personnel.
  - Request appropriate resources needed to treat all patients.
    - Optimal provider to patient ratios should be considered:
      - **Red** – One ALS and one BLS provider per each (1) patient
      - **Yellow** – One ALS and one BLS provider per three (3) patients
      - **Green** – One BLS provider per three (3) patients.
    - Consider assigning aide(s) necessary to maintain span of control.
  - Ensure no patient leaves Treatment Area without an attached COG disaster tag.
  - Assess physical and mental well-being of personnel.
    - Rotate assigned unit personnel through Rehab, as needed.
  - Demobilize Treatment Areas.
    - Reconcile all documentation.

**Immediate (RED) Treatment Area Manager**

The Immediate (Red) Treatment Area Manager reports to the Treatment Unit Leader and is responsible for overseeing the treatment of patients assigned to the Immediate (Red) Treatment Area.

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Ensure Treatment Area is prepared to accept patients.
- Ensure patients are appropriately treated.
- Re-triage patients and relocate as necessary.
- Obtain patient information and correctly fill out (or update) the COG disaster tag.
- Prioritize patients for transport.
  - Notify the Treatment/Transport Liaison when patient is transport ready.
- Maintain accountability of patients within assigned Treatment Area.
- Maintain appropriate resources within assigned Treatment Area.
  - Optimal provider to patient ratio should be considered.
    - One ALS and one BLS provider for each patient.
- Maintain communications with Treatment Unit Leader.
- Rotate assigned area personnel through Rehab, as needed.

**Delayed (Yellow) Treatment Area Manager**

The Delayed (Yellow) Treatment Area Manager reports to the Treatment Unit Leader and is responsible for overseeing treatment of patients assigned to the Delayed (Yellow) Treatment Area.

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Ensure Treatment Area is prepared to accept patients.
- Ensure patients are appropriately treated.
- Re-triage patients and relocate as necessary.
- Obtain patient information and correctly fill out (or update) the COG disaster tag.
- Prioritize patients for transport.
  - Notify the Treatment/Transport Liaison when patient is transport ready.
- Maintain accountability of patients within assigned Treatment Area.
- Maintain appropriate resources within assigned Treatment Area.
  - Optimal provider to patient ratio should be considered.
    - One ALS and one BLS provider per three patients.
- Maintain communications with Treatment Unit Leader.
- Rotate assigned area personnel through Rehab, as needed.

**Minor (Green) Treatment Area Manager**

The Minor (Green) Treatment Area Manager reports to the Treatment Unit Leader and is responsible for overseeing treatment of patients assigned to the Minor (Green) Treatment Area.

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Ensure Treatment Area is prepared to accept patients.
- Ensure patients are appropriately treated.
- Re-triage patients and relocate as necessary.
- Obtain patient information and correctly fill out (or update) the COG disaster tag.
- Prioritize patients for transport.
Notify the Treatment/Transport Liaison when patient is transport ready.

- Maintain accountability of patients within assigned Treatment Area.
- Maintain appropriate resources within assigned Treatment Area.
  - Optimal provider to patient ratio should be considered.
    - One BLS provider per three patients.
- Maintain communications with Treatment Unit Leader.
- Rotate assigned area personnel through Rehab, as needed.

**Staging Area Manager**

Normally established by the driver of the first due engine on the second Alarm; the Staging Area Manager reports to the IC. The Staging Area Manager’s role and responsibilities may greatly expand during the MCI; therefore, it is critical that Incident Staging be established early in the incident and is assigned sufficient resources to support this function (i.e., an entire suppression unit crew).

Responsibilities are:

- Establish position, announce location, and don appropriate vest.
- Establish staging area layout.
- Establish check-in function as appropriate, maintaining all appropriate ICS documentation.
- Maintain the Staging Area in an orderly condition.
- Post areas for identification and traffic control.
- Respond to requests for resource assignments. (Note: May be from Operations or via the IC.)
  - Utilize Check-in Sheets as a reference for anticipating resource needs
  - Establish and maintain communication with Air/Ground Ambulance Coordinator(s).
  - Facilitate the movement of transport units from the Staging Area to the appropriate transportation loading areas.
  - Ensure adequate transportation resources are available within the Staging Area and that ingress and egress is controlled for patient transport vehicles (staffed and unstaffed).
  - Ensure transporting units leaving Staging Area switch to assigned Transportation Channel.
- Determine and maintain required resource levels from the Operations Section.
- Advise the Operations Officer when reserve levels reach minimums.
- Maintain and provide status to Resource Unit of all resources in Staging Area.
- Demobilize Staging Area in accordance with Incident Demobilization Plan.
- Maintain log of activity as required.

**Transport Units (Air/Ground)**

Transport Unit(s) report to Staging. Staging will assign transport units to necessary loading areas.
Responsibilities are:

- Transport patients to assigned receiving facility.
- Report to Staging Area and await assignment.
- Change to Transportation Channel.
- Ensure that the driver stays with the unit.
- Ensure that the AIC/OIC reports to Air/Ground Ambulance Coordinator at the designated loading area.
- Accept patient(s) and hospital assignment.
- Assist Loaders with assigned patient, as necessary.
- Ensure Transport Record on disaster tag is given to Transport Recorder.
- Advise Staging Manager when unit leaves the scene with patient.
- Transport patient to specified hospital and ensure completion of disaster tag.
- When possible, notify Staging Manager of arrival at hospital and when available for service.
- Report back to Staging Area unless otherwise assigned.
COMMUNICATIONS

Multiple casualty incidents will necessitate special communications considerations.

EMS Branch Radio Channel Assignments

Radio channels for multiple casualty incidents will be assigned by command and should be commensurate to the scale of the incident. The following channels will be assigned in addition to channels already assigned to the incident.

EMS Task Force

One EMS tactical channel should be sufficient for the incident and may be held to the operations channel.

- EMS Tactical Channel 1 – Assigned to the Medical Group Supervisor.
- Operations Channel – The Medical Group supervisor will monitor the operations channel and maintain direct contact with the Medical Communications Coordinator.

MCI Alarm

Two EMS tactical channels will be required.

- EMS Tactical channel 1 – Assigned to the Medical Group Supervisor.
- EMS Tactical channel 2 – Assigned to the Transportation Group Supervisor.
- Operations channel – The EMS Branch director will monitor the operations and maintain direct contact with the groups assigned to the EMS Branch.
- Additional channels must be assigned if additional groups are established in the EMS Branch.
Emergency Communications/9-1-1 Center Operations Dispatching Resources

The amount of resources needed to effectively manage an incident will vary depending upon the size of the incident. On large-scale incidents, the amount of resources requested may initially overwhelm an Emergency Communications/9-1-1 Center. Some CAD systems may find it
difficult to manage the large number of resources requested for an incident. This manual provides a suggested solution for obtaining the amount of resources that are needed on a large-scale incident. Each Emergency Communications/9-1-1 Center will be responsible for implementing a policy on how to accomplish the task. Listed below is a suggested resolution to the problem of obtaining a large amount of resources.

It is recommended a dispatcher contact outlying jurisdictions with the nature of the emergency and amount of units requested (MCI Alarm or two MCI Alarms). This gives neighboring jurisdictions time to evaluate their current mission needs and unit availability. The dispatcher will inform the jurisdiction to have units they are supplying respond to a staging area. Responding units will not need to contact anyone via the radio, which will keep radio traffic to a minimum. If a staging area has not been designated, the dispatcher will need to identify a suitable area large enough to handle the amount of resources they are requesting prior to contacting jurisdictions for mutual aid.

Although each jurisdiction will develop their own unique method of obtaining the resources requested, it is imperative that a staging area be identified prior to obtaining mutual aid and the location passed on to responding units via their dispatch center. They should also inform the mutual aid units to limit radio traffic and to report to the staging area and not to the incident scene.

**2-1-1 Virginia**

The Virginia Hospital Alerting and Status System (VHASS) was established by the Virginia Hospital and Health Care Association and the Virginia Department of Health. All hospitals across the Commonwealth and the Office of the Medical Examiner (OME) participate in the system. It is available for use during an MCI where a large number of patients need to be cared for initially onsite and then transported to a hospital. Hospitals and the OME enter the MCI patient information into the system through [www.vhha-mci.org](http://www.vhha-mci.org).

During the MCI, 2-1-1 VIRGINIA’s Community Resource Specialists access the Reunification Call Center section of the site, which provides only basic information about patients and their location. Family members who call 2-1-1 are asked specific information about their missing family member and follow a very specific script. If the patient can be identified in the system by name, the caller must also provide at least one of five patient identifiers before the location of the patient is given. If there is not a patient with that name in the system, four identifiers must be matched before a possible hospital location is given. If the patient is deceased, then no information is provided to the caller and the OME is contacted to notify the family.
Sample Scene Layouts

MCI EVENT
SINGLE PIP
Recommended for smaller events or when delays to moving victims (like extrication) will slow the removal of victims to treatment

Figure 5: Sample Scene Layout 1
Figure 6: Sample Scene Layout 2

Larger MCI EVENT
PIP LOCATED ON ARRIVAL AT TREATMENT AREA
Recommended for large events where many victims will be moved to Treatment quickly

[Diagram showing a triage area with a PIP unit leader, red, yellow, and green treatment areas, and transportation area.]

Figure 6: Sample Scene Layout 2
Figure 7: Sample Scene Layout 3
Large MCI EVENT — Contaminated Patients

Decon Corridor

Triage Area

PIP (Tag & Scan)

Triage Unit Leader

Red Treatment Area

Yellow Treatment Area

Green Treatment Area

Medical Care Support Unit

Air/Ground Transport Coordinator

Transportation Area

Figure 8: Sample Scene Layout 4
APPENDIX A: DEFINITIONS

ALS (Advanced Life Support): Allowable procedures and techniques utilized by emergency medical personnel to stabilize critically sick and injured patients(s) who exceed Basic Life Support procedures. Example: Intravenous therapy, cardiac monitoring, advanced airway management, administration of medications, etc.

Available Resources: Resources assigned to an incident and available for an assignment.

Black Tag Patient: A patient who, under the START triage system, is deceased or has injuries incompatible with life.

BLS (Basic Life Support): Basic, non-invasive first-aid procedures and techniques utilized to stabilize critically sick and injured patients(s).

Branch: That organizational level having functional or geographic responsibility for major parts of incident operations. The Branch level is organizationally between Section and Division/Group in the Operations Section, and between Section and Units in the Logistics Section.

Casualty Collection Point: An area to where victims can be relocated that is outside the IDLH/hostile environment in which safe triage can occur.

CBRNE: Chemical, Biological, Radiological, Nuclear, Explosive.

Command: The act of directing, ordering and/or controlling resources by virtue of explicit legal, agency, or delegated authority.

Company: Any mobile piece of equipment having a minimum complement of personnel as determined by the assisting jurisdiction.

Company Officer/Commander: The individual responsible for command of a company. This designation is not specific to any particular rank.

Crew: A specific number of personnel assembled for an assignment such as search, ventilation, or hose line deployment and operations. A crew operates under the direct supervision of a Crew Leader.

Delayed (Yellow) Treatment: Patients, who require aid under the START triage system, but whose injuries are less severe.

Disaster: Any event of unusual or severe effect, threatening or causing extensive damage to life and/or property and requiring extraordinary measures to protect lives, meets human needs and achieves recovery. A disaster will demand resources beyond local capabilities and require extensive mutual aid and support needs.
**Disaster Tag or Triage tag:** A tag used by triage personnel to identify and document the patient's medical condition. The NOVA region uses the COG disaster tag.

**Division:** That organization level having responsibility for operations within a defined geographic area.

**Emergency:** A condition of disaster or of extreme peril to the safety of persons and property.

**Group:** That organizational level having responsibility for a specified functional assignment at an incident (such as Triage, Patient Movers, Extrication).

**IDLH:** Immediate Danger to Life and Health.

**Immediate (Red) Treatment:** The highest priority patients under the START triage system. These patients require rapid assessment and medical intervention for survival.

**Impact Area:** The immediate area of an incident scene where the patients received their injuries and were initially found.

**Incident:** An occurrence or event, either human-caused or caused by natural phenomena, that requires action by emergency response personnel to prevent or minimize loss of life or damage to property and/or natural resources.

**Incident Command Post (ICP):** That location at which the primary command functions are executed and usually collocated with the incident base.

**Incident Command System (ICS):** The combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure with responsibility for the management of assigned resources to effectively accomplish stated objectives pertaining to an incident.

**Incident Commander (IC):** The individual responsible for the management of all incident operations.

**Incident Objectives** Statements of guidance and direction necessary for the selection of appropriate strategies, and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow for strategic and tactical alternatives.

**Initial Response:** Resources initially committed to an incident.

**Jump START.** This is the initial triage system for pediatric patients adopted by the Metropolitan Washington Council of Governments.

**Landing Zone (LZ):** A designated location where a helicopter can safely take off and land.
Leader: The individual responsible for command of a Task Force, Strike Team, or Functional Unit.

Liaison Officer: Member of the Command Staff who is the point of contact for assisting or coordinating agencies.

Logistics Section: Responsible for providing facilities, services and materials for the incident.

Medical Protocols: Policies and procedures approved by the local EMS agency for use by a provider in situations where direct voice contact with medical control cannot be established or maintained.

Medical Strike Team: Combinations of physicians and related medical trained personnel who are responsible for on-scene patient treatment.

Minor (Green) Treatment: Patients, under the START triage system, whose injuries can be considered minor, requiring rudimentary first-aid.

Morgue (Temporary On-incident): Area designated for temporary placement of the dead. The Morgue is the responsibility of the Coroner's Office when a representative is on scene.

Multi-Casualty: The combination of numbers of injured people and types of injuries going beyond the capability of an entity's normal first response.

Operations Section: Responsible for all tactical operations at the incident.

Patient Exit Point (PEP): The physical location through which the patient exits the scene via the transport unit (air or ground) in which the transport stub is collected (by the Transport Recorder) from the disaster tag and affixed to the Transport Record. If available, the departure shall be scanned into the Patient Tracking System.

Patient Intake Point (PIP): The physical location(s) prior to entering the Treatment areas through which all patients are funneled and where a Disaster Tag is applied. When possible, the disaster tag shall be scanned into the Patient Tracking System.

Patient Tracker Device (PTD): The handheld device capable of scanning the disaster tag bar code and collecting patient information.

Patient Tracking System: The web based system where patient information is organized into a single record by scanning the barcode attached to the COG Disaster Tag. This information is then visible to Incident Command and receiving facilities as well as any providers who may ultimately provide care to the patient, in near real-time.

Resources: All personnel and major items of equipment available, or potentially available, for assignment to incident tasks on which status is maintained.
Regional Hospital Coordination Center: Also referred to as RHCC, the Regional Hospital Coordination Center is the agency that is a resource used to assist EMS personnel with the timely and appropriate distribution of patients to Northern Virginia Hospital Alliance (NVHA) member facilities and beyond, including both acute-care hospitals and freestanding emergency care centers through improved communication and coordination between field personnel and receiving hospitals.

Rehabilitation (Rehab): Required rest and evaluation of incident personnel who may be performing strenuous work and/or operating in extreme conditions.

RHCC: See Regional Hospital Coordination Center.

Staging: The location where units awaiting tasking are assigned. This location is usually located within a short travel distance but far enough away to not interfere in ongoing operations.

START: Acronym for “Simple Triage and Rapid Treatment.” This is the initial triage system that has been adopted by the Metropolitan Washington Council of Governments.

Staging Area: A location near the incident where incident personnel and equipment are assigned on a three-minute available status.

Strike Teams: Strike teams consist of five like resources with comparable capabilities used to augment the Task Force levels with common communications and a leader, temporarily assembled for a specific mission.

Supervisor: ICS title for individuals responsible for command of a Division or a Group.

Task Force: A group of mixed resources, with common communications and a leader, temporarily assembled for a specific mission.

Triage: The screening and classification of sick, wounded, or injured persons utilizing the START/JumpSTART triage system to determine priority needs in order to ensure the efficient use of medical personnel, equipment, and facilities.

Triage Crew: Responsible for utilizing the START/JumpSTART triage system to assess patients on-scene and portering them to the appropriate Treatment Areas.
# APPENDIX B: NOVA QUICK REFERENCE GUIDE FOR MCI

<table>
<thead>
<tr>
<th>UNIT</th>
<th>MCI PRIORITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Suppression Unit</td>
<td>Triage Unit Leader - Initiate and Complete Primary Patient Triage</td>
</tr>
<tr>
<td>2nd Suppression Unit</td>
<td>Treatment Unit Leader- Establish and Set-up Patient Treatment Area(s) Establish &amp; announce PIP</td>
</tr>
<tr>
<td>3rd Suppression Unit</td>
<td>Assume Air/Ground Coordinator Reinforce Transport Loading area</td>
</tr>
<tr>
<td>4th Suppression Unit</td>
<td>Report to Triage Unit Leader</td>
</tr>
<tr>
<td>5th Suppression Unit</td>
<td>Report to Treatment Unit Leader</td>
</tr>
<tr>
<td>6th Suppression Unit</td>
<td>Report to Staging or Establish same, if not already done</td>
</tr>
<tr>
<td>All Other Suppression Units</td>
<td>Report to Staging</td>
</tr>
<tr>
<td>1st EMS Transport Unit</td>
<td>Establish Transport Group &amp; Transport Recorder Establish and announce PEP</td>
</tr>
<tr>
<td>All Other EMS Units</td>
<td>Report to Staging</td>
</tr>
<tr>
<td>1st EMS Supervisor</td>
<td>Establish EMS Branch (then Med. Grp. Sup. once relieved)</td>
</tr>
<tr>
<td>2nd EMS Supervisor</td>
<td>Assume Transport Group Supervisor</td>
</tr>
<tr>
<td>3rd EMS Supervisor</td>
<td>Assume Treatment Unit Leader</td>
</tr>
<tr>
<td>1st Battalion Chief</td>
<td>Assume EMS Branch Director</td>
</tr>
</tbody>
</table>

MCI NOTES: MCI assignments are based on the ability of the IC to assign apparatus to EMS Branch based on incident priorities. In absence of direction from IC, units responding on the MCI Alarm will assume these roles.

- **Suppression Unit** = any engine, truck or squad
- **PIP** = Patient Intake Point (From IDLH to EMS Patient Treatment Area or Areas)
- **PEP** = Patient Exit Point (Where the ambulance exits the scene)
## APPENDIX C: NATIONAL CAPITAL REGION MEDICAL CARE SUPPORT UNITS

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>UNIT DESIGNATION</th>
<th>UNIT LOCATION</th>
<th>LEVEL</th>
<th>UASI FUNDED</th>
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<tbody>
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<td><strong>Washington, D.C.</strong></td>
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<td>MCU 1</td>
<td>Eng. Co. 24</td>
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</tr>
<tr>
<td>MCU 2</td>
<td>Eng. Co. 24</td>
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<td>NO</td>
<td></td>
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<tr>
<td>MCSU 3</td>
<td>Eng. Co. 33</td>
<td>III</td>
<td>YES</td>
<td></td>
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<tr>
<td>MAB 1</td>
<td>Eng. Co. 33</td>
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<td>NO</td>
<td></td>
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<td>MAB 2</td>
<td>Eng. Co. 24</td>
<td>III</td>
<td>YES</td>
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</tr>
<tr>
<td>MAB 3</td>
<td>Eng. Co. 33</td>
<td>III</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td><strong>Maryland</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frederick County</td>
<td>MCSU 928</td>
<td>Sta. 28 - Point of Rocks</td>
<td>II</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>MCSU 722</td>
<td>Sta. 22 – Germantown</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MCSU 726</td>
<td>Sta. 26 – Bethesda</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MAB 726</td>
<td>Sta. 22 – Bethesda</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MAB 722</td>
<td>Sta. 26 – Bethesda</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>MCSU 855</td>
<td>Sta. 55 – Bunker Hill</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MCSU 841</td>
<td>Sta. 51 – Calverton</td>
<td>II</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>MAB 830</td>
<td>Sta. 30 – Landover Hills</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td>Prince Georges County</td>
<td>MCSU 855</td>
<td>Sta. 28 - Point of Rocks</td>
<td>II</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>MCSU 722</td>
<td>Sta. 22 – Germantown</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MCSU 726</td>
<td>Sta. 26 – Bethesda</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MAB 726</td>
<td>Sta. 26 – Bethesda</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MAB 722</td>
<td>Sta. 22 – Germantown</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Virginia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro Washington</td>
<td>MCSU-302</td>
<td>Sta. 302 - Dulles</td>
<td>III</td>
<td>NO</td>
</tr>
<tr>
<td>Airports Authority</td>
<td>MCSU-301</td>
<td>Sta. 301 - Reagan</td>
<td>III</td>
<td>NO</td>
</tr>
<tr>
<td>Alexandria</td>
<td>MSU 202</td>
<td>Sta. 202 – 213 E. Windsor Ave.</td>
<td>III</td>
<td>NO</td>
</tr>
<tr>
<td>Arlington</td>
<td>MC 100</td>
<td>Sta. 2 – 4805 Wilson Blvd.</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MAB 100</td>
<td>Sta. 2 – 4805 Wilson Blvd.</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td>Fairfax County</td>
<td>MCSU 415</td>
<td>Sta. 15 - Chantilly</td>
<td>II</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>MCSU 429</td>
<td>Sta. 29 – Tysons Corner</td>
<td>II</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>MCSU 435</td>
<td>Sta. 35 – Pohick</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MAB 427</td>
<td>Sta. 27 – Springfield</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td>Loudoun County</td>
<td>MC 699</td>
<td>Loudoun Training</td>
<td>II</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>MC 615</td>
<td>Sta. 15 – Sterling Rescue</td>
<td>II</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>MC 614</td>
<td>Sta. 14 – Purcellville</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>MAB 623</td>
<td>Sta. 23 – Ashburn (Moorefield)</td>
<td>III</td>
<td>YES</td>
</tr>
<tr>
<td>Manassas City</td>
<td>MCU 501</td>
<td>Manassas City</td>
<td>II</td>
<td>NO</td>
</tr>
<tr>
<td>Prince William County</td>
<td>MCSU-12</td>
<td>Sta. 12, Berea</td>
<td>III</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>MAB-12</td>
<td>Sta. 12, Berea</td>
<td>III</td>
<td>NO</td>
</tr>
</tbody>
</table>

Last Update: April 2012
## APPENDIX D: MEDICAL CARE SUPPORT UNIT INVENTORY LISTS

<table>
<thead>
<tr>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>ITEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>80</td>
<td>Backboards (long)</td>
</tr>
<tr>
<td>40</td>
<td>80</td>
<td>Cervical collars (adjustable – adult )</td>
</tr>
<tr>
<td>40</td>
<td>80</td>
<td>Cervical collars (adjustable – pediatric)</td>
</tr>
<tr>
<td>40</td>
<td>80</td>
<td>Backboard straps (sets)</td>
</tr>
<tr>
<td>20</td>
<td>40</td>
<td>Military type patient litter, mesh, collapsible, with feet, with handles</td>
</tr>
<tr>
<td>50</td>
<td>100</td>
<td>Splints, disposable (minimum 12”, recommend 18”)</td>
</tr>
<tr>
<td>24</td>
<td>48</td>
<td>Splints, disposable, 34”</td>
</tr>
<tr>
<td>50</td>
<td>100</td>
<td>Blankets (disposable) 58 x 90, insulated</td>
</tr>
<tr>
<td>65</td>
<td>130</td>
<td>Blankets (space type)</td>
</tr>
<tr>
<td>40</td>
<td>80</td>
<td>Sheets (white linen – stored in either vacu-package or zip lock bag)</td>
</tr>
<tr>
<td>50</td>
<td>100</td>
<td>Multi-trauma dressing (sterile, size 12” x 30”)</td>
</tr>
<tr>
<td>500</td>
<td>1000</td>
<td>Non-sterile 4 x 4 dressing</td>
</tr>
<tr>
<td>100</td>
<td>200</td>
<td>Military/Civilian 6” rolls</td>
</tr>
<tr>
<td>100</td>
<td>200</td>
<td>Trauma dressing, sterile, 8” x 10”</td>
</tr>
<tr>
<td>250</td>
<td>500</td>
<td>Kling 4” rolls</td>
</tr>
<tr>
<td>150</td>
<td>300</td>
<td>Cravats (triangular bandage)</td>
</tr>
<tr>
<td>100 rolls</td>
<td>200 rolls</td>
<td>Tape 3” x 10 yards, silk</td>
</tr>
<tr>
<td>30</td>
<td>60</td>
<td>NP airway kit, latex free, set of 6, sizes 26 to 34 French</td>
</tr>
<tr>
<td>50</td>
<td>100</td>
<td>OP airways, set of 6, (Berman kit), size infant to large adult</td>
</tr>
<tr>
<td>50</td>
<td>100</td>
<td>Oxygen mask, non-rebreather, with tubing, adult</td>
</tr>
<tr>
<td>50</td>
<td>100</td>
<td>Oxygen mask, non-rebreather, with tubing, pediatric</td>
</tr>
<tr>
<td>50</td>
<td>100</td>
<td>Oxygen tubing, male connectors, minimum 7 ft.</td>
</tr>
<tr>
<td>20 each</td>
<td>40 each</td>
<td>Bag valve mask device, disposable (ea. BVM has adult, &amp; pediatric masks)</td>
</tr>
<tr>
<td>10</td>
<td>20</td>
<td>Hand powered portable suction units</td>
</tr>
<tr>
<td>30</td>
<td>60</td>
<td>Hand powered portable suction units replacement canisters</td>
</tr>
<tr>
<td>15</td>
<td>15</td>
<td>Combi- Nebulizers - Adult</td>
</tr>
<tr>
<td>15</td>
<td>15</td>
<td>Combi-Nebulizers - Pediatric</td>
</tr>
<tr>
<td>2 cases ea. size</td>
<td>4 cases ea. size</td>
<td>Gloves (medium, large, extra large) NFPA approved</td>
</tr>
<tr>
<td>100</td>
<td>200</td>
<td>Face masks w/eye shield</td>
</tr>
<tr>
<td>100</td>
<td>200</td>
<td>Eye protection</td>
</tr>
<tr>
<td>10</td>
<td>20</td>
<td>Scissors</td>
</tr>
<tr>
<td>18</td>
<td>36</td>
<td>Penlights</td>
</tr>
<tr>
<td>10</td>
<td>20</td>
<td>Stethoscopes, adult/ peds. (Sprague Rappaport)</td>
</tr>
<tr>
<td>10</td>
<td>20</td>
<td>Blood pressure cuffs, (pediatric, adult, large adult)</td>
</tr>
<tr>
<td>54</td>
<td>108</td>
<td>1000 cc Normal Saline IV (12 per case)</td>
</tr>
<tr>
<td>40</td>
<td>80</td>
<td>Small bottles irrigation saline (for green patient area)</td>
</tr>
<tr>
<td>54</td>
<td>108</td>
<td>IV tubing (10 drop sets) (48 per case) at least 100 inches</td>
</tr>
<tr>
<td>54</td>
<td>108</td>
<td>IV starter kits</td>
</tr>
<tr>
<td>100 ea.</td>
<td>200 ea.</td>
<td>IV needles – 16 g., 18 g, 20 g.</td>
</tr>
<tr>
<td>7</td>
<td>14</td>
<td>Sharps containers (minimum - 2 gallon size) (2 red/2 yellow)</td>
</tr>
<tr>
<td>12 bottles</td>
<td>24 bottles</td>
<td>Waterless hand cleaner</td>
</tr>
<tr>
<td>30</td>
<td>60</td>
<td>Towels - cloth</td>
</tr>
<tr>
<td>6 boxes</td>
<td>6 boxes</td>
<td>germicidal wipes for equipment</td>
</tr>
<tr>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
<td>ITEM</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>18</td>
<td>36</td>
<td>Rolls Duct tape</td>
</tr>
<tr>
<td>150</td>
<td>300</td>
<td>Zip lock storage bags (gallon size)</td>
</tr>
<tr>
<td>250 bags</td>
<td>500 bags</td>
<td>Biohazard bags (10 – 15 gallon size)</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Megaphone/bullhorn with extra batteries</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
<td>Flashlights with extra batteries</td>
</tr>
<tr>
<td>1 set</td>
<td>2 sets</td>
<td>Triage tarps, (red, yellow, green), with grommets, minimum 15’ x 20’ (recommend heavy canvas) for equipment cache (can be poly coated)</td>
</tr>
<tr>
<td>1 each</td>
<td>2 each</td>
<td>Triage flags (base, telescoping min. 8 ‘ pole, flag), red, yellow, green</td>
</tr>
<tr>
<td>18</td>
<td>36</td>
<td>Traffic cones with reflective stripe</td>
</tr>
<tr>
<td>18</td>
<td>36</td>
<td>Step-in posts, fiberglass</td>
</tr>
<tr>
<td>4 rolls each</td>
<td>4 rolls each</td>
<td>Rolls barricade tape, red, green, yellow (3” minimum width)</td>
</tr>
<tr>
<td>150</td>
<td>300</td>
<td>Triage tags (COG tag)</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
<td>Triage ribbon kits (red, yellow, green, black)</td>
</tr>
<tr>
<td>6 cases</td>
<td>6 cases</td>
<td>Bottled water, minimum 12 ounce</td>
</tr>
<tr>
<td>60 each color</td>
<td>60 each color</td>
<td>Cyalume light sticks, box of 24 (red, yellow, green - min. 12 hour)</td>
</tr>
<tr>
<td>100 each</td>
<td>100 each</td>
<td>Cyalume light sticks (white – hi intensity – 30 min.) 10 per box</td>
</tr>
<tr>
<td>1 set</td>
<td>2 sets</td>
<td>MCI Vests (1 set includes 14 vests)</td>
</tr>
<tr>
<td>6 boxes</td>
<td>6 boxes</td>
<td>Permanent markers</td>
</tr>
<tr>
<td>6 boxes</td>
<td>6 boxes</td>
<td>Ball point pens (12 per box)</td>
</tr>
<tr>
<td>18</td>
<td>18</td>
<td>Clipboards</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Oxygen multilator or minilator, minimum 5 ports, adjustable flow rate</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Oxygen hose 50 feet with regulator</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Oxygen bottles, minimum size M cylinder</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Oxygen kits (include Teflon tape, adjustable wrench, 5 Christmas trees – green nipple fitting)</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Wheeled hand carts (for equipment and secure oxygen bottle carrying capability)</td>
</tr>
</tbody>
</table>
APPENDIX E: MEDICAL CARE SUPPORT UNIT FIELD OPERATING GUIDE

Medical Care Support Unit (MCSU) Mission

The MCSU's are designed to assist in treating large number of patients as a result of a Multiple Casualty Incident (MCI). Each MCSU is designed to treat approximately 100 injured persons per call. Crew configurations will be dependent on incident profile and resources available. The MCSU Vehicles are strategically located around the metropolitan area for rapid deployment to incidents that may require this resource. They may also be dispatched to augment resources already deployed to an incident.

<table>
<thead>
<tr>
<th>Crew Configuration</th>
<th>Responsibilities</th>
<th>Crew Actions</th>
<th>MCSU Operational Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driver</strong></td>
<td></td>
<td><strong>Pre-Incident</strong>- <strong>Driver</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Responsible for daily mechanical readiness.</td>
<td>Vehicle Responsibility</td>
<td>A monthly supply and equipment inventory is required to maintain the MCSU readiness.</td>
</tr>
<tr>
<td></td>
<td>Primary operator of the vehicle and ensures a safe response to the incident scene.</td>
<td>Operational Readiness</td>
<td>Daily vehicle maintenance on the MCSU should be performed using the same procedure as the Initial Life Support apparatus.</td>
</tr>
<tr>
<td></td>
<td>Secures an area for vehicle staging.</td>
<td>Monthly Inventory</td>
<td>Upon dispatch, determine direction of travel to scene and proceed to respond with other vehicles in a &quot;scramble&quot; fashion.</td>
</tr>
<tr>
<td></td>
<td>Secures the vehicle at the incident scene.</td>
<td></td>
<td>Operations at the disaster scene vs. an MCI is more challenging. The crew of the MCSU may be met by EMS crews attempting to load the vehicle of supplies.</td>
</tr>
<tr>
<td><strong>Support Crew</strong></td>
<td></td>
<td><strong>On Scene</strong></td>
<td>Coordination and staging of the vehicle may be the first mission to maintain order.</td>
</tr>
<tr>
<td></td>
<td>Assists the driver of the MCSU in navigating to the scene of the incident in an orderly fashion.</td>
<td>Establishes a perimeter for the MCSU</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establishes radio communication and coordination with the Incident Commander</td>
<td>Establishes a method for distribution of supplies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coordinates with EMS Command for the dissemination and distribution of supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assistant Driver</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assists Primary Driver Ensures to Incident</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Navigation to Incident</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radio coordination with Incident Commander</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Operational Readiness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attempts to maintain a record of supplies on hand distributed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attempts to maintain a record of non-disposable items and their destination if possible, i.e. backboard, field dressing, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Equipment Documentation

- After the incident, determine which equipment/supplies were utilized and make a list of supplies needed to restock the MCSU
- Make effort to retrieve all disposable items
- Obtain needed supplies and restock MCSU

---

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Washington Metropolitan Council of Governments
Medical Care Support Unit (MCSU) Field Operations Guide (FOG)

Drivers Side - A

Officers Side - B

Driver's Side Inventory
1
2
3
4
5
6
7

Officer's Side Inventory
1
2
3
4
5
6
7
APPENDIX F: MEDICAL AMBULANCE BUS FIELD OPS GUIDE

Washington Metropolitan Council of Governments
Medical Ambulance Bus Field Operations Guide (FOG)

Medical Ambulance Bus (MAB) Mission

MAB’s are designed to assist in transporting patients as a result of an Multiple Casualty Incident (MCI). Each bus is designed to transport up to 20 patients on stretchers from the incident. Crew configuration will be dependent on each incident profile and resources available. These MAB’s are strategically located around the Washington Metropolitan Area for rapid deployment to incidents that may require this particular resource.

Crew Configuration

- **Crew Position**:  
  - **Responsibilities**:  
    - Responsible for daily mechanical readiness.
    - Primary operator of the vehicle and ensures a safe response to the incident scene.
    - Serves as an area for crew assembly and operations.
    - Designates an area for patient assembly and transfer to MAB.
    - Assures patient safety and security during transport.

Driver

- Assists the driver of the MAB in navigating to the scene of the incident in an “Escort” fashion.
- Helps establish radio communication and coordination with the Incident Commander.
- Provides direct medical care to patients being transported to the receiving facility.
- Provides documentation of patient injuries, treatment and identification if possible.

Medical Crew

- Vehicle Responsibility
  - Mechanical Readiness
  - Operational Readiness
    - Monthly Inventory

On-Scene

- Directs Assembling Shelter (if available)
  - Crew Protection & Assembly Area
- Designates patient Transfer Area
  - Near Rear of Bus
  - MAB Cots to Equipment Assembly near Transfer Area

- Patient Loading & Security
  - Ensures Law Enforcement to Assure Vehicle, Patient & Crew Safety
- Security of Patient’s Personal Property
- Coordination of Patient Exchange

- Assistant Driver or Medical Crew
  - Assists Primary Driver Enroute to Incident
    - Navigation to Incident
    - Radio Coordination with Incident Command

- Operational Readiness
  - Slowly turns oxygen bottles on and charges O2 system
- Overall Patient Care
- Transfer of Patient Information to Receiving Facility

Bus Operation with Patients

- Patient Loading: Key Points
  - Loading Procedure
    - Load Patient Care-Prioritization
    - Consider Weight of Patient: Heavy or Light
  - Allows Most Critical Patients to Be Loaded Last and Urged First at the Receiving Facility (Load in Middle Position If Possible)
  - Patients That May Require Invasive Care, i.e.: Airway Management, Should Be Loaded in the Middle Positions for Ease of Care
  - Bus is Loaded FRONTO REAR
  - Keep in Mind that Patient Weight and Triage Level Should Be Considered When Loading Patients. If Possible, Heavier or Least Critical Patients should be Loaded in Bottom Positions

Patient Documentation

- Patient Name, Triage Tag Barcode or Identification Number
- Age – If Possible
  - HPI – History of Present Illness or Injury
  - Patient Pertinent Medical History
- Prescribed Medications
- Medication Allergies
- Treatment Rendered
  - Treatment Outcome
- Vital Signs
- Final Disposition

Tertiary Care Centers

<table>
<thead>
<tr>
<th>Level 1 Trauma Centers</th>
<th>Level 2 Trauma Centers</th>
<th>Pediatric Trauma Centers</th>
<th>Spinal Trauma Centers</th>
<th>Burn Centers</th>
</tr>
</thead>
</table>
| Shock Trauma – Baltimore MED/MSS  
Johns Hopkins – Baltimore  
Inova Fairfax Hosp – Fairfax  
MedSTAR – Washington DC  
Howard University Hosp – DC  
George Washington (GW) - DC | Suburban Hosp – Bethesda  
PG Hospital Center - Cheverly | Children’s – Washington DC  
Johns Hopkins – Baltimore  
Inova Fairfax Hosp - Fairfax | Shock Trauma – Baltimore MED/MSS  
Johns Hopkins – Baltimore  
Inova Fairfax Hosp – Fairfax  
MedSTAR – Washington DC  
Johns Hopkins - Baltimore (Adult – Bayview) (Pediatric – Main Campus) | |
## EMS Multiple Casualty Incident Manual

### Medical Ambulance Bus Field Operations Guide (FOG)

<table>
<thead>
<tr>
<th>Bus Orientation</th>
<th>Stretcher Labeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Side “A” Driver's Side (Street Side)</td>
<td>Driver's Side or Street Side – Stretches are numbered A - #&lt;br&gt;Top stretcher is #1, middle is #2 and bottom is #3 – continues top to bottom and front of bus to rear of bus&lt;br&gt;Total of 9 stretchers on Side “A”</td>
</tr>
<tr>
<td>Side “B” Officer’s Side (Curb Side)</td>
<td>Officer’s side or Curb Side – stretchers are numbered B - #&lt;br&gt;Top stretcher is #1 and middle is #2 – continues top to bottom and front of bus to rear of bus&lt;br&gt;Total of 11 stretchers on Side “B”</td>
</tr>
</tbody>
</table>

---

**Patient Transfer Area**
- Patients ready for transfer and loading should be assembled near the REAR of the MAB.
- Least critical loaded first – Front to Rear with Heaviest patients on bottom if possible.
- If tent available, stage patients under tent until moved onto bus.

**MAB Equipment Assembly**

**Crew Assembly for Patient Loading**

**Depart**

---

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### APPENDIX G: EMS BRANCH COMMAND BOARDS

<table>
<thead>
<tr>
<th>TACTICAL CHANNEL</th>
<th>COMMAND CHANNEL</th>
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#### TRIAGE UNIT LEADER

- **HAZMAT/EXTRICATION GROUP SUPERVISOR**
- **MEDICAL GROUP SUPERVISOR**
- **TRANSPORTATION GROUP SUPERVISOR**
- **MEDICAL SUPPLY COORDINATOR**
- **TRIAGE UNIT LEADER**
- **TREATMENT UNIT LEADER**

#### RESPONSIBILITIES

**SAFETY:**
- Anticipate WMD or CBRNE agents (including 2" devices)
- Establish a perimeter for security & scene control
- Determine evacuation distances around impact area
- Assess appropriate level(s) of PPE

**SIZE UP:**
- Estimate extent of impact area
- Approximate number & severity of victims
- Determine resources required

**SEND INFO:**
- Request resources and personnel via command
- Activate RHCC

**SET UP:**
- Designate the casualty collection point (CCP)
- Establish & coordinate triage units & porter units
- Set up scene access and egress
- Set up scene perimeter (using law enforcement)

**START TRIAGE:**
- Relay information to medical group supervisor
- Relocate minor patients (walking wounded) to a designated & supervised casualty collection point

**RELOCATE MINOR PATIENTS (WALKING WOUNDED) TO A DESIGNATED & SUPERVISED CASUALTY COLLECTION POINT**

**ENSURE NO PATIENT LEAVES THE IMPACT AREA WITHOUT A TRIAGE RIBBON ATTACHED TO THE PERSON**

**PERSONNEL ACCOUNTABILITY & MONITOR PERSONNEL**

**ENSURE THE SCENE IS CLEAR OF Viable PATIENTS**

**SAFEGUARD THE DECEASED & REQUEST LAW ENFORCEMENT AND/OR MORGUE MANAGER**

**ADVISE MEDICAL GROUP SUPERVISOR WHEN TRIAGE IS DONE**

**ASSESS PHYSICAL & MENTAL WELL BEING OF PERSONNEL**

**REQUEST REASSIGNMENT OR REHAB BASED ON PERSONNEL NEEDS AND DEMOBILIZE**

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APPENDIX H: WORKSHEETS

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**DELAYED MANAGER**

**MINOR MANAGER**

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- DESIGNATE INGRESS & EGRESS
- FOR AIR - DETERMINE THE LANDING ZONE
- FOR GROUND - PROVIDE DIRECTIONS TO HOSPITALS
- REQUEST AIR AMBULANCES
- COORDINATE TRANSPORTATION EFFORTS WITH THE MEDICAL COMMUNICATIONS COORDINATOR AND TRANSPORT RECORDER
- TRACK STATUS AND LOCATION OF ALL INVOLVED AIR AMBULANCES
- ENSURE PROPER DOCUMENTATION IS COMPLETED

PATIENT COUNT

PATIENT COUNT

PATIENT COUNT

AIR/GROUND AMBULANCE COORDINATOR

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<td>Winchester Medical Center [Level II Trauma]</td>
<td>(540) 536-4601</td>
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APPENDIX I: START/JUMP START TRIAGE

START TRIAGE
(Simple Triage and Rapid Treatment)

All Walking Wounded

MINOR

RESPIRATIONS

YES

NO

Position Airway

RESPIRATIONS

Over 30/min

Under 30/min

IMMEDIATE

IMMEDIATE

DECEASED

PERFUSION

Radial Pulse Present

Radial Pulse Absent

Capillary Refill

Over 2 Seconds

Under 2 Seconds

Mental Status: CAN DO

Respiration: 30

Perfusion: 2

Mental Status: CAN DO

Control Bleeding

IMMEDIATE

MENTAL STATUS

Can’t Follow Simple Commands

Can Follow Simple Commands

IMMEDIATE

DELAYED

START Program developed by Hoag Memorial Hospital
and Newport Beach Fire Dept
JumpSTART’s objectives are:

1. To optimize the primary triage of injured children in the MCI setting.
2. To enhance the effectiveness of resource allocation for all MCI victims.
3. To reduce the emotional burden on triage personnel who may have to make rapid life-or-death decisions about injured children in chaotic circumstances.
APPENDIX J: SAMPLE COG DISASTER TAG

![Disaster Tag Diagram](image-url)
APPENDIX K: PATIENT TRACKING DEVICE

For accountability reasons, it is necessary to track patient flow through the incident scene. We, as emergency responders, have a responsibility to account for where we send our patients so they can be reunited with their families.

With the introduction of electronic Patient Tracking Devices (PTD) we will be able to track patient progress within the incident scene, through the transport recorder position and ultimately to the receiving facility. The data collected by the PTD allows us to provide a more detailed patient treatment record to the receiving facility and will allow for easier reunification of families.

The PTD is designed to mirror the information gathered on the COG Disaster Tag. Information is organized into a single record by scanning the barcode attached to the Disaster Tag. This information is then visible to command and receiving facilities as well as any providers who may ultimately provide care to the patient, in near real time.

- The more information about the patient (vital signs, medications, allergies, age, name, etc.) that can be obtained in the Treatment Area the better, but it is important that providers not focus on inputting information and neglect patient care. It is well understood that in a busy Treatment Area, there may not be enough personnel or time to input large amounts of information.

By placing PTDs in strategic locations within the incident and scanning the barcodes, it is possible for the IC to track patient flow and evaluate the progress of the incident.
APPENDIX L: RHCC

**Northern Virginia Regional Hospital Coordination Center (RHCC)**  
*EMS Activation Protocol [a.k.a. MedComm]*

**Purpose:** One of the responsibilities of the NoVA RHCC is to coordinate with EMS personnel to ensure the timely and appropriate distribution of patients to Northern Virginia Hospital Alliance member facilities, including both acute-care hospitals and freestanding emergency care centers; and to improve the communication between field personnel and receiving hospitals. The goal of this coordination is to match patients to the most appropriate hospital resources, based on the circumstances of the event, in a timely and efficient manner.

**Scope:** The RHCC will be notified to activate in support of EMS agencies in Northern Virginia for incidents meeting **ANY** of the following criteria:

1. A single, non-HAZMAT event in NoVA, involves (10) or more patients that will require transportation to a NVHA hospital; and/or where (3) or more NVHA hospitals are to receive patients
2. A single HAZMAT event in NoVA involves (3) or more patients that will be decontaminated in the field by EMS before being transported to a NVHA hospital
3. An event in NoVA involves a suspected or confirmed Category A biological agent
4. A NoVA Fire/EMS agency has activated an Urban Search & Rescue Team for an event occurring in the National Capital Region
5. A NoVA Fire/EMS agency has activated a Mass Casualty Unit, Task Force, or equivalent, for an event occurring in the National Capital Region.
6. A NoVA EMS agency has accessed and/or requested a CHEMPACK or MMRS Rx cache
7. A NoVA Emergency Operations Center (EOC) has activated and staffed the Health & Medical Services (ESF 8) function

**Procedures:**

1. If an incident occurs that meets the criteria enumerated under the SCOPE, an appropriate Fire/EMS agent will immediately contact the RHCC at:
   
   (1) **Phone:** 888-987-RHCC (7422); or

   (2) Medcomm Talk Group *For Hospital and Public Health Use Only*
      Alexandria.......................Zone 14 Channel 1 (H1 RHCC4)
      Arlington.......................Zone 5 Channel 10 (H RHCC4), Channel 11 (H RHCC6)
      Fairfax.........................Zone 14 Channel 1 (49A RHCC4), Channel 16 (49P RHCC6)
      Prince William...............Zone 11 Channel 1 (9*A RHCC4), Channel 16 (9P RHCC6)
      Loudoun.......................Zone 69 Channel 2 (B RHCC6) – New APX radios
      MWAA.............................Zone 21 Channel 11P (RHCC 4)
2. The appropriate agent\(^1\) will request the immediate support of the Regional Hospital Coordination Center (RHCC) via Phone or Radio per the communication mechanisms listed in (1);

3. The appropriate EMS agent will provide RHCC staff the following information, if known:
   - Total number of patients / casualties (actual and/or estimate)
   - Location and jurisdiction of incident
   - Type of incident (i.e. explosion, major car accident, chemical fire)
   - A telephone number (or Radio Talk Group) and Point of Contact from agency contacting the RHCC to be for ongoing communication
   - A Casualty Assessment (i.e., number of red/immediate, yellow/delayed, and green/minor patients)
   - The exact support needed from the RHCC
   - Product information, if known, in HAZMAT incident
   - Level of decontamination provided on-scene, if known, in HAZMAT incident;
   - The radio channel and/or phone number to use for ongoing communications during event

4. The information listed in (3) will be immediately conveyed by the RHCC to regional hospitals\(^4\) as detailed in the RHCC activation procedures outlined in the Northern Virginia Regional Hospital Emergency Operations Plan (RHEOP);

5. The RHCC will gather from all NVHA hospitals their immediate casualty capacity information (i.e., the number of red/immediate, yellow/delayed, and green/minor patients they could manage within the next 30 minutes). This information will be collected and relayed to the appropriate EMS field officer (i.e. Medical Communications Coordinator), within 10 minutes of activation, to assist with patient disposition.

6. Final hospital destination decisions will be decided by an appropriate EMS field officer (i.e. Medical Communications Coordinator) in coordination with the RHCC. At a minimum, the EMS field officer will relay to the RHCC the following information for each transporting unit, preferably BEFORE the unit leaves the scene:
   - Unit Number
   - Destination facility
   - Number and Category\(^5\) of patients on unit (with notice for peds)

En route to receiving hospitals, individual EMS units are requested to relay the following patient information to the receiving hospital, provided if time and communications capabilities permit:

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\(^1\) The individual who constitutes an “appropriate agent” is to be determined by each jurisdiction per their standard operating procedures.

\(^2\) Facilities automatically notified: Dewitt Army Community Hospital, Fauquier Hospital, Inova Alexandria, Inova ECC – Fairfax, Inova ECC—Healthplex, Inova ECC—Cornwall, Inova ECC—Reston, Inova Fair Oaks, Inova Fairfax, Inova Mt. Vernon, Inova Loudoun, Mary Washington Hospital, Potomac Hospital, Prince William Hospital, Reston Hospital Center, Virginia Hospital Center, DC Children’s Clearinghouse (DC & Suburban Maryland Hospitals) and Winchester (if the event is located in Loudoun)

\(^3\) i.e., Red, Yellow, Green
d. **Systolic Blood Pressure**

**Airway Status**

**G**lasgow Coma Scale (GCS)

**E**stimate Time of Arrival (ETA) to destination hospital

e. Other significant medical interventions performed (i.e. intubation, needle thoracostomy, decontamination, etc.).

7. The RHCC will relay information provided in (6.a-e) to the designated receiving facilities via pre-established communication channels;

8. The appropriate EMS officer (i.e. Medical Communications Coordinator) will keep the RHCC informed of major developments on the scene that could affect Northern Virginia Hospitals. Likewise, the RHCC will keep the designated EMS officer apprised of all major changes to the status of Northern Virginia Hospitals. All requests for on-scene support from Northern Virginia Hospitals (i.e., additional equipment, supplies, on-scene physician / nursing support, etc.) will be directed through the RHCC and not individual hospitals;

9. Under certain circumstances, and when deemed necessary and appropriate by both the primary EMS agency responding to the event and the RHCC, the EMS will dispatch an officer to report to the RHCC (8110 Gatehouse Drive, Suite 600, Falls Church, VA 22042) to serve as a liaison;

10. The appropriate EMS officer (i.e. Medical Communications Coordinator) will notify the RHCC when the scene incident has been demobilized and/or the last patient has been transported off-site;

11. At the conclusion of the scene incident the designated EMS Branch Director or designee will cross check their patient transfer information with the RHCC. The RHCC will be responsible for cross checking their patient transfer information with all of the receiving facilities. A copy of the final incident/transport record will be sent to the affected jurisdictional Fire and Rescue Department and a copy maintained in the RHCC records for a minimum of 7 years.

*Version 7.3*

For additional information contact:

**EMS**
Northern Virginia EMS Council
7250 Heritage Village Plaza, Suite 102
Gainesville, VA 20155
877-261-3550
northern@vaems.org

**Hospital**
Northern Virginia Hospital Alliance
Regional Hospital Coordination Center
8110 Gatehouse Drive, Suite 600 W
Falls Church, VA 22042
888-987-7422
rhcc@novaha.com
APPENDIX M: PANDEMIC PLAN

NORTHERN VIRGINIA REGIONAL
PANDEMIC PLAN

The following were agreed to by agency OMDs:

- The concept of an alternative mode of transport under the right circumstances
- Use of selective transport of non-acute patients
- Use of alternate destinations as defined by public health
- Response assets should be tailored to the resources that are available and the needs of the patient

The decision to move to an alternate strategy should be made by the Fire/EMS Chiefs who should be in contact with the OMD’s. The goal is to balance medical needs with operational needs, and the decisions must be made by consult with both parties. In some jurisdictions the OMD may be the sole decision maker, due to the structure of the specific EMS system. Regardless, the decisions should be made physically in the PSAP. Due to differences in the regional systems, some jurisdictions may move to selective dispatch before others.
Response Flow Chart

1. 911 Call
2. Call Processing (ILI Symptoms)
3. Selective Dispatch Modifications
   - Priorities Established (OMD)
   - Selective Response Decision (PSAP – OPS) (Balance the "big picture")
4. Resource Arrives
5. Transport Decision
6. Exclusion Criteria (OMD)
7. Normal Mode
8. Alternate Mode
   - Alternate Destination (Public Health)
9. Site
10. ED

- Alt. vehicle FD
- Call stacking
- Civilian vehicle
- Selective
# EMS Call Classification

<table>
<thead>
<tr>
<th>General EMD Call Classification</th>
<th>APCO or Medical Priority Dispatch EMD System (if used)</th>
<th>Selective Response Dispatch Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIORITY ALS</td>
<td>ALS Priority DELTA</td>
<td>• ALS Provider with transport capability if none available then</td>
</tr>
<tr>
<td>(Or the jurisdictional equivalent)</td>
<td></td>
<td>• ALS provider without transport capability if none available then</td>
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<tr>
<td></td>
<td></td>
<td>• BLS Provider with transport capability if none available then</td>
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<tr>
<td></td>
<td></td>
<td>• BLS provider without transport capability</td>
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<tr>
<td>STANDARD ALS</td>
<td>ALS Standard CHARLIE</td>
<td>• ALS Provider without transport capability if none available then</td>
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<tr>
<td>(Or the jurisdictional equivalent)</td>
<td></td>
<td>• ALS provider with transport capability if none available then</td>
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<td></td>
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<td>• BLS Provider with transport capability if none available then</td>
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<td></td>
<td></td>
<td>• BLS provider without transport capability</td>
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<tr>
<td>PRIORITY BLS</td>
<td>BLS Priority ALPHA</td>
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<td>• BLS provider without transport capability</td>
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<tr>
<td>STANDARD BLS</td>
<td>BLS Standard OMEGA</td>
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<td>(Or the jurisdictional equivalent)</td>
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<td>• ALS Provider without transport capability if none available then</td>
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<tr>
<td></td>
<td></td>
<td>• ALS provider with transport capability</td>
</tr>
</tbody>
</table>
### EXCLUSION CRITERIA FOR SELECTIVE TRANSPORT

When resources during a pandemic are “Level Red”, automatically offer to transport patients with the following presentation: This document is to be used to establish minimums—each jurisdiction may add to these criteria.

1. Provider discretion – suspicion of critical illness/injury

2. Altered vital signs (or age-specific abnormal vital signs), including any one of these:
   - SBP < 90
   - SpO2<92%
   - RR>30 (or respiratory distress)
   - HR>120, or delayed capillary refill

3. Breathing:
   - Respiratory Distress
   - Cyanosis, or pallor/ashen skin

4. Circulation / Shock:
   - Signs or symptoms of shock
   - Severe / uncontrollable bleeding
   - Large amounts of blood (or suspected blood) in emesis or stool

5. Neurologic:
   - Unconscious or altered level of consciousness
   - New focal neurologic signs (CVA, etc.)
   - Status, multiple or new-onset seizure
   - Severe headaches – especially sudden onset or accompanied with neck pain/stiffness
   - Head injuries with more than brief loss of consciousness or continued neck pain, dizziness, vision disturbances, ongoing amnesia or headache, and/or nausea and vomiting

6. Trauma:
   - Significant trauma with chest/spinal/abdominal/neurologic injury deemed unstable or potentially unstable
   - Suspected fractures or dislocations that cannot be safely transported by private vehicle

**Note:** Patients with flu-like illness may be offered alternative transportation or services if they do not meet the above criteria.