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

Multiple Casualty Incident Manual
Third Edition

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- NOVA Command Officer Operations Manual (third edition)
- National Incident Management System (updated October 2015)
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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.

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

1. Based on a review of drills, exercises, and events run in the region, the group reorganized the incident priorities to focus on the creation of the transportation area and its function.
2. Reorganized the manual and all positions to prioritize the rapid transport of critical patients to appropriate medical facilities. Get the Red Out!
3. Updated the Multiple Casualty Incident (MCI) response algorithm to include a second alarm; this will bring an additional 10 transport units to the event, but only an additional five suppression units.
4. Updated the EMS Task Force response algorithm.
5. Modified the unit assignments to make the Transportation Group’s organization and structure a priority.
6. Position responsibilities have been streamlined in an order of priority, focusing on key aspects that will make the position successful.
7. Identified and developed the structure for MCIs that involve multiple transport areas.
8. Eliminated the Patient Intake Points (PIP).
9. Moved Patient Tracking responsibilities to the Transport Recorder position and identified the required information.
10. Eliminated the Treatment/Transport Liaison.
11. Eliminated the Ground Ambulance Coordinator form.
12. Updated all the forms to meet the new incident priorities
13. Updated the Incident Command Boards to meet the new incident priorities.
14. Updated the communications section.
15. Coordinated with the High Threat Environment Committee to ensure common operations between both groups.
16. Adjusted the MCSU category to correlate with the NIMS resource typing:
   a. Level 1 – 100 patients,
   b. Level 2 – 50 patients, and
   c. Level 3 – 25 patients.
17. Updated the Multiple Casualty Support Unit (MCSU) inventory to meet the current threat environment.
18. Worked with the Regional Hospital Coordination Center (RHCC) to provide hospital availability to on scene resources upon initial contact.
19. Eliminated unnecessary terminology from the manual and glossary.
20. Identified the need for unit-level training on the manual and procedures.
Definitions

The key definitions used in this manual are as follows.

Casualty Collection Point (CCP) – An area where patients are relocated that is outside of the Immediately Dangerous to Life and Health (IDLH)/hostile environment where safe triage can occur. On high-threat incidents, the initial CCP may be in a warm zone while awaiting extraction.

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, meet human needs, and achieve recovery. A disaster will demand resources beyond local capabilities and require extensive mutual aid and support needs.

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

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

Patient Tracking System – The electronic system used by NOVA for recording and tracking patients associated with an MCI. By entering information into this system, users create a database of tracking information that can be used and accessed by all responding agencies to track the movement of patients.

Self-care Kits – Pre-packaged medical kits that are designed to allow for self-care of minor injuries.
OVERVIEW

The *Multiple Casualty Incident Manual* outlines procedures to be used 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 Virginia Office of Emergency Medical Services (VOEMS) defines a Multiple Casualty Incident (MCI) as, “any incident that injures enough people to overwhelm resources usually available in a particular system or area.”

Crisis Standard of Care

An MCI in our region is a low-frequency, high-demand event. As a result of the high number of patients at a MCI, emergency responders are not expected to provide normal levels of care for each individual patient as dictated by our respective protocols. Instead, because the number of patients exceeds the available resources, a crisis standard of care will be provided, where the goal is to provide the greatest good for the greatest number of people affected by the incident. The focus of emergency personnel will be to provide limited, life-saving interventions and to transport the most seriously injured patients off the scene as quickly as possible.

Rapid Transport of Critical Patients

The intent of this manual is to create a framework that enables the rapid transport of the most severely injured patients from the scene to appropriate facilities. Rapid triage of those in the impact area identifies the most severely injured patients and provides Incident Command with a count of casualties in each triage category. Patients who receive the Immediate or Red designation can often only be saved by interventions that occur at a hospital; there is very little that can be done on the scene to improve their outcomes. Consequently, this manual calls for the early development of the Transportation Group. By establishing an effective Transportation Group, patients can be transported to appropriate facilities quickly, which will have the greatest positive impact on their outcomes.

Patient Tracking and Family Reunification

Tracking patient destinations during a MCI incident is difficult. This manual establishes a method for emergency personnel to track patient destinations through the use of triage tags, paper forms, and the electronic patient tracking system. The information collected is used by the 2-1-1 Virginia call center which is the statewide system used by hospitals to facilitate family reunification.

MCI Types

This manual is designed to create a framework that is effective for rapidly transporting patients from any type of MCI such as large-scale hazardous materials incidents, High Threat Incidents such as mass shootings, or transportation accidents. In all of these cases, the MCI incident occurs in addition to another emergency. For this reason, all of the positions created are normally filled
by personnel dispatched on the MCI alarm, and not units already on scene mitigating the initial incident. Table 1 lists some special considerations for three MCI types.

Table 1: Special considerations by MCI type.

<table>
<thead>
<tr>
<th>MCI Type</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous Materials Incidents</td>
<td>Patients will go through appropriate decontamination prior to being moved to the Casualty Collection Point. The Casualty collection point should be established at the transition point between the warm and cold zone, where triage and normal MCI operations will begin.</td>
</tr>
<tr>
<td>High-threat Environments</td>
<td>The Joint Action Guide for High-threat Environments manual will be followed by initial arriving units. Once evacuation teams remove patients from the structure/warm zone to a casualty collection point, triage and normal MCI operations will begin.</td>
</tr>
</tbody>
</table>
| Evacuation of a Medical Facility| Hospitals and skilled nursing facilities should have an evacuation plan; in the event such a facility requires evacuation, command staff should coordinate with facility leadership to execute the plan.  
It may be necessary to establish a safe Casualty Collection Point early in the incident. Responders should coordinate with RHCC and local emergency management resources to develop appropriate destinations that can include hospitals, nursing facilities, or emergency shelters.  
The framework outlined in this manual offers a structure and method for resolving emergencies in these facilities. |

EMS Task Force and MCI Response Configurations

The EMS Task Force and MCI Alarms are designed to assemble necessary resources for a multiple casualty incident. A unit assigned to an EMS Task Force or MCI Alarm should fill the role designated in the Quick Reference Guide for the MCI (refer to Appendix A) based on their arriving order unless directed to do otherwise by the Incident Commander. In the absence of EMS Supervisors, qualified personnel should be placed into those positions. The incident response resources are outlined in Table 2.

Table 2: Incident response resources.

<table>
<thead>
<tr>
<th>Type</th>
<th>Dispatch Complement</th>
</tr>
</thead>
</table>
| **EMS TASK FORCE**    | • 5 EMS Transport Units  
• 1 Battalion Chief  
• 1 EMS Supervisor/Command Staff  
• 2 Suppression Units |
<table>
<thead>
<tr>
<th>Type</th>
<th>Dispatch Complement</th>
</tr>
</thead>
</table>
| **MCI ALARM** – Provides the resources to manage incidents with approximately 25 patients. The initial MCI alarm assignment is designed to complete the structure of the EMS Branch. | - 10 EMS Transport Units  
- 10 Suppression Units  
- 1 Battalion Chief  
- 3 EMS Supervisors / Command Staff  
- 1 Mobile Command Unit  
- 1 Green (Civilian) Transport Bus  
- 1 Medical Care Support Unit (MCSU)  
- 1 Medical Ambulance Bus (MAB) |
| **2ND AND SUBSEQUENT MCI ALARMS** – Provides the resources to supplement the initial MCI Alarm and is designed to manage approximately 25 additional patients. | - 10 EMS Transport Units  
- 5 Suppression Units  
- 1 Medical Care Support Unit (MCSU)  
- 1 Medical Ambulance Bus (MAB)  
- 1 Green (Civilian) Transport Bus |
INITIAL INCIDENT OPERATIONS

The first arriving unit, on the original incident, is to initiate the Five S’s and shall establish command per the NOVA Command Officer Operations Manual Guidelines, Figure 1.

- **Safety**: Identify IDLH/high-threat situations and warn incoming units of hazards.

- **Size-up**: Determine the need for additional resources based on the type of incident. Approximate the number and severity of victims.

- **Send**: Transmit a situation report. Request the appropriate Alarm based on the number of patients (EMS Task Force, MCI Alarm, MCI 2nd Alarm). Activate the Regional Healthcare Coordination Center (RHCC). Announce which Patient Tracking Event will be used.

- **Set-up**: Identify a staging area. Identify and announce scene access and egress.

- **Start**: Initiate triage.

Figure 1: The 5 S’s of the multiple casualty incident.
MCI COMMAND STRUCTURE

Incident Commander

An MCI will most likely be one component of a larger event involving multiple priorities. When a large number of patients are encountered, request an appropriate alarm. An EMS Task Force should be requested to treat approximately 10 patients and an MCI Alarm for approximately 25 patients.

Critical responsibilities:

- Early recognition and declaration of a MCI.
- Ensure resources meet incident demands.
- Establish and announce the Staging Area and Incident Entry Point.
- Maintain incident egress for transport units.
- Establish appropriate Branches, Groups, and Divisions.
- Manage and direct the initial MCI Alarm until the EMS Branch Director position has been established by the Battalion Chief on the MCI Alarm.

Additional responsibilities:

- Ensure dedicated MCI tactical channels for the EMS Branch, Transportation Group, and Medical Group have been established.
- Establish and announce a Casualty Collection Point¹ if required.
- Ensures RHCC has been alerted.

Communications:

- Channels: Operations, Command

Staging Manager

The Incident Commander or Operations Chief has the option to assign a Staging Manager (Staging). In the absence of such an assignment, the first suppression unit officer to arrive at the staging area shall assume or assign the role of Staging Manager for the duration of the incident. Depending on the size and complexity of the incident, a single crew member or the entire crew may be used to manage the staging or base functions of the incident. Requests for additional transport units may come directly from the Transportation Group Supervisor.

During an MCI Alarm response, the eighth, ninth, and tenth arriving suppression units are designated to report to staging.

Critical responsibilities:

¹ A CCP is established in IDLH/high threat situations. Patients will be relocated to a CCP when required, where primary triage will be performed.
- Establish staging area.
- Use the Staging Manager Form (Appendix F).
- Respond to requests for resource assignments from IC, Operations, or the Transportation Group Supervisor.
- In the event of multiple Transportation Areas, direct transport units to the appropriate transportation area as directed by the Transportation Group Supervisor.
- Ensure units leaving Staging Area switch to the appropriate channel.
- Advise the Operations Section when apparatus reserves reach minimum levels as established by the Incident Commander.

Communications:

- Channel: Command

**Single Transportation Area**

Figure 2 depicts the organization of an MCI with a single transportation area.

**Single Transportation Area**

![Diagram of Single Transportation Area]

*Figure 2: Single transportation area organizational structure.*
EMS Branch Director

The EMS Branch Director is established by the first arriving Battalion Chief on the initial MCI alarm and reports to the Operations Section Chief or to the IC. This position manages the Medical Group and Transportation Group Supervisors.

Critical responsibilities:

- Obtain EMS Branch Command Board.
- Ensure dedicated Transportation Group and Medical Group tactical channels have been assigned.
- Assign Units to MCI positions as designated in the MCI Quick Reference Guide included as Appendix A. (Suppression unit assignments may be modified based on incident priorities.)
- Coordinate actions of the Transportation and Medical Groups.
- Request resources from Operations Section Chief or Incident Commander to meet current and anticipated Transport Unit and personnel needs.

Additional responsibilities:

- Anticipate needs of persons not requiring medical transport.
- Ensure that a patient tracking event has been announced to responding units.

Communications:

- Channels: Operations, EMS Branch

Transportation Group

The Transportation Group is responsible for the set up and operation of the transportation section, to include coordinating and tracking patient transportation. Resources assigned are the first arriving Transport Unit, the first arriving EMS Supervisor, and the second and seventh arriving Suppression Units. The overall goal of the Transportation Group is to expedite transportation for the most critically injured. This group is essential to moving units and patients in and out of the scene efficiently.

Patient transport should not be delayed by the Transport Corridor/Patient Exit Point (PEP) operations. The PEP should be well organized to rapidly identify and assign patients to appropriate transport destinations, while maintaining on scene accountability of the transports.

Transportation Group Supervisor

Transportation Group Supervisor is established by the first arriving Transport Unit Officer/Attendant in Charge (OIC/AIC) and will be assumed by the first arriving EMS Supervisor. The first arriving transport unit OIC/AIC will then become the Medical Communications Coordinator. The Transportation Group Supervisor reports to the EMS
Branch Director and supervises the Medical Communications Coordinator, the Transport Recorder, and the Ambulance Coordinator. In the EMS Branch, there shall only be one Transportation Group Supervisor regardless of size or scope of the incident.

Prior to the arrival of the first arriving EMS supervisor the Transportation Group Supervisor will also have to perform the duties of the Medical Communications Coordinator. At the outset of the incident the Transportation Group Supervisor may assign patient destinations prior to receiving bed availability information from RHCC.

Critical responsibilities:

- Obtain Transportation Group Supervisor Command Board.
- Request a dedicated Transportation Group radio channel via the chain of command.
- Ensure designation of the PEP and Transportation Corridor.
- Once established, direct incoming Transport Units to the Transportation Corridor.
- Establish communications with RHCC (1-888-987-7422, or designated radio channel).
- Acquire patient counts from the Medical Group Supervisor and request sufficient Transport Units from Staging.
- Coordinate with EMS Branch to ensure that the appropriate Patient Tracking incident event has been announced.

Additional responsibilities:

- Determine the need for and request resources for air ambulance operations.
- In the event of multiple transport areas, direct transport units to the area with most critical patients first.
- At the conclusion of the incident, assist with the reconciliation of all casualty records from treatment, triage, and transport.

Communications:

- Channels: Transportation, EMS Branch, Command (Requesting Transport Units from Staging)

**Medical Communications Coordinator**

The Medical Communications Coordinator (MCC) is established by the AIC/OIC from the first arriving transport unit once relieved from the role of Transportation Group Supervisor. The MCC maintains a count of available beds via communications with the RHCC. In the EMS Branch, there shall only be one MCC regardless of size or scope of the incident.

Critical responsibilities:

- Establish and maintain communications with RHCC (1-888-987-7422 or designated radio channel).
  - RHCC will provide bed availability for the five hospitals and two trauma centers closest to the incident.
- Advise RHCC if additional beds or hospitals will be required. Use the Medical Communications Coordinator Form (Appendix F) to maintain current status of receiving facility availability and capability.
- Assign patient destination to transport units.

Communications:
- Channels: Transportation, RHCC, Medical Communications Liaison (only when multiple Transport Areas are established)

**Transport Recorder**

The Transport Recorder is established by the driver-operator of the first arriving transport unit and reports to the Transportation Group Supervisor or Transportation Unit Leader.\(^2\) A Transport Recorder must be assigned to each PEP.

Some priority patients may bypass the Treatment Area and arrive at the PEP without having a disaster tag applied. The Transport Recorder must ensure a disaster tag is applied and completed.

Critical responsibilities:
- Ensure a disaster tag is attached to each patient.
- At a minimum, the transport record must have the following fields completed:
  - Patient sex
  - Destination
  - Transportation Agency/Unit
  - Departure Time/Time Out
  - Triage Status
- Use a separate Transport Recorder Form (Appendix F) for each destination hospital.
- Affix the disaster tag Transport Record stub to the appropriate Transport Recorder Form.
- Enter the Transport Record Stub information into the Patient Tracking System.

Communications:
- Channel: Transportation

**Ambulance Coordinator**

The Ambulance Coordinator is established by the OIC of the second arriving suppression unit, reports to the Transportation Group Supervisor or Transportation Unit Leader\(^3\) and supervises the Transport Loaders. The Ambulance Coordinator manages the access, egress, positioning,

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\(^2\) Only applicable in instances of multiple transportation areas.
\(^3\) Only applicable in instances of multiple transportation areas.
and loading of transport units.

Critical responsibilities:

- Designate and clearly mark transportation corridor points of entry, exit, and transport unit loading area.
- Direct transport units where to park to receive patients.
- Ensure efficient traffic flow in the transport corridor.
- Direct Loaders to report to the Treatment Unit Leader to obtain a patient and exit through the PEP.

Communications:

- Channel: Transportation

**Air Ambulance Coordinator**

The Air Ambulance Coordinator will be a member of the suppression unit assigned to the landing zone and reports to the Transportation Group Supervisor. The Air Ambulance Coordinator is the liaison between the air medical crews and the Transportation Group Supervisor.

Communications:

- Channels: Transportation, Landing Zone
Transport Loaders

Transport Loaders (Loaders) are personnel from the second and seventh arriving suppression units and report to the Ambulance Coordinator. Loaders retrieve patients from treatment areas or the impact area and bring them through the PEP to the loading area.

Critical responsibilities:

- Retrieve patient movement device(s).
- On direction from the Ambulance Coordinator, report to the Treatment Unit Leader who will direct Loaders to a Treatment Area Manager.
- Bring the patient through the PEP and assist transport unit crew with patient loading.

Communications:

- Channel: Transportation

Transport Units

The intent of MCI management is to transport Immediate (red tag) patients as soon as possible. Initial responding Transport Units will be directed to the Transport Corridor.. While transporting, direct communications with the destination hospital is not necessary as the information is relayed by RHCC.

Critical responsibilities:

- AIC/OIC reports to the PEP to receive patients and hospital assignment.
- Ensure that the driver stays with the unit.
- Ensure the completed Disaster Tag Transport Record is given to Transport Recorder.
- Assist Loaders with patient loading.
- Transport patients to assigned receiving facility.
- Complete disaster tag and Patient Tracking System entry.
- When returning to service after transporting a patient, Transport Units will contact the communication center managing the incident for instructions.

Communications:

- Channel: Transportation

Medical Group Supervisor

Established by the second arriving EMS Supervisor on the initial MCI alarm. The Medical Group Supervisor reports to the EMS Branch Director and supervises the Triage Unit Leader, Treatment Unit Leader, Morgue Manager and Medical Supply Coordinator.
Critical responsibilities:

- Obtain Medical Group Supervisor Command Board.
- Request a dedicated tactical channel for the Medical Group.
- Receive patient counts from Triage and Treatment Unit Leaders
- Provide updated patient counts to the Transportation Group Supervisor.

Communications:

- Channels: EMS Branch, Medical Group

**Triage Unit Leader**

The Triage Unit is responsible for triaging patients within the impact area or Casualty Collection Point (CCP) using **START/JumpSTART** ([Appendix G](#)). Initial triage involves classification of patients, delivery of lifesaving interventions, and application of triage ribbons. Once triage has been completed the unit is responsible for porting patients based on priority to the PEP or treatment area(s) if immediate transport is not available. Resources assigned to the Triage Unit on the initial MCI Alarm are the first and fifth arriving Suppression Units.

The Triage Unit Leader is established by the OIC of the first arriving suppression unit on the initial MCI alarm. The Triage Unit Leader reports to the Medical Group Supervisor and supervises Triage Crews and Porters.

Critical responsibilities:

- Obtain the Triage Unit Leader Command Board.
- Designate the Casualty Collection Point (CCP) if needed.
- Direct walking wounded patients to a defined location.
- If Transport Units are available, direct Porters to move Red Tag patients directly to the Transport Area through the PEP.
- Obtain and frequently communicate patient counts to the Medical Group Supervisor.

Communications:

- Channel: Medical Group

**Triage Crews**

Triage Crews are assigned by and report to the Triage Unit Leader. Triage Crews are most efficient when comprised of two or three people.

Critical responsibilities:

- Direct walking wounded patients to a defined location.
- Perform START/JumpSTART and attach a colored ribbon to all injured patients.
- Initial treatment should be limited to appropriate lifesaving interventions:
  - Position the airway.
  - Deliver five rescue breaths (JumpSTART).
  - Control severe bleeding (tourniquet or pressure).
  - Chest seals may be applied if available.
- Communicate accurate counts, triage status, and locations of patients to the Triage Unit Leader.

Communications:
- Channel: Medical Group

Porters

Porters are assigned by and report to the Triage Unit Leader.

Critical responsibilities:
- Coordinate with Triage Unit Leader to determine location of triaged patients.
- Obtain necessary equipment to port patients.
- Port patients, as directed by the Triage Unit Leader, to the PEP or treatment area(s).

Communications:
- Channels: Medical Group

Treatment Unit Leader

The Treatment Unit is responsible for the location, set-up, and operation of the treatment areas. Upon entering a treatment area, patients will undergo secondary triage and have a disaster tag that includes as much patient information as possible, attached to them. Based on a medical assessment, patients will be treated appropriately until a Transport Unit is available. The Treatment Unit shall prioritize patients within a given Treatment Area for transport. Resources assigned to the Treatment Unit on the initial MCI Alarm are the fourth and sixth arriving suppression units. As time and resources permit the Treatment Unit may perform the initial patient tracking scan.

The Treatment Unit Leader is initially established by the OIC of the fourth arriving suppression unit on the initial MCI alarm and assumed by the third arriving EMS Supervisor. The Treatment Unit Leader reports to the Medical Group Supervisor and supervises the Treatment Area Managers. The Treatment Unit Leader will assign Treatment Area Managers, who may be members of their suppression unit or other available personnel.

Critical responsibilities:
- Obtain Treatment Unit Leader Command Board.
Identify and announce the location of all Treatment Areas.
Maintain communications and coordinate patient movement with the Medical Group Supervisor.
Maintain a real-time count of all patients within the Treatment Areas.
Direct Loaders and ambulance crews to appropriate Treatment Area Manager.

Communications

- Channels: Medical Group

**Immediate (Red) Treatment Area Manager**

The Immediate (Red) Treatment Area Manager is assigned by and reports to the Treatment Unit Leader. The Immediate Treatment Area Manager supervises the setup of the area, treatment of patients assigned to that area, and prioritizes patients for transport.

Critical responsibilities:

- Use Treatment Area Manager Worksheets.
- Ensure patients undergo secondary triage, are appropriately treated, and relocated as necessary.
- Frequently communicate patient counts to the Treatment Unit Leader.
- Ensure every patient receives a disaster tag and that the transport record stub has been completed as much as possible.
- Direct loaders or ambulance crews to the patient they will transport.

Additional responsibilities:

- As time permits, scan and enter patient information into the Patient Tracking System.

Communications:

- Channels: Medical Group

**Delayed (Yellow) Treatment Area Manager**

The Delayed (Yellow) Treatment Area Manager is assigned by and reports to the Treatment Unit Leader. The Delayed Treatment Area Manager supervises the setup of the area, treatment of the patients assigned to the area, and prioritizes patients for transport.

Critical responsibilities:

- Use Treatment Area Manager Worksheets.
- Ensure patients undergo secondary triage, are appropriately treated, and relocated as necessary.
- Frequently communicate patient counts to the Treatment Unit Leader.
Ensure every patient receives a disaster tag and that the transport record stub has been completed as much as possible.
- Direct loaders or ambulance crews to the patient they will transport.

Additional responsibilities:
- As time permits, scan and enter patient information into PTS.

Communications:
- Channels: Medical Group

**Minor (Green) Treatment Area Manager**

The Minor (Green) Treatment Area Manager is assigned by and reports to the Treatment Unit Leader. The Minor Treatment Area Manager supervises the setup of the area, treatment of the patients assigned to the area, and prioritizes patients for transport.

Critical responsibilities:
- Use Treatment Area Manager worksheets
- Ensure patients undergo secondary triage, are appropriately treated, and relocated as necessary
- Frequently communicate patient counts to the Treatment Unit Leader.
- Ensure every patient receives a disaster tag and that the transport record stub has been completed as much as possible.
- Direct loaders or ambulance crews to the patient they will transport.

Additional responsibilities:
- Distribute self-care kits.
- Anticipate needs for prolonged on-site care and management.
- As time permits, scan and enter patient information into PTS.
- Report needs of uninjured to the Treatment Unit Leader.

Communications:
- Channels: Medical Group

**Medical Supply Coordinator**

The Medical Supply Coordinator is established by the OIC of the first arriving MCSU on the initial MCI alarm and reports to the Medical Group Supervisor.

Critical responsibilities:
- Set up the MCSU in proximity to the Red and Yellow treatment area(s).
- Distribute supplies to the Triage and Treatment Area(s).
- Request and secure additional medical supplies as necessary

Communications:

- Channels: Medical Group

**Morgue Manager**

The Morgue Manager is assigned by and reports to the Medical Group Supervisor and assumes responsibility for Morgue Area activities until relieved by law enforcement.

Critical responsibilities:

- Establish a temporary morgue away from viable patients.
- Perform re-triage and ensure those in the morgue are pulseless and apneic.
- Deny access to unauthorized personnel.
- Maintain decedent confidentiality.

Additional responsibilities:

- Ensure a disaster tag has been applied.
- Scan the disaster tag and update decedents triage status and information.
- Obtain a picture of the patient’s face and identifying marks if possible and enter it into the Patient Tracking System.

Communications:

- Channels: Medical Group

**Transport Area Workflow**

Figure 3 shows the single transport area patient flow.
### Single Transport Area Patient Flow

<table>
<thead>
<tr>
<th>Event</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage Crews inform Triage Unit Leader of patient count</td>
<td>Triage Unit Leader relays patient count</td>
</tr>
<tr>
<td>Triage Unit Leader relays patient count</td>
<td>1st EMS Unit arrives and establishes Transportation Group</td>
</tr>
<tr>
<td>Transportation Corridor is designated by the Ambulance Coordinator</td>
<td>Transport units position to receive patients</td>
</tr>
<tr>
<td>1st EMS Group establishes contact with RHCC</td>
<td>1st EMS Supervisor assumes the role of Transportation Group Supervisor</td>
</tr>
<tr>
<td>Loaders obtain priority patients from either the Triage area or the Treatment area</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Event</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Porters move patients directly to the PEP</td>
<td>Completed COG Disaster Tag is applied at the PEP</td>
</tr>
<tr>
<td>Completed COG Disaster Tag is applied at the PEP</td>
<td>Patient is tracked via paper and PTS by Transport Recorder</td>
</tr>
<tr>
<td>Patient is tracked via paper and PTS by Transport Recorder</td>
<td>Patient transported to appropriate facility as directed by MedComm Coordinator</td>
</tr>
<tr>
<td>Med Group Advises Transp. Grp. of category# of pt’s awaiting transport</td>
<td>Transp. Grp. requests transport units from staging</td>
</tr>
<tr>
<td>Transp. Grp. Inform Amb. Coord. Of incoming units</td>
<td>Loaders report to Treatment Unit Leader to obtain the appropriate patient</td>
</tr>
<tr>
<td>Loaders report to Treatment Unit Leader to obtain the appropriate patient</td>
<td>Loaders assist with getting patient into the unit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Event</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area Managers receive patients, ensures patient receive a Disaster Tag and utilize the Treatment Area Manager Worksheet Use PTS if time allows</td>
<td>Area Managers keep Treatment Unit Leader apprised of patient count and resource needs</td>
</tr>
<tr>
<td>Area Managers keep Treatment Unit Leader apprised of patient count and resource needs</td>
<td>Med Group Advises Transp. Grp. of category# of pt’s awaiting transport</td>
</tr>
<tr>
<td>Med Group Advises Transp. Grp. of category# of pt’s awaiting transport</td>
<td>Transp. Grp. requests transport units from staging</td>
</tr>
<tr>
<td>Transp. Grp. Inform Amb. Coord. Of incoming units</td>
<td>Loaders report to Treatment Unit Leader to obtain the appropriate patient</td>
</tr>
<tr>
<td>Loaders report to Treatment Unit Leader to obtain the appropriate patient</td>
<td>Loaders assist with getting patient into the unit</td>
</tr>
</tbody>
</table>

### Figure 3: Single transport area patient flow.
Incident Requiring Multiple Treatment and Transportation Locations

Incidents with patients spread widely or separated by physical barriers may require expanding the incident structure to add Medical Divisions and Transportation Units for each geographic area.

If multiple transportation areas are required, the Transportation Group Supervisor shall assume responsibility for overall management of the Transport Group to include all subsequent Transport areas.

A Transportation Unit Leader will then be assigned to each designated Transport Area.

![Multiple Transportation Areas](image)

**Figure 4:** Sample organizational chart for multiple transportation areas.

The “Medical Division” should be renamed as appropriate for each incident. Based on the need, the following positions and responsibilities will be assigned at each transport area.
Transport Unit Leader

The Transport Unit Leader is assigned by the Transportation Group Supervisor and can be filled by any available resource. The Transport Unit Leader fills and supervises their respective Ambulance Coordinator, Medical Communications Liaison, Transport Recorder, and Loaders as needed. The Transport Unit Leader will coordinate with the appropriate Medical Division Supervisor to facilitate the movement of patients.

Critical responsibilities:

- Ensure designation of Division Patient Exit Point (PEP) and Transportation Corridor.
- Obtain Transportation Group Supervisor Command Board
- Establish and maintain communications with Transportation Group Supervisor and the corresponding Medical Division Supervisor
- Acquire patient counts from their corresponding Medical Division Supervisor and determine transport needs.
- Request resources from the Transportation Group Supervisor.
- Coordinate the air and ground transportation of patients in that area.

Communications:

- Channels: Transportation, Medical Division

Medical Communications Liaison

The Medical Communications Liaison (MCL) is appointed by the Transport Unit Leader and coordinates with the Medical Communications Coordinator (MCC) to assign patient transport destinations. A MCL will be assigned for each transport area.

Critical responsibilities:

- Establish and maintain communications with the MCC.
- Assign patient destination to transport units.

Communications:

- Channels: Medical Communications Liaison

Medical Division Supervisor

The Medical Division Supervisor reports to the EMS Branch Director and supervises their respective Triage and Treatment Unit Leaders.

Critical responsibilities:

- Obtain Medical Group Supervisor Command Board.
- Monitor actions of the Triage and Treatment Groups.
- Receives patient counts from Triage and Treatment Unit Leaders and request transport assets from the Transportation Unit Leader

Additional responsibilities:

- Ensure proper security, traffic control, and access for the Medical Division.

Communications:

- Channels: EMS Branch, Transportation Group, Medical Division

**Sample Scene Flowcharts**

The following figures show pictorial flowcharts of an MCI event, a high-threat MCI event, and a hazardous materials MCI Event.
MCI EVENT

Figure 5: Sample MCI event flowchart.
Figure 6: Sample MCI high-threat event flowchart.
Figure 7: Sample MCI hazardous materials event flowchart.
APPENDIX A: NOVA QUICK REFERENCE GUIDE FOR MCI

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

*Suppression Unit = any engine, truck, or squad*

*PEP = Patient Exit Point*

<table>
<thead>
<tr>
<th>UNIT</th>
<th>Priority of Unit Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} Suppression Unit</td>
<td>Triage Unit Leader</td>
</tr>
<tr>
<td>2\textsuperscript{nd} Suppression Unit</td>
<td>Ambulance Coordinator</td>
</tr>
<tr>
<td>3\textsuperscript{rd} Suppression Unit</td>
<td>Report to Triage (porters or triage crew)</td>
</tr>
<tr>
<td>4\textsuperscript{th} Suppression Unit</td>
<td>Treatment Unit Leader</td>
</tr>
<tr>
<td>5\textsuperscript{th} Suppression Unit</td>
<td>Report to Triage (porters or triage crew)</td>
</tr>
<tr>
<td>6\textsuperscript{th} Suppression Unit</td>
<td>Report to Treatment</td>
</tr>
<tr>
<td>7\textsuperscript{th} Suppression Unit</td>
<td>Report to Ambulance Coordinator (loaders)</td>
</tr>
<tr>
<td>8\textsuperscript{th}-10\textsuperscript{th} Suppression Unit</td>
<td>Report to staging, establish if not done already</td>
</tr>
<tr>
<td>1\textsuperscript{st} EMS Transport Unit</td>
<td>Establish Transportation Group (Med Comm and Transport Recorder)</td>
</tr>
<tr>
<td>Remaining Transport Units</td>
<td>Report to transportation corridor or Staging as directed by Transportation Group Supervisor</td>
</tr>
<tr>
<td>1\textsuperscript{st} EMS Supervisor</td>
<td>Assume Transportation Group Supervisor</td>
</tr>
<tr>
<td>2\textsuperscript{nd} EMS Supervisor</td>
<td>Establish Medical Group Supervisor</td>
</tr>
<tr>
<td>3\textsuperscript{rd} EMS Supervisor</td>
<td>Assume Treatment Unit Leader</td>
</tr>
<tr>
<td>1\textsuperscript{st} Battalion Chief</td>
<td>Establish EMS Branch</td>
</tr>
</tbody>
</table>
## APPENDIX B: NATIONAL CAPITAL REGION MEDICAL CARE SUPPORT UNITS

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>UNIT DESIGNATION</th>
<th>UNIT LOCATION</th>
<th>LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington, D.C.</td>
<td>MCSU 1</td>
<td>Washington DC</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>MCSU 2</td>
<td>Washington DC</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MCSU 3</td>
<td>Washington DC</td>
<td>2</td>
</tr>
<tr>
<td>Maryland</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles County</td>
<td>MC1016</td>
<td>LaPlata, MD</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MC1013</td>
<td>Waldorf, MD</td>
<td>3</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>MCSU 722</td>
<td>Germantown, MD</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>MCSU 726</td>
<td>Bethesda, MD</td>
<td>1</td>
</tr>
<tr>
<td>Prince Georges</td>
<td>MCSU 855</td>
<td>Bunker Hill, MD</td>
<td>1</td>
</tr>
<tr>
<td>County</td>
<td>MCSU 841</td>
<td>Calverton, MD</td>
<td>2</td>
</tr>
<tr>
<td>Virginia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MWAA</td>
<td>MCSU 302</td>
<td>Dulles</td>
<td>1 (can treat 200 patients)</td>
</tr>
<tr>
<td></td>
<td>MCSU 301</td>
<td>Reagan</td>
<td>1 (can treat 200 patients)</td>
</tr>
<tr>
<td>Alexandria</td>
<td>MSU 202</td>
<td>Alexandria, VA</td>
<td>1</td>
</tr>
<tr>
<td>Arlington</td>
<td>MC 100</td>
<td>Arlington, VA</td>
<td>1</td>
</tr>
<tr>
<td>Fairfax County</td>
<td>MCSU 415</td>
<td>Chantilly, VA</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MCSU 442</td>
<td>Vienna, VA</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MCSU 435</td>
<td>Springfield, VA</td>
<td>1</td>
</tr>
<tr>
<td>Loudoun County</td>
<td>MC 603</td>
<td>Middleburg, VA</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MC 615</td>
<td>Sterling, VA</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MC 614</td>
<td>Purcellville, VA</td>
<td>1</td>
</tr>
<tr>
<td>City of Manassas</td>
<td>MCSU 501</td>
<td>Manassas, VA</td>
<td>2</td>
</tr>
<tr>
<td>Prince William</td>
<td>MCSU 523</td>
<td>Woodbridge, VA</td>
<td>2</td>
</tr>
<tr>
<td>County</td>
<td>MCSU 524</td>
<td>Haymarket, VA</td>
<td>2</td>
</tr>
<tr>
<td>Stafford County</td>
<td>MCSU-12</td>
<td>Berea station (Fredericksburg, VA)</td>
<td>2</td>
</tr>
</tbody>
</table>

### NIMS Typing

- **Level 1+ = 200 patients**: MWAA Tractor Trailer MCSU
- **Level 1 = 100 patients**
- **Level 2 = 50 patients**
- **Level 3 = 25 patients**
# APPENDIX C: NATIONAL CAPITAL REGION MEDICAL AMBULANCE BUSES

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>UNIT DESIGNATION</th>
<th>UNIT LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington, D.C.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington, D.C.</td>
<td>MAB 1</td>
<td>Washington DC</td>
</tr>
<tr>
<td></td>
<td>MAB 2</td>
<td>Washington DC</td>
</tr>
<tr>
<td></td>
<td>MAB 3</td>
<td>Washington DC</td>
</tr>
<tr>
<td>Maryland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montgomery County</td>
<td>MAB 726</td>
<td>Bethesda, MD</td>
</tr>
<tr>
<td></td>
<td>MAB 722</td>
<td>Germantown, MD</td>
</tr>
<tr>
<td>Prince Georges County</td>
<td>MAB 830</td>
<td>Landover Hills, MD</td>
</tr>
<tr>
<td>Virginia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arlington</td>
<td>MAB 100</td>
<td>Sta. 2 – 4805 Wilson Blvd.</td>
</tr>
<tr>
<td>Fairfax County</td>
<td>MAB 427</td>
<td>Springfield, VA</td>
</tr>
<tr>
<td>Loudoun County</td>
<td>MAB 623</td>
<td>Moorefield (Ashburn, VA)</td>
</tr>
<tr>
<td>Stafford County</td>
<td>MAB 12</td>
<td>Berea station (Fredericksburg, VA)</td>
</tr>
</tbody>
</table>

**Last Update: March 2016**
## APPENDIX D: MCSU EQUIPMENT LIST

<table>
<thead>
<tr>
<th>ITEM</th>
<th>LEVEL 1 Qty.</th>
<th>LEVEL 2 Qty.</th>
<th>2016 MCSU Inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Backboards (long)</td>
<td>80</td>
<td>40</td>
<td>ITEM</td>
</tr>
<tr>
<td>Backboard straps (sets)</td>
<td>80</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Cervical Immobilization Device (CID rolls, headbed, etc.)</td>
<td>80</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Cervical collars (adjustable – adult)</td>
<td>80</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Cervical collars (adjustable – pediatric)</td>
<td>80</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Military type patient litter, mesh, collapsible, with feet, with handles</td>
<td>40</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Splints, disposable (minimum 12” , recommend 18”)</td>
<td>100</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Splints, disposable, 34”</td>
<td>48</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Blankets (disposable) 58 x 90, insulated</td>
<td>100</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Blankets (space type)</td>
<td>130</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Multi-trauma dressing (sterile, size 12” x 30”)</td>
<td>100</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Non-sterile 4 x 4 dressing</td>
<td>1000</td>
<td>500</td>
<td></td>
</tr>
<tr>
<td>Military or &quot;H&quot; style; civilian 4” or 6&quot; compression bandages</td>
<td>100</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Trauma dressing, 8” x 10”</td>
<td>100</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Kling 4” rolls</td>
<td>500</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td>Cravats (triangular bandage)</td>
<td>300</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>Tape 3” x 10 yards, silk</td>
<td>200 rolls</td>
<td>100 rolls</td>
<td></td>
</tr>
<tr>
<td>NP airway kit, latex free, set of 6, sizes 26 to 34 French</td>
<td>10</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>OP airways, set of 6, (Berman kit), size infant to large adult</td>
<td>50</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Oxygen mask, non-rebreather, with tubing, adult</td>
<td>50</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Oxygen mask, non-rebreather, with tubing, pediatric</td>
<td>50</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Oxygen tubing, male connectors, minimum 7 ft.</td>
<td>50</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Bag valve mask device, disposable (ea. BVM has adult, &amp; pediatric masks)</td>
<td>10 each</td>
<td>5 each</td>
<td></td>
</tr>
<tr>
<td>Hand powered portable suction units</td>
<td>20</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Hand powered portable suction units replacement canisters</td>
<td>40</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Gloves (medium, large, extra-large)</td>
<td>2 case of each size</td>
<td>1 case of each size</td>
<td></td>
</tr>
<tr>
<td>Face masks w/eye shield</td>
<td>100</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Scissors</td>
<td>20</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Penlights</td>
<td>36</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Stethoscopes, adult/ peds</td>
<td>20</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Blood pressure cuffs, (pediatric, adult, large adult)</td>
<td>20</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>1000 cc Normal Saline IV (12 per case)</td>
<td>48 - 4 cases</td>
<td>24 - 2 cases</td>
<td></td>
</tr>
<tr>
<td>LEVEL 1 Qty.</td>
<td>LEVEL 2 Qty.</td>
<td>ITEM</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>40</td>
<td>Small bottles irrigation saline</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>24</td>
<td>IV tubing (10 drop sets) (48 per case) at least 100 inches</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>24</td>
<td>IV starter kits</td>
<td></td>
</tr>
<tr>
<td>100 each</td>
<td>50 each</td>
<td>IV needles – 16 g., 18 g. 20 g.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>Sharps containers (minimum - 2 gallon size)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>6</td>
<td>Waterless hand cleaner (antiseptic)</td>
<td></td>
</tr>
<tr>
<td>1 box</td>
<td>1 box</td>
<td>germicidal wipes (equipment clean up)</td>
<td></td>
</tr>
<tr>
<td>130</td>
<td>65</td>
<td>Patient belonging bags</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>18</td>
<td>Rolls Duct tape</td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>150</td>
<td>Zip lock storage bags (gallon size)</td>
<td></td>
</tr>
<tr>
<td>250 bags</td>
<td>250 bags</td>
<td>Biohazard bags (10 – 15 gallon size)</td>
<td></td>
</tr>
<tr>
<td>2 sets</td>
<td>1 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>
<td></td>
</tr>
<tr>
<td>2 each</td>
<td>1 each</td>
<td>Triage flags (base, telescoping min. 8 ‘ pole, flag), red, yellow, green</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>18</td>
<td>Traffic cones with reflective stripe</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>18</td>
<td>Step-in posts, fiberglass</td>
<td></td>
</tr>
<tr>
<td>4 rolls each</td>
<td>4 rolls each</td>
<td>Rolls barricade tape (red, green, yellow - 3” minimum width)</td>
<td></td>
</tr>
<tr>
<td>200</td>
<td>100</td>
<td>Disaster tags (COG tag)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>6</td>
<td>Triage ribbon kits (red, yellow, green, black)</td>
<td></td>
</tr>
<tr>
<td>1 sets</td>
<td>1 sets</td>
<td>MCI Vests (New set includes 13 vests) (old set included 14 vests)</td>
<td></td>
</tr>
<tr>
<td>6 boxes</td>
<td>6 boxes</td>
<td>Permanent markers</td>
<td></td>
</tr>
<tr>
<td>6 boxes</td>
<td>6 boxes</td>
<td>Ball point pens (12 per box)</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>18</td>
<td>Clipboards</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Oxygen multilator or minilator, minimum 5 ports, adjustable flow rate</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Oxygen hose 50 feet with regulator</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Oxygen bottles, minimum size M cylinder</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Oxygen kits (include Teflon tape, adjustable wrench, 5 Christmas trees – green nipple fitting)</td>
<td></td>
</tr>
</tbody>
</table>

### MCI ICS Vest Inventory

<table>
<thead>
<tr>
<th>Role</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMS Branch Director (blue)</td>
<td>Air Ambulance (blue)</td>
</tr>
<tr>
<td>Medical Group Supervisor (blue)</td>
<td>Minor Manager (blue)</td>
</tr>
<tr>
<td>Medical Comm. (blue)</td>
<td>Immediate Manager (blue)</td>
</tr>
<tr>
<td>Medical Supply (blue)</td>
<td>Delayed Manager (blue)</td>
</tr>
<tr>
<td>Ground Ambulance (blue)</td>
<td>Triage Leader (blue)</td>
</tr>
<tr>
<td>Transport Group (blue)</td>
<td></td>
</tr>
<tr>
<td>Treatment Recorder (blue)</td>
<td></td>
</tr>
<tr>
<td>Treatment Leader (orange)</td>
<td></td>
</tr>
<tr>
<td>Delayed Manager (blue)</td>
<td></td>
</tr>
</tbody>
</table>
### Optional Equipment Listing

<table>
<thead>
<tr>
<th>ITEM</th>
<th>LEVEL 1 Qty.</th>
<th>LEVEL 2 Qty.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tourniquets</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>APLS Thermal Guard Mylar</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Patient self-care kits (gloves, kling, band aid, etc.)</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Nebulizer kits</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>Morgan Lenses</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Patient Transport device with wheels</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>EZ-UP tents (color coded if possible)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Skeds (Patient drag system)</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Combi- Nebulizers - Adult</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Combi-Nebulizers - Pediatric</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Eye protection</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>Megaphone/bullhorn with extra batteries</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Flashlights with extra batteries</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Bottled water, minimum 12 ounce</td>
<td>6 cases</td>
<td>6 cases</td>
</tr>
<tr>
<td>Sheets (white linen – stored in either vacu-package or zip lock bag)</td>
<td>80</td>
<td>40</td>
</tr>
<tr>
<td>Towels - cloth</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Cyalume light sticks, box of 24 (red, yellow, green - min. 12 hour)</td>
<td>24 each color</td>
<td>24 each color</td>
</tr>
<tr>
<td>Cyalume light sticks (white – hi intensity – 30 min.) 10 per box</td>
<td>50 each</td>
<td>50 each</td>
</tr>
</tbody>
</table>

### NIMS Typing

<table>
<thead>
<tr>
<th>NIMS Typing</th>
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</thead>
<tbody>
<tr>
<td>Level 1 = 100 patients</td>
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<tr>
<td>Level 2 = 50 patients</td>
<td></td>
</tr>
<tr>
<td>Level 3 = 25 patients</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E: EMS BRANCH COMMAND BOARDS

1. EMS BRANCH DIRECTOR
   - EMS BRANCH DIRECTOR
   - STAGING AREA MANAGER
   - MEDICAL GROUP SUPERVISOR
   - TRANSPORTATION GROUP SUPERVISOR
   - MEDICAL SUPPLY COORDINATOR
   - TRIAGE UNIT LEADER
   - MORGUE MANAGER
   - TREATMENT UNIT LEADER

RADIO CHANNEL

EMS BRANCH
OPERATIONS

NOTES

MEDICAL GROUP

- CHANNEL
- LOCATION
- TOTAL

SITUATION/RESOURCES

TRANSPORTATION GROUP

- CHANNEL
- GROUND AMBULANCE STAGING AREA
- AIR AMBULANCE LOADING AREA

SITUATION/RESOURCES

RESPONSIBILITIES

- ENSURE DEDICATED TRANSPORTATION GROUP AND MEDICAL GROUP TACTICAL CHANNELS
- ASSIGN UNITS TO MCI POSITIONS (SEE REVERSE SIDE OF THIS BOARD)
- COORDINATE ACTIONS OF TRANSPORTATION AND MEDICAL GROUPS
- REQUEST RESOURCES FROM OPS SECTION/IC
**FIRST MCI ALARM**

<table>
<thead>
<tr>
<th>UNIT TYPE</th>
<th>SUGGESTED LOCATION</th>
<th>UNIT ID/ASSIGNMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1ST SUPPRESSION UNIT</td>
<td>TRIAGE UNIT LEADER</td>
<td></td>
</tr>
<tr>
<td>2ND SUPPRESSION UNIT</td>
<td>GROUND AMBULANCE COORDINATOR</td>
<td></td>
</tr>
<tr>
<td>3RD SUPPRESSION UNIT</td>
<td>REPORTS TO TRIAGE (PORTERS)</td>
<td></td>
</tr>
<tr>
<td>4TH SUPPRESSION UNIT</td>
<td>TREATMENT UNIT LEADER</td>
<td></td>
</tr>
<tr>
<td>5TH SUPPRESSION UNIT</td>
<td>REPORT TO TRIAGE</td>
<td></td>
</tr>
<tr>
<td>6TH SUPPRESSION UNIT</td>
<td>REPORT TO TREATMENT</td>
<td></td>
</tr>
<tr>
<td>7TH SUPPRESSION UNIT</td>
<td>REPORT TO GROUND AMBULANCE (LOADERS)</td>
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</tr>
<tr>
<td>8-10 SUPPRESSION UNIT</td>
<td>REPORT TO STAGING</td>
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</tr>
<tr>
<td>1ST TRANSPORT UNIT</td>
<td>ESTABLISH TRANSPORTATION GROUP/MED COMM/ TX RECORDER</td>
<td></td>
</tr>
<tr>
<td>REMAINING TRANSPORT UNITS</td>
<td>REPORT TO TRANSPORT COORDOR OR STAGING</td>
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<tr>
<td>1ST EMS SUPERVISOR/ COMMAND STAFF</td>
<td>ASSUME TRANSPORT GROUP SUPERVISOR</td>
<td></td>
</tr>
<tr>
<td>2ND EMS SUPERVISOR/ COMMAND STAFF</td>
<td>ESTABLISH MEDICAL GROUP SUPERVISOR</td>
<td></td>
</tr>
<tr>
<td>3RD EMS SUPERVISOR/ COMMAND STAFF</td>
<td>ASSUME TREATMENT UNIT LEADER</td>
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<tr>
<td>1ST BATTALION CHIEF</td>
<td>ESTABLISH EMS BRANCH</td>
<td></td>
</tr>
<tr>
<td>MOBILE COMMAND UNIT</td>
<td>EMS BRANCH OPERATIONS</td>
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</tr>
<tr>
<td>MCSU</td>
<td>REPORT TO MEDICAL GROUP SUPERVISOR</td>
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</tr>
<tr>
<td>MAB</td>
<td>TRANSPORT COORDOR OR STAGING AS DIRECTED</td>
<td></td>
</tr>
<tr>
<td>GREEN CIVILIAN TRANSPORT BUS</td>
<td>TRANSPORT COORDOR OR STAGING AS DIRECTED</td>
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**SECOND/SUBSEQUENT MCI ALARMS**

<table>
<thead>
<tr>
<th>UNIT TYPE</th>
<th>SUGGESTED LOCATION</th>
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<tbody>
<tr>
<td>1ST SUPPRESSION UNIT</td>
<td>REPORT TO STAGING</td>
<td></td>
</tr>
<tr>
<td>2ND SUPPRESSION UNIT</td>
<td>REPORT TO STAGING</td>
<td></td>
</tr>
<tr>
<td>3RD SUPPRESSION UNIT</td>
<td>REPORT TO STAGING</td>
<td></td>
</tr>
<tr>
<td>4TH SUPPRESSION UNIT</td>
<td>REPORT TO STAGING</td>
<td></td>
</tr>
<tr>
<td>5TH SUPPRESSION UNIT</td>
<td>REPORT TO STAGING</td>
<td></td>
</tr>
<tr>
<td>10 TRANSPORT UNITS</td>
<td>TRANSPORT COORDOR OR STAGING AS DIRECTED</td>
<td></td>
</tr>
<tr>
<td>MCSU</td>
<td>REPORT TO STAGING</td>
<td></td>
</tr>
<tr>
<td>MAB</td>
<td>TRANSPORT COORDOR OR STAGING AS DIRECTED</td>
<td></td>
</tr>
<tr>
<td>GREEN CIVILIAN TRANSPORT BUS</td>
<td>TRANSPORT COORDOR OR STAGING AS DIRECTED</td>
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</tr>
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</table>

**EMS TASK FORCE**

<table>
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<tbody>
<tr>
<td>5 TRANSPORT UNITS</td>
<td>PREPARE TO RECEIVE PATIENTS</td>
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</tr>
<tr>
<td>BATTALION CHIEF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS SUPERVISOR/ COMMAND STAFF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1ST SUPPRESSION UNIT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2ND SUPPRESSION UNIT</td>
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</tbody>
</table>
### 2 TRANSPORTATION GROUP SUPERVISOR

#### RESPONSIBILITIES

- Request a dedicated Transportation Group Radio Channel
- Designate the PEP and transport corridor
- Direct transport units to the transportation corridor
- Establish communications with RHCC (1 888-987-7422) or by radio-(Med Comm Coordinator)
- Acquire patient counts and request sufficient transport units
- Determine helicopter needs
- When multiple transport areas exist, direct transport units to the appropriate loading area
- Reconcile records from treatment, triage, transport, and patient tracking system
- Announce patient tracking incident event number
- Ensure transport recorder forms are being used appropriately

#### PATIENTS AWAITING TRANSPORT

<table>
<thead>
<tr>
<th>PATIENT COUNTS</th>
<th>TRANSPORT UNITS REQUESTED</th>
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<tbody>
<tr>
<td>DIVISION</td>
<td>RED</td>
</tr>
<tr>
<td>DIVISION</td>
<td></td>
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<tr>
<td>DIVISION</td>
<td></td>
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<tr>
<td>DIVISION</td>
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</tbody>
</table>

#### NOTES

- Transportation Group Director
- Staging Manager
- EMS Branch Director
- Ground Ambulance Coordinator
- Air Ambulance Coordinator
- Medical Communications Coordinator

---

**Version 2017**
### 3 MEDICAL GROUP SUPERVISOR

<table>
<thead>
<tr>
<th>PATIENT COUNTS</th>
<th>TRIAGE</th>
<th>TREATMENT</th>
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<tbody>
<tr>
<td>IMMEDIATE</td>
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</tr>
<tr>
<td>DELAYED</td>
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</tr>
<tr>
<td>MINOR</td>
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<td>TOTAL</td>
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#### RESPONSIBILITIES

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<thead>
<tr>
<th>RESPONSIBILITIES</th>
<th>TIME COMPLETED</th>
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<tr>
<td>REQUEST DEDICATED CHANNEL FOR MEDICAL GROUP</td>
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</tr>
<tr>
<td>OBTAIN PATIENT COUNTS FROM TRIAGE AND TREATMENT</td>
<td></td>
</tr>
<tr>
<td>PROVIDE UPDATED PATIENT COUNTS TO TRANSPORTATION GROUP</td>
<td></td>
</tr>
<tr>
<td>ANTICIPATE THE NEEDS OF THE TRIAGE AND TREATMENT UNITS</td>
<td></td>
</tr>
<tr>
<td>ESTABLISH MEDICAL SUPPLY CACHE</td>
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</tr>
<tr>
<td>ESTABLISH A MORGUE AS NEEDED</td>
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#### DIAGRAM

- EMS BRANCH DIRECTOR
- MEDICAL GROUP SUPERVISOR
- TRANSPORTATION GROUP SUPERVISOR
- MEDICAL SUPPLY COORDINATOR
- MORGUE MANAGER
- TRIAGE UNIT LEADER
- TREATMENT UNIT LEADER
- RED AREA MANAGER
- YELLOW AREA MANAGER
- GREEN AREA MANAGER
- TRIAGE CREWS
- PORTER CREWS
MCI EVENT

Triage

Treatment

 ambulances Available For Transport

Primary Travel Path

Secondary Travel Path

No ambulances Available

Immediate Treatment Area Manager

Delayed Treatment Area Manager

Minor Treatment Area Manager

PEP

"GET THE RED OUT"

Ambulance Coordinator

Transportation Group Supervisor

Med Comm Coordinator

Transport Recorder

VERSIO N 2017
**NORTHERN VIRGINIA INCIDENT COMMAND SYSTEM WORKBOARD ©**

**TRIAGE UNIT LEADER**

**MEDICAL GROUP SUPERVISOR**

**TRIAGE UNIT LEADER**

**TREATMENT UNIT LEADER**

**PORTER UNITS**

**NOTES**

<table>
<thead>
<tr>
<th>TRIAGE UNITS</th>
<th>IMMEDIATE</th>
<th>DELAYED</th>
<th>MINOR</th>
<th>DECEASED</th>
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**TOTAL PATIENTS**

<table>
<thead>
<tr>
<th>TOTAL PATIENTS</th>
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<tbody>
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**RESPONSIBILITIES**

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**DESIGNATE THE CASUALTY COLLECTION POINT (CCP) IF NEEDED**

**DIRECT WALKING WOUNDED PATIENTS TO A DEFINED LOCATION**

**COORDINATE WITH TRANSPORT GROUP SUPERVISOR AND INSTRUCT PORTERS TO BRING IMMEDIATE PATIENTS THROUGH THE PEP TO AWAITING TRANSPORT UNITS**

**OBTAIN AND COMMUNICATE PATIENT COUNTS TO THE MEDICAL GROUP SUPERVISOR**

**ENSURE ALL DECEASED PATIENTS HAVE A DISASTER TAG APPLIED AND ARE ENTERED INTO PTS**

**FIVE S's**

<table>
<thead>
<tr>
<th>COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**SAFETY:**

* IDENTIFY IDLH/HIGH THREAT SITUATIONS AND WARN INCOMING UNITS OF HAZARDS

**SIZE UP:**

* DETERMINE NEED FOR ADDITIONAL RESOURCES

**SEND INFO:**

* TRANSMIT A SITREP
* REQUEST APPROPRIATE RESOURCES
* ACTIVATE RHCC

**SET UP:**

* IDENTIFY A STAGING AREA
* IDENTIFY AND ANNOUNCE SCENE ACCESS AND EGRESS

**START TRIAGE:**

* INITIATE TRIAGE
TREATMENT UNIT LEADER

MEDICAL GROUP SUPERVISOR

TRIAGE UNIT LEADER

TREATMENT UNIT LEADER

IMMEDIATE TREATMENT AREA

LOCATION

REQUESTED RESOURCES/PERSONNEL

RECEIVED RESOURCES/PERSONNEL

PATIENT COUNT

INITIAL

FINAL

MANAGER

DELAYED TREATMENT AREA

LOCATION

REQUESTED RESOURCES/PERSONNEL

RECEIVED RESOURCES/PERSONNEL

PATIENT COUNT

INITIAL

FINAL

MANAGER

MINOR TREATMENT AREA

LOCATION

REQUESTED RESOURCES/PERSONNEL

RECEIVED RESOURCES/PERSONNEL

PATIENT COUNT

INITIAL

FINAL

MANAGER

RESPONSIBILITIES

IDENTIFY AND ANNOUNCE THE LOCATION OF ALL TREATMENT AREAS

MAINTAIN COMMUNICATIONS WITH THE MEDICAL GROUP SUPERVISOR

COORDINATE PATIENT MOVEMENT WITH THE MEDICAL GROUP SUPERVISOR

DIRECT LOADERS AND AMBULANCE CREWS TO APPROPRIATE TREATEMENT AREA MANAGERS

MAINTAIN REAL-TIME COUNT OF ALL PATIENTS

COMPLETED

NOTES
MCI EVENT

Triage

Treatment

“GET THE RED OUT”

PEP

Transportation Group Supervisor

VERSION 2017
## APPENDIX F: WORKSHEETS

### Treatment Area Manager Form

<table>
<thead>
<tr>
<th>TASK OR OBJECTIVES</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ REQUEST &amp; ASSIGN PERSONNEL TO PATIENT TREATMENT AREAS</td>
<td>☐ TARP, FLAG, TENT, AND/OR CONES</td>
</tr>
<tr>
<td>☐ ENSURE SECONDARY TRIAGE IS COMPLETED</td>
<td>☐ ADMINISTRATION BOX</td>
</tr>
<tr>
<td>☐ COMMUNICATE PATIENT COUTS TO TREATMENT UNIT LEADER</td>
<td>☐ PATIENT ASSESSMENT BOX</td>
</tr>
<tr>
<td>☐ ENSURE PROPER DOCUMENTATION IS COMPLETED- DISASTER TAG/PTS</td>
<td>☐ IV BOX AND IV FLUIDS</td>
</tr>
<tr>
<td></td>
<td>☐ TRAUMA/BULK BANDAGE BOX</td>
</tr>
<tr>
<td></td>
<td>☐ LITTERS AND BACKBOARDS</td>
</tr>
<tr>
<td></td>
<td>☐ OXYGEN MULTILATOR SYSTEM</td>
</tr>
<tr>
<td></td>
<td>☐ INDIVIDUAL PATIENT CARE KITS</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>TIME</th>
<th>BAR CODES</th>
<th>AGE/SEX</th>
<th>NOTES</th>
<th>TIME OUT</th>
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</tr>
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<table>
<thead>
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<th>TIME</th>
<th>BAR CODES</th>
<th>AGE/SEX</th>
<th>NOTES</th>
<th>TIME OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

42
### Transportation Recorder Form

**NORTHERN VIRGINIA INCIDENT MANAGEMENT SYSTEM**

**TRANSPORT RECORDER FORM**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
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<tr>
<td>7</td>
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<td>8</td>
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</table>

**RECEIVING MEDICAL FACILITY**  
(Hospital)

**TRANSPORTATION LOCATION**  
(DIVISION)

**DISASTER TAG - TRANSPORT STUBS**
Staging Manager Form

<table>
<thead>
<tr>
<th>TIME IN</th>
<th>TIME OUT</th>
<th>UNIT</th>
<th>ASSIGNMENT</th>
<th>NOTES</th>
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STAGING MANAGER
Medical Communications Coordinator Form

### NORTHERN VIRGINIA INCIDENT MANAGEMENT SYSTEMS

#### MEDICAL COMMUNICATIONS COORDINATOR

Contact Regional Healthcare Coordination Center (RHCC) ASAP

Phone: 888-987-RHCC (7422)

Channel:

<table>
<thead>
<tr>
<th>HOSPITAL/FACILITY</th>
<th>CAPACITY</th>
<th>SENDING</th>
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<tbody>
<tr>
<td>INOVA FAIRFAX (Level 1)</td>
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<tr>
<td>CHILDREN’S NATIONAL DC (Peds, Trauma, Burns)</td>
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<tr>
<td>MEDSTAR Washington DC (Level 1)</td>
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<tr>
<td>RESTON HOSPITAL (Level 2)</td>
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<tr>
<td>GEORGE WASHINGTON DC (Level 2)</td>
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<tr>
<td>WINCHESTER MEDICAL Center (Level 2)</td>
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### HOSPITAL/FACILITY

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<th>EXAMPLE: ABC HOSPITAL</th>
<th>I</th>
<th>D</th>
<th>M</th>
<th>I</th>
<th>D</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>10</td>
<td>10</td>
<td>III</td>
<td>III</td>
<td>III</td>
</tr>
</tbody>
</table>
APPENDIX G: START/JUMP START TRIAGE

START TRIAGE
(Simple Triage and Rapid Treatment)

All Walking Wounded

RESPIRATIONS

MINOR

YES

RESPIRATION

NO

Position Airway

RESPIRATION

OVER 30/min

UNDER 30/min

PERFUSION

Radial Pulse Present

Radial Pulse Absent

Capillary Refill

YES

IMMEDIATE

NO

IMMEDIATE

DECEASED

MENTAL STATUS

Control Bleeding

IMMEDIATE

CAN’T FOLLOW SIMPLE COMMANDS

IMMEDIATE

CAN FOLLOW SIMPLE COMMANDS

DELEYED

START Program developed by HOAG Memorial Hospital and Newport Beach Fire Dept

Respiration 30
Perfusion 2
Mental Status CAN DO
JumpSTART Pediatric MCI Triage

Able to walk? YES → MINOR → Secondary Triage

Breathing? NO → Position upper airway → APNEIC → BREATHING

Palpable pulse? NO → DECEASED

APNEIC → BREATHING

5 rescue breaths → APNEIC

IMMEDIATE

Respiratory Rate

<15 OR >45 → IMMEDIATE

15-45

Palpable Pulse? NO → IMMEDIATE

YES → T* (INAPPROPRIATE, POSTURING OR "U") IMMEDIATE

AVPU

"K", "Y" OR "T" (APPROPRIATE) → DELAYED

Evaluate infants first in secondary triage using the entire JS algorithm.

©Lou Romig MD, 2002
## APPENDIX H: SAMPLE DISASTER TAG

![Sample Disaster Tag Image]

### Chief Complaint
- Head Injury
- C-Spine
- Blunt Trauma
- Penetrating Injury
- Burn
- Fracture
- Laceration
- Amputation

### Medical
- Cardiac
- Respiratory
- Diabetic
- OB/GYN
- Haz-Mat Exposure

### EMOTIONAL (uncontrollable)
- Head Injury
- C-Spine
- Blunt Trauma
- Penetrating Injury
- Burn
- Fracture
- Laceration
- Amputation

### Comments
- [Empty]

### Transportation Agency/Unit
- [Empty]

### Destination
- [Empty]
### Disaster Tag

**VITAL SIGNS**

<table>
<thead>
<tr>
<th>TIME</th>
<th>PULSE</th>
<th>B/P</th>
<th>RESP</th>
<th>LOC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY**

**Allergies**

<table>
<thead>
<tr>
<th>TIME</th>
<th>Treatment Record</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BVM</td>
<td>ET</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Oxygen by ___________ L/min
- Bleeding Control ___________
- Tourniquet @ ___________
- Spinal Immobilization ___________
- Extremity Splint ___________
- IV Started at ___________ at ___________
- MAST Inflated at ___________
- Gross Decon. ___________
- Final Decon. ___________
- Chest Decompression ___________ R. ___________ L.
- MEDS Dose/Route ___________
# APPENDIX I: PATIENT TRACKING DEVICE

## PTS Quick Reference

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Login</strong>&lt;br&gt;· User = Your current unit ID (e.g. E405, M422)&lt;br&gt;· Pass = <em>novapts</em>*&lt;br&gt;*&lt;br&gt;<strong>First time Login Note</strong>&lt;br&gt;· Module Launcher will appear, select Patient Tracking System&lt;br&gt;· Next login will skip this step</td>
<td><strong>Sync</strong>&lt;br&gt;· After login, the app will automatically sync with the server. Then this screen will appear.&lt;br&gt;· Tap &quot;Individual&quot;</td>
</tr>
</tbody>
</table>

## Step 3

**Incident**<br>· On this screen, at a minimum, the *Incident* and the *Position* fields must be filled out correctly.<br>· For Weekly Triage use “Daily Patients” as the incident<br>· On an actual MCI incident, use “Event ###” - The event number is determined by the jurisdictional location of the event (e.g. an incident occurring in Fairfax Co. would be “Event 400”, and an incident occurring within Arlington is “Event 100” etc.).

## Step 4

**Scan**<br>· Uncover the camera on the back.<br>· Tap scan – a camera view will appear.<br>· Align the red line on screen with the triage barcode.<br>· A barcode that has been previously scanned and saved will have any information that was entered by that unit/first responder uploaded after it is scanned again.<br>(If an engine triages a patient and transfers them to a medic unit; when the medic unit scans that same barcode they will receive all the information previous entered) information will automatically populate.

## Step 5

**Triage**<br>· Select the appropriate triage color for the patient.<br>· If a patient’s triage status changes at any time or in any station during the MCI, navigate back to the status tab, and update this screen.

## Step 6

**Transport**<br>· All the information on this screen is required for the transporting unit. Scroll down for *Arrival Time*.<br>· A unit that is only doing initial triage does not fill out this screen.<br>· Once the jurisdiction is selected, the “unit” drop down menu will populate with a corresponding list of units.
### Step 7
**Information**
- Fill in as much information on this screen as you are able.
- **Minimum information** (gender, age/dob and first & last name).
- The scan button on this screen allows you to read the barcode on the back of ID cards and Driver’s licenses, and auto-populate the fields with the information.

*Not all IDs and DLs have a readable barcode, but the scan feature will work with most VA issued IDs and DLs.*

### Step 8
**Complaint**
- Select any complaints that the patient has.
- Comments are not required but any information that may be useful to pass on can be noted here.

### Step 9
This button, found in the upper right hand corner of most of the screens, will give the user a few different options to exit, as well as provide some shortcuts to other features. Almost all options to exit will auto-save the patient information. *Close* is the only option that will allow you to close out the patient record without auto-saving.
APPENDIX J: PATIENT TRACKING AND FAMILY REUNIFICATION

The Patient Tracking System (PTS) project was created to address the need to accurately track the location of patients from the scene of an incident to area hospitals within Northern Virginia and the National Capital Region (NCR).

In a Mass Casualty Incident (MCI), the system will be used to record patient distribution as well as reunite patients with their families. The three instances of patient tracking in Maryland, the District of Columbia, and Northern Virginia are integrated for sharing data across state lines, both for special events and for MCIs. During events, hospitals will be alerted of patients that are en route to their facility and system managers will have ability to monitor all activity.

Additionally, PTS is integrated with many agencies’ electronic patient care reporting systems, the Virginia Hospital Alerting and Status System (VHASS), 2-1-1 Virginia (Virginia’s state-wide system for family re-unification in emergencies), and the Regional Healthcare Coordinating Center (RHCC) that manages patient flow to appropriate receiving facilities.

The Patient Tracking Incident should be dictated by the location of the incident.

- Event 000- DC
- Event 100- Arlington
- Event 200- Alexandria
- Event 300- MWAA
- Event 400- Fairfax
- Event 500- Prince William
- Event 600- Loudoun
- Event 700- Montgomery
- Event 800- PG

2-1-1 Virginia is system that is designed to reunite families after events and is connected to the Patient Tracking System. The RHCC will activate 2-1-1 on a request from hospitals or Incident Commanders. All inquiries about the transport destination of patients involved in and MCI shall be referred to 2-1-1.

2-1-1 relies on information entered into the Patient Tracking System in order to identify patients, so it is important when completing patient records to be as complete and accurate as possible.
APPENDIX L: RHCC

*Northern Virginia Regional Hospital Coordination Center (RHCC) EMS Activation Protocol*

**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) RHCC Radio Talk Group
      Alexandria......................Zone 14 Channel 1 (H1 RHCC4)
      Arlington......................Zone H RHCC4, Zone H RHCC6
      Fairfax.............................Zone 14 Channel 1 (49A RHCC4), Channel 16 (49P RHCC6)
Prince William .................Zone 11 Channel 1 (9A RHCC4), Channel 16 (9P RHCC6)
Loudoun ..........................Zone 69 B RHCC6
MWAA ............................Zone VA Hospital 17 P RHCC4

2. The appropriate agent 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:
   - Point of contact and phone number
   - Nature of event, i.e., chemical spill, explosion, etc.
   - Number of patients
     - Types of injuries
     - Special needs, i.e., pediatrics
   - Incident location
   - Lead agency
   - Current Activities

4. The information listed in (3) will be immediately conveyed by the RHCC to regional hospitals 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:
   1. Unit Number
   2. Destination facility
   3. Number and Category (Red, Yellow, Green) of patients on unit (with notice for peds)
   4. The RHCC will relay information to the designated receiving facilities via pre-established communication channels.

7. The 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;

8. 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;

9. At the conclusion of the scene incident the designated Medical Communications Coordinator 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
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Falls Church, VA 22042
888-987-7422
rhcc@novaha.com