Mass Casualty Incident and Disaster Response Plan

2022-2023

Lord Fairfax EMS Council, Inc.
180-1 Prosperity Drive
Winchester, VA 22602
www.lfems.vaems.org

I. Preface

The goal of the Lord Fairfax Emergency Medical Services Council (LFEMSC) Mass Casualty Incident and Disaster Response Plan, hereafter referred to as the MCI Plan, is to prepare on a regional basis for a unified, coordinated, and immediate emergency medical services (EMS) mutual aid response in order to aid pre-hospital and hospital agencies in the effective emergency medical management of victims of any type of mass casualty incident (MCI) or disaster. It includes patients who are involved in any emergency evacuation of a health care facility in the LFEMSC region and/or any such facility outside the region that is a signatory to the LFEMSC region to include the mandatory evacuation of the Washington, D.C. Metropolitan Statistical Area.

This document will serve as the basis for hospital and out-of-hospital response under the EMS Council MCI Plan in the LFEMSC region Planning District 7. This document will follow the latest National Incident Management System guidance.

Success of the MCI Plan depends upon effective cooperation, organization, and planning among health care professionals and administrators in hospitals and out-of-hospital EMS agencies, state and local government representatives, and in addition to individuals and/or organization associated with disaster-related support agencies in the planning district and related jurisdictions which comprise the LFEMSC region as provided in the Code of Virginia, Section 32.1-113.

Both pre-hospital and hospital providers should become familiar with the below related plans. These plans represent a tiered response to a growing number of patients:

1. Disaster/Weapons of Mass Destruction Plans
2. MCI Plan
3. Surge Capacity Plans

II. Approvals

This Mass Casualty Incident (MCI) Plan was prepared by Lord Fairfax EMS Council to develop and maintain a viable MCI capability. This MCI plan complies with applicable internal agency policy, state regulations and supports recommended provisions.

Approved: _____ Date: _____

President, LFEMS Board of Directors

_____ Date: _____

LFEMS Regional Medical Director

III. Record of Changes

The Board of Directors of the Lord Fairfax EMS Council has the responsibility of effectively fulfilling planning and response functions with the overall maintenance and oversight of the LFEMSC MCI Plan.

This document will be reviewed each year by the LFEMSC Board of Directors, or its designated committee, referencing the MCI Plan Memorandum of Understanding. Proposed revisions, amendments and other changes will be referred to the full Committee for its action.

Authorities and Reference	Change Effective Date
Original Document	03/2006
Revised and Approved by Board of Directors	06/2010
Revised and Approved by Board of Directors	06/2008
Revised and Approved by Board of Directors	03/2010
Approved by Board of Directors w/no revisions	12/2010
Approved by Board of Directors w/revisions	10/2011
Approved by Board of Directors w/no revisions	8/2012
Approved by Board of Directors w/no revisions	3/2014
Approved by Board of Directors w/no revisions	12/2014
Approved by Board of Directors w/no revisions	2/2016
Approved by Board of Directors w/minor revisions	2/2017
Approved by Executive Committee w/no revisions	3/2018
Approved by Executive Committee with no revisions	3/2019
Approved by Board of Directors w/no revisions	1/2020
Approved by Board of Directors w/revisions	5/2021
Approved by Executive Committee w/no revisions	3/2022

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V. Introduction

This MCI Plan addresses techniques in EMS field operations that must be employed when the number of patients exceeds immediately available resources.

It is intended as the primary reference for use in developing agency standard operating procedures, training, guidance and assistance for first responders, dispatchers, and medical control personnel in the management of multiple and mass casualty incidents.

EMS efforts in a multiple or mass causality incident will begin with the first arriving unit and expand to meet the needs of the incident. The first arriving unit should establish Incident Command. That unit is responsible to assess scene **Safety**, conduct a scene **Size-up** and **Send** that information to the Emergency Communications/911 Center, begin to **Set up** the triage and treatment areas, and begin to triage victims using the **START and JumpSTART** triage methods.

The three priorities (listed in order of importance) of incident management are:
1. Life Safety
2. Incident Stabilization
3. Property Conservation

The incident command structure will expand or contract as needed based on the size and complexity of the incident, and maintain the span of control. Only those functions/positions that are necessary will be filled and each element must have a person in charge.

In most multiple or mass casualty incidents, the following Incident Command System (ICS) functions/positions should be staffed: incident command, staging area, extrication, triage, treatment and transportation. In a small scale incident, one person may assume more than one function, i.e. triage and treatment may be done by the same person or transportation and staging can be handled by the same person. In a larger incident, the Incident or Unified Commander may establish a Medical Group or Medical Branch to oversee some or all of the above functions.

Larger agencies may be capable of managing greater numbers of patients without mutual aid whereas other agencies may need mutual aid resources from several jurisdictions to manage an incident of the same magnitude.

Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning district and related jurisdictions which comprise the region.

VI. Plan Purpose

- Provide a standardized action plan that will assist in the coordination and/or management of any regional EMS mutual aid response to a MCI within the LFEMSC region.
- Ensure an effective utilization of the various human and material resources from various Jurisdictions involved in a regional mutual aid EMS response to a disaster or MCI that affects a part or the entire LFEMSC region.
- Ensure the largest number of survivors in mass casualty situations or health care facility evacuations.
- It is recommended that a copy of this document be kept in each licensed EMS response vehicle in the LFEMSC region, in each hospital Emergency Department, in each licensed EMS agency in the region, and also in each Emergency Communications Center (ECC) and Emergency Operations Center (EOC).

This plan will provide guidance on a regional basis for a unified, coordinated, and immediate emergency medical services (EMS) mutual aid response by pre-hospital and hospital agencies to, and the effective emergency medical management of, the victims of any type of Mass Casualty Incident (MCI) or disaster. It includes patients who are involved in any emergency evacuation of a health care facility in the region and/or any such facility outside the region that is a signatory to the region.

It is recommended that a copy of this document be kept in each licensed EMS response vehicle in the LFEMSC region, in each hospital Emergency Department, in each licensed EMS agency in the region, and also in each Emergency Communications Center (ECC) and Emergency Operations Center (EOC).

VII. Scope

This plan is intended to address techniques in field operations that must be employed during multiple or mass casualty incidents when the number of patients exceeds immediately available resources. In addition, this Plan may also serve as the basis for routine operations, preplanning for mass gathering events and other EMS special operations.

This plan standardizes operations during multiple and mass casualty incidents. It is intended to be an "all hazards" plan to meet the needs of any multiple or mass casualty incident regardless of cause. If necessary, these procedures can be modified based on the number of patients, the cause or severity of injuries, and special circumstances involved in the incident. The initial response will be determined by the number of patients.

The LFEMSC is defined as Planning District 7. The regional MCI Plan involves the counties of Clarke, Frederick, Page, Shenandoah, Warren, and the City of Winchester. The MCI Plan addresses only the EMS mutual aid response of the regional EMS system, hospital and pre-hospital, to a MCI or Health Care Facility Evacuation.

MCI that involve fatalities within the LFEMSC region will be handled in cooperation with, and under the direction of, the Virginia Office of the Chief Medical Examiner, local law enforcement officials and/or Virginia State Police, and the Virginia Department of Emergency Management and/or Virginia Department of Health.

VIII. Authorities and References

The LFEMSC is one of the regional EMS councils established within the Code of Virginia, Section 32.1-113. The LFEMSC is charged by law, "with the development and implementation of an efficient and effective regional emergency medical services delivery system" to include the regional coordination of emergency medical disaster planning and response.

References

Emergency Medical Services (EMS) Surge Planning Template and Toolbox for Mass Casualty Incidents (MCI) in Virginia (August 2010).

"Hazard Management Guidelines for Mutual Aid Agreements", The Chamber of Minerals & Energy, Western Australia, September 2005.

"Hazard Management Guidelines for Mutual Aid Agreements", The Chamber of Minerals & Energy, Western Australia, September 2005.)

National Incident Management System – Federal Emergency Management Agency (FEMA), Department of Homeland Security (DHS).

Northern Virginia MCI Plan

Peninsulas Emergency Medical Services Council, Inc. and Tidewater Emergency Medical Services Council, Inc., Hampton Roads Mass Casualty Incident Response Guide, April 2010

Virginia Department of Health, Office of Emergency Medical Services MCI Template.

IX. General Considerations

- Do the greatest good for the greatest number of people
- Make the best possible use of resources
- Avoid relocating the MCI, especially to any receiving hospital

- Scene safety is always the first consideration in an MCI of any level. Responder safety must be consistently monitored throughout the event. A Safety Officer should be appointed as soon as is practical to ensure that operations are safely carried out.

- The incident command structure will expand or contract as needed based on the size and complexity of the incident, and maintain the span of control. Only those functions/positions that are necessary will be filled and each element must have a person in charge.

- In most multiple or mass casualty incidents (MCIs), the following ICS functions/positions should be staffed: incident command, staging area, extrication, triage, treatment and transportation.

- Larger agencies may be capable of managing greater numbers of patients without mutual aid whereas other agencies may need mutual aid resources from several jurisdictions to manage an incident of the same magnitude.

- Some incidents may be so large, or the sense of danger so pervasive (such as a terrorist incident), that victims may not wish to remain on the scene and will self-refer to known medical facilities. During such incidents, EMS triage and treatment resources may have to be co-located at hospitals, assembled at multiple locations, and/or situated a great distance away from the initial scene location to ensure the safety of first responders and victims.

- A personnel accountability system must be implemented at MCIs to help ensure the safety of first responders and ensure efficient operations.

- The resources needed to mitigate multiple simultaneous incidents are dependent on the size and complexity of the incidents as well as their location. Expected mutual aid resources may not be available or may be significantly delayed. Providers must be prepared to sustain their patients for long periods of time. Non-traditional modes of transportation and alternate patient transport destinations will need to be considered.

- Care must be taken to meet the communication, mobility, cognitive and other needs of "all needs" victims.

X. Jurisdictional Area Description and Potential Hazards

A. Jurisdictional Description

Location: The LFEMSC's jurisdiction is a primarily rural region located in the Shenandoah Valley of northwestern Virginia and is comprised of the Counties of Clarke, Frederick, Page, Shenandoah, and Warren in addition to the City of Winchester. The Council serves an estimated population of 228,087 and consists of 1,652 square miles of very diverse area containing a mix of landscapes including forest, farms, suburbs, several small towns, and one city.

This region is home to some of the fastest growing counties in the commonwealth of Virginia. The area has seen an average population growth of 21.3% since the 2000 census. Population growth in the northern Shenandoah Valley from 2000 to 2019 is shown below:

Jurisdiction Name	2000 Population	2019 Population	Percentage of Population Growth (2000 to 2019)
Clarke County	12,652	14,423	12.3%
Frederick County	59,209	86,415	31.5%
Page County	23,177	23,788	2.6%
Shenandoah County	35,075	43,224	18.9%
Warren County	31,584	39,492	20.1%
Winchester City	23,585	27,897	15.5%
Totals	**185,282**	**235,239**	**21.3% (average)**

Data Source: https://data.census.gov/cedsci/map?g=0500000US51840

The Federal Government has several facilities in the Shenandoah Valley (i.e. FEMA, FBI, etc) which increased the number of personnel moving into the region and commuting from other localities to the area. The growth of individuals moving to the Shenandoah Valley has caused an increase in commuter traffic into the Northern Virginia Area. Rapid growth is expected to continue in the area for the next four (4) years due in part to the proximity to the Northern Virginia area and the incorporation of Clarke & Warren Counties into the Washington D.C. Metropolitan Statistical Area.

Geography: The Shenandoah National Park and George Washington National Forest runs the length of the region from Front Royal to Luray and attracts 2 million visitors a year. The Shenandoah River runs the complete length of the region and cuts through four of the region's six counties (Clarke, Page, Shenandoah, and Warren). Three mountain ranges run through the region. The Blue Ridge Mountains on the east side, Massanutten Range in the middle, and the Appalachians on the west side of the region.

Transportations Routes: The area has nine major roadways (Interstates 81 and 66 and Routes 7, 11, 50, 55, 211, 340, and 522) which bisect the region. There are two major railroad systems (CSX and Norfolk-Southern) which pass through all jurisdictions in the LFEMS region, and a local railroad also passes through Frederick County and the City of Winchester. The region also hosts airports in Page County, Warren County, and Winchester City (the Winchester Regional Airport has seen increased flight traffic after the Federal Government increased restricted airspace around Washington D.C.). Additionally there is an inland port located in Warren County.

B. Potential Hazards

Hurricanes, winter storms (snow and ice), localized floods, tornadoes, and, to a lesser extent, earthquakes all periodically impact the state. As a result, the most significant natural disasters to historically affect the area have resulted from severe flooding, high winds, or slow-moving thunderstorms.

However the region's potential hazards are not limited to changing weather conditions. The concern over a terrorist event involving the use of a "Weapon of Mass Destruction" or "Radiological Dispersion Device" is heightened in the area due to its proximity to the National Capital Region and the numerous Federal facilities located here.

Due to the major roadways in the area there is also concern of hazardous materials incidents and it is also noteworthy to mention that Page County falls within the emergency planning area for the North Anna nuclear power station. The response of the jurisdiction to emergencies will be determined by the substances (e.g., chemical, nuclear particles, or organisms and their characteristics) involved, the mechanism of the event (natural or man-made), the scale of the event, and by the authorities, plans, and operations that are put into action.

XI. Concept of MCI Response

a. Trigger points for requesting assistance
Major vehicular accidents with multiple victims
Urban, residential and woodland fires
Tornados or other severe weather-related events
Public transportation mishaps (aircraft, train, bus).
Construction and/or industrial and farm accidents including hazardous materials, building collapses with multiple victims
River and/or localized flooding, impassable highways, roads and bridges
Healthcare facility evacuations
Educational institutions (e.g. Schools, Colleges, and Universities)
Acts of terrorism and/or civil disobedience
Military related incidents and federal disaster response
Mass gather events

b. Deployment and mobilization system and structure
Any Prehospital Provider can activate the MCI and Disaster Plan when a mass casualty incident will usually be declared by the first arriving unit at the scene of the incident. A formal declaration of an MCI is usually made by an officer or chief of the agency in charge.

MCI Level 1 (3-10)

Note: Larger agencies may be capable of handling incidents less than 10 patients without necessitating implementation of the MCI Plan. The decision to declare a MCI Level I is left to the Incident Commander.

- 5 Ambulances
- 2 Engine Companies or minimum of 6 first responder personnel
- 1 EMS Supervisor/Operational Chief

MCI Level 2 (11-20)

- 10 Ambulances
- 5 Engine Companies or 15 first responder personnel
- 2 EMS Supervisors/Operation Chiefs
- 1 MCI Trailer

MCI Level 3 (21-100)

- 15 Ambulances
- 10 Engine Companies or 30 first responder personnel
- 3 EMS Supervisors/Operation Chiefs

- 1-2 MCI Trailers

MCI Level 4 (101-1000)

- 20 ambulances (Minimum)
- 10 Engine Companies or 30 first responder personnel
- 2 Buses
- 5 EMS Supervisors/Operation Chiefs
- 2 MCI Trailers
- 1 Communications Trailer

c. Response Procedures
   i. Ordering additional resources will be done through the agency's Emergency Operations Center (EOC).

d EMS needs outside of MCI
   i. The LFEMSC Prehospital Standard Patient Treatment Guidelines unless authorized to deviate from the guidelines by the physician at the receiving hospital.
   ii. The Incident Commander will notify the Emergency Communications Center of any additional needs for the scene.

e. Financial Considerations
   a. The cost of EMS supplies and equipment will remain the responsibility of the locality.
   b. Workers compensation injuries will be processed by the providers' locality.
   c. Liability coverage for personnel and equipment is the responsibility of the agency.

f. Replacement of equipment during the incident
   a. EMS supplies will be replaced by the local hospital until the incident is declared terminated by the Incident Commander.
   b. Use of MCI trailers will be determined by the Incident Commander.
   c. Re-supplying of any EMS equipment will be determined by the Incident Commander.

g. Legal Considerations
   a. Medical Direction - EMS providers will follow local protocol unless suspended by the Operational Medical Directors.
   b. Liability - Workers compensation injuries will be processed by the providers' locality.
   c. Immunity - EMS providers have immunity under a declared state of emergency.

d. Dispute resolution - Localities and EMS agencies will seek the advice of legal counsel or other means to resolve disputes between parties including negotiations, mediation, arbitration, collaboration, and litigations.

h. Credentialing of other responders is the responsibility of the locality and shall follow the NIMS guidelines as set forth by U.S. Department of Transportation (USDOT), Occupational Safety and Health Administration (OSHA), National Fire Protection Association, State and Local emergency response procedures.

XII. Command Structure

NIMS/ICS System

In the LFEMSC region, all personnel will follow the NIMS which is a comprehensive, national approach to incident management which includes the Incident Command System, multi-agency Coordination systems, and Public Information systems and must be adopted by all jurisdictions to be compliant for DHS grants and awards.

ICS standardized on-scene emergency management is constructed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by all jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Notification procedures and roles of:

a. Dispatch Centers/Public Safety Communication Centers are in each jurisdiction and are responsible for dispatching fire and EMS apparatus to emergency incidents.
b. Hospitals - there are 4 hospitals in our region (one Level II Trauma Center).
c. Local Emergency Management personnel are appointed by the local jurisdiction and are responsible for the management of emergencies.
d. Mutual Aid agreements are coordinated by each jurisdiction with surrounding agencies to provide additional support in the event of a MCI. Predetermined EMS mutual aid response will be expected to maintain their own emergency medical response capabilities to meet local needs.

Decision making authority

a. Incident Commander is responsible for all incident activities to include the development of strategies and tactics and the ordering and release of resources. The position has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.
b. Command Staff consists of positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed.
c. General Staff are incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief.

XIII. MCI Scene Set up

a. General Layout
The initial triage must be conducted at the incident scene if it is safe to do so. It is important for responders to establish an orderly flow of patients from the incident scene through the transport area. Ultimately the way a scene is organized will depend on scene security and location, terrain, weather, the number of patients, and numerous other factors.

b. Secondary Triage Area
A more in-depth assessment method, known as secondary triage, must be conducted on all patients arriving at the treatment area from the incident scene. Each patient will have a Virginia Triage Tag applied upon their entry into the treatment area. Patients in the area must be continuously reevaluated (re-triaged) throughout their stay in the treatment area.

c. Treatment Area
Patients are placed in the Treatment Area and emergency medical care is provided on the basis of the triage priority. If needed, separate areas may be created in the Treatment Area for Red Tagged/Immediate, Yellow Tagged/Delayed, and Green Tagged/Minimal patients. Personnel, equipment and supplies are allocated to patients based on their triage priority. Designate a separate, secure and isolated area for the Incident Morgue. The incident morgue is for the placement of victims who die in the Treatment Area. (This area should be secured by Law Enforcement Officers not EMS providers.)

d. Transport Area
The Incident Commander and Transport Officer needs to be aware that the use of vehicles other than ambulances for transport, fueling/refueling, and vehicle maintenance (as needed) may be necessary.

XIV. Response Overview

a. First Arriving Unit Responsibilities. It is the responsibility of the first arriving unit to establish command and to perform the initial scene size-up using what is known as the “5 S’s" shown below and report the information to their dispatcher.

1. SAFETY assessment: Assess the scene for safety by looking for:
   - ✓ Electrical hazards.
   - ✓ Flammable liquids.
   - ✓ Hazardous Materials
   - ✓ Other life threatening situations.
   - ✓ Be aware of the potential for secondary explosive devices.

2. SIZE UP the scene: How big and how bad is it? Survey the incident scene for:
   - ✓ Type and/or cause of incident.
   - ✓ Approximate number of patients.
   - ✓ Severity level of injuries (either Major or Minor).
   - ✓ Area involved, including problems with scene access.

3. SEND information:
   - ✓ Contact dispatch with your size-up information.
   - ✓ Request additional resources.
   - ✓ Notify the closest hospital.

4. SETUP the scene for management of the casualties:
   - ✓ Establish staging.
   - ✓ Identify access and egress routes.
   - ✓ Identify adequate work areas for Triage, Treatment, and Transportation.

5. START Triage**.** Triage all patients using Simple Triage and Rapid Treatment (START) and JumpSTART triage methods as appropriate**.**
   - ✓ Begin where you are.
   - ✓ Ask anyone who can walk to move to a designated area.
   - ✓ Use surveyor’s tape to mark patients.
   - ✓ Move quickly from patient to patient.
   - ✓ Maintain patient count.

- ✓ Provide only minimal treatment.
- ✓ Keep moving!

b. EMS Initial Actions
First Arriving Unit Responsibilities. It is the responsibility of the first arriving unit to establish command and to perform the initial scene size-up and report the Information to their dispatcher.

c. Triage
Initial: The initial triaging of victims must begin right where the patients lay. The EMS Provider must begin to triage patients right where they enter the scene and then progress in a deliberate and methodical pattern to ensure that all of the victims are triaged. When using both the START and JumpSTART triage methods, all ambulatory patients are initially directed to a designated Green/Minor treatment area where they will be assessed and further triaged as personnel become available. It is appropriate to provide these patients with self-care kits, if available, so that they may begin treating themselves while awaiting the arrival of EMS providers. For all remaining patients, triage personnel must quickly triage each patient and apply the appropriate color-coded triage ribbons (surveyor's tape).

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

Secondary triage: The secondary triage is the first step in patient treatment. Every patient is brought from the scene to a single point where one of the most medically qualified people on scene will triage the patient, making a determination of what triage color category the patient should be placed in for treatment, and ensure that the Virginia Triage Tag is applied to the patient. Secondary triage is a more in depth reassessment of each patient and is based on the clinical experience and judgment of that provider. Ongoing triage is then performed periodically thereafter depending upon the patient’s condition. Additional triage assessments must be performed during transport to and again upon the patient’s arrival at the Emergency Department.

d. Patient Care and Transport
   i. Traditional
      During traditional incidents, only licensed EMS vehicles will be permitted to transport patients.
   ii. Non-Traditional (i.e. Pandemic event, etc.)
      When using non-EMS transport vehicles, depending on the number of green patients, the Transportation Group Leader will communicate with the Triage Officer and the Incident Commander on the type and number of non-EMS transport vehicle's needed. The Transportation Group Leader will be responsible for vehicle tracking and the documentation of where these patients will be transported.

e. Event Actions
   i. Safety
      1. Scene and Body Substance Isolation (BSI)
         All EMS personnel involved in a regional response to a MCI or Evacuation will be expected to observe Standard Precautions (Universal Precautions/BSI) and other infection control practices as specified by the Centers for Disease Control and Prevention (CDC), OSHA, and the National Fire Protection Association Standard 1581 "Fire Department Infection Control Program" or mandated by their agency. In addition, the designated infection control officers for the involved public safety agencies and the appropriate hospital infection control personnel should be notified. Each agency will follow their Infection Control Plan.
      2. Vaccinations/shots
         Each agency will be responsible for ensuring the safety and welfare of its providers. This includes any recommended or required vaccinations to protect the first responders.

   ii. Incident stabilization (in order of importance)
      1. Life safety
         The Incident Commander must ensure the safety of first responders from personal injury or danger to the best of his/her ability.
      2. Conservation of property and equipment
         The Incident Commander must ensure the safety of property and equipment to the best of his/her ability.
      3. Accountability and tracking of patients
         All patients on the scene and enroute to a medical or treatment facility, must be tracked by the Transportation Officer.

XV. Responder Accountability and Welfare

Accountability system (on scene and to and from incident)

The Public Safety Communication Center (PSCC) is responsible for tracking all dispatched units to the incident.

The Incident Commander or designee is responsible for the accountability of all personnel on the scene of an MCI by the use of written or electronic tracking.

Critical Incident Stress Management (CISM)

CISM has been determined to be an integral part of any emergency medical response to a MCI incident. CISM may be defined as any situation faced by emergency service personnel that cause them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later. No one working in emergency services is immune to critical incident stress, regardless of past experiences or years of service.

CISM should be considered and requested early in MCI incidents. Requests for a CISM debriefing team should be made through the incident commander.

The LFEMSC CISM Region Team can be activated through their 24-hour communications line at 540-665-5645 or through the Frederick County Emergency Communications Center (FCECC) through their respective communication centers. Other CISM assets can be activated through the Virginia EOC at 1-800-468-8892.

Upon requesting a CISM Team's assistance for any incident, the requestor must prepare to describe the incident type and the number of emergency personnel involved in the incident. The category of CISM debriefing desired should also be suggested.

Debriefings are divided into the following categories:

<u>On-Scene</u> – Critical incidents where personnel are involved with operations for long time periods.

<u>Defusing</u> – Spontaneous non-evaluative discussion that is conducted shortly after an incident.

<u>Formal Debriefing</u> – A confidential non-evaluative discussion that is conducted within 72 hours of an incident.

Follow-Up – An informal debriefing that occurs weeks or months after an incident.

One-On-One – A debriefing that is conducted one-on-one between an emergency responder and peer debriefer.

Responder Rehabilitation

The Incident Commander is responsible for establishing rehab according to the incident complexity or work period based on local guidelines.

XVI. Special Resources Response

a. Hazardous Materials (HAZMAT) Teams

The local fire department should be contacted in the event of an incident involving hazardous materials. The local fire department will contact the **Virginia Department of Emergency Management (VDEM) EOC at 1-800-468-8892** to request technical assistance or to have the VDEM Regional Hazardous Materials Officer (RHMO) respond to the incident scene. Based on the request and assessment by the RHMO, the RHMO may activate one or more regional hazardous materials response teams as required.

All personnel involved in a Mass Casualty Hazardous Materials incident should meet the appropriate training level in accordance with established guidelines as set forth by USDOT, OSHA, National Fire Protection Association, State and Local emergency response procedures. **All responders who do not meet these guidelines should stage and stay well outside of the hot and warm zones of the incident.**

Decontamination, within the public safety community, involves the removal or deactivation of contaminants from people, equipment, or the environment. It protects personnel from hazardous substances that may contaminate and permeate their protective clothing, respiratory equipment, tools, vehicles and other equipment used on the scene. By expeditiously removing the contaminant from the victims, first responder personnel may be able to preclude the occurrence of adverse health effects from the materials. The Incident Commander or Decontamination Leader will determine when patients will be released to the personnel for treatment and/or transportation to a health care facility.

b. Health and Medical Emergency Response Team (HMERT)

When requested through the jurisdiction emergency operations center to the State EOC, **1-800-468-8892**, EMS personnel and or teams, coordinated through the OEMS, can be requested to augment the available capability of local emergency medical services systems. Incident Support Teams (IST) can be activated and deployed with or without other personnel.

The Incident Commander in cooperation with the Logistics Office will coordinate and process the request for additional resources. This request will be determined by the needs for the next operation period, current service and support capabilities, and estimate of the future service and support requirements.

c. **Technical Rescue Teams**

MCIs involving extended technical rescue operations (i.e. large transportation extrications, confined spaces, collapsed man-made or natural structures,

search and rescue operations, etc.) should use the resources of the local jurisdiction.

When needs exceed local capabilities or resources, utilize existing methods to locate specialized resources. Several local teams exist in Virginia which have technical rescue capabilities. Local dispatch centers should keep team contact phone numbers available for use during an incident.

The Virginia Emergency Operation Center, 1-800-468-8892, is the Search and Rescue Coordination Center for Virginia and can contact SAR teams for local jurisdictions.

All personnel involved in the technical rescue aspects of an MCI regional response must have appropriate training and maintain compliance with local, state and federal OSHA standards.

c. "All Needs" victims

Care must be taken to meet the communication, mobility, cognitive and other needs of "all needs" victims. Responders must make certain that assistive devices and equipment are transported with the victim or patient. (e.g. glasses, hearings aids, and mobility devices such as walkers and wheel chairs.) Theses items should be labeled with the patient's name if known or the patient's Virginia Triage Tag number.

I. Service and non-service domestic animals

Patients should not be separated from their caregivers or their assistance animals. Assistance animals are vital to the recovery of these patients and their prompt return to their activities of daily living. If a patient must be transported to a health care facility then arrangements must be made for the housing and care of the assistance animal. Information on the location and health of the animal must be provided to the patient, their family, or other care giver. This also applies to working dogs such as canine law enforcement officers (e.g. drug dogs, bomb detection dogs, etc.), search and rescue dogs, and cadaver dogs.

XVII. Communications

a. Responsibilities

I. Pre-Hospital

1. Tactical - The PSCC and Incident Commander will be responsible for assigning all units to tactical radio frequencies for scene operations. The primary frequency will be maintained for dispatch-to-unit radio traffic.
2. Field to Hospital – Transportation Group Supervisor (or designee) should make the initial contact to the hospital relaying triage types and number of patients.
3. Ambulance to Hospital – AIC should attempt to use their normal methods for conducting ambulance to hospital communication for Red and Yellow patients.

II. Hospital

1. Hospital communication will be conducted through their normal channels of communications.
2. Hospital Command Post communication channel will be assigned by the jurisdictional PSCC.

III. The local hospital should be contacted through the Public Safety Answering Point (PSAP), the incident commander or their designee during a Mass Casualty Incident.

The Regional Healthcare Coordinating Center (RHCC) should be contacted for an MCI that may exceed local hospital capacity. In the LFEMSC region, the Northwest Region Healthcare Coalition (NWRHC) RHCC will coordinate hospital bed capacity for large scale incidents where the number and severity of patients overwhelms the ability to determine the patient's destination. Winchester Medical Center serves as the secondary coordinating center in the LFEMS region.

NWRHC RHCC: 855-469-7422

WMC: 540-667-0609

Emergency coordination between hospitals at the regional level within the Commonwealth is provided by the establishment of RHCC. These centers are responsible for serving as the contact between regional healthcare facilities, other regions and the statewide response system through the hospital representative seat at the Virginia Department of Health Emergency Communications Center (VDH/ECC).

The hospital seat at the VDH/ECC serves as the contact between the healthcare provider system and the statewide emergency response system. This function provides an interface through the

VDH/ECC to the VEOC.

It must be emphasized that the structure noted above is in addition to and does not replace the relationships and coordinating channels established between the individual health-care facilities and their local ECC and/or health department officials. This structure is intended to enhance the communication and coordination of specific issues related to the healthcare component of the emergency response system.

IV. Multi-Regional Communications

The statewide VHF frequencies are designated to provide a standard communications mechanism throughout Virginia.

XVIII. Demobilization

a. Developing and executing a demobilization plan

The Incident Commander will be responsible for notifying MCI Medical Control that all patients have been assigned to transport units and that all on-scene patient care activities have been completed and ended at the MCI or Evacuation site(s).

The on-scene Incident Commander should confer with the appropriate official (e.g., Emergency Services Coordinator, healthcare facility Chief Executive Officer) to determine any additional patient care need for EMS prior to contacting the MCI Medical Control.

b. MCI Medical Control in coordination with the incident commander and the operations division will deactivate the MCI Plan among activated hospitals when the designated MCI Medical Control hospital is notified by the on-scene Incident Commander that EMS activities are completed at the MCI or Evacuation site(s), and when it is determined that all other patient care issues have been resolved.

c. Debriefing/Hotwash

Immediately following the resolution of the mass casualty incident, the Incident Commander should facilitate an incident debriefing or hotwash with responders representing the various incident assignments. The incident debriefing/hotwash is an opportunity for first responders to voice their opinions regarding the response to the incident and their own performance. At this time agency leaders can also seek clarification regarding actions taken during the incident, and what prompted first responders to take those actions. The incident debriefing/hotwash should not last more than 30 minutes. Scribes should be assigned to take notes during the incident debriefing/hotwash and include these observations in their analysis. The resulting notes will be used to compile the incident After Action Report.

d. After Action Report(AAR)

An AAR examines the culmination of the incident response. It is a written report outlining the strengths and areas for improvement identified by the response. The AAR will include the incident timeline, executive summary, incident description, mission outcomes, and capability analysis. The AAR will be drafted by a core group of individuals from each of the public safety agencies involved in the incident response. The report shall be completed within 6 months after the conclusion of the incident as recommended by the Homeland Security Exercise and Evaluation Program (HSEEP). A

copy of the AAR's from actual mass casualty incidents should be forwarded to licensed EMS Agency's respective EMS Council and the Virginia OEMS.

After Action Report Conference
The After Action Conference is a forum for jurisdiction officials to hear the results of the evaluation analysis, validate the findings and recommendations in the draft AAR, and begin development of the Improvement Plan (IP).

Improvement Plan
The Improvement plan identifies how recommendations will be addressed, including what actions will be taken, who is responsible, and the timeline for completion. It is created by key stakeholders from the participating agency officials during the After Action Report Conference.

Lessons Learned Information Sharing
The improvement process represents the comprehensive, continuing preparedness effort of which the incident response activities are a part.

Lessons Learned Information Sharing
The improvement process represents the comprehensive, continuing preparedness effort of which the incident response activities are a part.
The incident AAR and lessons learned from the response should also be considered for posting on the Department of Homeland Security's Lessons Learned Information web site (LLIS.gov) located at https://www.llis.dhs.gov/.

Lessons Learned Information Sharing (LLIS.gov) is the national network of Lessons Learned and Best Practices for emergency response providers and homeland security officials. LLIS.gov's secure, restricted-access information is designed to facilitate efforts to prevent, prepare for and respond to acts of terrorism and other incidents across all disciplines and communities throughout the US. All Lessons Learned and Best Practices are peer-validated by homeland security professionals. LLIS.gov serves as a clearing house for AARs and Lessons Learned from exercises and actual incidents.

XIX. Training and Exercise

To maintain the agency's MCI capability, an all hazards MCI training, testing, and exercise program.

a. Training
Hospital and pre-hospital components in the region will jointly coordinate a regional training exercise(s) of the MCI Plan on an annual basis. These exercises in various jurisdictions in the region will be coordinated in cooperation with the jurisdiction by LFEMSC through the designated LFEMSC Disaster Committee. The MCI Plan should be reviewed based on the results of said training exercise and updated technology that may impact training exercise.

b. Testing and Exercise
The LFEMSC will provide evidence of development and execution of an exercise that tests the validity of the plan every two years. The exercise will test at least one aspect of the plan. The exercise is designed to promote emergency preparedness; test or evaluate emergency operations plans, procedures, or facilities; train personnel in emergency response duties; and demonstrate operational capability. The exercise could a table-top, function, or full scale.

XX. Plan Maintenance

Plan Maintenance Procedures

The LFEMSC Disaster Committee is responsible for reviewing this plan semi-annually. Any changes or updates will be incorporated to maintain its effectiveness, reviewing and evaluating any activation of the MCI Plan, and for planning or participating in biannual exercises in the region.

Revisions and/or amendments will be acted upon by the Committee no sooner than 45 days, and not longer than 90 days, after all signatories have been notified of the proposed changes and have had an opportunity to respond through their representatives or in writing to the Committee Chair.

Revisions and/or amendments to the Plan will require a majority vote of the members present of the Lord Fairfax EMS Council Board of Directors to be enacted.

XXI. Annexes

A. Communications Directory (all agencies noted in the plan)
B. Glossary of commonly used terms and acronyms
C. Forms and Worksheets
    1. Patient Count and Distribution Worksheet (ICS 308)
    2. MCI Patient Tracking Form (ICS 306)
    3. Air Operations Summary Form (ICS 220)
    4. Prehospital Job Checklists:
        a. First Unit on Scene Unit
        b. Incident Commander
        c. Medical Branch Supervisor
        d. Staging Area Manager
        e. Triage Unit Leader
        f. Treatment Unit Leader
        g. Red, Yellow (Prime), Green Treatment Area Attendant-in-Charge
        h. Incident Morgue Attendant-in-Charge
        i. Medical Supply Coordinator
        j. Transportation Unit Leader
        k. Transport Recorder
        l. Transport Loader
        m. Medical Communications Coordinator
        n. Air Operations Group Supervisor (as needed)
            1. Air Operations Annex
        o. Hospital Driving Directions
        p. Training Resources
            OEMS MCI I and II
            Other State
            Federal
            Private
        q. Other Resources
D. Hospital Driving Directions
E. Training

Annex A - Communication Directory

Clarke County

CLARKE COUNTY EMERGENCY SERVICES (01032)
102 NORTH CHURCH STREET
BERRYVILLE VA 22611
540-955-1234
MCI Capabilities: NONE

Frederick County

FREDERICK COUNTY FIRE and RESCUE DEPARTMENT (00595)
1080 COVERSTONE DRIVE
WINCHESTER VA 22602
540-665-5645
MCI Capabilities: Trailer – Equipped to treat 50 patients

Page County

PAGE COUNTY FIRE - EMS (01190)
117 SOUTH COURT STREET
LURAY VA 22835
540-843-0911
MCI Capabilities: Trailer

Shenandoah County

SHENANDOAH COUNTY FIRE AND RESCUE (01162)
600 NORTH MAIN STREET, SUITE 1
WOODSTOCK VA 22664
540-459-6101
MCI Capabilities: NONE

Warren County

WARREN COUNTY DEPARTMENT OF FIRE and RESCUE SERVICES (00943)
220 NORTH COMMERCE AVENUE SUITE 300
FRONT ROYAL VA 22630
540-635-4128
MCI Capabilities: NONE

Winchester City

WINCHESTER FIRE and RESCUE DEPARTMENT (00614)
231 EAST PICCADILLY STREET SUITE 330
WINCHESTER VA 22601
540-662-4131
MCI Capabilities: Carried on BC Vehicles - 5 Large aid bags and 6 casualty response kits for mass shooting type events

Private

VALLEY MEDICAL TRANSPORT (00057)
190 PROSPERITY DRIVE
WINCHESTER VA 22602
540-450-3225
MCI Capabilities:

Annex B - National Incident Management System Terms

GLOSSARY OF TERMS AND ACRONYMS

For the purposes of NIMS, the following terms and definitions apply:

Agency: A division of government with a specific function offering a particular kind of assistance. In ICS, agencies are defined either as jurisdictional (having statutory responsibility for incident management) or as assisting or cooperating (providing resources or other assistance).

Agency Representative: A person assigned by a primary, assisting, or cooperating Federal, State, local, or tribal government agency or private entity that has been delegated authority to make decisions affecting that agency's or organization's participation in incident management activities following appropriate consultation with the leadership of that agency.

Area Command (Unified Area Command): An organization established (1) to oversee the management of multiple incidents that are each being handled by an ICS organization or (2) to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned. Area Command has the responsibility to set overall strategy and priorities, allocate critical resources according to priorities, ensure that incidents are properly managed, and ensure that objectives are met and strategies followed. Area Command becomes Unified Area Command when incidents are multi-jurisdictional. Area Command may be established at an emergency operations center facility or at some location other than an incident command post.

Assignments: Tasks given to resources to perform within a given operational period that are based on operational objectives defined in the IAP.

Assisting Agency: An agency or organization providing personnel, services or other resources to the agency with direct responsibility for incident management

Available Resources: Resources assigned to an incident, checked in, and available for a mission assignment, normally located in a Staging Area.

Chain of Command: A series of command, control, executive, or management positions in hierarchical order of authority.

Command/Incident Commander – The Command Function of an Incident Command System (ICS) is responsible for directing and/or controlling resources by virtue of explicit legal, agency, or delegated authority. The individual responsible for the overall management of the response is called the Incident Commander. The Command Function sets objectives and priorities and defines the ICS organization for the particular response. Even if other positions are not assigned, the Incident Commander will always be designated

Command Staff – The IC may appoint a person or persons to be in charge of specific staff functions including the Information, Safety, and Liaison functions. These tasks also may include public and Congressional affairs, media relations, and legal issues, among others. The members of the Command Staff report directly to the Incident Commander and will support, advise, and keep the other key functional managers informed. The Incident Commander may appoint functional managers responsible for specific tasks (operations, planning, logistics, and finance and administration). These tasks remain the responsibility of the Incident Commander unless they are delegated to someone else. The tasks are as follows:

♦ **OPERATIONS** – Operations Staff direct tactical actions to meet incident objectives, administer staging areas, and identify and utilize resources.

♦ **PLANNING** – Planning Staff collect, evaluate, and display incident information; prepare an action plan and health and safety plan; evaluate disposal options; plan for demobilization; and maintain documentation.

♦ **LOGISTICS** – Logistics Staff provide adequate service and support to meet incident or event needs, including supplies, first aid, food, communications, ground support, and transportation and vehicle maintenance.

♦ **FINANCE/ADMINISTRATION** – Finance and Administration Staff track incident costs, personnel and equipment records, claims, and procurement contracts; and provide legal expertise.

Emergency: Any unplanned event that interrupts the daily function of the jurisdiction and requires an emergency response.

Emergency Operations Plan (EOP): The "steady-state" plan maintained by various jurisdictional levels for responding to a wide variety of potential hazards. Emergency Public Information: Information that is disseminated primarily in anticipation of an emergency or during an emergency. In addition to providing situational information to the public, it also frequently provides directive actions required to be taken by the general public.

Emergency Management Assistance Compact (EMAC): An agreement between *all* states for mutual aid so that needed resources are obtained, transported and utilized during a disaster.

Emergency Operation Center (EOC): A facility from which local government officials exercise direction and control in an emergency or disaster.

Emergency Support Functions (ESF): Various state agencies may be requested or mandated to participate in disaster related activities, responses or support.

Exercise: An activity designed to promote emergency preparedness; test or evaluate emergency operations plans, procedures, or facilities; train personnel in emergency

response duties; and demonstrate operational capability. The exercise maybe a table top, functional, or full scale drill.

Federal Response Plan (FRP): The Federal plan developed under Public Law 93-288 (Stafford Act) in order to facilitate the delivery of all types of Federal Response Assistance to States to help them deal with the consequence of significant disasters. Any response provided will supplement state and local response efforts. Requests for Federal assistance will be made by the State after an assessment of state and local ability to respond to the specific disaster.

General Staff – The group of incident management personnel comprised of: the Incident Commander or Unified Command, the Operations Section Chief, the Planning Section Chief, the Logistics Section Chief, and the Finance/Administration Section Chief.

HSPD-5: Homeland Security Presidential Directive-5

Incident Action Plan (IAP) – Contains objectives reflecting the overall incident strategy and specific tactical actions and supporting information for the next operational period. The Plan may have a number of forms as attachments (e.g., safety plan).

Incident Command System (ICS): A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Joint Information Center (JIC): Joint Information Center - A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating agencies should co-locate at the JIC.

JumpSTART Triage – Jump Simple Triage and Rapid Treatment; A pediatric triage method adopted for use in the Commonwealth of Virginia.

Liaison: A form of communication for establishing and maintaining mutual understanding and cooperation.

Major Disaster: As defined under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122), a major disaster is any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which

in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, tribes, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

Mass Casualty Incident – incidents resulting from man-made or natural causes resulting in illness or injuries that exceed or overwhelm the EMS and hospital capabilities at a local, jurisdictional or regional level. Mass casualty incident is likely to impose a sustained demand for health and medical services rather than the short, intense peak demand of those services typical of multiple casualty incidents.

Multiple Casualty Incident - incidents involving multiple victims that can be managed, with heightened response (including mutual aid of necessary), by a single EMS agency or system. Multi-casualty incidents typically do not overwhelm the hospital capabilities of a jurisdiction and/or region, but may exceed the capabilities for one or more hospitals within a locality. There is usually a short, intense peak demand for health and medical services, unlike the sustained demand for these services typical of mass casualty incidents. (FEMA)

National Incident Management System (NIMS): A comprehensive, national approach to incident management includes the Incident Command System, multi-agency Coordination systems, and Public Information systems and must be adopted by all jurisdictions to be compliant for DHS grants and awards.

National Response Plan (NRP) - A plan mandated by HSPD-5 that integrates Federal domestic prevention, preparedness, response, and recovery plans into one all-discipline, all-hazards plan.

Operational Period – The period of time scheduled for execution of a given set of operation actions as specified in the IAP. Operational Periods can be various lengths, usually not over 24 hours. The Operational Period coincides with the completion of one planning cycle.

PIO: Public Information Officer

Planning Meeting: A meeting held as needed prior to and throughout the duration of an incident to select specific strategies and tactics for incident control operations and for service and support planning. For larger incidents, the planning meeting is a major element in the development of the Incident Action Plan (IAP).

Preparedness: The range of deliberate, critical tasks and activities necessary to build, sustain, and improve the operational capability to prevent, protect against, respond to, and recover from domestic incidents. Preparedness is a continuous process. Preparedness involves efforts at all levels of government and between government and private-sector and nongovernmental organizations to identify threats, determine vulnerabilities, and identify required resources. Within the NIMS, preparedness is operationally focused on establishing guidelines, protocols, and standards for planning,

training and exercises, personnel qualification and certification, equipment certification, and publication management.

Recovery: The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private sector, nongovernmental, and public-assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.

Resources: Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an EOC.

Resource Management: Efficient incident management requires a system for identifying available resources at all jurisdictional levels to enable timely and unimpeded access to resources needed to prepare for, respond to, or recover from an incident. Resource management under the NIMS includes mutual-aid agreements; the use of special Federal, State, local, and tribal teams; and resource mobilization protocols.

Standard Operating Procedure (SOP) - a list of specific or detailed actions, methods or skills used to accomplish a specific task or job; also known as SOGs, Standard Operating Guides.

START Triage - **S**imple **T**riage and **R**apid **T**reatment; An adult triage method adopted for use in the Commonwealth of Virginia

Unified Command (UC) – A unified team that manages an incident by establishing a common set of incident objectives and strategies. This is accomplished without loss or abdication of agency or organizational authority, responsibility, or accountability.

Annex C - Forms and Worksheets

1. Patient Count and Distribution Worksheet (ICS 308)

Date: _____ Incident Name / Location: _____

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

Available Transport Units					

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

2. MCI Patient Tracking Form (ICS 306)

#	Triage Tag No.	Priority (R/Y/G)	Patient's Primary Injuries	Unit Transporting Pt to ED/Hospital	Time left Scent	Patient Destination
1						
2						
3						
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3. Air Operations Summary Form (ICS 220)

AIR OPERATIONS SUMMARY

1. Incident Name

Helibases / Fixed Wing Bases

4. Personnel and Communications	Name	Air/Air Frequency	Air/Ground Frequency	5. Remarks (Spec. instructions, Safety Notes, Hazards, Priorities)
Air Operations Director				
Air Attack Supervisor				
Helicopter Coordinator				
Air Tanker Coordinator				

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

14. Air Operations Support Equipment

15. Prepared by (Include Date and Time)

4. Prehospital Job Checklists:

a. Position: First Unit On-Scene

Mission/Tasks: First unit on scene gives visual size-up, assumes and announces command, and confirms incident location, then performs the 5 S's:

SAFETY assessment. Assess the scene observing for:

- □ Electrical hazards.
- □ Flammable liquids.
- □ Hazardous Materials
- □ Other life threatening situations.
- □ Be aware of the potential for secondary explosive devices.

SIZE UP the scene: How big and how bad is it? Survey incident scene for:

- □ Type and/or cause of incident.
- □ Approximate number of patients.
- □ Severity level of injuries (either Major or Minor).
- □ Area involved, including problems with scene access.

SEND information:

- □ **Contact dispatch with your size-up information and declare a Multiple or Mass Casualty Incident.**
- □ **Request additional resources.**
- □ **Notify the closest hospital / emergency department of the incident.**
- □ **Notify NW RHCC @ 855-469-7422.**

SETUP the scene for management of the casualties:

- □ Establish staging.
- □ Identify access and egress routes.
- □ Identify adequate work areas for Triage, Treatment, and Transportation.

START (Simple **T**riage **A**nd **R**apid **T**reatment) and **JumpSTART** (for pediatric patients).

- □ Begin where you are.
- □ Ask anyone who can walk to move to a designated area.
- □ Use surveyor's tape to mark patients.
- □ Move quickly from patient to patient.
- □ Maintain patient count.
- □ Provide only minimal treatment.
- □ Keep moving!
- □ **Remember…**Establish COMMAND, **S**AFETY, **S**URVEY, **S**END, **S**ET-UP AND **S**TART/JumpSTART

b. Position: Incident Commander

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

Tasks:

□ Assumes command and announces name and title to the communications center.

□ Dress in identifying vest.

□ Identify potentially hazardous situations.

□ Assess current situation.

□ Estimate number of patients.

□ Request additional resources as appropriate.

□ **Notify closest hospital / emergency department.**

□ Establish a visible command post.

□ Initiate, maintain and control communications.

□ Assign ICS functions.

□ Assign and direct resources.

□ Track current resources committed.

□ Develop, evaluate and revise operational plans.

□ Coordinate with other agencies.

□ Control and facilitate media.

c. Position: Medical Branch Supervisor Check List

Mission: To ensure that supervision and coordination is provided for extrication, triage, treatment, and transportation of all patients.

Tasks:

□ Report and provide frequent updates to the INCIDENT COMMANDER or Operations Section Chief. The Medical role may be assumed by the Incident Commander on small incidents.

□ Dress in identifying vest.

□ Locate in a visible position.

□ Assume responsibility of MEDICAL GROUP.

□ Coordinate, direct and manage all MEDICAL GROUP operations.

□ Account for all personnel assigned to this group.

□ Monitor safety and welfare of group personnel.

□ Consider relief crews.

□ Consider Critical Incident Stress Management (CISM) assistance.

□ Appoint and assign Medical Group Supervisor / Unit Leaders and support staff.

□ Verify the location of the staging area if needed.

* On small incidents the Incident Commander may assume responsibility for the Medical Group/Branch.

d. Position: Staging Area Manager Check List

Mission: To maintain separate stockpiles of manpower, reserve equipment and expended equipment at a staging area away from the incident.

Tasks:

□ Report to INCIDENT COMMANDER (or OPERATIONS CHIEF if appointed)

□ Dress in identifying vest.

□ Locate in a visible position.

□ Establish STAGING AREA in conjunction with INCIDENT COMMAND or Operations Section Chief as needed.

□ Provide appropriate staffing, vehicles, equipment, and supplies as requested.

□ Maintain status of number and types of resources in staging area.

□ Recommend additional staffing, equipment, and resources when necessary.

□ Order all personnel to remain with their units until assigned.

□ Verify the equipment pool location.

□ Control and document all resources entering and leaving the staging area.

□ Ensures unimpeded access and egress to and from staging area.

□ Coordinate security for staging area.

Helpful Hints

 Maintain communications with OPERATIONS and TRANSPORT.

 Locate and secure buses for use by Transport Group Supervisor/Unit Leader.

 Use a mobile radio when possible to communicate with incoming units.

 Size of incident may require that a separate ambulance staging area be established.

 Direct ambulance crews to leave stretchers in ambulances unless needed for patient movement.

e. Position: Triage Unit Leader

Mission: To assess and sort casualties to appropriately establish priorities for treatment and
transportation.

Tasks:

- Report and provide updates to INCIDENT COMMANDER (or MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR)
- Dress in identifying vest.
- Locate in a visible position between the incident site and the treatment area.
- If the patients are in imminent danger, move all patients out of INCIDENT AREA before establishing TRIAGE.
- Establish controlled pathway from the incident site to the treatment area.
- Direct walking wounded to designated treatment area.
- If START/JumpSTART not yet completed by first arriving crews, appoint triage teams to perform START/JumpSTART using triage ribbons.
- Obtain an accurate count of all victims by triage category (Red/Yellow/Green/Black) and report the count to the MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR.
- Continue to use START/JumpSTART algorithms, to continually reassess patients.
- Coordinate the transfer of patients to Treatment Unit Leader.
- Triage all patients upon entry into the Treatment Area
- Appoint "porters" to transport patients via backboards to treatment area. At hazardous materials incidents, requiring decontamination, a team must be assigned to move patients from the warm zone decontamination line to the cold zone treatment area.
- Maintain communications with MEDICAL GROUP SUPERVISOR / MEDICAL
- BRANCH DIRECTOR and other units as needed.

Helpful Hints

- Continue START/JumpSTART until all patients have been triaged. Have triage teams work in an orderly fashion.
- Remind Treatment Area Attendants-In-Charge to perform secondary triage on all patients in their respective section of the treatment area.
- Move all RED patients to the TREATMENT AREA first, unless tight quarters necessitate moving others first in order to gain access to RED patients.
- Move YELLOW patients next.
- Move GREEN patients to a designated location at the TREATMENT AREA.
- Leave ALL BLACK tagged victims in place unless the remains interfere with the ability to reach the survivors or are in danger of being destroyed.
- Notify that the MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR have Incident Command notify the Medical Examiner if black tags are issued.
- Once a triage tag is applied and color identified the triage ribbons may be removed.

f. Position: Treatment Unit Leader

Mission: Provide patient counts, triage, and treatment to patients awaiting transportation.

Tasks:

- Report and provide updates to the INCIDENT COMMANDER (or MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR)
- Dress in identifying vest.
- Locate in a visible position.
- Establish the TREATMENT Area large enough to accommodate all patients allowing for a 3 foot clearance on all sides of each patient.
- Designate an Attendant-In-Charge for the Red, Yellow and Green patient care areas
- Ensure that all patients are re-triaged upon entry into the Treatment Area.
- Maintain a count of all victims entering the Treatment Area by triage category.
- Ensure that patients are re-triaged using Secondary Triage and that a triage tag is applied to each patient upon entry to the respective Red, Yellow and Green patient care areas.
- Appoint a MEDICAL SUPPLY COORDINATOR (if needed).
- Working with the Attendants-in-Charge, determine the transportation priority and most appropriate transport method for each patient.
- Maintain contact with the appropriate Attendants-In-Charge of each patient care area (Red Tagged/Immediate, Yellow Tagged/Delayed and Green/Minor.
- Continually reassess each patient's condition and triage status.

Helpful Hints

- Arrange and clearly identify the TREATMENT Area. Identify patient treatment areas for each triage category using colored tarps, flags, tape, chemical lights, etc.
- Have Green/Minor Patients ("Walking Wounded") move to a supervised and controlled area. Isolate emotionally disturbed patients.
- Continuously triage ALL patients. Remove the triage ribbons once triage tags are applied. *Refer to Secondary Triage Decisions.
- Consider establishing specialty patient care teams (i.e. IV teams, bandaging teams, etc).
- Maintain contact with the TRANSPORTATION UNIT LEADER and coordinate the movement of patients to the transportation area based on patient priority.
- Establish "cattle shoots" staffed with triage personnel as "gatekeepers" at entrance to and
  exit from the TREATMENT AREA to control patient flow.

g. Position: Red, Yellow, or Green Tagged Treatment Area Attendant-In-Charge

Mission: Provide patient counts, triage, and treatment to patients awaiting transportation.

Tasks:

- Report and provide updates to the TREATMENT UNIT LEADER
- Dress in identifying vest.
- Establish the TREATMENT Area large enough to accommodate all patients allowing for a 3 foot clearance on all sides of each patient.
- Clearly identify your treatment area with the appropriate colored flag, tarp, and/or chemical light.
- Ensure that patients are re-triaged upon entry to the treatment area using Secondary Triage and ensure a triage tag is applied to each patient.
- Maintain accountability of all victims in your treatment area.
- Determine the transportation priority and most appropriate transport method for each patient.
- Report the transportation priority of patients and recommended transport method for each patient to the Treatment Unit Leader.
- Continually reassess each patient's condition and triage status.
- Request the establishment of special patient care teams (e.g. IV team, bandaging team, etc.) as necessary to support the care of your patients.
- Request additional personnel as needed to provide the care for your patients.
- Provide palliative care for catastrophically injured (Yellow Prime) patients until resources allow for their transportation to a hospital.
- Coordinate the relocation of any patient who dies in the treatment area to the Incident Morgue (Black Tagged Treatment Area). Leave all medical devices in place.

Helpful Hints

- Have Green/Minor Patients ("Walking Wounded") move to a supervised and controlled area.
- Isolate emotionally disturbed patients.
- Remove the triage ribbons once triage tags area applied.

h. Position: Incident Morgue Attendant-In-Charge (Black Tagged Patient Treatment Area)

Mission: To establish and maintain an incident morgue area for deceased persons who die enroute to or in the Treatment Area.

Tasks:

- Report to the TREATMENT UNIT LEADER.
- Dress in identifying vest.
- Verify with the TREATMENT UNIT LEADER that the closest Office of the Chief Medical Examiner has been notified of deceased persons:
- Secure the area from all unauthorized personnel and provide security to the morgue area with the assistance of Law Enforcement.
- Reassess each patient upon entry to the Incident Morgue / Black Tagged Patient Care Area. Annotate the patient assessment on the triage tag. If the patient does not have a triage tag then attach a completed triage tag to the patient.
- Leave all medical interventions in place (i.e. IV's, bandages, etc.)
- Cover patient(s) with sheets or enclose remains in disaster pouches or similar body bags.
- Ensure that no human or animal remains are moved from the incident site prior to the arrival and approval of the Medical Examiner/chief law enforcement officer.
- Establish a secure morgue area separate from the TREATMENT AREA, but ensure it is accessible to vehicles (i.e. emergency vehicles, law enforcement).
- With the assistance of Law Enforcement, secure the area from all unauthorized personnel and provide security to the morgue area.
- Coordinate activities with the Medical Examiner's Office, funeral directors, and law enforcement as necessary.
- Maintain accountability of all victims received in the treatment area using the MCI
- Patient Tracking Form.

Helpful Hints

- The only remains that should be moved to the incident morgue are those whose location is hindering rescue operations, or victims who died enroute to, or in the treatment area.
- Do NOT allow photographs in the morgue without the medical examiner's permission.

Office of the Chief Medical Examiner
Commonwealth of Virginia

Northern District
10850 Pyramid Place, Suite 121
Manassas, VA 20110
(703) 530-2600
Toll Free (800) 856-6799
Fax (703) 530-0510

Western District
6600 Northside High School Road
Roanoke, Va. 24019
(540) 561-6615
Fax (540) 561-6619

i. Position: Medical Supply Coordinator

Mission: Acquire, distribute and maintain the status of medical equipment and supplies.

Tasks:

- Report and provide updates to the MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR)
- Dress in identifying vest.
- Locate medical supplies in a central position in the Treatment Area using caution not to block access and egress to and from the Treatment Area.
- Maintain an inventory list of equipment, supplies, and Disaster Medical Support Units (DMSUs) received and distributed. Provide receipts upon request.
- Continually assess status of medical supplies and equipment. Request additional supplies and equipment through the Medical Group Supervisor / Medical Branch Director as needed.
- Distribute medical supplies and equipment to the Patient Care Areas.
- Request personnel to assist in the collection and distribution of supplies and equipment. Consider a need to have a vehicles(s) transport supplies and equipment.

Helpful Hints

- Do NOT strip ambulance of medical supplies and equipment unless absolutely needed to
  manage the initial phase of the incident.
- Establish a perimeter around the medical supply area to assist in controlling the distribution of supplies and equipment.
- Use the SALTT acronym to request resources.

j. Position: Transportation Unit Leader

Mission: Track and distribute patients to medical facilities by assigning the mode of transportation and destination for each patient.

Tasks:

- Report and provide updates to the INCIDENT COMMANDER (MEDICAL GROUP SUPERVISOR / MEDICAL BRANCH DIRECTOR.)
- Dress in identifying vest.
- Locate in a visible position.
- Verify the Staging Area location.
- Collaborate with the Treatment Unit Leader to determine patient transportation priorities, Emergency Department bed availability and patient destinations using ICS 308 form.
- Communicate transportation resource needs to the MEDICAL GROUP SUPERVISOR / BRANCH DIRECTOR.
- Appoint TRANSPORT RECORDER for each area of patient egress and ensuring each patient is tracked by triage tag number using the MCI Patient Tracking Form (ICS 306).
- Appoint TRANSPORT LOADERS.
- Inform transport crews of their destination, remind units to return to the Staging Area unless otherwise directed.
- Document patient and unit movements and destination using the MCI Patient Tracking Form (ICS 306).
- Maintain close communications with INCIDENT COMMAND or MEDICAL, TREATMENT, GROUND and AIR OPERATIONS.
- Once the last patient has been transported, and before demobilization, work with the
- Transport Recorder, Transport Loader, Medical Communications Coordinator and the
- Coordinating Emergency Department to **account for 100% of the patients**/victims.

Helpful Hints

- Ensure that transport ambulances are parked to allow easy patient loading and egress without being blocked by other ambulances or require ambulances to back in for patient loading.

k. Position: Transport Recorder

Mission: To assist in ensuring proper documentation of victim/patient and unit movements.

Tasks:

- Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER
- Dress in identifying vest.
- Locate at assigned patient egress point in the TRANSPORT area.
- Document patient transport information on triage tag and collect tag stubs.
- Complete an entry on the MCI Patient Tracking Form (ICS 306 Form) for each patient leaving the Transportation Area.
- Deliver triage tag Transportation Record to MEDICAL
- COMMUNICATIONS/TRANSPORTATION as directed.

Helpful Hints

- Determine whether or not TRANSPORT will be handling the MEDICAL
- COMMUNICATIONS role or will the function be assigned to a separate individual.

I. Position: Transport Loader

Mission: Ensure patients are safely loaded into the assigned vehicle or air ambulance, verify and vehicle destination and travel directions.

Tasks:

- Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
- Dress in identifying vest.
- Ensure patients selected for transportation are:
  - Ready for transport
  - Safely loaded aboard the ambulance or other vehicle designated by TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER
- Provide the following information to ambulance personnel:
  - Inform crews of the destination hospital/Emergency Department.
  - Provide travel directions to the receiving hospital/Emergency Department
  - Remind ambulance crews that they do not need to contact receiving facility unless there is significant deterioration in the patient's condition or if they need physician's orders.
  - Remind crews to return to the Staging Area upon completion of their assignment unless otherwise directed.

- Ensure all patients being loaded have triage tags attached and the transport stub has been removed.
- Maintain close communications with TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER and TRANSPORT RECORDER.

Helpful Hints

- Obtain maps or directions to area hospitals for distribution to ambulance crews.
- If the TRANSPORT Area is some distance from TREATMENT, consider using a stretcher from a committed ambulance to move patients to the receiving units.

m. Position: Medical Communication Coordinator

Mission: To maintain and coordinate medical communications at the incident scene between
TRANSPORT GROUP SUPERVISOR/UNIT LEADER and the Designated Coordinating Emergency Department.

Tasks:

- Report to TRANSPORT GROUP SUPERVISOR/UNIT LEADER.
- Dress in identifying vest.
- Remain in close proximity to the TRANSPORT and TREATMENT areas.
- Establish and maintain a dependable communications link with the designated Coordinating Hospital. The following minimal information should be provided and updated:
  - Type of incident
  - Number of patients
  - Severity of injuries
- Coordinate patient distribution with the Coordinating Emergency Department.
- Report individual patient information to Coordinating Emergency Department as relayed by TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
  - Unit transporting
  - Destination hospital
  - Number of patients
  - Triage tag numbers
  - Triage category, major injuries and age of patients
- Assist TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER with documentation.

Helpful Hints

- Locate in close physical proximity to the TRANSPORTATION area.
- Maintain contact with designated Coordinating Emergency Department, relaying triage tag number, patient condition and destination.
- Maintain communications with TRANSPORT GROUP SUPERVISOR/UNIT LEADER.

n. Position: Air Operations Group Supervisor

Mission: To assume responsibility for the coordination, landing, and communication with air ambulance aircraft.

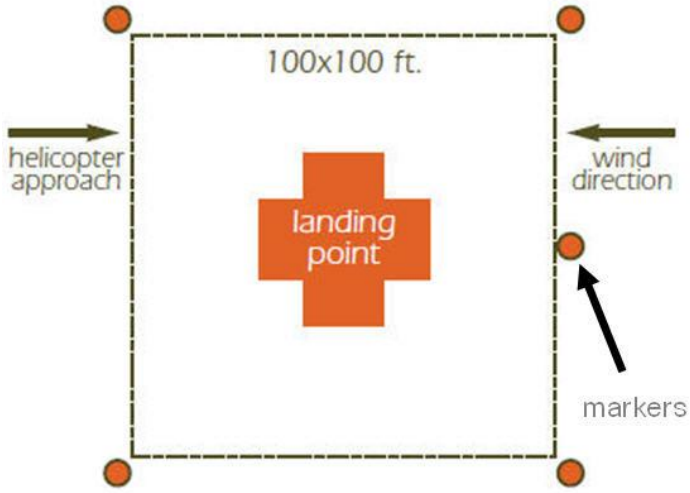
Tasks:

- Report to TRANSPORT GROUP SUPERVISOR/UNIT LEADER.
- Dress in identifying vest.
- Assign a fire unit and personnel and establish a HELISPOT (a.k.a. landing zone.)
- Secure and maintain a helispot of sufficient size on the most firm and level surface available (less than 5° slope) and clear of debris. Night operations and low visibility conditions require a larger helispot! (See the Helicopter Profiles and helispot Requirements table for landing area space requirements).
- Locate helispot at least one mile upwind from HAZMAT incident sites when explosives, gases, vapors, or chemicals are in danger of exploding or burning on sites, or when a plume is present. For radioactive materials incidents with no steam or smoke the helispot can be located ¼ mile upwind from the incident site.
- Clearly mark the area with five weighted cones, flares, or beacons.
- Maintain helispot/landing zone security. Request law enforcement assistance if needed.
- Maintain radio contact with incoming helicopters. (All civilian helicopters stationed in Virginia can communicate on the Statewide Mutual Aid channel, VHF 155.205).
- Advise the pilot of the following BEFORE landing:
- Obstructions at the landing area, as well as "near-by" (e.g. radio or cell towers, antennas, telephone lines, other wires, cranes, tall buildings, etc).
- Wind direction or ground wind gusts.
- Location of any HAZMAT incidents, plume location and direction.
- Relay patient information from the Medical Communication Coordinator to the air ambulance crew (e.g. patient condition, patient weight, and airway status).
- Coordinate loading and transport of patients with TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.

Helpful Hints

- ✓ Air ambulances will NOT transport contaminated or combative patients.
- ✓ Use of white lights should be avoided.
- ✓ If landing aircraft repeatedly consider using non-flare lighting to mark the helispot.
- ✓ All markers (flashing lights) should be put out and/or cut off before takeoff.
- ✓ Assign personnel to secure helispot after landing.
- ✓ Have fire equipment wet down the helispot if it is extremely dusty.
- ✓ ALWAYS AVOID THE TAIL ROTOR.
- ✓ NEVER APPROACH THE CRAFT DURING LANDING OR TAKE OFF.

Helispot Set-up Diagram



Helispot (Landing Area) Requirements and Safety

The following guidelines should be used to select and establish a helispot for rotary wing
aircraft:

- ✓ **Locate an area that is large enough to land a helicopter safely.** The touchdown or landing area should be 60 X 60 feet during the day and 100 X 100 feet at night for most civilian (BK 117) air ambulances such as LifeEvac and Nightingale. The area should be on level, firm ground which is free of overhead obstructions, rocks, and other ground debris. If landing more than one helicopter each aircraft must have its own 100' x 100' box to land in.

NOTE: The size of the landing area varies upon the type of helicopter. U.S. Coast Guard and military helicopters (i.e. JayHawk, MH-60s) require a much larger landing area. Refer to the following table for assistance in determining the appropriate landing area size for U.S. Coast Guard and Department of Defense helicopters.

The Incident Commander or Operations Section Chief may establish an Air Operations Branch depending upon the needs of the incident. Air operations at major incidents are complicated. **Flight safety is, and must remain, a vital concern of all personnel involved in air operations.**

The Air Medical Transport Decision

Aero-medical ambulances should be considered when their use can:

- ✓ Decrease transport time from the incident scene to the hospital.
- ✓ Provide advanced critical care not available from ground EMS Units.
- ✓ When special medical resources must be brought to the scene or moved to an intermediate care facility.
- ✓ When ground EMS Units cannot access or egress the scene.
- ✓ Evacuate critical ill patients from the affected disaster area or local hospitals.
- ✓ Provide the Incident Commander with an aerial scene evaluation.

Requesting Air Ambulance Services

The initial request for air ambulance services will follow normal request procedures from the incident commander, via the jurisdiction's dispatch center, to the dispatch center of an air ambulance service provider.

Contact VEOC at 1-800-468-8892 if air ambulance services are needed from providers outside of the jurisdictional/regional area. The VEOC can assist in providing the telephone numbers for other air ambulances service providers such as the Virginia Army National Guard, Virginia Air National Guard, U.S. Coast Guard and the Department of Defense (Air Force, Army, Marine Corp, and Navy).

Airspace Restrictions

Airspace over an MCI is regulated by the Federal Aviation Administration (FAA). Questions or requests concerning the use or restriction of that airspace during an MCI should be directed to the FAA's Washington Air Route Traffic Control Center (ARTCC) also known as the Washington Center at 703-771-3470. Temporary flight restrictions for disaster areas are designated by the ARTCC which will notify other FAA facilities as appropriate. The VEOC at 1-800-468-8832 has access to additional contact information to assist in this function.

Aircraft Communications

The primary incident Emergency Communications Center / 911 Dispatch Center normally contacts air ambulance services to request medevac services. The scene helispot (landing area) location, coordinates, control and frequency information will be given to the pilots by their agency's dispatch center when the aircraft is dispatched.

Scene to Aircraft Communications

Ground to helicopter communications. The Virginia Medevac Committee recommends using the VHF Statewide Mutual Aid channel to communicate with air ambulances. Helicopters whose primary base-of-operations are not in Virginia, including those operated by the U.S. Coast Guard and the Department of Defense cannot communicate on 800 MHz channels. However, all of these helicopters can communicate using VHF frequencies. The designated mutual aid VHF frequencies are as follows:

155.205 MHz - Statewide Mutual Aid
154.265 MHz - Peninsulas Mutual Aid Frequency
154.295 MHz - Tidewater Mutual Aid Frequency

Ground to helicopter communications may also be performed on a locally assigned VHF channel that does not interfere with incident communications. Communications may also be established using 800 MHz channels **IF** the responding air ambulances service has that capability.

Aircraft to Aircraft Communications

Helicopter to helicopter communication is accomplished using the 123.025 VHF frequency, allowing pilots to communicate flight or scene hazards to each other.

Communications and Multiple Aircraft Response

The use of multiple aircraft in an incident response brings with it an increased risk of an aircraft related mishap. The Air Operations Branch Director must establish effective and clear communications with each responding aircraft. During landing area operations, all aircraft-ground communications must occur on an assigned and common incident radio frequency, ideally the VHF 155.205 MHz - Statewide Mutual Aid channel as recommended by the Virginia Medevac Committee. Alternate radio communications between aircraft may
be accomplished using VHF 123.025 MHz. Assigned frequencies should be documented on the Air Operations Summary Form (ICS 220).

The following multiple aircraft response communications procedure has been recommended for adoption by all agencies involved in air operations at any incident where more than one air ambulance, or aircraft, is responding. This procedure was designated as a "*Best Practice*" by the Virginia Medevac Committee in January 2008:

1. The initial request for medevac services should be made to the jurisdictions primary medevac service provider (air ambulance service).
2. If requests were made for additional air ambulances or other aircraft to respond to the scene, the requesting emergency communication center must contact the dispatch center for each air ambulance or other aircraft, and advise them that this is a multiple aircraft response.
3. The medevac service provider/air ambulance service's dispatch or communications

center should take the following actions after they are notified that another aircraft has been requested to the facility or scene.

→ Contact all other responding aircraft communications centers and advise them of the multiple aircraft response.

→ Inform their prospective aircraft that multiple helicopters or aircraft are responding and replay the following information to the individual flight crews:

→ The number of inbound aircraft.

→ The assisting aircraft's name (i.e. AirCare, MedStar, Pegasus, LifeEvac, MedFlight, etc.)

Annex D - Hospital Driving Directions

Berkeley Medical Center
Address: 2500 Hospital Drive
Martinsburg, WV 25401
ED Phone: 304-264-1357

Jefferson Memorial Hospital
Address: 300 South Preston Street
Ranson, WV25438
ED Phone: 304-728-1642

Loudoun - Cornwall
Address: 224 Cornwall Street
Leesburg, VA 20176
ED Phone: 703-737-7520

Loudoun - Lansdowne
Address: 44045 Riverside Parkway
Leesburg, VA 20176
ED Phone: 703-858-6040

Page Memorial Hospital
Address: 200 Memorial Drive
Luray, VA 22835
ED Phone: 540-743-8018

Shenandoah Memorial Hospital
Address: 759 South Main Street
Woodstock, VA 22664
ED Phone: 540-459-1175

Warren Memorial Hospital
Address: 531 Valley Health Way
Front Royal, VA 22630
ED Phone: 540-635-0929

Winchester Medical Center
Address: 1840 Amherst Street
Winchester, VA 22601
ED Phone: 540-667-0609

Annex E - Training Resources

1. Lord Fairfax EMS Council
   a. MCI I & II

2. State
   a. Virginia Office of EMS
   b. Virginia Department of Emergency Management

3. Federal
   a. National Fire Academy
      i. EMS Operations at Multi-Casualty Incidents Course (Q157)
      ii. EMS: Special Operations Course (R152)
      iii. Future students must apply to the National Fire Academy to attend this course. The Academy employs a competitive application process. Application procedures vary with the different courses and programs. Each course or program has specific application requirements listed. Applicants should carefully read the course descriptions and requirements and follow the procedures listed; this will save time and speed up the application process. To apply go to: http://www.usfa.dhs.gov/nfa/
   b. Centers for Disease Control and Prevention - Mass Casualty Event Preparedness and Response; www.bt.cdc.gov/masscasualties

   c. **Other Resources - <u>MCI PLANNING EXCERPTS</u>**

      Concept of MCI Levels

      MCI size and EMS efforts will begin small and expand to meet the needs of the incident. The first arriving unit at a mass casualty incident should establish Incident Command. This is to ensure that Staging, Extrication/Rescue, Triage, Treatment and Transportation functions are implemented as needed. In a larger incident, Incident Command may establish an EMS/Medical Group Supervisor or Branch Director to oversee some or all of the above functions.

      The first arriving unit should establish Incident Command. That unit should assess scene **Safety**, conduct a scene **Size-up** and **Send** that to communications, begin to **Set up** (triage, and treatment areas), and **START** Triage. This will ensure that Staging, Extrication/Rescue, Triage, Treatment and Transportation functions are implemented as needed. In a larger incident, Incident Command may establish a Medical

Group or Medical Branch to oversee some or all of the above functions. Some incidents may be so large, or the sense of danger so pervasive (such as a terrorist incident), that victims may not wish to remain on the scene and will self-refer to known medical facilities. During such incidents, EMS triage and treatment resources may have to be co-located at hospitals, assembled at multiple points, and/or situated remotely out of harm's way.

Basic Principals

Mass Casualty Incident Management Goals

1. Do the greatest good for the greatest number.

2. Make the best use of personnel, equipment and facility resources

3. Do not relocate the disaster.

Standard Triage Methods

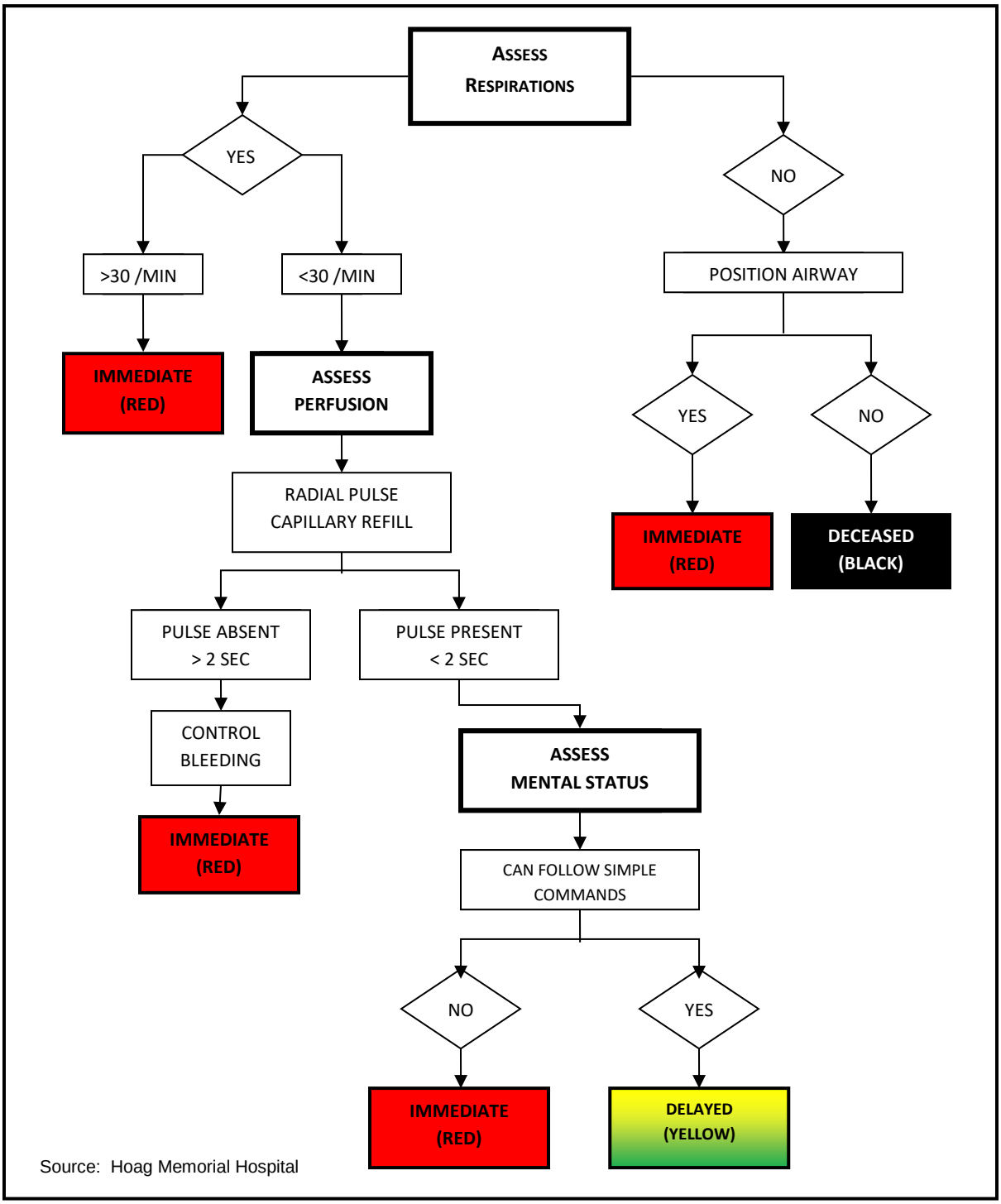
The method of initial field triage to be utilized is the S.T.A.R.T. method for adult patients. There are some incidents where S.T.A.R.T. triage may not be the most appropriate tool to sort patients. Pediatric patients, ages 8 and under, will be better served by using Jump S.T.A.R.T.

Patients who have been exposed to various HAZMAT or WMD may need to be triaged using guidelines that are specific to the agent to which they have been exposed. Patients who have been exposed, or who believe they have been exposed to chemical, biological or radiological weapons have much different triage needs than trauma patients. **S.T.A.R.T. triage is the preferred tool for sorting trauma patients.**

Ambulatory patients are initially directed to a designated treatment area where they will be assessed and further triaged as personnel become available. For all remaining patients, triage personnel quickly move from patient to patient, using START to assess and apply color-coded triage ribbons (surveyor's tape).

S.T.A.R.T – Simple Triage and Rapid Treatment

Remember **RPM** (**R**espirations, **P**erfusion, **M**ental Status)



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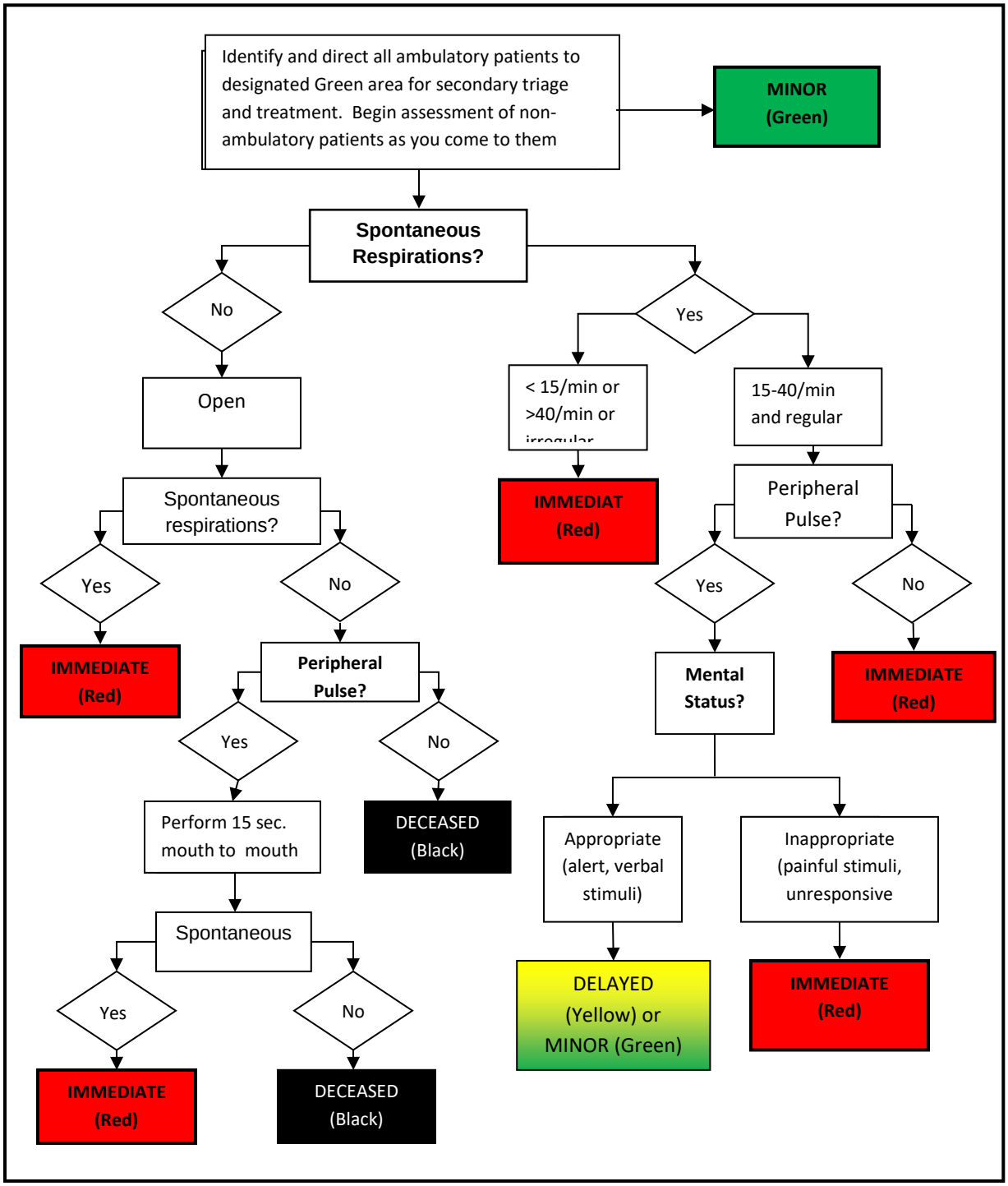
JumpSTART

Field Pediatric Multi-casualty Triage System

Patients aged 1-8 years



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Mass Casualty Patient Flow

The Incident Scene

- Ambulatory patients are directed to a safe place as soon as one is identified. (Green Treatment Area).
- Those who are able should be asked to assist with others.
- Self-treatment supplies should be distributed
- All victims are accounted for; trapped victims are rescued or extricated.
- Patients are accounted for and quickly triaged (START)
- Triage ribbons are applied.
- Non-ambulatory patients are removed from the scene to the Treatment Area by porters.
- Patients are decontaminated (as needed) prior to leaving the incident scene, prior to arrival in the Treatment Area.
- Deceased victims are left as they are unless required to access live patients.

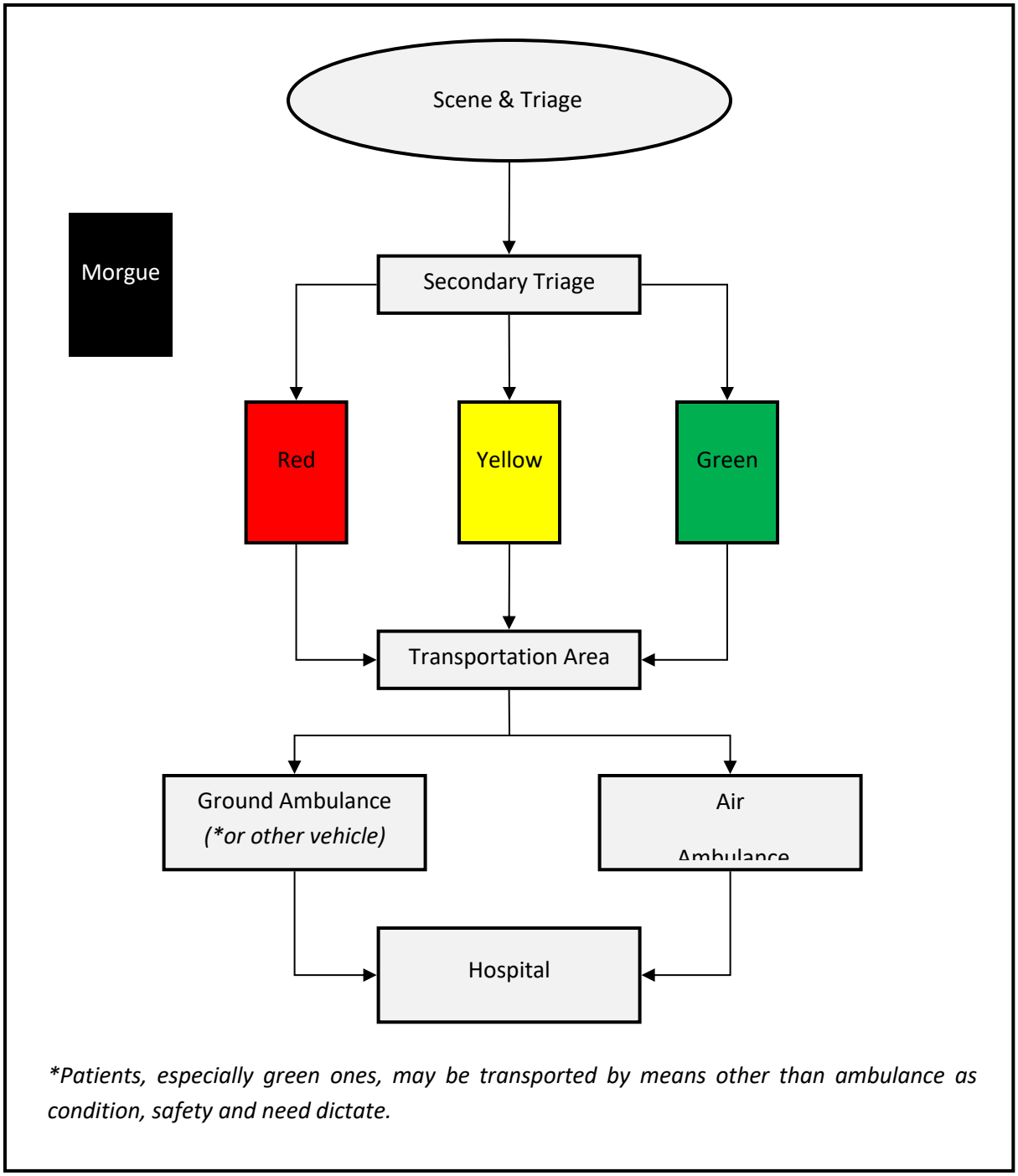
The Treatment Area

- Patients are continuously reevaluated (re-triage).
- Patients arriving from the incident scene are prioritized for treatment using a more in-depth assessment method (Secondary Triage) and a triage tag applied.
- Patients are placed in the Treatment Area and emergency medical care is provided on the basis of the triage priority.
- Separate areas may be created in the Treatment Area for Immediate (Red), Delayed (Yellow), and Minor (Green) injured patients.
- A separate isolated area (Temporary Morgue) is created for victims who die in the Treatment Area.
- Personnel, equipment and medical care resources are allocated to patients based on the triage priority.

The Transportation Area

- Emergency Departments are contacted (early in the incident) to obtain information to assist with the most appropriate patient distribution to medical facilities.
- The closest Emergency Department ("Coordinating ED") will usually be contacted, which will then notify other emergency departments.
- The "Coordinating ED" role may be handed off to another facility.
- Transportation resources are assigned based on triage priority.
- Patients are moved to the Transportation Area to the appropriate vehicle by Porters/Transport Loaders.
- Patients are transported to the most appropriate medical facility by the most appropriate means available.
- Emergency medical care is continued en route to the hospital.
- Patient movements are documented.

Patient Flow Diagram



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Annex F - CASUALTY INCIDENT PLANNING

***SUGGESTED* Mass Casualty Support Unit Inventory Lists (Generic)**

Level 1	Level 2	Level 3	Item
20	40	80	Backboards (long)
20	40	80	Cervical collars (adjustable – adult)
20	40	80	Cervical collars (adjustable – pediatric)
20	40	80	Backboard straps (sets)
36	72	100	Blankets (disposable) 58 x 90, insulated
26	52	102	Blankets (space type)
20	40	80	Burn sheets (sterile, disposable) (NOT blue ones)
50	100	200	Multi-trauma dressing (sterile, size 12” x 30”)
50	100	200	Military/Civilian 4” rolls
50	100	200	Military/Civilian 6” rolls
80	100	200	Trauma dressing, sterile, 8” x 10”
150	300	500	Kling 4” rolls
800 each	1600	2000	Non-sterile 4 x 4 dressing
75	150	300	Cravats (triangular bandage
50 rolls	100	200	Tape 3” x 10 yards, silk
24 rolls	36	36	Tape, duct
25	50	100	NP airway kit, latex free, set of 6, sizes 26 to 34 French
25	50	100	OP airways, set of 6, (Berman kit), size infant to large adult
25	50	100	Oxygen mask, non-rebreather, with tubing, adult
25	50	100	Oxygen mask, non-rebreather, with tubing, pediatric
25	50	100	Oxygen tubing, male connectors, minimum 7 ft.

Level 1	Level 2	Level 3	Item
10 each	20	40	Bag valve mask device, disposable (each BVM has adult, & pediatric masks)
12	25	25	Combi- Nebulizers - Adult
12	25	25	Combi-Nebulizers - Pediatric
5	10	20	Hand powered portable suction units
15	30	60	Hand powered portable suction units replacement canisters
1 case each size	2	4	Gloves, nitrile (medium, large, extra large)
50	100	200	Face masks w/eye shield
50	100	200	Eye protection
25	25	100	Splints, disposable (minimum 12" , recommend 18")
12	24	48	Splints, disposable, 34"
36	72	108	1000 cc Normal Saline IV (12 per case)
48	48	96	IV tubing (10 drop sets) (48 per case) at least 100 inches
25	50	100	IV starter kits (prepackaged prep kits w/o needles – example: Criticon)
9 cans	18	24	Waterless hand cleaner
30	60	120	Towels - cloth
30	60	100	Patient belonging bags
3 boxes	6	6	Sani-cloths (50 indiv. envelope per box)
4	8	14	Sharps containers (minimum - 2 gallon size) (2 red/2 yellow)
1	2	2	Megaphone with extra batteries
1 case of 250	2	4	Biohazard bags (10 – 15 gallon size)
3	6	12	Flashlights with extra batteries

Level 1	Level 2	Level 3	Item
100	200	300	Zip lock storage bags (gallon size)
10	20	40	Military type patient litter, mesh, collapsible, with feet, with handles
1 set	2	2	Triage tarps, (red, yellow, green), with grommets, minimum 15' x 20'(recommend heavy canvas) for equipment cache (can be poly coated)
1 each	2	2	Triage flags (base, telescoping min. 8 ' pole, flag), red, yellow, green
18	36	36	Traffic cones with reflective stripe
18	36	36	Step-in posts, fiberglass
2 rolls each	4	4	Rolls barricade tape, red, green, yellow (3" minimum width)
75	150	200	Triage tags
3	6	12	Triage ribbon kits (red, yellow, green, black)
3 cases	6	6	Bottled water, minimum 12 ounce
30 each color	60	60	Cyalume light sticks, box of 24 (red, yellow, green - min. 12 hour)
50 each	100	100	Cyalume light sticks (white – hi intensity – 30 min.) 10 per box
5**	10**	20**	Scissors
5**	10**	20**	Penlights
5**	10**	20**	Stethoscopes, adult/ peds. (i.e. Sprague Rappaport, etc.)
5**	10**	20**	Blood pressure cuffs, (pediatric, adult, large adult)
5**	10**	20**	2 Red, 2 Yellow, 1 Green Treatment Area Kits would include above items marked with "**"
6	12	12	Safety vests, orange mesh
3 boxes	6	6	Permanent markers
9	18	18	Clipboards

Level 1	Level 2	Level 3	Item
3 boxes	6	6	Ball point pens (12 per box)
2	4	4	Oxygen multilator or minilator, minimum 5 ports, adjustable flow rate
2	4	4	Oxygen hose 50 feet with regulator
2	4	4	Oxygen bottles, minimum size M cylinder
2	4	4	Oxygen kits (include Teflon tape, adjustable wrench, 5 Christmas trees – green nipple fitting)
1	2	2	Wheeled hand carts (for equipment and secure oxygen bottle carrying capability)

** May be placed in the patient assessment kit.

RECOMMENDATIONS

All supplies and equipment are based on Basic Life Support (BLS) treatment

Patient numbers are figured on the following percentages:

30% Red

30% Yellow

40% Green

Delivery of these units for INTER-JURISDICTIONAL should include a driver, officer, and 2 other personnel trained in MCI response. For interjurisdictional, it is up to each jurisdiction to decide what the crew will be comprised of.

Consider stocking Albuterol for the nebulizer treatments

(*Tables taken from Northern Virginia MCI Plan with permission)*

SUGGESTED Patient Treatment Area Package

Packaged with itemized list on outside.

Recommend 1 patient box for Red and Yellow Areas and 5 patients boxes for Green Areas.

Each patient box should be shrink wrapped.

1 Patient Box	5 Patient Box	Item
1	5	Space Blanket
2	5	Trauma pads – 8x10
2	5	Trauma pads – 5x9
2	5	4” Kling*
8	10	4x4 Bandages
3	6	Cravats
2	5	4” Kling
2 pairs each	2 pairs each	Gloves-Nitrile (L, XL, and XXL)
2	2	3” Tape
1 each	2 each	Mask & eye protection
1	1	Airway Kit (OP and/or NP set)
1	5	Patient belongings bag
1	5	Disaster (triage) tag

SUGGESTED Optional Equipment List

Item
Fire extinguisher, minimum 20lb. ABC
Patient transport device with all terrain wheels
Water cooler – or bottled water
Disposable cups, minimum 12 ounce
Electrolyte replenishment
Body bags with handles
Saw horses
Pop-up color-coded tents

SUGGESTED Patient Assessment Kit

(For 25 Patients: recommend 2 assessment kits for Red and Yellow areas and 1 assessment kit for Green area.)

QUANTITY	ITEM
1	Adult stethoscope
1	Pediatric stethoscope
1	Adult BP cuff
1	Pediatric BP cuff
1	Pair scissors
1	Penlight

SUGGESTED Administrative Package – Level III

Boxes identified with Red, Yellow, or Green markings on outside will include the following:

RED	YELLOW	GREEN	ADMIN ITEMS (100 Patients) LEVEL III
11	11	14	Rolls duct tape
0	1	1	Megaphone with extra batteries
400	300	300	Bio-hazard bags (10-15 gal.)
3	3	3	Flashlight (with spare batteries [and bulbs])
120	90	90	Zip lock storage bags (gallon size)
2	2	2	Appropriate color tarp, with grommets, minimum 15'x20' (recommend heavy canvas)
2	2	2	Appropriate color area triage flag
12	12	12	Traffic cones
12	12	12	Step-in posts, fiberglass
4	4	4	Rolls appropriate color barricade tapes (3"minimum width)
60	60	80	Disaster (triage) tags (reduce TOTAL number by 25 if also used in pt. care package)
4	4	4	Triage ribbon kit (includes red, yellow, green, black ribbons)
2 cases	2 cases	2cases	Bottled water
18 each color	18 each color	24 each color	Red, yellow, green Cyalume light sticks (12 hour)
30	30	40	Cyalume light sticks white hi intensity (30 min)
4	4	4	Safety vests
2 boxes	2 boxes	2 boxes	Permanent markers
6	6	6	Clipboards
2 boxes	2 boxes	2 boxes	Ball point pens

(NOTE: This is the recommendation for LEVEL 3 response, LEVEL I (25 patients) and LEVEL II (50 patients) have different and sometimes less amounts of the same equipment.)

(Supply lists taken from Northern Virginia MCI Plan, copied with permission)

Annex G - AMBULANCE FORMULA

The formula below can be used to estimate the number of ambulances needed at an incident with a large number of patients.

$$\text{Number of Ambulances} = \frac{\text{(Total Number of Patients) (Time Required for Round Trip)}}{\qquad}$$

Example:

Total number of patients = 60

Time required for round-trip to hospital = 60 minutes

Total time to complete operations = 120 minutes

Number of patients per ambulance = 2

Consider:

$$\text{Number of Ambulances} = \frac{\text{(60) (60)}}{\qquad}$$

Example Answer:

$$\text{15 Ambulances} = \frac{\text{(3600)}}{\qquad}$$

Annex H - Virginia Department of Emergency Management Statewide Mutual Aid (SMA)

Operations Manual, September 2006 Excerpts

(Note: SMA use is a good long range planning tool for resources; however, response times may be too long to assist in a surge event)

Purpose

The Statewide Mutual Aid (SMA) program was developed to assist Jurisdictions (as used in this document, jurisdiction means "political subdivision" as defined in Virginia Code § 44-146.16) to more effectively and efficiently exchange services and resources in response to declared disasters and emergencies. SMA is a local government program established in partnership with the Commonwealth of Virginia. The program provides a framework for resolution of some interjurisdictional issues and for reimbursement for the cost of services. The program is supplemental to, and does not affect, day-to-day mutual aid agreements between Jurisdictions. All types of local resources may be requested or provided pursuant to this program. The SMA Operations Manual, of which this is a part, provides additional information and forms and is available from the Virginia Department of Emergency Management (VDEM) website: www.vaemergency.com. Title 44 of the Virginia Code governs aspects of this program and authorizes emergency declarations.

Concept of Operation

A. Mission of the Virginia Emergency Operations Center:

To coordinate, monitor and assist with the Statewide Mutual Aid Program during response and recovery activities before, during and after an emergency event has occurred within the Commonwealth of Virginia.

B. Responsibility of SMA Members:

SMA members will proactively monitor situations for the possibility of the need to implement SMA and, to the extent resources are available, will respond to requests and will support member Jurisdictions impacted by the effects of an emergency or natural disaster.

C. Planning Assumptions:

1. All eligible Virginia Jurisdictions have adopted the Statewide Mutual Aid for Emergency Management Model Authorizing Resolution (Appendix A), agreeing to provide assistance when requested, subject to availability of resources, and setting out general requirements and procedures. When a disaster or emergency is expected, or when it occurs, a Statewide Mutual Aid Event Agreement (Appendix B) is entered into by the parties, specifying the resources to be provided and the terms and conditions of the assistance, including predicted duration.

2. Participation in the SMA program requires that members comply with the provisions of the Resolution, including the following:

   a. Insurance coverage: Each jurisdiction including volunteer organizations providing services to the jurisdiction and participating in SMA shall maintain automobile and liability insurance coverage with minimum limits of at least one million dollars and maintain appropriate equivalent self-insurance programs. Jurisdictions shall provide workers compensation coverage for their own employees in conformance with State law. Jurisdictions may provide workers compensation or accident coverage for their own volunteers in accordance with State law.

   b. Responsibility for wages: Each jurisdiction is responsible for payment of its own personnel.

   c. Reimbursement and documentation: The Assisting Jurisdiction is required to bill the Requesting Jurisdiction for the cost of services and provide proper documentation for all cost incurred for reimbursement within 60 days of completion of the service provided. The Requesting Jurisdiction shall reimburse for all expenses within 60 days of receipt of proper documented cost from the Assisting Jurisdiction.

   d. Support by the Virginia Department of Emergency Management (VDEM): VDEM will provide assistance and support to Jurisdictions with requesting and receiving SMA, as needed.

D. Operational Objectives:

1. VDEM, in cooperation with Jurisdictions, will develop a 24-hour contact capability so that Jurisdictions can request assistance from each other using the jurisdiction point-of-contact listing posted on the VDEM on-line Emergency Operations Center (EOC).
2. VDEM, in cooperation with Jurisdictions, will develop a system for posting requests for assistance from Jurisdictions to the VDEM website for review and support within the capability of other Jurisdictions.
3. VDEM, in cooperation with Jurisdictions, will develop an on-line reporting system to post missions being supported by Jurisdictions.
4. VDEM, in cooperation with Jurisdictions, will develop an After Action Review (AAR) format for reporting lessons learned and problem areas in need of corrective action.
5. VDEM, in cooperation with Jurisdictions, will develop and maintain a 24-hour operational readiness capability at VDEM to support Jurisdictions with the SMA program as needed.

Annex I - Quick Reference Check List

Objectives

Check all emergency and back up equipment:

- ☐ Notify/recall off duty personnel as required
- ☐ Prepare to assist with public notification
- ☐ Review SOPs and other guidance
- ☐ Establish contact with local area and surround medical and emergency services facilities
- ☐ Respond to EMS routine and MCI incidents
- ☐ Consider other key EMS issues

Emergency Management Actions – Emergency Medical Services

Normal Operations:

- ☐ Develop and maintain plans and procedures to implement EMS operations in times of emergency
- ☐ Provide emergency medical treatment and pre-hospital care to the injured and as feasible assist with warning, evacuation and relocation of citizens during a disaster.

Increased Readiness:

- ☐ Alert Duty Personnel
- ☐ Alert mutual aid partners
- ☐ Review and update plans and procedures
- ☐ Check rescue and communication equipment

Response: (conditions worsen requiring full-scale mitigation and preparedness activities)

- ☐ Alert personnel to stand-by
- ☐ Begin to implement record keeping of all incurred expenses and continue for the duration of the emergency, Record all disaster-related expenses
- ☐ Designated EMS representative should report to EOC and assist with emergency operations
- ☐ Continually review need for personnel and equipment present and long range
- ☐ Assign duties to personnel
- ☐ Call for mutual aid as necessary and appropriate
- ☐ Follow established procedures and protocol for providing rescue services , emergency medical treatment and pre-hospital care to the injured, including all safety procedures

Recovery:

- ☐ Continue to provide essential services as required
- ☐ Continue all search and rescue and EMS activities as necessary and required
- ☐ Assist in clean up
- ☐ Continue to compile disaster related expenses

Annex J - Guidelines for Mutual Aid Agreements (MAA)

Common characteristics of MAA include:

a) They are usually imprecise in designating resources or capabilities needed or to be provided;

b) They are based on the concept that resources, materials or services are usually voluntarily provided by the parties on the understanding that there will be a reciprocal exchange of assistance if and when required;

c) That resources, materials or services provided would not result in profit to the providing party;

d) They commit parties to a mutually beneficial, cooperative agreement based on principles and concepts of contract law which support protecting lives and property;

e) They provide mechanisms for coping with emergency situations or events that allows maximum flexibility in the use of resources;

f) That parties providing assistance may withhold all or part of their resources under certain conditions; and

g) They usually provide that a party requesting assistance will indemnify the party providing the assistance for any resulting liability.

Practical Mutual Aid Agreements:

a) Establish an agreement between the parties and document proof of the agreement and its contents;

b) Identify the parties involved, identify respective responsibilities, define how and when they are to be implemented, who performs what and how, who pays for specific services, how long the agreement is in effect, how the agreements are terminated and who administers the agreements;

c) Provide liability protection to all the participating parties;

d) Can enhance communication and cooperation between the participating parties;

e) Help reduce the misunderstandings between participating parties, which often exist when assistance is requested or provided on an informal basis, and;

f) Provide an agreement that spans changes in key personnel.

(Information on this page taken from "Hazard Management Guidelines for Mutual Aid Agreements", The Chamber of Minerals & Energy, Western Australia, September 2005.)

The annex section of this document was copied from the Emergency Medical Services (EMS) Surge Planning Template and Toolbox for Mass Casualty Incidents (MCI) in Virginia (August 2010) Version 1.1