SOUTH PLAINS EMERGENCY MEDICAL SERVICES AND REGIONAL ADVISORY COUNCIL TSA B

REGIONAL MULTI-CASUALTY INCIDENT PLAN & MUTUAL AID AGREEMENT

2006

2006 SPEMS AND RAC TSA-B Mutual Aid & Disaster Planning Committee

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SOUTH PLAINS EMERGENCY MEDICAL SERVICES/REGIONAL ADVISORY COUNCIL
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REGIONAL TSA-B MULTI-CASUALTY INCIDENT PLAN

I. AUTHORITY

The Executive Boards of South Plains Emergency Medical Services and the Regional Advisory Council of TSA-B (SPEMS and RAC TSA-B) have approved this plan.

The organizational and operational concepts set forth in this plan are promulgated under the authority and in accordance with the following:

1. The Federal Emergency Medical Services Act of 1973, as amended (P.L. 93-154).
2. The Texas Emergency Medical Services Act, as amended (Chapter 773, Health and Safety Code).
3. The Texas Disaster Act of 1975, as amended (Art. 6889-7, V.T.C.S.).
4. Executive Order of the Governor establishing the Texas Emergency Management Council.
5. The Texas Emergency Management Plan.
6. Homeland Security Presidential Directive–5
7. The SPEMS and RAC TSA-B Council Resolution establishing the SPEMS and RAC TSA-B Mutual Aid & Disaster Planning Committee.

II. PURPOSE AND SCOPE

A.Purpose: The purpose of this plan is to provide guidelines, procedures, and instructions for organizing and effective response by the Regional Emergency Medical Services (EMS) system serving the 22 counties of the SPEMS and RAC TSA-B Region to a major incident which exceeds the resources of a local EMS system.

The intent of this plan is to complement other plans and procedures of the Texas Emergency Management Council; the Texas Department of Public Safety; The Texas Department of State Health Services; local governments, EMS providers and hospitals; and other public and private entities involved in emergency management.

Nothing in this plan is intended to supersede or abrogate the provisions of any other plan, annex, or appendix. Nor is anything in this plan intended to restrict personnel involved in the management of a major EMS incident from exercising flexibility based on professional judgment and the best available information.

B. Scope: This plan constitutes general guidelines for EMS personnel while engaged in mitigation of, preparedness for, response to, and recovery from major EMS incidents. Five major areas must be addressed to meet this mission:

1. Development of standard terminology and incident organizational structure.

2. Development and provision of multi-agency communications.

3. Development of a coordinated regional resource allocation process for use during major EMS incidents.

4. Development of improved methods for status keeping and forecasting of major EMS incidents.

5. Provision of multi-agency training in major EMS incident response procedures.

III. SITUATION AND ASSUMPTIONS

A. Situation

1. The 22 counties of the SPEMS and RAC TSA-B Region are vulnerable to a variety of incidents, which could cause serious or life-threatening injury or illness to large numbers of persons or significant disruptions of the local or regional EMS systems. These potential major incidents include, but are not limited to:

   a. natural disorders such as tornadoes, severe thunderstorms, floods, grass fires, and ice storms;

   b. accidental disasters such as hazardous materials releases, major fires and explosions, and major transportation accidents;

   c. disorder and disruptive disasters such as major utility outages, water supply contaminations, civil disturbances, and major petroleum product shortages;

   d. terrorism and enemy attack disasters and accidental missile launches.

2. A state plan exists governing the functions of state agencies, which would be called into action in the event of a disaster anywhere in the state, which exceeds local resources and capabilities.

3. City, county, hospital, and local EMS agency disaster plans exist within the framework of the state Plan; but frequently there is no formal coordination of these plans.

4. The SPEMS and RAC TSA-B system provides a mechanism for achieving the coordination among EMS organizations in the 22 county region necessary for effective preparation for and response to major EMS incidents.

5. The Regional EMS Communications Center (COMM CENTER) maintained and operated by Lubbock EMS at University Medical Center (UMC) and the regional network of UHF repeaters, maintained by SPEMS and RAC TSA-B, provide the structure for coordinating the use of local EMS resources and providing quick access to state resources during a major EMS incident.

6. The coordination of EMS training through Texas Tech University Health Sciences Center throughout the SPEMS and RAC TSA-B region and use of uniform EMS course curricula as approved by the SPEMS and RAC TSA-B Training Committee provides a mechanism for conducting standardized initial and continuing education related to responding to and commanding major EMS incidents.

B. Assumptions

1. A major EMS incident could overload or destroy the ability of a local EMS system to provide care to victims of the incident.

2.. EMS personnel, vehicles, equipment and supplies would have to be sent from unaffected communities to support the affected local EMS system.

3. All services utilizing this plan have adopted NIMS for management of incidents.

IV. EXECUTION

A. General

1. A community affected by a major EMS incident will first attempt to manage the incident using resources at its immediate disposal.

2. If the local resources are inadequate, requests for additional resources generally will be directed next to other communities within the affected county, following procedures established in the county emergency management plan. However, geographical considerations or incident scope may necessitate bypassing this step and moving directly to a regional response.

3. If further aid is needed, the Regional EMS Multi-Casualty Incident Plan will be activated and assistance will be coordinated through the COMM CENTER at UMC.

4. The SPEMS and RAC TSA-B Medical Director, the SPEMS AND RAC TSA-B Associated Medical Director, or a designated alternate will be responsible for coordinating the acute care aspects of the regional response to a major EMS incident. This function will be performed from the COMM CENTER.

5. If the nature or the magnitude of the circumstances surrounding a major EMS incident results in the activation of the State Disaster District Emergency Operations Center (EOC), the SPEMS and RAC TSA-B Medical Director or his alternate will coordinate requests for acute medical care support received from the District EOC. The primary contact at the District EOC will be the Regional Director, Texas Department of State Health Services or his designated alternate.

6. The management of a major EMS incident generally will proceed through the following phases:
    a. Activation
        (1) notification and initial response
        (2) organization of on-scene command structure
    b. Operations
        (1) search and rescue
        (2) triage, on-scene treatment, and transport
        (3) definitive hospital care
        (4) management of fatalities
    c. Recovery
        (1) scene withdrawal
        (2) return to routine operations
        (3) casualty accounting

(4) critical incident stress management (CISM)
(5) post incident operational critique

B. Activation

1. Enroute Declaration/Pre-Command Mode

a. An EMS unit dispatched to a situation that has the potential to be or become a major EMS incident may declare a POSSIBLE major EMS incident while enroute to the scene. Notification should be transmitted directly to the COMM CENTER by the technician in charge of the responding EMS unit.

b. THE EMS UNIT THAT DECLARES A POSSIBLE MAJOR INCIDENT WHILE ENROUTE MUST, AS SOON AS POSSIBLE, VERIFY THAT A MAJOR INCIDENT DOES OR DOES NOT EXIST.

c. When advised that a POSSIBLE major EMS incident has occurred, the Communications Technician at the COMM CENTER will initiate a PRE-COMMAND MODE by:

(1) notifying the Rapid Response And Medical Support Team (RRAMS Team) Coordinator, who then notifies;

(a) Medical Support Unit Leader, who notifies;

i) Medical Support Team members
ii) Red Cross
iii) Salvation Army

(b) CISM Coordinator, who notifies;

i) CISM Team members
ii) Regional hospitals in area
iii) Regional Services
iv) RRAMS Team members
v) SPEMS and RAC TSA-B Medical Director

(2) notifying the Lubbock EMS Shift Chief on duty,
(3) notifying the Lubbock EMS Communications Center Supervisor.

d. The COMM CENTER may initiate Pre-Command Mode based upon information received from a caller or from routine monitoring of EMS or other Public Safety Agency communications. /if the COMM CENTER elects to initiate the PRE-Command Mode, the FIRST responding EMS unit will be so advised.

e. If the FIRST EMS unit on the scene of a POSSIBLE major incident determines that one DOES NOT actually exist, the COMM CENTER will immediately notify all personnel and agencies previously placed in Pre-Command Mode that they may stand down.

2. Scene Arrival/Notification

a. Upon arrival at the scene, the EMS technicians should position their vehicle at a safe location which provides visibility of the incident and easy access. Since the initial EMS unit at the scene of a major incident will be the site of the temporary EMS COMMAND POST. Every effort will be made to protect the safety of and accessibility to this unit.

b. The EMS technicians will conduct a quick "size-up" of the situation. This size-up should be conducted in a manner which protects the safety of the technicians, but at the same time provides the best possible information about the nature of the incident, the possible number of patients, and the severity of their injuries.

c. ATTEMPTS SHOULD GENERALLY NOT BE MADE TO RENDER PATIENT CARE DURING THE SIZE-UP.

d. If the decision is made to declare a major EMS incident, the technician-in-charge should notify the COMM CENTER and provide the following:

(1) a statement that a major EMS incident has occurred, that the Regional Major EMS Incident Plan should be activated, and that he is assuming EMS COMMAND;
(2) the nature of the incident (hazardous materials, major MVC, etc);
(3) an estimate of the number and types of casualties;
(4) the number of EMS units or other transport vehicles needed at the scene;

(5) the location of the EMS STAGING area and the landing zone, if helicopter support is requested;
(6) the location of the temporary EMS COMMAND POST, pending establishment of a permanent FIELD COMMAND POST by the responsible fire or law enforcement agency;
(7) any additional information needed for a safe, efficient response (hazards, best
access to scene, routes known to be blocked etc)

e. If the incident involves an actual or suspected release of a hazardous material, the notification of the COMM CENTER should include the SPELLED name of the material(s) (if known), the UN or NA number(s) of the product(s) (if known), the nature of the release (spill, leak, fire, vapor cloud, etc.), and an estimate of the on-site wind direction. Wind direction should be reported as both the direction from and the direction to which the wind is blowing (e.g., "wind blowing from northwest to southeast")

f. When advised that a major EMS incident has occurred, the communications technician
at the COMM CENTER will:
(1) notify the persons notified in Pre-Command Mode that an actual incident has occurred (Regional EMS units will be dispatched by the RRAMS Team Coordinator);
(2) notify the House Supervisor or Administrator on Duty at UMC, CMC, Highland Hospital, and Heart Hospital
(3) notify off-duty Lubbock EMS Shift Supervisors;
(4) notify the Texas DPS District Communications Center;
(5) notify off-duty Lubbock EMS personnel and Lubbock County EMS Agencies;
(6) notify the TDSHS Field Representative;
(7) notify local amateur operator groups;
(8) notify Program Coordinator for SPC EMS Training Program.

g. A DECLARATION OF A MAJOR INCIDENT BY ANY EMS FIELD UNIT WILL BE REGARDED AS A CONFIRMATION OF THE INCIDENT. NO FURTHER CONFIRMATION WILL BE NECESSARY TO ACTIVATE THIS PLAN.

h. Continuity of EMS COMMAND MUST be maintained from the arrival of the first EMS unit on the scene. To accomplish this goal, THE FIRST ARRIVING EMS UNIT WILL GENERALLY BE THE LAST TO LEAVE THE INCIDENT SCENE, AND THE TECHNICIAN IN CHARGE OF THAT EMS UNIT WILL EXERCISE EMS COMMAND UNTIL FORMALLY RELIEVED.

3. Organization of On-Scene Command

a. EMS COMMAND is responsible for coordination of all EMS activities at the scene, including liaison with other emergency services. While EMS is usually not in charge of the overall scene and is acting in support of the public safety agency in overall command, EMS COMMAND is in charge of all EMS functions at the scene.

b. At large major EMS incidents, it will be most effective to establish a FIELD COMMAND POST (CP) in conjunction with other agencies on the scene. The CP location will usually be designated by the agency in overall command of the scene. EMS COMMAND generally should remain at the CP at all times. If EMS COMMAND must leave the CP, a deputy should remain at the CP and maintain continuous radio contact with EMS

COMMAND. Any movement of the CP or any departure of EMS COMMAND from the CP must be reported to the COMM CENTER.

c. Organizing a major incident may require designation of special functional areas. If there are sufficient personnel, each area should be under the direction of a designated officer. Until an officer is designated for a particular function, EMS COMMAND is personally responsible for that function.

d. SAFETY OFFICER: Responsible for the safety of rescuers and victims through all phases of EMS operations. May appoint DEPUTY SAFETY OFFICERS as needed for the incident. The SAFETY OFFICER answers only to EMS COMMAND. The SAFETY OFFICER is responsible for:

(1) monitoring all rescues for unsafe situations;
(2) insuring that all EMS sectors are setup in safe locations and monitor them occasionally for new problems;
(3) verifying that a safe landing zone is set before any air operations are started;
(4) coordinating with CISM and MEDICAL SUPPORT OFFICER to make sure personnel are adhering to the rotation schedule;
(5) assisting CISM and MEDICAL SUPPORT OFFICER in monitoring for critical incident stress in personnel.

e. RESCUE/TRIAGE AREA: The rescue/triage area is the area actually involved in the incident. The RESCUE/TRIAGE GROUP SUPERVISOR is responsible for the following:

(1) determining, in cooperation with the fire department, whether triage and primary treatment are to be conducted "on-site" or at the TREATMENT AREA;
(2) coordinating with the fire department to assure that patients are immediately removed from dangerous areas;
(3) evaluating resources needed for extrication of trapped patients, initial triage, primary treatment, and relocation of patients to TREATMENT AREA;
(4) rapidly assessing each patient using the Simple Triage And Rapid Treatment (START) system and assigning each patient to the IMMEDIATE (RED), DELAYED (YELLOW), or UNSALVAGEABLE (BLACK, BLUE, or WHITE)
(5) marking each patient with an appropriate indication of this priority;
(6) communicating resource requirements to EMS COMMAND;
(7) allocating assigned resources;
(8) supervising assigned personnel and resources;
(9) progress reporting to EMS COMMAND;
(10) reporting to EMS COMMAND when all patients have been delivered to the TREATMENT AREA;
(11) coordinating with other areas as required.

f. STAGING AREA: The STAGING AREA is the location to which incoming EMS units and personnel, and other patient care/transport resources report as they arrive at the scene. All EMS units and personnel will report to this area unless SPECIFICALLY directed to another location by EMS COMMAND through the COMM CENTER or RRAMS COORDINATOR. The STAGING AREA MANAGER is responsible for:

(1) coordinating with law enforcement agencies to block streets and secure access as required for staging operations;
(2) ensuring that all apparatus and vehicles are parked in an appropriate and orderly manner at staging;
(3) maintaining a log of ALL units AND personnel reporting to staging and where each was assigned;
(4) reviewing with EMS COMMAND what minimum resources must be maintained in the STAGING AREA and coordinating the request for these resources with EMS COMMAND;
(5) dispatching EMS vehicles and personnel, and other transport vehicles to secondary treatment areas or casualty concentrations as directed by EMS COMMAND;
(6) dispatching EMS vehicle and transport units to the TRANSPORT AREA(S) as

directed by the TRANSPORT GROUP SUPERVISOR(S);
(7) keeping EMS COMMAND updated on the status of staging operations;
(8) functioning as AIR OPERATIONS MANAGER until that position is established separately.

g. TREATMENT AREA: The TREATMENT AREA is the location at which patients are collected for re-triage and treatment prior to transport from the incident scene. WITH THE EXCEPTION OF IMMEDIATE LIFE-SAVING CARE INVOLVING BASIC MANAGEMENT OF THE ABC's OR CARE GIVEN TO ENTRAPPED PATIENTS, ALL PATIENT MANAGEMENT SHOULD TAKE PLACE IN THE TREATMENT AREA. In smaller communities with hospitals, the TREATMENT AREA may be most effectively established at the local hospital. If there is no local hospital, a structure with a large unobstructed floor area such as a community center may make an effective TREATMENT AREA. The TREATMENT AREA should be divided clearly into areas for Priority I, II, III, IV patients. The TREATMENT GROUP SUPERVISOR is responsible for:
(1) establishing a TREATMENT AREA of appropriate size at a location appropriate for weather conditions and the nature of the incident;
(2) assessing, classifying, and tagging each patient in the TREATMENT AREA as Priority I (RED), II (YELLOW), III (GREEN), or IV (BLACK< BLUE OR WHITE)
(3) coordinating personnel activities in the TREATMENT AREA to assure each patient receives appropriate treatment;
(4) coordinating the flow of patients through the TREATMENT AREA to the TRANSPORT AREA;
(5) keeping EMS COMMAND updated on the status of treatment operations and reporting when the last patient has been treated and moved to the TRANSPORT AREA;
(6) coordinating with the Red Cross and the local or state Health Department to establish holding areas for "walking wounded" with obvious minor injuries;
(7) coordinating with other areas as required;
(8) coordinating with EMS COMMAND as needed to establish temporary morgue facilities.

h. SUPPORT AREA: The EMS SUPPLY GROUP SUPERVISOR is responsible for:
(1) establishing a suitable location for SUPPORT AREA operations - normally near the TREATMENT AREA;
(2) determining the medical supply and equipment needs of other areas; coordinating procurement of medical supplies from hospitals with the TRANSPORTATION GROUP SUPERVISOR, AIR OPERATIONS MANAGER, and EMS COMMAND;
(3) coordinating procurement of additional supplies not available from hospitals;
(4) reporting additional resource requirements to EMS COMMAND;
(5) keeping accurate logs of all supplies and equipment brought on scene and if used or returned;
(6) allocating supplies and equipment as needed;
(7) reporting progress to EMS COMMAND;
(8) coordinating with other areas as needed.

i. TRANSPORT AREA: The TRANSPORT AREA should be established near the TREATMENT AREA. At the TRANSPORT AREA, patients are retriaged and are assigned to appropriate vehicles for transport from the scene. The TRANSPORT GROUP SUPERVISOR is responsible for:
(1) establishing a TRANSPORT AREA near the TREATMENT AREA;
(2) reassessing and retriaging patients as they are brought from the TREATMENT AREA to the TRANSPORT AREA and establishing priorities for transport;
(3) requesting EMS vehicle from STAGING AREA as needed;
(4) communicating with the COMM CENTER to obtain medical facility status and treatment capability;
(5) directing transport of patients to hospitals capable of providing appropriate

treatment without exceeding hospital capabilities;
(6) advising the COMM CENTER of the triage priorities, destinations, and estimated times of arrival of patients as they are transported;
(7) maintaining a record of patient name (if known), triage tag number, priority, and destination;
(8) reporting progress to EMS COMMAND;
(9) coordinating with other areas;
(10) advising EMS COMMAND and the COMM CENTER when the last patient has been transported from the scene;
(11) coordinating with EMS COMMAND as needed to provide transport for the dead.

j. AIR OPERATIONS: If helicopters will be operating on the incident, an AIR OPERATIONS MANAGER should be established. The AIR OPERATIONS MANAGER is responsible for:
(1) determining what aircraft are operating within the incident area;
(2) surveying the assigned incident area to determine situation, aircraft hazards and other potential problems;
(3) coordinating establishment of locations and landing/departure patterns for landing zones;
(4) coordinating loading of patients into helicopters with the TRANSPORT GROUP SUPERVISOR;
(5) coordinating the use of assigned ground to air and air to air communication frequencies in cooperation with the COMM CENTER;
(6) ensuring that all assigned helicopters know appropriate operating frequencies in cooperation with the COMM CENTER;
(7) ensuring that approved night flying procedures are in operation;
(8) maintaining continuous observation of assigned helicopter operating areas and landing zones;
(9) informing EMS COMMAND of incident conditions including any aircraft malfunction or maintenance difficulties;
(10) informing EMS COMMAND when mission is completed and reassign helicopters as needed.

k. MEDICAL SUPPORT AREA: The MEDICAL SUPPORT AREA is for rest, and monitoring the physical and emotional condition of the rescue personnel. The MEDICAL SUPPORT UNIT LEADER is responsible for:
(1) establishing the MEDICAL SUPPORT AREA where it is out of direct view of the incident scene;
(2) monitor and log the vital signs of all personnel going through the area, at least initially and when exiting the area;
(3) monitor personnel for signs of critical incident stress;

l. To ensure effective command and control of resources operating on a major EMS incident, EMS COMMAND and all area officers should attempt to maintain a SPAN-OF-CONTROL of three to seven units, with the ideal span being five. If the SPAN-OF-CONTROL for a position exceeds seven, the position affected should designate deputies to reestablish an optimum SPAN-OF-CONTROL.

C. Implementation

1. Search and Rescue
a. Location and initial rescue of patients within the area actually affected by the incident will generally be the responsibility of the Fire Department.

b. The TRIAGE GROUP SUPERVISOR will coordinate EMS activities with the Fire Officer in charge of search and rescue to assure efficient use of patient care resources in the incident area.

c. If significant hazards exist in the RESCUE/TRIAGE AREA, patients will be evacuated to the perimeter of the area immediately. EMS personnel without proper protective clothing and training will not enter the RESCUE TRIAGE AREA under these circumstances.

d. As patients are located they should receive basic care to correct any immediate life threats, involving airway, breathing, or circulation and be tagged with the appropriate triage priority. ONLY RAPID LIFESAVING MANEUVERS CAN BE DONE AT THIS POINT. CPR IS NOT DONE.

e. Disentanglement of patients is a non-medical task which should be left to Fire Department crews during these incidents.

f. Good communication between EMS personnel and extrication crews will help select the best strategy. The extrication crews should be separate from the patient care crews to facilitate the movement of the patient care crews from patient to patient in order of priority.

2. Triage, On-Scene Treatment, and Transport

a. The TRIAGE GROUP SUPERVISOR(S) will locate casualties in the RESCUE/TRIAGE AREA, correct any immediately life threatening problems, and assign each patient an initial triage priority as IMMEDIATE (RED), DELAYED (YELLOW), and UNSALVAGEABLE (BLACK, BLUE, or WHITE).

b. Once the patient receives immediate life saving care, is triaged, and is extricated, the patient will be moved to the closest TREATMENT AREA as directed by the TRIAGE GROUP SUPERVISOR.

c.. In large scale incidents it may be necessary to establish multiple TREATMENT AREAS to provide greater control over field operations.

(1) if the personnel on an EMS vehicle dispatched to a casualty concentration determine that a triage situation exists they may establish a secondary TREATMENT/TRANSPORT AREA;

(2) the technician in charge of an EMS vehicle establishing a secondary TREATMENT/TRANSPORT AREA will remain at the location and function as TREATMENT/TRANSPORT GROUP SUPERVISOR. His partner will function as TRIAGE GROUP SUPERVISOR.

d. As patients are brought to the TREATMENT AREA(S), they will be retriaged and their initial triage priorities revised as needed. A more specific priority of IMMEDIATE (I) (RED), DELAYED (II) (YELLOW), MINOR (III) (GREEN), or EXPECTANT (IV) (BLACK, BLUE, OR WHITE) will be assigned. Specific areas for each patient priority group should be designated within the TREATMENT AREA.

e. To avoid delays which are typically experienced in the TREATMENT and TRANSPORT AREAS, only standardized SPEMS AND RAC TSA-B triage tags should be utilized. The SPEMS AND RAC TSA-B tags will be color coded and imprinted to signify the patient's priority level. The tags will also be numbered to facilitate patient tracking throughout the medical system. Obtaining and documenting additional information typically slows the process and should be avoided.

f. The TREATMENT GROUP SUPERVISOR will assess each patient's need for care and coordinate the delivery of care by treatment area personnel.

g. The TREATMENT GROUP SUPERVISOR should avoid becoming involved in direct patient care unless sufficient personnel are unavailable.

h. When care is complete, patients should be moved from the TREATMENT AREA to the TRANSPORT AREA.

i. As patients are brought to the TRANSPORT AREA, the TRANSPORT GROUP SUPERVISOR will reassess triage priorities. He will then record triage tag numbers, triage priorities, and destination hospitals.

j. On request of the TRANSPORT GROUP SUPERVISOR, the STAGING AREA MANAGER will send EMS vehicles to the TRANSPORT AREA.

k. As patients are loaded, the TRANSPORT GROUP SUPERVISOR, will inform the COMM CENTER of their destination, priorities, and estimated times of arrival. INDIVIDUAL EMS UNITS WILL NOT PROVIDE DIRECT REPORTS TO THE RECEIVING HOSPITALS.

l. The TRANSPORT GROUP SUPERVISOR should “mix load” patients of varying severity into each rather than attempting to transport all Priority I patients first, all Priority II patients second, etc. “Mix loading” will allow the technician on the unit to provide more effective care and will allow hospitals to receive and treat patients without having to “close” repeatedly.

m. The COMM CENTER will notify hospitals of the status of incoming patients and maintain a tally of the number of patients in each priority sent to each hospital. If a hospital approaches capacity, the COMM CENTER will provide the TRANSPORT GROUP SUPERVISOR with alternate destinations.

n. After delivering patients, EMS vehicles will return to the STAGING AREA “Code 3" until advised that operations have been terminated.

o. If an incident produces large numbers of "walking wounded" with obvious minor injuries, EMS COMMAND and the TREATMENT GROUP SUPERVISOR(S) will coordinate with the Red Cross, the local Health Department, and the State Department of Health to establish holding areas for these patients away from the TREATMENT AREA(S).

4. Definitive Hospital Patient Care

a. Management of patients in regional facilities during disasters will be based on the in-house plans prepared by each facility.

b. If a local facility is overwhelmed by a sudden influx of patients, it may request support through the COMM CENTER.

c. The COMM CENTER will coordinate support to overwhelmed facilities through contacts with other regional hospitals and EMS organizations or by referring the request to the Texas Department of State Health Services representative at the District EOC.

d. In some circumstances, augmentation of local facilities should be considered as an alternative to long distance transport of patients. By transporting additional personnel or equipment to the facility serving the immediate incident area, it may be possible to avoid having to immediately relocate large numbers of patients outside the community allowing EMS resources to operate directly on the scene itself.

e. It is the responsibility of the receiving hospital to establish procedures for accepting patients and transferring them to hospital stretchers on the ambulance dock. Every effort must be made to expedite the return of EMS vehicles to the incident scene.

5. Management of Fatalities

a. Persons found dead at the scene of a major EMS incident will be the responsibility of the Medical Examiner or Justice of the Peace for the affected jurisdiction(s).

b. Bodies will not normally be moved unless the responsible authority or his authorized

deputy gives permission.

c. Obviously dead bodies will be tagged by the TRIAGE GROUP SUPERVISOR, then covered with a sheet or blanket until removal. While first priority will be given to the living, efforts will be made to safeguard bodies.

d. Personal belongings will be left with the bodies to aid in identification.

e. Bodies may be moved prior to The arrival of the responsible authority to provide patient care, to prevent further damage, or at the direction of law enforcement authorities to restore normal traffic flow. Under these circumstances the following procedures must be followed:

(1) do not remove any personal effects from the body;

(2) attach a tag to the body with following information:
- (a) date and time found:
- (b) exact location where found:
- (c) name and address of decedent;
- (d) if identified, how and when:
- (e) name of person making identification or filling out tag.

(3) place body in disaster pouch or in plastic sheeting securely tied to prevent unwrapping. Attach a second tag to sheeting or pouch;

(4) if personal effects are found and thought to belong to a body, place them in a separate container and tag. Do not assume that any loose effects belong to a specific body;

(5) if possible take photographs or mark location of body with stake and tag number;

(6) move the properly tagged bodies with their personal effects to one location, preferably one with refrigeration. Avoid exposure of bodies to heat or direct sunlight. If at all possible, do not locate temporary morgue facilities at or near TREATMENT AREA(S). Do not use vehicles or storage area with a floor that can be permeated with body fluids, such as the wooden floor of a gymnasium. If refrigerated trucks or rail cars are used, COVER THE COMPANY NAME ON THE VEHICLE.

f. EMS COMMAND will coordinate with POLICE COMMAND, the authority responsible for the dead, and local health authorities in arranging for temporary morgue facilities and transportation of bodies.

g. EMS COMMAND will consult with local or state health authorities, if they are present, on appropriate procedures to safeguard the health of personnel assigned to move the dead. In absence of such advice, universal precautions against communicable disease will be exercised.

h. Release of information about persons killed in an incident will be the responsibility and prerogative of the Justice of the Peace or authorized law enforcement officials.

D. Recovery

1. Scene Withdrawal

a. Following the report by the TRANSPORT GROUP SUPERVISOR that the last patient has been transported from the scene, EMS COMMAND will instruct the RESCUE/TRIAGE GROUP SUPERVISOR to systematically check the RESCUE/TRIAGE AREA for any missed victims in coordination with fire and law enforcement authorities.

b. If EMS COMMAND is satisfied that the scene is clear of patients, he may direct the COMM CENTER to begin releasing units from the scene in cooperation with the STAGING AREA MANAGER.

c. As units are released from the scene , the COMM CENTER will adjust mutual aid assignments to ensure continuing uniform EMS coverage for the region as a whole.

d. EMS COMMAND may release part of the units from an operation while maintaining a command mode and retaining a limited number of units at the scene if there is a possibility that additional patients may be discovered (e.g. buried in debris), a secondary incident may occur (e.g. re-ignition, fire, or explosion), MEDICAL SUPPORT SECTOR still needed (other agencies still in operation), or POLICE COMMAND and the Justice of the Peace request assistance in transportation of the dead.

2. Return to Normal Operations

a. When EMS COMMAND determines that the incident has been terminated, the scene secured, and all EMS units released to routine operations, he shall transmit this fact to the COMM CENTER and announce that the COMMAND MODE FOR FIELD OPERATIONS HAS BEEN TERMINATED.

b. The SPEMS AND RAC TSA-B Medical Director or his alternate will determine when the in-hospital patient care phase of the incident management has been terminated. This determination will be made in cooperation with the District EOC if that facility has been activated. This determination will not affect the ability of hospitals to continue emergency operations under their internal disaster plans.

c. Although the COMMAND MODE has been terminated, the COMM CENTER may elect to maintain mutual aid coverage temporarily to allow units which responded to the incident to restock their supplies and change out crews.

d. The COMM CENTER will announce when all mutual aid assignments have been terminated and the region has returned to normal operations.

3. Casualty Accounting

a. When on-scene operations have been completed, the TRANSPORT GROUP SUPERVISOR and the COMM CENTER will use their Patient Transport Logs to determine the number of patients transported and the number sent to each hospital. If the COMM CENTER's total differs from the TRANSPORT GROUP SUPERVISOR's, the hospitals will be called by the COMM CENTER to obtain the correct number of patients received.

b. The TRANSPORT GROUP SUPERVISOR will combine the number of patients transported with the totals of those dead at the scene and of those uninjured or refusing treatment to determine the total number of persons involved in the incident.

c. The total count of persons involved will, when possible, be compared to preexisting information listing the number of persons who could have been involved (e.g. passenger manifests, hotel registers, etc.).

d. As hospitals identify patients they will match the patient's identity, condition, and disposition with the number on the patient's triage tag. Identities of casualties will then be reported to the COMM CENTER. Triage tags must NOT be removed from the patients at the hospital until the patients are identified.

e. Casualty numbers and identities will be reported to the American Red Cross and to the District EOC for Health and Welfare Inquiries and accounting purposes.

4. Critical Incident Stress Management (CISM)

Studies of major incidents have brought attention to the fact that EMS and rescue personnel themselves can become psychological casualties from the overwhelming carnage and suffering they may witness. The purpose of this section is to establish procedures and guidelines for helping emergency personnel cope with what they have seen and to continue productive careers with minimal long term effects.

a. During the Incident

(1) Breaks from direct incident involvement will be scheduled and enforced whenever possible. Normally, personnel will be required to rest 15 minutes for every one (1) hour during involvement in the incident. This will not be enforced for those involved in lengthy rescues.
(2) A duty rotation will be established by the MEDICAL SUPPORT UNIT LEADER, SAFETY OFFICER and EMS COMMAND, and personnel will NOT be allowed to operate on an incident continuously for more than 12 hours.
(3) Personnel will be monitored for signs and symptoms of acute critical incident stress syndrome (CISS) by the SAFETY OFFICER(S), CISM team members, and the MEDICAL SUPPORT UNIT LEADER. Personnel displaying indications of CISS will be removed from the scene as soon as possible.
(4) To the greatest extent possible, personnel who operate on a major incident will NOT be required to remain on duty when the incident is resolved and the region returns to normal operations.

b. Initial Defusing

(1) Within 12 hours of the termination of the incident, supervisory personnel of the participating organizations will conduct mandatory meetings of all personnel who operated on the incident.
(2) Through an open discussion of reactions and feelings, the members and leaders will check on each other's well-being and provide support to those who seem to be the hardest affected by the incident.

c. Formal Critical Incident Stress Debriefing (CISD)

(1) Within 48 hours of the conclusion of the incident, a formal debriefing will be conducted by a qualified CISM Team.
(2) The formal CISD will be mandatory for all personnel involved in the incident.
(3) The CISD will NOT serve as the incident critique. Criticism or discussion of incident operations will not be permitted.

d. The CISM procedure may be activated at any time independently of the rest of this plan if EMS personnel or their supervisors feel they would benefit from the process.

5. Post-Incident Critique

a. When this plan is implemented as a result of an actual incident, the operation will be critiqued at the earliest possible date.

b. Operational critiques will not be conducted until personnel participating in the critique who also operated on the actual incident have participated in the CISM process.

c. The SPEMS AND RAC TSA-B Coordinator will be responsible for convening the critique session. The session will be presided over by the Chairman of the Disaster/Mutual Aid Committee or by the Vice-Chairman, if the Chairman represents an agency which actively participated in the response to the incident.

d. The EMS Commander(s) will provide written After Action Reports of the incident for use during the critique.

e. A written report of the critique, including any areas of strength or weakness identified, and any resulting changes in this plan will be prepared and issued to all plan holders within 30 days of the date of the critique.

V. COMMAND, CONTROL, AND COMMUNICATIONS

A. Command and Control

1. Responsibility for direction of the medical aspects of the on-scene response to a major EMS incident shall rest with the EMS Provider Organization which normally serves the jurisdiction in which normally serves the jurisdiction in which the incident occurs. If an incident crosses jurisdictional boundaries, responsibility shall rest with the EMS organization which makes the

declaration of a major incident and establishes a COMMAND MODE.

2. Each EMS Provider shall include in it's major incident plan a procedure for designating one of it's members as EMS COMMAND for a major EMS incident. The procedure shall provide for establishment and continuation of EMS COMMAND from the time of arrival of the first EMS unit at the scene of a major incident.

3. EMS COMMAND shall be responsible to INCIDENT OPERATIONS COMMAND for all medical aspects of the on-scene response. INCIDENT OPERATIONS COMMAND normally will be a senior police or fire official designated by the local emergency management plan as being responsible for on-scene INCIDENT COMMAND or the senior DPS trooper at the scene of a major incident on a state or interstate highway outside an incorporated area.

4. All medical aspects of the on-scene response shall be integrated into the total response to the incident ass specified in the Emergency Management Plan of the affected jurisdiction. While EMS will not generally be in command of the scene, EMS COMMAND will be in charge of all determinations regarding the need for EMS resources and all decisions affecting patient treatment and transport.

5. Ultimate control of the local response to any disaster, including a major EMS incident, shall rest with the chief elected official(s) of the affected jurisdiction(s).

6. Responsibility for the in-house response by regional medical facilities to a major EMS incident shall rest with the Chief Executive Officer of each facility or his alternate as designated in the facility's Disaster Plan.

7. The Medical Director of SPEMS AND RAC TSA-B or his designated alternate shall be responsible for coordinating the regional response to a major EMS incident with the RRAMS Team Coordinator.

8. Arrival of a more senior member of the responsible EMS organization on the scene of an incident will not automatically result in transfer of command to that individual. Command will be transferred only when:

a. the individual previously exercising command has thoroughly briefed the arriving senior member of the circumstances and any command decisions which have been implemented;

b. the individual assuming command has had sufficient time to feel reasonably certain that he understands the tactical and strategic situation;

c. transfer of command is formally announced on the radio net and acknowledged by the COMM CENTER;

9. COMMAND personnel will be issued visible identification which clearly identifies their role in the operation.

10. Personnel reporting to the incident who are not in uniform will be issued identification by the STAGING AREA MANAGER which clearly identifies their role in the operation. The STAGING AREA MANAGER keeps a log of all personnel reporting to the scene, and they should check out through the STAGING AREA MANAGER when leaving the scene.

11. Public information releases on site will be coordinated through the Public Information Officer (PIO) designated by the INCIDENT COMMANDER. EMS personnel will direct all members of the press to the PIO.

B. Communications

1. All communications between organizational elements at an incident should be in PLAIN ENGLISH. No codes should be used, and all communications should be confined only to essential messages.

2. Upon declaration of a major EMS incident, the COMM CENTER will assign a location designation to that incident (e.g. Slide Command, Littlefield Command, etc.). The location designator will precede all further communications from that incident.

3. If multiple triage, treatment, or transport areas are designated by EMS COMMAND, they will be numbered in order of designation or relative direction (e.g., Olton Triage One, Levelland Treatment North, etc.).

4. Radio traffic will be directed to positions in the command structure, NOT to the person occupying the position (e.g., "Crosbyton EMS Command to Crosbyton Triage", etc.).

5. Administrative communications will be conducted primarily by telephone or by messenger to keep radio channels available for emergency communications.

6. Procedures will be developed for using amateur radio operators to provide alternate channels for communications during major EMS incidents.

7. To provide efficient use of communication resources, following activation of this plan, the COMM CENTER will be responsible for assignment and coordination of channels for medical communications.

VI. RESOURCES, SUPPORT, AND FINANCE

A. Resources

1. Following activation of this plan, all resources of the SPEMS AND RAC TSA-B member EMS organizations will be available for use in managing the incident through direct response or delivery of mutual aid in support of organizations directly responding.

2. The response of units to a major incident will be directed by the COMM CENTER, FOLLOWING activation of this plan, to provide efficient use of resources available for response. EMS units shall NOT respond to the incident site FOLLOWING declaration of a major incident except when directed to do so by the COMM CENTER or RRAMS Team Coordinator.

3. Day-to-day functions that do not contribute directly to the management of the emergency may be suspended for the duration of any emergency. The efforts that normally would be required for those functions will be redirected to the accomplishment of emergency tasks.

4. Unless agreed to in writing, SPEMS AND RAC TSA-B and it's member organizations will not be responsible for financial obligations or losses incurred by volunteer, governmental, or quasi governmental organizations during any type of major incident.

5. To facilitate access to supplies and equipment on EMS vehicles, all EMS organizations will visibly number the storage compartments in their units, index all supplies by compartment, and post this index in clearly visible location within the patient compartment.

6. During transport of patients from the scene, all vehicles will be driven by a representative of the agency which owns the vehicle. However, the STAGING AREA MANAGER or TRANSPORT GROUP SUPERVISOR may assign a member of another agency to provide patient care if this would be in the patient's best interest.

7. Following return to routine operations, SPEMS AND RAC TSA-B and it's member organizations will assist in the recovery or non-expendable equipment used by agencies responding to the incident. However, no financial responsibility for lost or damaged equipment is implied or assumed.

B. Support

1. To provide for efficient response by assisting agencies, each EMS agency will provide the SPEMS AND RAC TSA-B EMS Disaster Coordinator with an accurate inventory of ambulances with level certified at, personnel with level of certification, first responder vehicles, special

equipment, and maps of the jurisdiction.

2. Since disasters do not respect geographic or political boundaries, SPEMS AND RAC TSA-B and it's member organizations will coordinate their major incident response procedures with those of EMS agencies in adjacent areas of the Panhandle, Permian Basin, and Eastern New Mexico to the greatest extent possible.

3. When non-SPEMS AND RAC TSA-B EMS Organizations assist in disaster operations within the SPEMS AND RAC TSA-B Region, they will function under their own local medical direction and treatment protocols as deemed appropriate by their local medical director and/or other local regulatory bodies. Similarly, when SPEMS AND RAC TSA-B EMS organizations leave the SPEMS and RAC TSA-B Region to assist in other regions, they should operate under the appropriate SPEMS AND RAC TSA-B Treatment Protocols when geographic distance or other factors prelude direct radio communication with Medical Control.

4. Requests for support from entities with which SPEMS AND RAC TSA-B or it's member organizations maintain routine working relationships will be handled by way of routine channels. Requests for support from the state or federal government will be coordinated with the District Disaster Committee, through the affected jurisdiction's EOC or the Area Command.

C. Finance

1. Each organization sending resources, whether they be manpower or supplies, should keep accurate records from the start of the incident of time personnel are involved and what supplies were sent and if they were returned. This should be done for two reasons, first, to aid each EMS organization in budgeting for the next year and second, to allow for reimbursement if any is available. SPEMS AND RAC TSA-B WILL NOT REIMBURSE EMS ORGANIZATIONS OR OTHER SUPPLIERS FOR EXPENSES.

2. On-scene command will aid in the finance sector by writing all requests for resources down, in the MCI Event Log, note when it arrives, when it is used or returned.

3. After the incident, the command officers and service administrators will meet to reconcile field notes with the organizations notes.

VII. TRAINING, DRILLS, AND EXERCISES

A. Training

1. The Program Director, EMS Training Program, South Plains College, will assist in developing and maintaining standardized lesson plans for initial instruction of EMS personnel in the purpose and use of this plan. These lessons will be incorporated into initial EMS training offered in the Region at each level of state certification.

2. The Training Officers of each EMS organization in the SPEMS AND RAC TSA-B System will provide ongoing continuing education and review for their personnel in the purpose and use of this plan. The EMS Training Program – SPC will conduct "train-the-trainer" courses for regional training officers in support of this effort. The RRAMS Team is also available to provide initial training and continuing education.

B. Drills and Exercises

1. To maintain an ongoing state of readiness for major incidents, the on-scene incident command system and titles in this plan will be implemented whenever an incident involves a response by three or more EMS units WHETHER OR NOT A MAJOR INCIDENT IS DECLARED.

2. Triage priorities and markers will be applied to all patients in all accidents involving four or more patients WHETHER OR NOT A MAJOR INCIDENT IS DECLARED. Additionally, utilizing the color codes of the "Four Category Triage System" (Appendix F).

3. A major exercise of this plan should be conducted at least annually on a regional basis. when possible, this exercise will be conducted in cooperation with drills or exercises held by other public

or private entities involved in emergency management activities in the SPEMS AND RAC TSA-B.

4. SPEMS AND RAC TSA-B will participate as required in drills and exercises conducted by the Governor's Division of Emergency Management, the State Disaster District Committee, or the Texas Department of State Health Services.

5. Each EMS provider organization participating in SPEMS AND RAC TSA-B will conduct at least one local drill or exercise annually in addition to the regional exercise. This drill will test the ON-SCENE COMMAND, TRIAGE, TREATMENT, and TRANSPORT functions defined in this plan. When possible, this drill or exercise should be coordinated with the local hospital(s) and the neighboring communities most likely to provide mutual aid.
6. On at least a quarterly basis, the Lubbock EMS Regional Communications Center will implement a simulated exercise. Simulated exercises will be done in different sections of the region during the year with the primary purpose of assessing regional mutual aid and EMS "intercity move up coverage" planning and implementation capabilities.

VIII. PLAN MAINTENANCE

A. Responsibility

1. The Executive Board of SPEMS AND RAC TSA-B has overall authority and responsibility for planning related to regional response to major EMS incidents in the 24 counties of the Texas South Plains.

2. The Mutual Aid and Disaster Planning Committee appointed by the Executive Board shall be responsible for plan review and updating, and for coordination of this plan with plans of other relevant local, regional, and state agencies. The SPEMS AND RAC TSA-B Regional EMS Disaster Coordinator will provide support to the Mutual Aid and Disaster Planning Committee.

B. Distribution

1. This plan shall be issued to all EMS provider organizations and hospitals participating in SPEMS AND RAC TSA-B and to all local and county emergency management coordinators in SPEMS AND RAC TSA-B member counties.

2. Copies of this plan will be provided to the Texas Department of Public Safety, the Texas Department of State Health Services, The South Plains Chapter of the American Red Cross, and the EMS Training Program - SPC.

3. Copies of this plan will be provided at no cost to other public agencies, educational institutions, and other requesting parties when such free distribution, in the judgment of the Executive Boards, would be to the benefit of SPEMS AND RAC TSA-B. Other organizations or individuals receiving copies of the plan will be charged the standard administrative fees for duplicating, handling, and/or mailing, as appropriate.

C. Coordination

1. The Mutual Aid and Disaster Planning Committee will ensure that this plan is not in conflict with the Emergency Management Plans of any entities which might assist or request assistance from SPEMS AND RAC TSA-B during an emergency.

2. In cooperation with the Texas Department of State Health Services and the Governor’s Division of Emergency Management, the Mutual Aid and Disaster Planning Committee will encourage and assist in the development and testing of local plans for management of major EMS incidents in the 24 counties of the Texas South Pains and environs

D. Review and Revision

1. This plan and all associated annexes and appendices shall be reviewed at least annually by all persons or agencies holding copies of the plan.

2. Questions concerning the plan and recommendations for revisions shall be submitted to the Mutual Aid and Disaster Planning Committee through the SPEMS AND RAC TSA-B Coordinator.

3. Annually, or more frequently if necessary, the SPEMS AND RAC TSA-B office shall publish and distribute to all plan holders any changes deemed necessary by the Mutual Aid and Disaster Planning Committee to maintain currency of this plan. If no changes are required, a notice shall be distributed certifying that the plan has been reviewed and is correct.

4. This plan will be reviewed and revised as necessary following any drills or exercises.

5. When this plan is implemented as a result of actual incidents, the operation will be critiqued at the earliest possible date, and the plan revised as needed. The SPEMS AND RAC TSA-B Coordinator will be responsible for convening the critique session. The EMS COMMANDER will provide written After Action Reports of the incident for use during the post-incident critique.

6. Revised pages of this plan shall be dated and marked to show where changes have been made.

IX. SEVERABILITY

This plan is an exercise of the legal responsibilities of South Plains Emergency Medical Services Regional Advisory Council system. If any provision of this plan or the application hereof is held invalid, such invalidity shall not affect other provisions or applications of this plan, and to this end the provisions of this plan are held to be severable. This plan supersedes all prior Major EMS Incident Plans of SPEMS AND RAC TSA-B to the extent that they are in conflict. All planned, regulations, and policies not in conflict herewith are continued in full force and effect.

X. IMPLEMENTATION

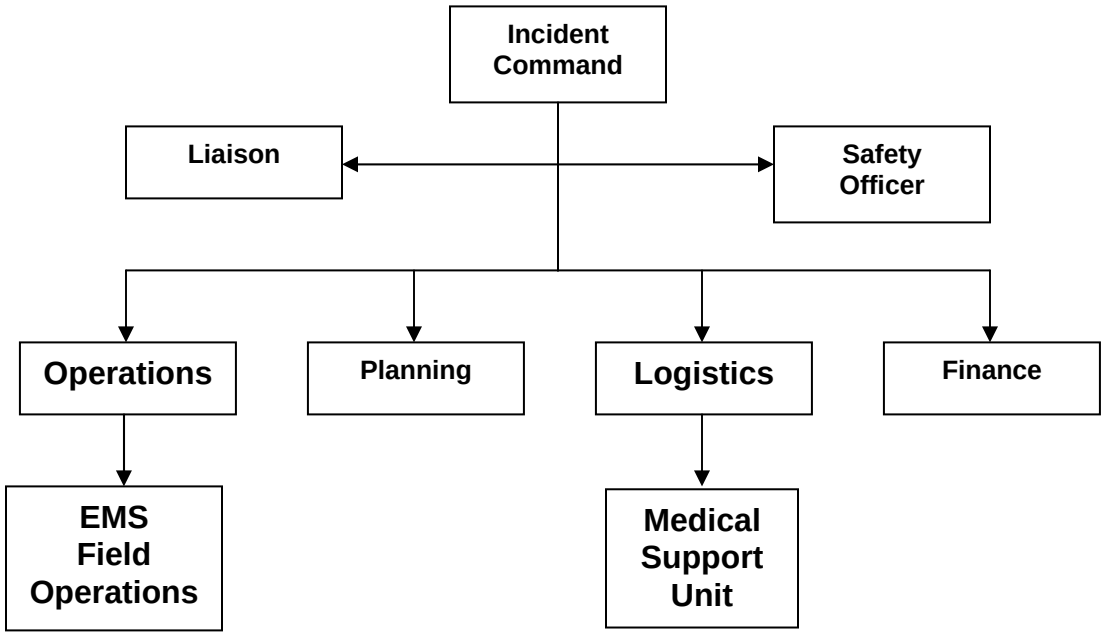
This plan is effective immediately upon adoption by the Executive Board of SPEMS AND RAC TSA-B and signing by the Chairman of the SPEMS AND RAC TSA-B Executive Board and the SPEMS AND RAC TSA-B Medical Director.

Provisions of this plan dealing with prevention and mitigation of major EMS incidents and those provisions directed toward maintenance of a regional response capability shall be continually in effect. Other provisions concerning actual response shall be implemented upon activation of the plan.

XI. APPENDICES

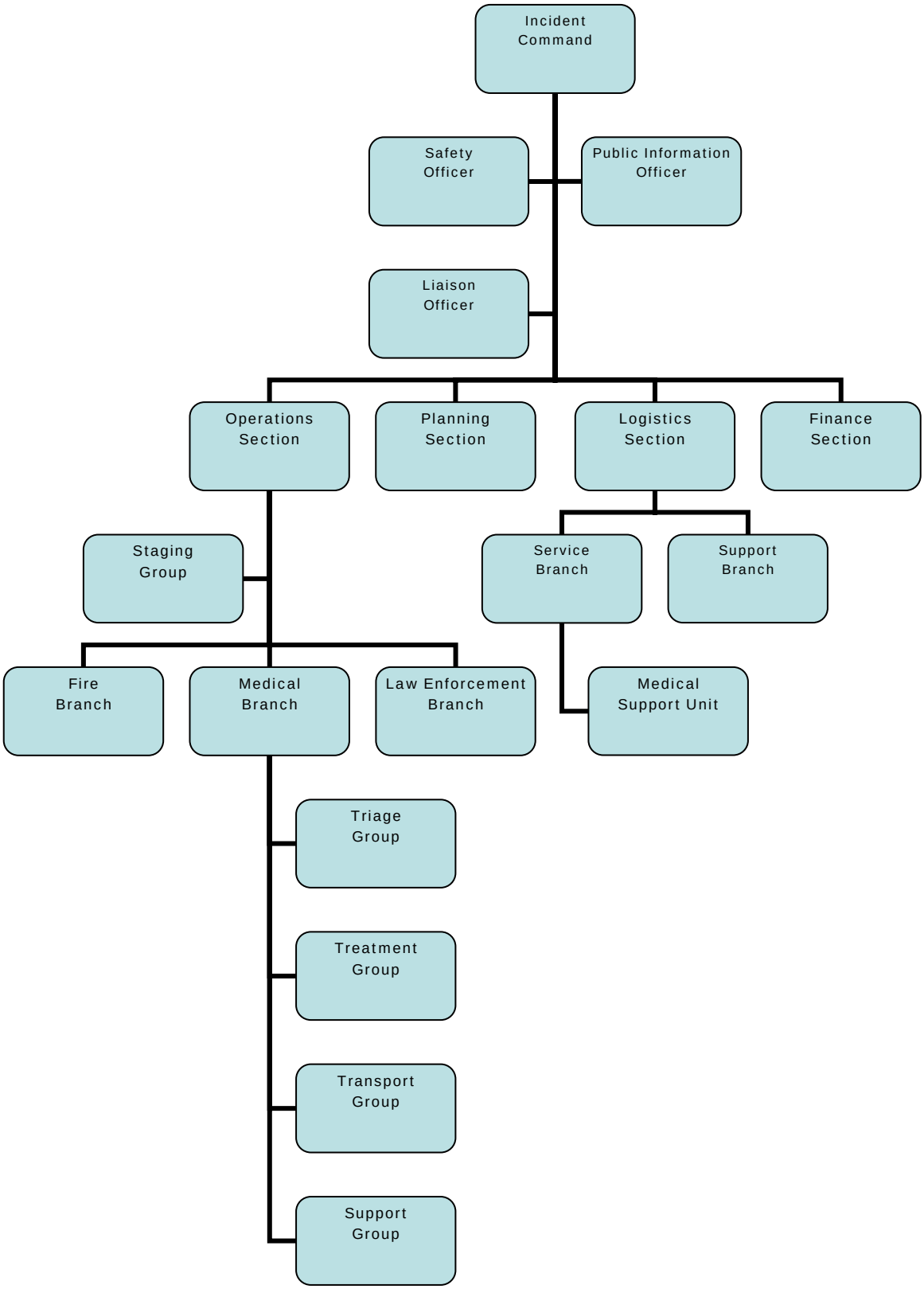
Appendix A

EMS as Part of IMS

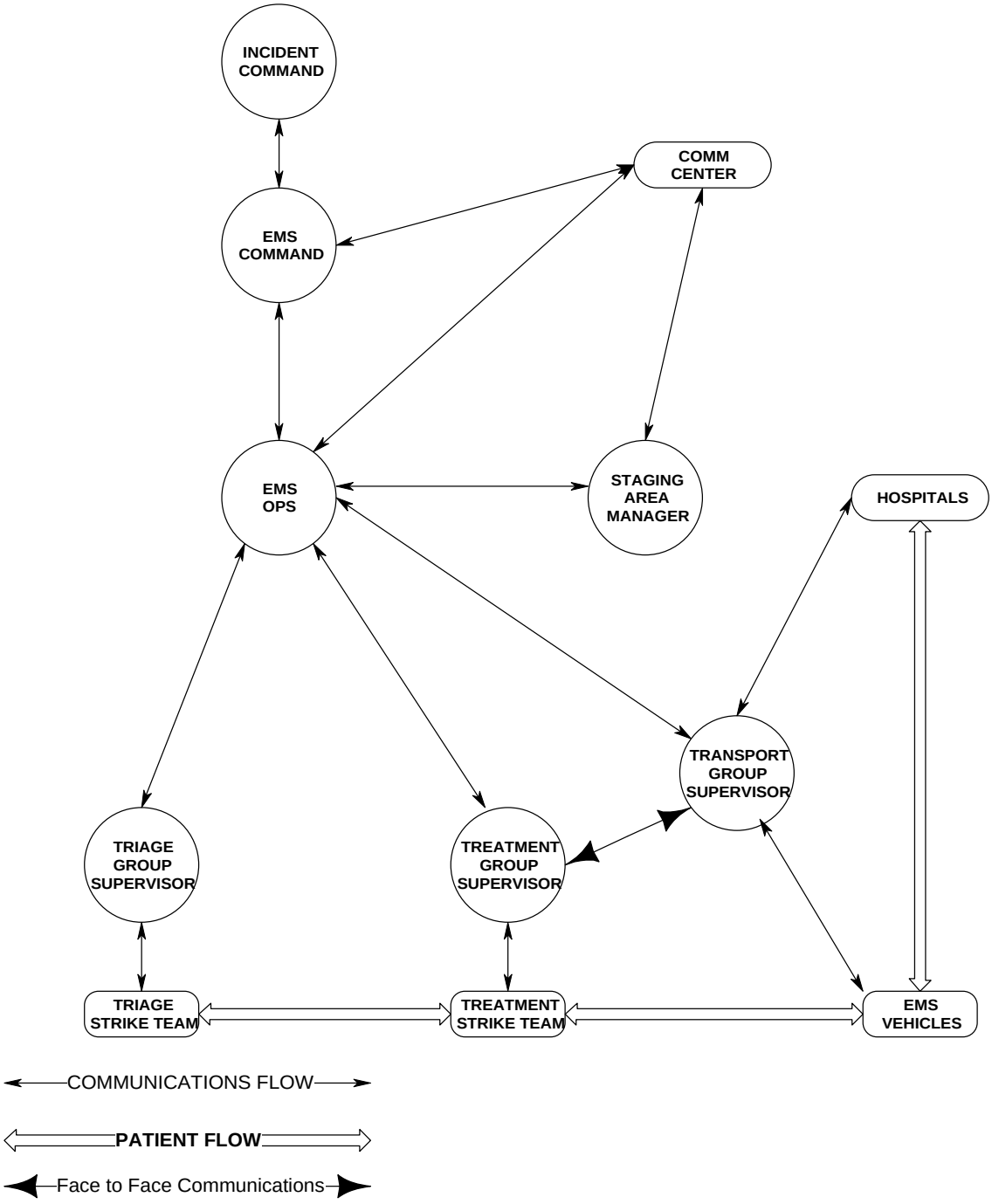


Appendix B

Expanded IMS Organizational Chart


Incident Command
Safety Officer
Public Information Officer
Liaison Officer
Operations Section
Planning Section
Logistics Section
Finance Section
Staging Group
Service Branch
Support Branch
Fire Branch
Medical Branch
Law Enforcement Branch
Medical Support Unit
Triage Group
Treatment Group
Transport Group
Support Group

APPENDIX C
Patient and Communications Flowchart



Appendix D

Initial Action Checklist

1. Position vehicle at safe location which provides good visibility of incident and easy access. Avoid having to relocate vehicle unless absolutely necessary.

2. Quickly "size up" the situation to determine:
   a. Nature of incident;
   b. Possible number of patients;
   c. Severity of patient injuries;
   d. Danger zones and nature of hazards present; and
   e. Need to establish multiple treatment areas.

3. Select staging area for EMS vehicles at location which can be easily accessed without having to back-up vehicles to turn them around.

4. Select a helicopter landing zone if you believe helicopter transport of patients will be needed.

5. Contact the COMM CENTER and provide:
   a. Your unit number and the MED channel you are operating on;
   b. A statement that a major EMS incident has occurred, that the Regional Major Incident Plan should be activated, and that you are assuming EMS COMMAND;
   c. The nature of the incident (HazMat, Bus Wreck, etc.);
   d. The number and types of casualties;
   e. The number of EMS units and other transport vehicles needed;
   f. The location of the STAGING AREA and helicopter landing zone;
   g. The location of the Temporary EMS Command Post; and
   h. Any additional information needed for a safe, efficient response.

6. Coordinate with the police to begin securing the perimeter, routes for EMS vehicles entering and leaving the scene, and the helicopter landing zone.

7. Coordinate with the Fire Department to begin the search, rescue, and initial triage process.
8. Establish locations for one or more TREATMENT AREAS based on environmental conditions, the size of the incident area, and your best estimate of the number of casualties.

9. As additional personnel arrive, make functional area assignments as necessary:
   a. STAGING AREA MANAGER
   b. TRIAGE GROUP SUPERVISOR(S) - TRIAGE TEAMS
   c. TREATMENT GROUP SUPERVISOR(S) - TREATMENT TEAMS
   d. TRANSPORT GROUP SUPERVISOR(S)
   e. AIR OPERATIONS OFFICER
   f. EMS SUPPLY GROUP SUPERVISOR

10. Remain at the Field Command Post until the operation is terminated or you are formally relieved of command.

Appendix E

Assignment Descriptions

EMS COMMAND

TRIAGE GROUP SUPERVISOR

STAGING AREA MANAGER

TREATMENT GROUP SUPERVISOR

TRANSPORT GROUP SUPERVISOR

EMS SUPPLY GROUP SUPERVISOR

AIR OPERATIONS OFFICER

EMS COMMAND

Radio Designation: **EMS COMMAND**

Commanded By: INCIDENT COMMAND

Subordinates: Deputy EMS COMMANDERS, TREATMENT GROUP SUPERVISOR, TRANSPORT GROUP SUPERVISOR, TRIAGE GROUP SUPERVISOR, STAGING OFFICER, EMS SUPPLY GROUP SUPERVISOR, and AIR OPERATIONS OFFICER.

Function: Establish, command, and control on-site EMS activities to insure the best possible care for the greatest number of patients.

Duties:

1. Establish EMS Command Post, usually at Incident Command Post.
2. Designate officers for functional areas.
3. Coordinate all EMS activities on-site.
4. Coordinate joint operations with all other commands and INCIDENT COMMAND.

TRIAGE GROUP SUPERVISOR

Radio Designation: **TRIAGE**

Commanded By: EMS COMMAND or DEPUTY EMS COMMAND

Subordinates: Triage Team Leaders or Triage Team Members

Function: Assume responsibility for coordination of EMS activities in areas actually impacted by the incident.

Duties:

1. Determine in cooperation with fire department whether triage and primary treatment are to be conducted on site or at TREATMENT AREA.
2. Coordinate with fire department to insure that patients are immediately removed from danger areas.
3. Evaluate resources needed for extrication of trapped patients, initial triage and primary treatment.
4. Assure that patients are rapidly assessed using START system, assigned to the Immediate, Delayed, or unsalvageable categories, and marked with an indication of their priorities.
5. Communicate resource requirements to EMS COMMAND.
6. Allocate assigned personnel.
7. Supervise assigned personnel and resources.
8. Report progress to EMS COMMAND.
9. Advise EMS COMMAND when all patients have been delivered to TREATMENT AREA.

NOTE: Do not allow bodies of persons killed in the incident to be moved from their original locations unless absolutely necessary. If possible, take pictures and mark locations.

STAGING AREA MANAGER

Radio Designation: **EMS STAGING**

Commanded By: EMS COMMAND

Subordinates: AIR OPERATIONS OFFICER, other personnel as needed

Function: Assume responsibility for coordination of Staging activities for ground and air transport units.

Duties:

1. Coordinate with Law Enforcement agencies to block streets and secure access as required for staging operations.
2. Insure that all apparatus and vehicles are parked in an appropriate and orderly manner at staging.
3. Maintain a log of units available at the STAGING AREA and an inventory of all specialized equipment and medical supplies that might be required at the scene.
4. Review with EMS COMMAND what minimum resources must be maintained in the STAGING AREA and coordinate requests for these resources with EMS COMMAND.
5. Dispatch EMS vehicles or personnel to secondary TREATMENT AREAS or casualty concentrations as directed by EMS COMMAND.
6. Dispatch EMS vehicles to the TRANSPORT AREA (S) as directed by the TRANSPORT GROUP SUPERVISOR.
7. Keep EMS COMMAND updated on status of staging operations.
8. Function as AIR OPERATIONS OFFICER until that position is established separately.

TREATMENT GROUP SUPERVISOR

Radio Designation: **TREATMENT**

Commanded By: EMS COMMAND or DEPUTY EMS COMMAND

Subordinates: Treatment Team Leaders or Treatment Team Members.

Function: Assume responsibility for coordination of patient care in the TREATMENT AREA.

Duties:

1. Establish a TREATMENT AREA of appropriate size at a location appropriate for weather conditions and the nature of the incident.
2. Assure assessment, classification and tagging of each patient in the TREATMENT AREA as Priority I, II, III, or IV.
3. Coordinate personnel activities in the TREATMENT AREA to assure each patient receives appropriate treatment. AVOID BECOMING DIRECTLY INVOLVED IN PATIENT CARE UNLESS ABSOLUTELY NECESSARY.
4. Coordinate flow of patients through the TREATMENT AREA to the TRANSPORT AREA.
5. Keep EMS COMMAND updated on the status of treatment operations and report when the last patient has been treated and moved to the TRANSPORT AREA.
6. Coordinate with the Red Cross and the local or state Health Department to establish holding areas for the "walking wounded" with **OBVIOUS** minor injuries.
7. Coordinate with other areas as required.
8. Coordinate with EMS COMMAND as needed to establish temporary morgue facilities.

TRANSPORTATION OFFICER

Radio Designation: **TRANSPORT**

Commanded By: EMS COMMAND or DEPUTY EMS COMMAND

Subordinates: Personnel, as needed.

Functions: Coordination of patient transportation and maintenance of records relating to patient identification, injuries, mode of transport and destination.

Duties:

1. Establish a TRANSPORTATION AREA near the TREATMENT AREA.
2. Reassess and retriage patients as they are brought from the TREATMENT AREA to the TRANSPORTATION AREA and establish priorities for transport.
3. Request EMS vehicles from STAGING AREA.
4. Communicate with COMM CENTER to obtain medical facility status and treatment capability.
5. Direct transport of patients to hospitals capable of providing appropriate treatment without exceeding hospital capabilities.
6. Advise COMM CENTER of triage priorities, destinations, and estimated times of arrival of patients as they are transported.
7. Maintain record of patient destinations.
8. Report progress to EMS COMMAND.
9. Coordinate with other areas.
10. Advise EMS COMMAND and COMM CENTER when last patient has been transported.
11. Coordinate with EMS COMMAND as needed to provide transport for the dead.

EMS SUPPLY GROUP SUPERVISOR

Radio Designation: **EMS SUPPORT**

Commanded By: EMS COMMAND

Subordinates: Personnel, as needed.

Function: Acquire and distribute appropriate medical equipment medical equipment and supplies as dictated by nature of incident and number and types of patients.

Duties:

1. Establish suitable location for SUPPORT AREA operations - normally near the TREATMENT AREA.
2. Determine medical supply and equipment needs of other areas.
3. Coordinate procurement of medical supplies from hospitals with TRANSPORTATION OFFICER, AIR OPERATIONS OFFICER, and EMS COMMAND.
4. Coordinate procurement of additional supplies not available from hospitals.
5. Report additional resource requirements to EMS COMMAND.
6. Allocate supplies and equipment as needed.
7. Report progress to EMS COMMAND.
8. Coordinate with other areas.

AIR OPERATIONS MANGER

Radio Designation: **AIR OPS**

Commanded By: EMS STAGING AREA MANAGER

Subordinates: Personnel, as needed.

Function: Establish landing zones and coordinate use of helicopters for patient transport.

Duties:

1. Determine what aircraft are operating within incident area of assignment.
2. Survey assigned incident area to determine situation, aircraft hazards, and other potential problems.
3. Coordinate establishment of locations and landing-departure patterns for landing zones.
4. Coordinate loading of patients into helicopters with TRANSPORTATION OFFICER.
5. Coordinate use of assigned communications frequencies with COMM CENTER.
6. Insure all assigned helicopters know appropriate operating frequencies in cooperation with COMM CENTER.
7. Insure approved night flying procedures are in operation.
8. Maintain continuous observation of assigned helicopter operating areas and landing zones.
9. Inform EMS COMMAND of incident conditions including any aircraft malfunction.
10. Inform EMS COMMAND when mission is completed and reassign helicopter as directed.

SAFETY OFFICER

Radio Designation: **EMS SAFETY**

Commanded By: EMS COMMAND or DEPUTY EMS COMMAND

Subordinates: DEPUTY SAFETY OFFICERS, as needed

Function: Responsible for the safety of rescuers and victims through all phases of the incident.

Duties:

1. Monitors all rescues for unsafe situations.
2. Insure that all EMS sectors are setup in safe locations and monitor them occasionally for new problems.
3. Verify that a safe landing zone is set before any air operations are started.
4. Coordinate with CISD and Medical Support to make sure personnel are adhering to the rotation schedule.
5. Assists CISM and MEDICAL SUPPORT OFFICER in monitoring for critical incident stress in personnel.

MEDICAL SUPPORT UNIT LEADER

Radio Designation: **EMS MEDICAL SUPPORT**

Commanded By: EMS COMMAND or DEPUTY EMS COMMAND

Subordinates: MEDICAL SUPPORT Team members

Function: Responsible for the physical and emotional health of rescuers through all phases of the incident.

Duties:

1. Establish the MEDICAL SUPPORT AREA in an area out of direct view of the incident.
2. Monitor and log the vital signs of all personnel going through the area, at least when entering and leaving the area.
3. Monitor personnel for critical incident stress and notify the SAFETY OFFICER when signs are noticed.
4. Coordinate with the American Red Cross and the Salvation Army for Fluid and dietary needs.

Appendix F

Triage Principles/Protocols

The objective of triage is to accomplish the greatest medical good for the greatest number of patients by allowing limited resources for treatment and transport to be applied to persons who will benefit the most from them.

During a major incident, triage is an ongoing process which involves continuing reevaluation of patients. Triage is performed by:

1. The TRIAGE GROUP SUPERVISOR or Triage Team members in the rescue/triage area.
2. The TREATMENT GROUP SUPERVISOR in the TREATMENT AREA.
3. The TRANSPORTATION OFFICER in the TRANSPORTATION AREA.

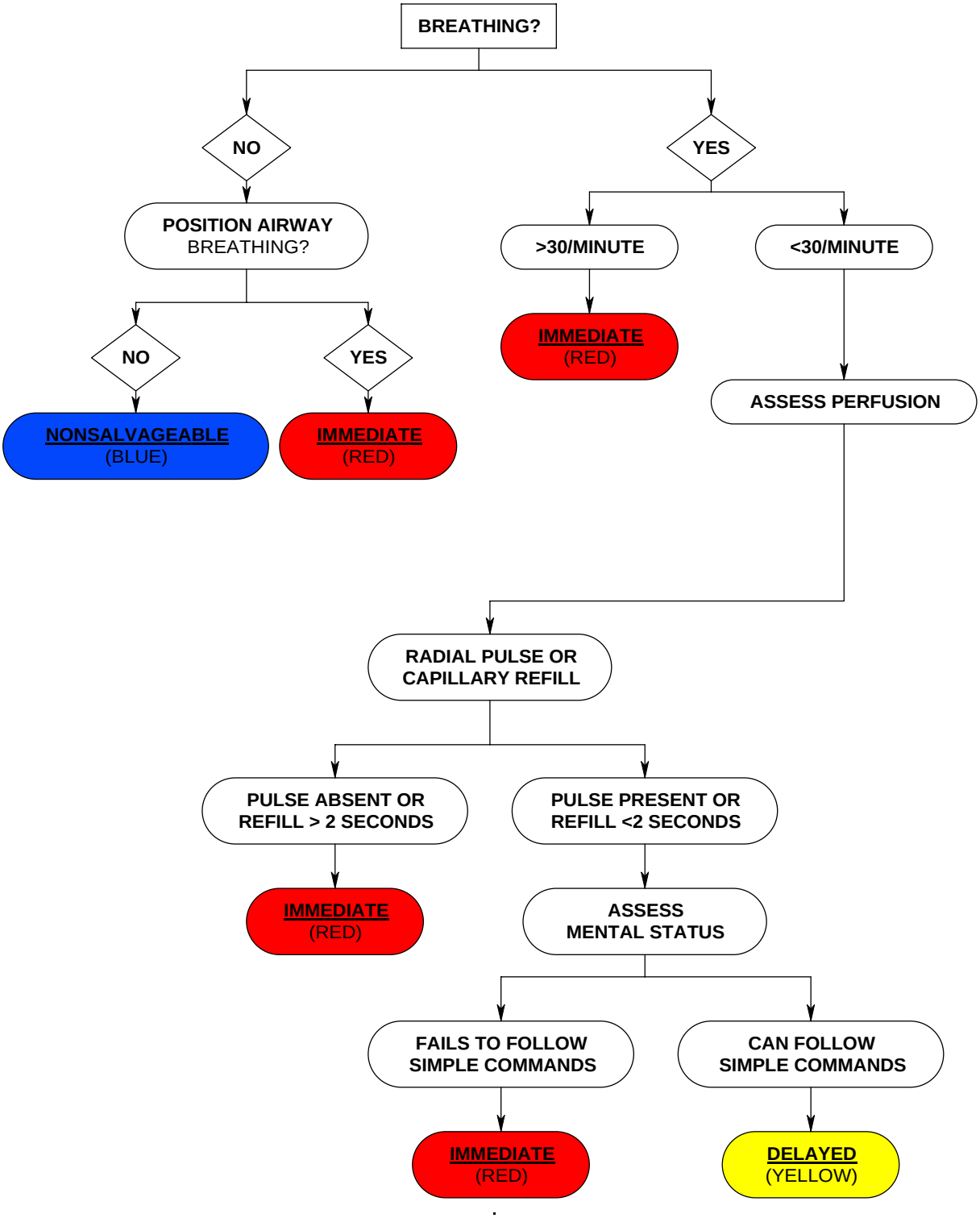
At any step in the triage/treatment/transportation process, the patient's triage priority may be revised to reflect changes in his condition.

Initial triage should be performed using the Simple Triage and Rapid Treatment (START) system. The START system allows patients to be triaged quickly based on a rapid assessment of ventilation, perfusion, and mental status. The patient should be triaged as IMMEDIATE (Red), DELAYED (Yellow), or NONSALVAGEABLE (Blue) and marked with ribbon, tape or wrist bands of the appropriate color.

Triage at the TREATMENT and TRANSPORTATION AREAS will be performed using the more detailed Four Category system which takes location and nature of injury and patient history into consideration.

Initial triage can also be performed using the M.A.S.S. method, if there are a large number of casualties. It is based on START, but faster for large number of victims.

S.T.A.R.T. Trage


BREATHING?
NO
YES
POSITION AIRWAY
BREATHING?
>30/MINUTE
<30/MINUTE
NO
YES
IMMEDIATE
(RED)
NONSALVAGEABLE
(BLUE)
IMMEDIATE
(RED)
ASSESS PERFUSION
RADIAL PULSE OR
CAPILLARY REFILL
PULSE ABSENT OR
REFILL > 2 SECONDS
PULSE PRESENT OR
REFILL <2 SECONDS
IMMEDIATE
(RED)
ASSESS
MENTAL STATUS
FAILS TO FOLLOW
SIMPLE COMMANDS
CAN FOLLOW
SIMPLE COMMANDS
IMMEDIATE
(RED)
DELAYED
(YELLOW)

FOUR CATEGORY TRIAGE SYSTEM

Priority I (IMMEDIATE: Red)

1. **All** airway problems or potential airway problems
2. **All** penetrating chest trauma.
3. Blunt chest trauma associated with shock, significant dyspnea, paradoxical movement of chest wall, possible pneumo/hemothorax.
4. **All** penetrating abdominal trauma.
5. Blunt abdominal trauma associated with shock, altered level of consciousness, guarding, rigidity, or diffuse tenderness.
6. Uncontrolled or suspected severe hemorrhage.
7. **All** shock, regardless of cause.
8. **All** altered level of consciousness regardless of cause.
9. Major medical emergencies (non-traumatic chest pain, dysrhythmias, poisoning, status epilepticus, significant non-traumatic dyspnea, etc.).
10. Obstetrical complications.
11. Burns, if:
    a. Third degree > 10% body surface area;
    b. Second degree > 25% body surface area;
    c. Face or neck involved;
    d. < 11 or > 50 years old;
    e. Associated with additional major trauma or chronic medical problems; or
    f. Electrical.

Priority II (DELAYED: Yellow)

1. Burns, if:
    a. Third degree 2-10% body surface area;
    b. Second degree 15-20% body surface area;
    c. Hands, feet or perineum involved.
2. Spinal injuries with or without spinal cord damage.
3. Blunt chest trauma without shock or significant dyspnea.
4. Blunt abdominal trauma without shock or signs of peritoneal irritation (guarding, rigidity, diffuse tenderness).
5. Major orthopedic or soft tissue injuries, including open fractures, impaired neurological function, or loss of distal pulse.

Priority III (MINOR: Green)

1. Burns, if:
    a. Third degree < 2% body surface area;
    b. Second degree < 15% body surface area.
2. Minor orthopedic and soft tissue injuries, including closed fractures with distal neurovascular function intact.
3. Psychological or behavioral problems.

Priority IV (EXPECTANT - NONSALVAGEABLE: Blue)

1. Full arrest without adequate manpower.
2. Neurological death (traumatic coma with areflexia and fixed, dilated pupils).
3. Third degree burns > 80% body surface area.
4. Obvious mortal wounds (severe open skull fracture; massive crushing trauma to chest, abdomen, or pelvis, etc.).
5. Obvious D.O.S. (Decapitated, burned beyond recognition, dismembered).

M.A.S.S. Triage

This method can be used when the number of casualties or number of Triage personnel make it difficult to achieve Initial Triage in a timely fashion. This method is still based off the S.T.A.R.T. system and is only for use in the Initial Triage phase. Reassessment is also a required throughout all patient contact.

M – Move
A – Assess
S – Sort
S – Send

MOVE Of M.A.S.S. Triage		
Goal:	**Action:**	**Category:**
Group ambulatory patients	"Everyone who can hear me and needs medical attention, please move to the area with the green flag." (or other identifier)	**Minor** initial group
Group awake, follow commands	Ask the remaining victims "Everyone who can hear me please raise an arm or leg so we can come help you."	**Delayed** initial group
Identify who is left	Proceed immediately to these patients and deliver immediate life-saving interventions (open airway and bleeding control)	**Immediate** initial group Or **Expectant/Dead** initial group

Tag all patients in the Delayed, Immediate, or Expectant/Dead categories.
As you continue assessing patients their categories could change due to change in patient condition or change in available resources. As patients are moved to the Treatment area, they will be triaged by the Four Category System. The Four Category System will also be used in aiding which patients should be moved first to Treatment.

APPENDIX G

Medical Support Protocol