Winter 17

Central Shenandoah
EMERGENCY MEDICAL SERVICES
COUNCIL

Mass Casualty Incident Plan

Central Shenandoah EMS Council, Inc.

Serving Emergency Services Providers in:

Augusta, Bath, Highland, Rockbridge, Rockingham,
Buena Vista, Harrisonburg, Lexington, Staunton and Waynesboro

Last Revised: December 2016

2312 W. Beverley Street, Staunton, VA 24401

CONTENTS

Preface....4
DEFINITIONS....4
SCOPE OF THE MCI PLAN....5
AUTHORITY....6
PURPOSE OF MCI RESPONSE GUIDE....6
GENERAL PROVISIONS....7
LEVELS AND CATEGORIES....7
POTENTIAL INCIDENTS....8
MANAGEMENT GOALS....8
INCIDENT PRIORITIES....8
PARTICIPANTS....9
LOCAL EMERGENCY PLANS....9
INITIAL RESPONSE TO AN INCIDENT....10
ACTIVATING THE MCI PLAN....10
RESPONSIBILITIES – HOSPITAL....11
PRE-HOSPITAL RESPONSIBILITIES....12
CONSIDERATIONS FOR HEALTH CARE FACILITY EVACUATIONS....13
FATALITIES AND MASS FATALITIES INCIDENTS....13
UNIVERSAL PRECAUTIONS....14
EMERGENCY COMMUNICATIONS....14
EMERGENCY MEDICAL RESPONSE....15
TECHNICAL RESCUE OPERATION....16
HAZARDOUS MATERIALS....16
CRITICAL INCIDENT STRESS MANAGEMENT....17
AIRSPACE RESTRICTIONS....17
MED-EVAC OPERATIONS....17
HELICOPTER OPERATIONS....18
TERRORISM....19
Types of Incidents....19
Preparation Process....20
Responding to an Incident....20
Program Goals....20

MEDIA RELATIONS 21
VIRGINIA EMS DISASTER TASK FORCES 21
DEACTIVATING THE MCI PLAN 22
THE DISASTER COMMITTEE 22
POST-INCIDENT ANALYSIS (PIA) 22
ADOPTION OF THE MCI PLAN MEMORANDUM OF UNDERSTANDING 23
REVISIONS AND AMENDMENTS TO THE MCI PLAN 23

PREFACE

The goal of the Central Shenandoah Emergency Medical Services Council (CSEMS) Mass Casualty Incident Plan, as stated in the accompanying Memorandum of Understanding, is to prepare 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). It includes patients who are involved in any emergency evacuation of any health care facility in the CSEMS Council region and/or any such facility outside the region that is a signatory to the CSEMS MCI Plan's Memorandum of Understanding.

This Response Guide, as most recently amended, will serve as the basis for hospital and out-of-hospital response under the EMS Council MCI Plan (hereafter referred to as the MCI Plan) in the CSEMS Council region Planning Districts 6.

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 CSEMS Council region as provided in the Code of Virginia, Section 32.1-113.

To submit questions, comments, or suggestions please contact:

Central Shenandoah EMS Council, Inc.
2312 W. Beverley Street
Staunton, VA 24401
Telephone: 540-886-3676
Facsimile: 540-886-3735
E-mail: csems@vaems.org
Web Site: www.csems.org

DEFINITIONS

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

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

HEALTH CARE FACILITY EVACUATION (Evacuation) – An event resulting in the need to evacuate any number of patients from a health care facility on a temporary basis when

the movement of those patients exceeds the EMS capabilities of the facility, locality, jurisdiction and/or region.

HEALTHCARE FACILITY – Any hospital, clinic, infirmary or other healthcare provider that offers emergency services or acute cares services.

M.C.I. MEDICAL CONTROL – That medical facility, designated by the hospital community, which provides remote overall medical direction of the MCI or Evacuation scene according to predetermined guidelines for the distribution of patients throughout the healthcare community. Generally the initial receiving hospital will contact designated hospital medical control to determine distribution of patients beyond the capabilities of local hospital.

PRE-HOSPITAL E.M.S. AGENCY – Any volunteer, career, private or governmental Emergency Medical Services agency or service that is certified by the Commonwealth of Virginia to render pre-hospital emergency care and provide emergency transportation for such and/or injured people as described in the Code of Virginia, Section 32.1-148.

E.M.S. PROVIDER – Any person "responsible for the direct provision of EMS in a given medical emergency" as described in the Code of Virginia, Section 32.1-148.

NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS) –NIMS has been adopted and utilized by all participating emergency response agencies in the CSEMS region. It helps control, direct and coordinate emergency personnel, equipment and other resources, from the scene of an MCI or Evacuation, to the transportation of patients to definitive care, to the conclusion of the incident.

VIRGINIA S.T.A.R.T. TRIAGE – The Virginia Simple Triage and Rapid Treatment method whereby patients in an MCI are assessed and evaluated on the basis of the severity of injuries and assigned the following emergency treatment priorities.

SCOPE OF THE MCI PLAN

The CSEMS council is defined as Planning District 6. The regional MCI Plan involves the counties of Augusta, Bath, Highland, Rockbridge, Rockingham and the cities of Buena Vista, Harrisonburg, Lexington, Staunton and Waynesboro.

The MCI Plan addresses only the EMS mutual aid response of the regional emergency medical services (EMS) system, hospital and pre-hospital, to a Mass Casualty Incident or Health Care Facility Evacuation.

Mass Casualty Incidents with limited fatalities and those that involve mass fatality incidents within the CSEMS Council 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 (see Section 18).

AUTHORITY

The CSEMS Council is one of the regional EMS councils established within the Code of Virginia, Section 32.1-113. The CSEMS Council 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.

The Board of Directors of CSEMS Council has the responsibility of effectively fulfilling those planning and response functions and with the overall maintenance and oversight of the CSEMS MCI Plan.

PURPOSE OF MCI RESPONSE GUIDE

The purposes of the MCI Plan's Mutual Aid Response Guide are to:

- Provide a standardized action plan that will assist in the coordination and/or management of any regional EMS mutual aid response to an MCI within the CSEMS Council region.
- Ensure an effective utilization of the various human and material resources from various localities involved in a regional mutual aid EMS response to a disaster or MCI that affects a part or the entire CSEMS Council region.
- Assist in the evacuation and care of a significant number of patients from any health care facility when the care and transportation of those patients exceeds the EMS capabilities of the facility, locality, jurisdiction and/or region.
- 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 CSEMS Council region, in each hospital Emergency Department, and in each licensed EMS agency in the region.
- This document will be reviewed each year by the CSEMS 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. The CSEMS Council will provide updated copies.

GENERAL PROVISIONS

The CSEMS Council MCI Plan calls for the following general provisions:

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

LEVELS AND CATEGORIES

MCIs within the CSEMS Council region will be classified by levels, following assessment by EMS providers using the Virginia START triage system:

Level	Description	Resources Needed
Level 1	Multiple-casualty situation resulting in less than 10 surviving victims.	7 Ambulances should be requested
Level 2	Multiple-casualty situations resulting in 10 to 25 surviving victims.	13 Ambulances should be requested
Level 3	Mass casually situation resulting in more than 25 surviving victims.	20+ Ambulances should be requested

POTENTIAL INCIDENTS

MCIs can occur in varying degrees, at anytime, and in practically any conceivable situation. High risks in the region include:

- Heavily traveled highways and interstates between populated area
- Freight and passenger rail lines.
- Light and heavy industrial plants.
- Navigable rivers and recreational lakes.
- Severe and usual weather conditions also prevail throughout the region, including tornados, windstorms, hurricanes and heavy rains, heavy snows usually to the west, sleet and freezing rains and flooding of the rivers.

Based on these numerous components, potential MCIs in the CSEMS Council region could include:

- 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.
- Acts of terrorism and/or civil disobedience.
- Military-related incidents and federal disaster responses.

MANAGEMENT GOALS

Goals of MCI management:

- Perform the greatest good for the greatest number of people.
- Make the best possible use of manpower, equipment and facility resources.
- Avoid relocating the MCI to any receiving hospitals.

INCIDENT PRIORITIES

Priorities of an MCI (or other complex emergency situation):

- Life safety.
- Incident stabilization.
- Conservation of property and equipment.

- Provide safety, accountability and welfare.

PARTICIPANTS

The regional EMS mutual aid response to an MCI or Evacuation may involve, as required by the scope of the incident:

- Certified and/or licensed EMS providers at all levels of emergent patient care, from pre-hospital Basic Life Support (BLS) and Advanced Life Support (ALS) to acute medical and surgical treatment nurses and physicians in the hospital in the region, and related healthcare providers, especially those with facilities to care for critically injured or sick patients.
- Healthcare facilities, in particular those with acute-care or emergency facilities to care for critically injured or sick patients.
- Local, state and federal government agencies include, but not limited to: the Virginia Department of Emergency Management; the Virginia Department of Health including the Office of Emergency Medical Services, the local Health Districts, the Office of the Chief Medical Examiner; the Virginia Department of State Police; the Virginia Department of Transportation; the Virginia Department of Military Affairs; the U.S. Armed Forces (including the U.S. Coast Guard); the Federal Emergency Management Agency (FEMA); and Local Emergency Planning Committees from jurisdictions within the CSEMS Council region.
- Non-transport and related support components such as the American Red Cross, Salvation Army, regular and reserve components of the armed forces, Civil Air Patrol, amateur radio organizations, and any other groups that support EMS operations.
- The key to successful EMS mutual aid response to a major disaster or MCI is the close cooperation and coordination of these components and the CSEMS Council community through effective communications, planning and training.

LOCAL EMERGENCY PLANS

It is recognized that each county and locality has an emergency operations plan. Whenever possible, regional EMS mutual aid response should conform to the local emergency guidelines.

Regional EMS response planning will be transparent to, and support the health and medical annexes of, jurisdiction emergency operations plans. Planning guidance in this document will be made available to local Emergency Services Coordinators to assist them in the preparation and maintenance of their plans. The CSEMS Council MCI Plan will be employed in circumstances such as when:

- The disaster or MCI is of such magnitude that the locality should institute mutual aid to avoid exhausting its EMS resources.
- The disaster or MCI crosses local boundaries to other jurisdictions may need to institute mutual aid to avoid exhausting their EMS resources.

- A hospital or other health care facility must evacuate patients on a temporary basis and transportation requirements exceed the EMS capabilities of the facility, locality, and/or region.
- The local Emergency Services Coordinator should be made aware as early as possible that the MCI Plan has been activated, or that there is a need for mutual aid.

INITIAL RESPONSE TO AN INCIDENT

The MCI Plan calls for the 5-S approach to an MCI as taught in the Virginia Mass Casualty Incident Management training program:

- Scene Safety Assessment – Determine providers are safe before entering the scene.
- Survey the Scene – Determine type of incident, number of patients, severity of injuries, and best access.
- Send information and requests for assistance – Contact dispatch with survey information, request resources, activate the MCI Plan.
- Establish scene management structure utilizing IMS to include extrication, triage, treatment, and transportation.

Begin "Simple Triage And Rapid Treatment" of incident victims.

- Initial Triage - (Using the START Method) - Utilize the Triage Ribbons (color coded plastic strips). One should be tied to an upper extremity in a VISIBLE location (wrist if possible). RED – Immediate, YELLOW – Delayed, GREEN – Ambulatory (minor), BLACK – Deceased (non-salvageable.
- Secondary Triage - Will be performed on all victims during the Treatment Phase. If a victim is identified in the initial triage phase as a RED and transport is available, do not delay transport to perform a secondary assessment. The triage priority determined in the Treatment Phase should be the priority use for transport.
- START - Locate and remove all of the walking wounded into one location away from the incident, if possible. Begin assessing all non-ambulatory victims where they lay, if possible. Each victim should be triaged in 60 seconds or less. Assess respirations, perfusion, and mental status.

ACTIVATING THE MCI PLAN

The following individuals can active the MCI Plan for EMS mutual aid:

- The Incident Manager at the scene of a MCI according to the existing local protocol.
- The Emergency Services Coordinator, or that person's representative, of a political subdivision that has authority for the management of the incident.
- The Chief Executive Officer, or the appointed representative, of a health care facility that is required to evacuate or move patients when additional resources of personnel or vehicles are required.

- Any health care facility in the CSEMS Council region when additional resources are necessary to provide appropriate patient care.

It is strongly recommended that this Plan be activated through the local Emergency Communications Center, which will communicate directly with MCI Medical Control and with localities whose pre-hospital resources may be used within the CSEMS Council region.

To activate the MCI Medical Control component of this Plan, call land telephone line or cellular phone of hospital.

- The person authorized to request activation should identify herself/himself and request activation of this plan (Central Shenandoah EMS Council Mass Casualty Plan).
- The person should give a brief summary of the incident. The information should include time of the incident, type of incident, location, initial number of patients involved, and a callback phone number.

RESPONSIBILITIES – HOSPITAL

MCI Medical Control – Augusta Medical Center will serve as primary MCI Medical Control for the CSEMS Council region in the event of an incident that requires activation of the Regional MCI Plan. Other hospitals in our council region include Carilion Stonewall Jackson Hospital, Bath County Community Hospital and Rockingham Memorial Hospital.

- The indicated hospital may designate another acute care medical facility to act as primary MCI Medical Control for any appropriate reason including better communications, better or closer geographical location to the MCI site, or because of any other circumstances that would be in the best interest of effective patient care.
- The indicated hospital will notify the designated hospital, by med com or telecommunication, that it is relinquishing the MCI Medical Control function, and will receive an appropriate sign of acceptance of the MCI Medical Control responsibility from the designated hospital.

Representatives of participating health care facilities will establish Hospital Triage Level and Mutual Aid Capability tables. These tables will be reviewed every six months and which will be confirmed or adjusted at the time of the incident.

MCI Medical Control will activate or alert the appropriate acute care medical facilities and other appropriate health care facilities in those numbers and in those locations that best can accommodate the scope of the MCI and/or Evacuation, and which are in the best interests of effective patient care.

Hospitals that are activated or alerted under the MCI Plan will provide upon request from MCI Medical Control confirmation or adjusted information on the predetermined numbers of patients they can accommodate in the three START Triage categories: Red, Yellow and Green (Hospital Triage Level), or confirm or adjust the predetermined numbers and categories of patients they can receive from another hospital through Mutual Aid in the event of an Evacuation/Mutual Aid Capability).

MCI Medical Control will assign patients to the medical facilities closest to the site of an MCI or evacuation and which can provide the appropriate levels of emergency care. The levels will be contained in the suggested Hospital Triage Level and Mutual Aid Capability tables that are agreed to in advance by hospital officials (See Section 15.4).

MCI Medical Control also will be responsible for any on-line medical control during patient transport to designated receiving hospitals. On-line medical direction likely will be affected by limited access to the radio system during an MCI.

In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with patient care protocols as established by the Medical Directors of Planning District 6.

Hospitals will be responsible for providing definitive patient care to the levels of their capabilities during and after the incident.

PRE-HOSPITAL RESPONSIBILITIES

Transportation of patients under this Plan during an incident or evacuation will be done by licensed pre-hospital EMS agencies in the CSEMS Council region and from neighboring regions when necessary and available.

Units and personnel involved in mutual aid response to a regional MCI or an evacuation will be dispatched through the local emergency communications and/or dispatching center who is responsible for monitoring individual unit response to and from the incident.

Individual providers will report to their respective agencies and will not self-dispatch to the scene of the incident. Responding Units will respond to a designated check-in site so that on-scene command may direct them. Providers who so respond in privately owned vehicles (POVs) will be directed to report to their respective agencies or at the discretion of the Incident Manager and if they have appropriate EMS identification, may be directed to the incident Staging Area. No one will be allowed direct access to the MCI site without first checking in at the primary check-in site to the Incident Commander or his authorized designee (Staging Officer).

All out-of-hospital providers and/or agencies responding to an MCI site in the CSEMS Council region agree to operate under the Virginia Mass Casualty Incident Management System, the Virginia START® Triage System and the Pre-hospital Patient Care Protocols of the region.

Localities affected by an MCI will be responsible for activating mutual aid through their own Emergency Communications Systems. Use of the available resources of the Virginia Office of EMS, Virginia Department of Emergency Management, the Virginia Association of Volunteer Rescue Squads, or the CSEMS Council is encouraged.

Pre-hospital EMS agencies and/or localities agree to respond with personnel and equipment when the MCI Plan is activated, but should not be expected to reduce local emergency response capabilities below acceptable levels. When considering their responses to requests for

assistance under the MCI Plan, localities and/or individual pre-hospital EMS agencies will be expected to maintain their emergency response capabilities to meet local needs.

The crews of pre-hospital EMS units responding to an MCI or Evacuation will be required to carry self-identification and proof of affiliation with their agency.

The crews of pre-hospital EMS units responding to an MCI or Evacuation will be responsible for maintaining all operational documentation, and for making that documentation available to appropriate authorities.

Pre-hospital agencies in the CSEMS Council region will participate when possible in annual training exercises of the MCI Plan held in various locations within the council region. These annual training exercises include the regional airport, all hospitals within the region and in some cases, local industries.

Pre-hospital agencies will encourage their providers to participate in on-going regional training for rescue and EMS personnel in the Incident Management System, Virginia START Triage System, hazardous materials awareness programs and other related MCI skills.

CONSIDERATIONS FOR HEALTH CARE FACILITY EVACUATIONS

When a health care facility must evacuate any number of patients on a temporary basis, the following shall apply:

- The administrative staff of the evacuating health care facility will be responsible for directing the evacuation and transfer of patients to the designated receiving hospital or health care facility in coordination with MCI Medical Control.
- Physicians whose patients have been evacuated will receive Courtesy Medical privileges from the receiving hospital for the duration of the emergency. These privileges will be stipulated in predetermined and pre-negotiated protocols and/or agreements which may be added to this document as an appendix.
- Each evacuated patient will be accompanied by his/her medical records.
- Receiving health care facility will use routine admitting procedures for patients from the evacuated hospital including, if possible, consent for treatment.

FATALITIES AND MASS FATALITIES INCIDENTS

By Virginia State Statute, the Chief Medical Examiner is responsible for the medical investigation of sudden, unexpected, and violent deaths throughout the Commonwealth. Persons who die under those circumstances require the expeditious and skilled attention of the Medical Examiner. Depending on the nature of the incident local, state, and federal Emergency Management, law enforcement officials, and others may be involved in activities such as morgue operations, suspicious death investigations, and so forth.

It is critical that the Medical Examiner's Office be notified as early as possible in any mass casualty incident which involves, or which may involve, fatalities. Suspected or actual exposures

to communicable diseases or bio-terrorism agents will be reported to appropriate health district as soon as practical.

The Office of the Chief Medical Examiner can be reached by calling 804-786-3174.

The dead must be treated with respect and dignity in thought and in actions at all times.

Delineate temporary morgue, moving bodies/parts when released by the medical examiner. Under the direction of the Chief Medical Examiner or designee the State Funeral Directors MCI Plan may be activated.

Preliminary setup for dealing with families, new media and by-standers. Information released through Medical Examiner only.

Transportation to hospital morgue for thorough exam and delineation of cause of death, preferably by the funeral home. EMS agencies do not transport fatalities to hospital morgue in an MCI setting and under this plan.

MCI also may be a Mass Fatalities Incident.

- A Mass Fatalities Incident is any situation where there are more bodies than can be handled using local resources.
- In a disaster situation, identification of the dead is a critical issue. Therefore, security of the area in which the dead are located is critical. Close cooperation with the Medical Examiner and police authorities, both in MCI preplanning and during the incident, is essential.
- During a mass fatalities incident, extreme stress and grief are natural and expected reactions by emergency responders and EMS providers, as well as survivors.

UNIVERSAL PRECAUTIONS

All EMS personnel involved in a regional response to an MCI or Evacuation will be expected to observe Universal Precautions and other infection control Body Substance Isolation practices as specified by their agency. Suspected or actual exposures to communicable diseases or bio-terror agents will be reported to the appropriate health district as soon as practical. In addition, the infectious control officers for the involved public safety agencies and the appropriate hospital infection control personnel should be notified.

EMERGENCY COMMUNICATIONS

Radio communication will remain the primary method of hospital-to-hospital and hospital-to-field communications during a MCI. The system will provide a dedicated channel for hospital-to-hospital communications.

Other communications tools that can be used during an MCI include the statewide Rescue Mutual Aid Frequency (155.205), and cellular telephones.

- The Statewide Mutual Aid Frequency (155.205) should be monitored to provide updated information and to receive information that will assist in staging ambulances, other EMS vehicles or human an/or material resources in line with the Incident Management System.
- The HEAR radio frequency 155.340 or established Med Com is the primary channel for communications between the MCI Medical Control hospital and the EMS Transportation Sector at the incident.
- The HEAR radio frequency 155.280 or the established Med Com is the primary channel for communications between the MCI Medical Control hospital and other health care facilities involved in the incident.

Unless there is an extreme emergency, pre-hospital ambulance crews should not use the HEAR frequency or statewide Mutual Aid frequency for communicating when responding to an incident, or when transporting a patient to a designated hospital from the MCI site.

If it is absolutely necessary for an ambulance crew to communicate with a hospital or other emergency services agency en route from the MCI scene, the UHF MED channels, if available, should be used in accordance with established radio protocols.

Ten codes are prohibited from use during an MCI or evacuation.

In the case of cellular phones, no cells dedicated to EMS are available at this time. Therefore, because the cellular system is likely to be very busy during an MCI, once an open cell line has been established by the Incident Manager or other key element of the Incident Management System (i.e., Transportation Officer or Command Post/Communications Center), it should be kept open for the duration of the MCI. Ham operations should be considered.

EMERGENCY MEDICAL RESPONSE

The MCI Plan assumes that localities and/or out-of-hospital agencies will respond to all emergency scenes under local dispatch protocols. Units and crews will continue to operate under local protocols until such time as it has been determined that a regional MCI exists and the MCI Plan has been activated by the MCI Medical Control.

In the interest of safety, efficiency and accountability, response to the scene of an MCI by individual providers in their privately owned vehicles (POVs) is strongly discouraged. Providers who so respond will be directed to report to their respective agencies or, at the discretion of the Incident Manager and if they have appropriate EMS identification, may be directed to the Incident Staging Area. They will not be allowed direct access to the MCI site. (See Article 16.3).

The MCI Plan stipulates the use of the Virginia Simple Triage and Rapid Treatment (START) system within standardized Incident Management System that is used by Virginia Emergency Services and Emergency Medical Services agencies. The MCI Plan also calls for the use of the Virginia Triage/MCI Patient Information Tags during any response.

A standardized Incident Management System (IMS), as developed and taught within the CSEMS Council region, allows EMS personnel from anywhere in the region to quickly and easily become

integrated into local and/or regional response efforts. It also provides effective command and control of EMS resources, and provides for cooperative integration with other emergency support functions.

TECHNICAL RESCUE OPERATION

A technical rescue may include any operation that requires the use of specialized equipment and knowledge to extricate victims from collapsed area, confined spaces, high angle, and search and rescue operations. Personnel shall comply with National Fire Protection Association 1983, Standard on Fire Service Life Safety Rope and System Components and 29 Code of Federal Regulation 1926.650, Excavations.

Mass Casualty Incidents involving extended technical rescue operations should use the resources available from the local, state, and/or federal system.

When the incident overwhelms the abilities and assets of the local jurisdiction and local mutual aid, the locality may request aid from several Virginia jurisdictions that have established technical rescue teams. The Virginia Department of Emergency Management EOC, 1-800-468-8892, is the Search and Rescue Coordination Center for Virginia and can initiate contact with State SAR and Technical Rescue teams for the locality.

All personnel involved in Mass Casualty technical response operations must have appropriate training and maintain compliance with Occupational Health and Safety Administration (OSHA) standards.

HAZARDOUS MATERIALS

Definition: Substances or materials, which pose unreasonable risks to health, safety, property or the environment when used, transported, stored or disposed of, which may include materials which are: gases, liquids, or solids. They may include toxic substances, flammable and ignitable materials, explosives, corrosives, and radioactive materials. (Title 44-146.34)

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 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.

While all hospitals are encouraged to have basic decontamination capabilities to treat patients exposed to hazardous materials, Augusta Medical Center will serve as primary decontamination facility for hazardous materials incidents within the CSEMS region.

Decontamination, within the public safety community, involves the removal or deactivation of contaminants from people, equipment, or the environment. It protects responders 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 responders may be able to preclude the occurrence of adverse health effects from the materials.

All personnel involved in a Mass Casualty Hazardous Materials should meet the appropriate training level in accordance with established guidelines as set forth by U.S. Department of Transportation (USDOT), Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), State and Local emergency response procedures.

CRITICAL INCIDENT STRESS MANAGEMENT

Critical Incident Stress Management (CISM) has been determined to be an integral part of any emergency medical response to an MCI or evacuation. CISM may be defined as a comprehensive, integrated, multi-component crisis intervention system. Local, regional and national teams of certified mental health and peer debriefers are available for assistance.

- No one working in emergency services is immune to critical incident stress, regardless of past experiences or years of service. Request a briefing from a CISM team if stress symptoms continue beyond the first 48-72 hours of an incident. CISM Team Peer Group can be activated and respond to the scene, as needed.
- CISM teams in the CSEMS Council Region can be activated through their 24-hour communications line at 540-245-5501.
- Other CISM assets can be activated through the Virginia EOC at 804-674-2400 or 1-800-468-8892.
- Members of the Central Shenandoah Regional CISM Team are certified.

AIRSPACE RESTRICTIONS

The airspace over any MCI is regulated by the Federal Aviation Administration (FAA). Questions or requests concerning the use or restriction of that airspace during an incident should be referred as early as possible to the appropriate air traffic control tower. The Virginia EOC at 804-674-2400 or 1-800-468-8892 has contact information to assist in this function if needed.

MED-EVAC OPERATIONS

Med-Evac services are available 24 hours a day. This resource should be coordinated through jurisdictions' local emergency communication centers.

In a large-scale emergency, the Virginia EOC may be contacted to ascertain phone numbers of the Virginia Army National Guard, Virginia Air National Guard, and the U.S. Coast Guard for possible use of the aviation assets of those organizations.

Fixed-wing and helicopters can be used to evacuate patients from the scene of an MCI with the exception of a Haz-Mat incident. However, other possible uses should be considered. These uses for both types of aircraft include:

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

Specific uses for helicopters include:

- Use of the Flight Paramedic for triage or treatment; use of the helicopter to deliver or shuttle special personnel, equipment or supplies; use of the helicopter to deliver or remove resources at the scene; use of the helicopter to overcome natural or other physical barriers.

HELICOPTER OPERATIONS

If needed, a helicopter-landing zone (LZ) should be designated as early as possible by the Incident Manager or the Manager's designated EMS Air Ambulance Coordinator.

- The LZ should be as near as possible to the MCI scene but should not affect patient care areas.
- The LZ should be away from power lines, towers, trees, buildings and other potential height hazards. It should be selected with consideration for pedestrian and vehicular traffic control needs. The LZ should be a minimum of 200 feet away from any traffic.
- Roads or highways, with proper traffic control, make suitable LZs. However, safety considerations must include any nearby power lines.
- The overall size of an LZ should not be less than 500 feet by 500 feet.
- The helicopter touchdown site in daylight should not be less than 75 feet by 75 feet.
- The helicopter touchdown site at and after dusk should not be less than 100 feet by 100 feet.
- The touchdown site should have a wide and clear path of flight approach and departure. Helicopter pilots prefer to land and take off with the aircraft's nose into the prevailing wind.
- The helicopter pilot is the final judge in selecting an appropriate site to land the aircraft, and on deciding whether or not to land.
- The LZ should be staffed, marked and prepared before, during and after landings and takeoffs.
    - Minimum staff in daylight should be a person with easy-to-spot clothing, with arms above head and back to the down-draft. LZ personnel should wear effective eye and ear protection and be familiar with dangers of working around helicopters, especially during a "hot" operation, when the aircraft engines and rotors are operating.

- Precise marking of the LZ in bright daylight is not essential as long as the intended area is obvious to the helicopters' flight crew.
- The LZ at dusk and in darkness shall not be marked with flares but with lights (lantern, vehicular, etc.). All lighting must be secured against the helicopter's downdraft.
- LZ personnel must guard against flashing any lights toward the aircraft. Strobe lights bleed through as white.
- The LZ should be inspected for loose debris, foreign objects and loose dirt. The LZ can be wet down if necessary to reduce dust and enhance visibility.

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

- In the absence of other directives, the Statewide Rescue Mutual Aid frequency (155.205) should be used when communicating with the helicopter. Good communications with the flight crew will ensure the prompt and safe landing of the aircraft.
- Before and during final approach, the flight crew should be advised of potential hazards, wind direction, ground conditions and, if available, the patient's general status. LZ personnel should check constantly and repeatedly for pedestrian traffic and other hazards in or near the LZ.
- The helicopter flight crew should be advised immediately to abort the landing if any threat develops to the flight crew or to ground personnel.

TERRORISM

Responders to acts of domestic terrorism are likely to range from untrained civilians, to local and state law enforcement personnel, to public health and public service employees, to certified EMS providers (fire and rescue), to highly trained hazardous materials (hazmat) and technical rescue personnel.

Hospital physicians, nurses and other staff will be involved treating patients who are brought by EMS personnel to those facilities, and patients who will arrive by other means of transportation at those facilities.

TYPES OF INCIDENTS

- Terrorism deals specifically with those weapons of mass destruction that generally are categorized as nuclear, biological, radiological, chemical or explosive. The initial response will be according to the local emergency plan, followed by the MCI Plan if a regional response is necessary.
- It is unlikely that emergency First Responders immediately will be able to determine if an incident is an accident or an act of domestic terrorism. An explosion could be accidental or purposeful. The release of chemical or biological agents could be an accidental incident or planned act of terrorism.
- First Responders must be aware that a mass casualty incident could be a possible act of domestic terrorism. They must be aware of methods of protecting themselves from

becoming victims by avoiding exposure to chemical or biological agents, radiation, nuclear, and secondary explosions.

PREPARATION PROCESS

Pre-hospital and hospital agencies shall prepare to respond to acts of domestic terrorism through:

- Regular consultations and interactions among participating leaders to review and revise appropriate documents, plans and procedures, including the MCI Plan.
- Regular training programs in specific MCI skills.
- Regular review and assessment of the threat(s).
- Regular review and assessment of regional resources.
- Regular exercises and evaluations of local/regional MCI response.
- Regular review of areas of operational responsibility.

RESPONDING TO AN INCIDENT

- Assess and promptly report any incident.
- Protect first responders and bystanders.
    - Treat victims as appropriate to their assessed injuries, including all phases of decontamination.
- Attempt to reduce the threat to hospital emergency departments by appropriate decontamination and subsequent treatment of victims.
- When possible, help to mitigate the incident (including law enforcement investigation and rehab).
- Enhance seamless interagency and regional interactions using pre-established agreements and procedures.

PROGRAM GOALS

- Maximum threat awareness for likely First Responders and hospital staff to include nuclear, biological or chemical incidents and those using explosives.
- Maximum utilization of the Virginia MCI Management System
- Seamless interaction of the local, state and federal agencies that respond to an incident by establishing – in advance – specific areas of responsibilities.
- Maximum utilization of human and material resources while minimizing loss of life and suffering among the victims and First Responders.
- Enhance effective interaction, to include communications, between hospitals and out-of-hospital EMS agencies during any act of domestic terrorism, or MCI.
- Encourage the acquisition by appropriate agencies of specialized equipment necessary to counter the effects of domestic terrorism, including caches of medications and mass decontamination facilities.

MEDIA RELATIONS

Public information is a vital function of emergency services; therefore, each jurisdiction's public information office should be notified of all emergency situations that require notification of their county/city leadership and/or fire chief/emergency manager. The PIO should maintain a current contact list to expedite the information to media.

When the MCI plan is in effect, PIOs in each jurisdiction will serve as the primary source of contact for release of all information when the incident is in their region. Any news media contacting an ECC shall be referred to the PIO in the jurisdiction. If practical, whenever two or more agencies are involved in an incident, PIOs should use the Joint Information System concept. This enables emergency personnel to resolve emergencies and provide media with one source for information.

Emergency services personnel should direct all media requests to the jurisdictional PIO.

State-level emergency public information will be broadcast by the Emergency Alert System (EAS) consisting of broadcast and cable network; AM, FM, and television broadcast stations; low power television stations; and other organized entities operating during emergencies at the national, state, and local events. The State EOC has the primary responsibility of keeping the public informed when the emergency affects a widespread area.

VIRGINIA EMS DISASTER TASK FORCES

In a declared state or local emergency, local resources can be supplemented by requesting deployment of state EMS Disaster Task Forces through the EMS Desk in the Virginia Emergency Operations Center (1-800-468-8892 or 804-674-2400).

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

- Standard Task Force: Composed of one Basic Life Support (BLS) ambulance, one Advanced Life Support (ALS) ambulance, one heavy-duty or medium-duty rescue truck, and a disaster truck or trailer if available, with a Task Force Commander and minimum of eight (8) EMS providers.
- Personnel Package: Composed of standard Task Force staffing with appropriate transportation. Providers carry no equipment other than personal kits.
- Augmentation Package: A standard task force with vehicles and personnel tailored to meet the needs of the requesting jurisdiction.

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

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

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

DEACTIVATING THE MCI PLAN

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

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

If appropriate and possible, on-scene contact to MCI Medical Control should be made by phone. Otherwise, radio communication should be used.

MCI Medical Control will deactivate the MCI Plan among activated hospitals when the designated MCI Medical Control hospital is notified by the on-scene Incident Manager that EMS activities are completed at the MCI or Evacuation site or sites, and when it is determined that all other patient care issues have been resolved.

THE DISASTER COMMITTEE

The Disaster Committee is a working committee of the CSEMS Council. It is made up of representatives of the hospital and pre-hospital components, career and volunteer, that render emergency medical care in Planning District 6.

Other members of the Committee include, but are not limited to, representatives of related local, state and federal agencies (including law enforcement and emergency communications), disaster relief organizations, representatives of major industries, transportation and utilities companies, along with local businesses and other individuals whom members of the committee may call upon from time to time for advice and expertise.

Members will be recommended by the committee and appointed by the CSEMS Council President. Members shall serve in an uncompensated capacity on the Committee for as long as they are willing and able to render service to the cause of regional disaster preparedness.

POST-INCIDENT ANALYSIS (PIA)

Within six months of the conclusion of the incident the Central Shenandoah EMS Council will facilitate a post-incident analysis, including all agencies involved in the MCI. The purpose of the PIA is to analyze the incident to determine “lessons learned.”

ADOPTION OF THE MCI PLAN MEMORANDUM OF UNDERSTANDING

Participation in the plan shall be through the adoption by the appropriate governing body and signing by an authorized representative of the CSEMS Council Mass Casualty Incident Plan Memorandum of Understanding, as most recently revised.

- Copies of the Memorandum of Understanding (attached) and this Mutual Aid Response Guide shall be provided to each locality and hospital by the CSEMS Council.
- CSEMS Council shall be responsible for providing the signatory agencies with copies of the most recent updated Memorandum and Mutual Aid Response Guide, and not more than 60 days following any revision(s).
- Copies of the Memorandum and one copy of the Mutual Aid Response Guide shall be filed by CSEMS with the Virginia Office of Emergency Medical Services.
- In the case of a hospital, a resolution of adoption shall include an appendix that provides for appropriate adjunctive or emergency privileges to be accorded to attending physicians during an MCI (See Section 17).

REVISIONS AND AMENDMENTS TO THE MCI PLAN

The CSEMS Council Disaster Committee is responsible for reviewing each year this MCI Plan in line with the CSEMS Council MCI Plan Memorandum of Understanding, for proposing revisions and/or amendments to the Mutual Aid Response Guide as necessary to maintain its effectiveness, for reviewing and evaluating any activation of the MCI Plan, and for planning annual MCI exercises in the region.

Revisions and/or amendments will be acted upon by the Committee no sooner than 45 days, and not longer than 60 days, after all signatories have been notified of the proposed changes and have had an opportunity to respond through their representatives or in writing to the Committee Chair.

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