



EMS Mass Casualty Incident Plan

2009

Thomas Jefferson EMS Council
EMS Mass Casualty Plan
(Revised 02-25-2009)

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1. PREFACE

The goal of the Thomas Jefferson EMS (TJEMS) Council EMS Mass Casualty Plan is to prepare, on a regional basis, for a unified, coordinated and immediate emergency medical services (EMS) response by prehospital and hospital resources to, and the effective emergency medical management of, victims of any type of Mass Casualty Incident (MCI).

This EMS MCI Plan, as most recently amended, will serve as the basis for out-of-hospital responses in the TJEMS region (planning district 10 and Madison County of planning district 9).

Success of the MCI plan depends upon effective cooperation, organization and planning among health care professionals, hospitals, EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning districts which compromise the TJEMS region as provided in the Code of Virginia, § 32.1-111.11.

2. BASIC DEFINITIONS

2.1 For the purpose of the EMS MCI Plan, the following definitions will apply:

2.1.1 EMS Agency – an entity licensed by the Office of EMS to engage in the business, service, or regular activity, whether or not for profit, of transporting or rendering immediate medical care to persons who are sick, injured, or otherwise incapacitated. Any volunteer, career, private or governmental Emergency Medical Services agency that is licensed by the Commonwealth of Virginia to render prehospital care and provide emergency transportation for the sick and/or injured as described in the Code of Virginia, § 32.1-148.

2.1.2 EMS Provider – a person who holds a valid certification issued by the Office of EMS.

2.1.3 Mass Casualty Incident (MCI) – sometimes called a Multiple Casualty Incident or Multiple Patient incident, an MCI is an event resulting from a natural, technological or human hazard that causes illness and/or injuries that exceed the Emergency Medical Services (EMS) capabilities of a locality, jurisdiction and/or region.

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2.1.4 MCI Medical Control – that medical care facility, designated by the local healthcare community, which provides remote overall medical direction of the MCI and coordinates the distribution of patients throughout the healthcare community.

2.1.5 Medical Care Facility – any institution, place, building, or agency, whether licensed or required to be licensed by the Board of Health, whether operated for profit or nonprofit and whether privately owned or privately operated or owned and operated by a local government unit, by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical.

2.1.6 Incident command system - a management system designed to enable effective and efficient incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. A basic premise of ICS is that it is widely applicable. It is used to organize both near-term and long-term field-level operations for a broad spectrum of emergencies, from small to complex incidents, both natural and manmade. ICS is used by all levels of government—Federal, State, local, and tribal—as well as by many private sector and nongovernmental organizations. ICS is also applicable across disciplines. It is normally structured to facilitate activities in five major functional areas: command, operations, planning, logistics, and finance and administration.

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

3. AUTHORITY

3.1 The Thomas Jefferson EMS Council is one of eleven regional EMS councils established within the Code of Virginia, § 32.1-111.11. TJEMS 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.

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4. SCOPE OF THE EMS MCI PLAN

4.1 The Thomas Jefferson EMS Council region consists of planning district 10 and Madison County from planning district 9. As such, the EMS MCI Plan is applicable to the counties of: Albemarle, Fluvanna, Greene, Louisa, Madison and Nelson and the city of Charlottesville.

4.2 The EMS MCI Plan addresses the EMS mutual aid responses of the regional emergency medical services (EMS) system.

4.3 Mass Casualty Incidents that involve fatalities will be handled in cooperation with the Virginia Office of the Chief Medical Examiner, local law enforcement officials and/or Virginia State Police and the Virginia Department of Emergency Management.

5. GENERAL PROVISIONS

5.1 The EMS MCI Plan necessitates the following general provisions and assumptions:

5.1.1 The proximity and capabilities of appropriate medical care facilities will be the primary considerations of MCI Medical Control when designating the medical care facilities to which patients are distributed during any local or regional emergency situation that results in the activation of the EMS MCI Plan.

5.1.2 Localities and/or individual EMS agencies will respond with appropriate personnel and equipment as available when the EMS MCI Plan is activated. The response will be dispatched by the local Emergency Communications Center. EMS agencies should not “self-dispatch.”

5.1.3 When considering their responses to activation of the EMS MCI Plan, localities and/or EMS agencies will be expected to maintain emergency medical response capabilities necessary to meet local needs.

5.1.4 Personnel affiliated with all participating EMS agencies and/or jurisdictions will operate during a MCI or under a standard Incident Command System (ICS) as required by Homeland Security Presidential Directive (HSPD)–5, *Management of Domestic Incidents*.

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5.1.5 Hospital and pre-hospital components in the region should participate in training exercises that require use of the MCI Plan. TJEMS will assist with the coordination of these exercises as requested.

6. LEVELS AND CATEGORIES

6.1 EMS MCI's within the TJEMS region will be classified by levels based upon an assessment by EMS providers using the Virginia S.T.A.R.T. Triage System:

6.1.1 **Level 1:** MCI resulting in less than 10 surviving victims.

6.1.2 **Level 2:** MCI resulting in 11 to 25 surviving victims.

6.1.3 **Level 3:** MCI resulting in greater than 25 surviving victims.

7. POTENTIAL INCIDENTS

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

7.1.1 University of Virginia

7.1.2 North Anna Nuclear Power Plant

7.1.3. Charlottesville-Albemarle Regional Airport

7.1.4 Heavily traveled highways and interstates between populated areas

7.1.5 Freight and passenger rail lines

7.1.6 Light and heavy industrial plants

7.1.7 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.

7.2 Based on these risks, potential Mass Casualty Incidents in the TJEMS region could include:

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7.2.1 Multi-family residential structure fires

7.2.2 Radioactive substance release

7.2.3 Public transportation crash (aircraft, train, bus, *etc.*)

7.2.4 Major vehicular accidents with multiple victims

7.2.5 Construction and/or industrial and farm accidents including hazardous materials, building collapses with multiple victims

7.2.6 River and/or localized flooding, impassable highways, roads and bridges

7.2.7 Medical care facility evacuations

7.2.8 Acts of terrorism and/or civil disobedience

7.2.9 Tornadoes or other severe weather-related events

8. MANAGEMENT GOALS

8.1 Goals of MCI management:

8.1.1 Perform the greatest good for the greatest number of people.

8.1.2 Make the best possible use of labor, equipment and facility resources.

8.1.3 Avoid relocating the MCI to a medical care facility.

9. INCIDENT PRIORITIES

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

9.1.1 Life safety

9.1.2 Incident stabilization

9.1.3 Conservation of property and equipment

9.1.4 Provide for the safety, accountability and welfare of victims and responders.

10. PARTICIPANTS

10.1 The regional EMS system response to an MCI may involve:

10.1.1 Certified and/or licensed EMS providers at all levels of emergent patient care, from prehospital Basic (BLS) and Advanced (ALS) Life Support to acute medical and surgical treatment nurses

and physicians in the hospital setting as well as related healthcare providers, especially those with facilities to care for critically injured or sick patients.

10.1.2 Medical care facilities, in particular those with acute-care or emergency facilities to care for critically injured or sick patients.

10.1.3 Local, state and federal government agencies may include, but not be 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 TJEMS region.

10.1.4 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 and emergency operations.

10.2 The key to successful EMS system response to a MCI is the close cooperation and coordination of these components and the emergency response community through effective communications, planning and training.

11. LOCAL EMERGENCY OPERATIONS PLANS

11.1 It is recognized that each Virginia county and locality has an emergency operations plan. **Whenever possible, regional EMS system response to a MCI should conform to the local emergency operations**

**guidelines and established agreements between Designated
Emergency Response Agencies (DERA).**

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

11.2.1 The MCI is of such magnitude that it completely exhausts the EMS resources of one locality.

11.2.2 The MCI crosses local boundaries and exhausts the EMS resources of one or more localities.

11.2.3 A medical care facility must evacuate patients on a temporary basis and transportation requirements exceed the capabilities of the facility, locality and/or region.

11.3 The local Emergency Services Coordinator should be notified as soon as possible that the EMS MCI Plan is activated, or of the possible need.

12. INITIAL RESPONSE TO AN INCIDENT

12.1 The EMS MCI Plan calls for the 5-S approach as taught in the Virginia Mass Casualty Incident management training program:

12.1.1 Assess the scene for **S**afety – determine if providers will be safe.

12.1.2 **S**urvey the Scene – determine the type of incident, number of patients, severity of injuries (category) and best access.

12.1.3 **S**end information and request assistance – contact dispatch with survey information, request resources, activate MCI Plan.

12.1.4 **S**et up scene management structure (ICS) – include extrication, triage, treatment and transportation.

12.1.5 Begin **S**.T.A.R.T. triage of patients.

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13. ACTIVATING THE MCI PLAN

13.1 The MCI Plan can be activated by the following individuals:

13.1.1 The Incident Manager/Incident Commander at the scene of the MCI according to existing local protocol.

13.1.2 The EMS or Emergency Services Coordinator, or that person's representative, of a political subdivision who has authority for the management of the incident.

13.2 It is strongly recommended that the MCI Plan be activated through the local Emergency Communications Center:

13.2.1 The person authorized to request the activation should identify himself/herself and request to activate the MCI Plan. This person should give a brief description of the incident. The information should include time of incident, location; initial numbers of patients involved and re-contact information (call back number, radio designation, etc.).

13.3 Local protocol will dictate the necessity for mutual aid agencies to be notified (DERA's) and the notification of any additional resources.

14. RESPONSIBILITIES – EMS AGENCIES

14.1 Transportation of patients under the authority of the EMS MCI Plan will be performed by licensed EMS agencies in the Thomas Jefferson EMS Council region and from neighboring regions when necessary and available.

14.2 Units and personnel involved in an EMS system response to a MCI will be dispatched through the local emergency communications center.

14.3 Individual providers will report to their respective agencies and will not self-dispatch to the scene of the incident. Providers who respond in privately-owned vehicles (POV's) will be directed to report to their respective agencies or, at the discretion of the Incident Commander and if they have appropriate EMS Identification, may be directed to the Incident Staging Area.

14.4 All EMS providers and/or agencies responding to a MCI in the TJEMS region agree to operate under the Virginia Mass Casualty Incident

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Management System, and the Virginia START Triage system. The respective regional Patient Care Guidelines are to be utilized by EMS agencies providing patient care at the incident.

14.5 Crew members of EMS units responding to a MCI will be required to carry self-identification and should be prepared to provide proof of affiliation with their agency.

14.6 Crew members of EMS units responding to a MCI will be responsible for maintaining all medical and operational documentation, and for making that documentation available to the appropriate authorities.

15. RESPONSIBILITIES – MEDICAL CARE FACILITIES

15.1 MCI Medical Control – The University of Virginia Medical Center (UVAMC) will serve as primary MCI Medical Control for the TJEMS region in the event of an incident that requires activation of the EMS MCI Plan.

15.1.1 UVAMC may request the Martha Jefferson Hospital 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.

15.2 MCI Medical Control will activate the appropriate medical care facilities that best can accommodate the scope of the MCI, and which are in the best interests of effective patient care.

15.3 Medical care facilities that are activated under the auspices of the EMS MCI Plan will provide upon request from MCI Medical Control confirmation or revised information on the numbers of patients they can accommodate in the three START Triage categories: Red, Yellow and Green.

15.4 MCI Medical Control will assign patients to the medical care facilities closest to the site of an MCI and which can provide the appropriate levels of emergent care.

15.5 MCI Medical Control also will be responsible for any on-line medical direction during patient transport to medical care facilities.

15.5.1 In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with the regional patient care guidelines in effect in the region in which the transporting personnel are released to practice as EMS providers.

16. FATALITY and MASS FATALITY INCIDENTS

16.1 By Commonwealth of Virginia 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.

16.2 It is critical that the Medical Examiner's Office be notified as early as possible in any MCI that involves, or may involve fatalities.

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

16.3 An MCI also may be a Mass Fatality Incident.

16.3.1 A Mass Fatality Incident is any situation where there are more bodies than can be handled using local resources. The Chief Medical Examiner may activate the State Funeral Directors Mass Fatalities Plan.

17. STANDARD PRECAUTIONS

17.1 All EMS personnel involved in a response to a MCI will be expected to observe Standard Precautions and other Body Substance Isolation practices as specified by the Centers for Disease Control, OSHA or mandated by their agency. Suspected or actual exposures to communicable diseases or bioterrorism agents will be reported to the appropriate health district as soon as practical. In addition, the infection control officers for the involved EMS agencies and the appropriate hospital infection control personnel should be notified.

18. EMERGENCY COMMUNICATIONS

18.1 The H.E.A.R system will remain the primary method of field-to-hospital communications during a MCI. The VHF system provides a dedicated channel for communications and is recorded for future review. Telephone communications are discouraged due to volume and inconsistencies in cellular coverage.

18.1.1 The H.E.A.R radio frequency (EMS 1, 155.340) is the primary channel for communications between the medical care facility and the EMS Transportation Unit at the incident.

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18.2 The Statewide Mutual Aid frequency (155.205) should be implemented when a MCI event requires the response of EMS agencies from outside the primary jurisdiction of the event. It may also be utilized within a jurisdiction as a tactical channel.

18.3 Unless there is an extreme emergency, ambulance crews **should not** use EMS 1 or the Statewide Mutual Aid frequency for communicating when responding to an incident, or when transporting a patient to a medical care facility from a MCI site. The EMS Transportation Unit Leader will communicate patient information to the receiving facility.

18.4 The use of ten-codes is prohibited. EMS providers will use "plain English" to communicate information during a MCI.

19. CRITICAL INCIDENT STRESS MANAGEMENT

19.1 Critical Incident Stress Management (CISM), a comprehensive, integrated, multi-component crisis intervention system, may be requested as an integral part of any emergency medical response to a MCI. A regional team of certified mental health and peer "debriefers" is available for assistance.

19.1.1 The TJEMS CISM team can be activated through their 24-hour phone number: 434-872-8260.

19.1.2 Other CISM assets can be activated through the Virginia EOC at 804-674-2400 or 1-800-468-8892.

20. VIRGINIA HEALTH and MEDICAL EMERGENCY RESPONSE TEAMS (EMS DISASTER TASK FORCES)

20.1 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).

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

20.2.1. 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

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or trailer, if available, with a Task Force Commander and minimum of eight (8) EMS providers.

20.2.2 Personnel Package: Composed of standard Task Force staffing with appropriate transportation. Providers carry no equipment other than personal kits.

20.2.3 Augmentation Package: A standard task force with vehicles and personnel tailored to meet the needs of the requesting jurisdiction.

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

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

21. DEACTIVATING THE MCI PLAN

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

21.2 MCI Medical Control will deactivate the EMS MCI Plan among medical care facilities when MCI Medical Control is notified by the on-scene Incident Commander that EMS activities are completed at the MCI site or when it is determined that all other patient care issues have been resolved.