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Central Virginia
Mass Casualty Incident Plan
EMS Mutual Aid Response Guide
Effective Date: July 1, 1999

1. PREFACE

The goal of the Central Virginia 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 prehospital 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 Old Dominion Emergency Medical Services Alliance (ODEMSA) region and/or any such facility outside the region that is a signatory to the Central Virginia 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 Central Virginia MCI Plan (hereafter referred to as the MCI Plan) in the 9,000-square-mile ODEMSA region, Planning Districts 13, 14, 15 and 19.

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 districts which comprise the ODEMSA region as provided in the Code of Virginia, Section 32.1-111.11.

2. BASIC DEFINITIONS

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

2.1.1. **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.

2.1.2. **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.

2.1.3. **HEALTHCARE FACILITY --** Any hospital, clinic, infirmary or other

healthcare provider that offers emergency services or acute care services.

2.1.4. **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.

2.1.5. **PREHOSPITAL 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 prehospital emergency care and provide emergency transportation for sick and/or injured people as described in the Code of Virginia, Section 32.1-148.

2.1.6. **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.

2.1.7. **INCIDENT MANAGEMENT SYSTEM (IMS)** -- A written plan, adopted and utilized by all participating emergency response agencies, that 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.

2.1.8. **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.

3. GENERAL AGREEMENT

3.1. The Central Virginia MCI Plan calls for the following general provisions:

3.1.1. 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.

3.1.2. Localities and/or individual prehospital 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.

3.1.3. 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.

3.1.3. Predetermined EMS mutual aid responses will be employed by hospital and prehospital members when any of the signatory health care facilities must be

evacuated under the MCI Plan.

3.1.4. Personnel affiliated with all participating EMS agencies and/or jurisdictions will operate during an Incident or Evacuation under a standard Incident Management System (IMS) as endorsed by the Central Virginia MCI Committee and taught within the ODEMSA region.

3.1.5. Hospital and prehospital 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 ODEMSA through the Central Virginia MCI Committee.

4. AUTHORITY

4.1. The Old Dominion EMS Alliance is one of eight regional EMS councils established within the Code of Virginia, Section 32.1-111.11. Created in 1980, ODEMSA 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.

4.2. The Board of Directors of ODEMSA has assigned to its Central Virginia MCI Committee, and that Committee's Operations Group, the responsibility of effectively fulfilling those planning and response functions and with the overall maintenance and oversight of the Central Virginia MCI Plan.

5. SCOPE OF THE M.C.I. PLAN

5.1. The Old Dominion EMS Alliance is defined as the 9,000-square-mile region made up of Virginia Planning Districts 13, 14, 15 and 19. The regional MCI Plan involves the counties of: Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Cumberland, Dinwiddie, Halifax, Hanover, Henrico, Goochland, Greensville, Lunenburg, Mecklenburg, New Kent, Nottoway, Powhatan, Prince Edward, Prince George, Surry, Sussex; the cities of Colonial Heights, Emporia, Hopewell, Petersburg, Richmond, and South Boston; and the towns of Ashland, Farmville and South Hill.

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

5.3. Mass Casualty Incidents with limited fatalities and those that involve mass fatality incidents within the ODEMSA 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 Services (See Section 19).

6. M.C. I. OPERATIONAL GUIDE

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

6.1.1. 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 ODEMSA region.

6.1.2. 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 all of the ODEMSA region to include Planning Districts 13, 14, 15 and 19.

6.1.3. 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.

6.1.4. Ultimately, to ensure the largest number of survivors in mass casualty situations or health care facility evacuations.

6.2. A copy of the Central Virginia Mutual Aid Response Guide will be kept in each licensed EMS response vehicle in the ODEMSA region, in each hospital Emergency Department, and in each licensed EMS agency in the region.

6.3. The Response Guide will be reviewed each year by the Committee's Operations Group, referencing the MCI Plan Memorandum of Understanding. Proposed revisions, amendments and other changes will be referred to the full Committee for its action. Updated copies will be provided by ODEMSA (See Section 31).

7. LEVELS AND CATEGORIES

7.1. MCIs within the ODEMSA region will be classified by levels, following assessment by EMS providers using the Virginia START Triage system:

7.1.1 **Level 1** Multiple-casualty situation resulting in less than 10 surviving victims.

7.1.2 **Level 2** Multiple-casualty situation resulting in 10 to 25 surviving victims.

7.1.3 **Level 3** Mass casualty situation resulting in more than 25 surviving victims.

8. POTENTIAL INCIDENTS

8.1. MCIs can occur in varying degrees, at anytime, and in practically any conceivable situation. Central Virginia's population stands at some 1.2 million people. These

residents live in areas ranging from densely-populated urban such as Richmond and the Petersburg-Hopewell-Colonial Heights areas, to suburban locations, to largely rural areas with farms, forests and recreational areas. High risks include:

8.1.1. Three major Interstate highways (64, 85 and 95), numerous highly-traveled primary highways (U.S. 1, 58, 60, 360 and 460) between major population areas.

8.1.2. Freight and passenger rail lines, a major navigable river, a major hub airport and a number of smaller airports that serve high-speed, multi-passenger aircraft.

8.1.3. Industrial plants ranging from chemical manufacturing, to cigarette manufacturing, to petroleum fuels storage, to light industry.

8.1.4. A major amusement theme park that draws thousands of people to the region during temperate months.

8.1.5. Severe and usual weather conditions also prevail throughout the region, including tornadoes, windstorms, hurricanes and heavy rains, heavy snows usually to the west of Richmond, sleet and freezing rains east of Richmond, and flooding in the James River and Appomattox River basins.

8.2. Based on these components, potential MCIs in the region could include:

8.2.1. Major vehicular accidents with multiple victims.

8.2.2. Urban, residential and woodland fires.

8.2.3. Tornadoes or other severe weather-related situations.

8.2.4. Public transportation accidents (aircraft, train, bus).

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

8.2.6. River and/or localized flooding, impassable highways, roads and bridges.

8.2.7. Healthcare facility evacuations.

8.2.8. Acts of terrorism and/or civil disobedience.

8.2.9. Military-related incidents and federal disaster responses.

9. MANAGEMENT GOALS

9.1. The goals of MCI management are:

9.1.1. Do the greatest good for the greatest number of people.

9.1.2. Make the best possible use of resources.

9.1.3. Avoid relocating the MCI, especially to any receiving hospitals.

10. INCIDENT PRIORITIES

10.1. The top priorities of an MCI (or other complex emergency situation) are:

10.1.1. Provider safety, accountability and welfare.

10.1.2. Life safety.

10.1.3. Incident stabilization.

10.1.4. Conservation of property and equipment.

11. PARTICIPANTS

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

11.1.1. Certified EMS providers from both the out-of-hospital arena (career services and volunteer rescue squads and emergency crews) and trained medical staff from critical care hospitals, especially trauma centers, to provide on-scene care for the critically injured or sick.

11.1.2. Healthcare facilities, in particular trauma centers and hospitals with acute-care or other emergency or special facilities, to receive and treat critically injured or sick patients.

11.1.3. Certified and/or licensed healthcare providers at all levels of emergent patient care, from prehospital Basic Life Support (BLS) and Advanced Life Support (ALS) to acute medical and surgical treatment nurses and physicians in hospitals, local health department personnel, and other related healthcare professionals.

11.1.4. Trained First Responders and specially trained emergency services personnel to include firefighters, hazardous materials specialists and individuals trained in technical/tactical rescue skills, search and rescue procedures and dive rescue.

11.1.5. Local, state and federal government agencies including, but not limited to: Local Emergency Planning Committees (LEPCs) of jurisdictions within the ODEMSA region; Virginia Department of Emergency Management; Virginia Department of Health (VDH) including the Office of Emergency Medical Services, Office of the Chief Medical Examiner and local public health departments; Virginia Department of State Police; local police and sheriffs' offices; Virginia Commission of Game and Inland Fisheries; Virginia Department of Transportation; Virginia Department of Corrections; Virginia Department of Military Affairs; Federal Emergency Management

Agency (FEMA); Federal Bureau of Investigation (FBI); and U.S. Armed Forces (including the U.S. Coast Guard).

11.1.6. Non-transport and/or related support components such as the American Red Cross, Salvation Army, public utilities (gas, power, water), airlines, regular and reserve components of the armed forces, Civil Air Patrol, amateur radio organizations, and any other group that supports EMS operations.

11.2. 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 Central Virginia EMS Community through effective communications, planning and training.

12. LOCAL EMERGENCY OPERATIONS PLANS

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

12.2. Regional EMS 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 local Emergency Services Coordinators to assist them in the preparation and maintenance of their plans. The ODEMSA MCI Plan will be employed in circumstances such as when:

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

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

12.2.3. 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.

12.3. The local Emergency Services Coordinator should be contacted as soon as possible that the MCI Plan is activated, or of a possible need for mutual aid.

13. INITIAL RESPONSE TO AN INCIDENT

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

13.1.1. Assess scene for Safety -- Determine if providers will be safe.

13.1.2. Survey the Scene -- Determine type of incident, number of patients, severity of injuries, and best access.

13.1.3. Send information and requests for assistance -- Contact dispatch with survey information, request resources, activate the MCI Plan.

13.1.4 Set up scene management structure -- include extrication, triage, treatment and transportation.

13.1.5 Begin START Triage of incident victims.

14. ACTIVATING THE M.C.I. PLAN

14.1. The MCI Plan for EMS mutual aid can be activated by the following individuals:

14.1.1. The Incident Manager at the scene of an MCI according to the existing local protocol.

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

14.1.3. The Chief Executive Officer, or that person's representative, of a health care facility that is required to evacuate or move patients.

14.1.4. Any health care facility in the ODEMSA region when additional resources are necessary to provide appropriate patient care.

14.2. It is strongly recommended that the MCI Plan be activated through the local Emergency Communications Center which will communicate directly with MCI Medical Control and with localities whose prehospital resources may be used within the ODEMSA region.

14.3. The MCI Medical Control component of the MCI Plan is activated by calling on land telephone line or cellular phone the VCU/Medical College of Virginia Hospitals (MCVH) at 804-828-8888.

14.3.1. The person authorized to request activation should identify herself/himself, ask to activate the MCI Plan.

14.3.2. The person should give a brief summary of the incident. The information should include time of the incident, location, initial number of patients involved, and a callback phone number.

14.4. Depending on local protocol and the scope of the incident, the local Emergency Communications Center will activate the Prehospital Component of the MCI Plan through established mutual aid agreements among prehospital volunteer and career EMS agencies in the region as provided for in this document.

14.4.1. The Emergency Communications Center dispatcher should emphasize that the mutual aid request for ambulances and/or equipment is under the activated Central Virginia MCI Plan.

15. RESPONSIBILITIES--HOSPITAL

15.1. MCI Medical Control -- The VCU/Medical College of Virginia Hospitals will serve as primary MCI Medical Control for the ODEMSA region in the event of an incident that requires activation of the MCI Plan.

15.1.1. VCU/MCV Hospitals 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.

15.1.2. VCU/MCV Hospitals will notify the designated hospital, by HEAR radio 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.

15.2. Representatives of participating hospitals will establish Hospital Triage Level and Mutual Aid Capability tables. These tables will be reviewed each six months and which will be confirmed or adjusted at the time of the incident.

15.3. 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.

15.4. Hospitals 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 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 in the event of an Evacuation (Mutual Aid Capability).

15.5. 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.).

15.6. 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 HEAR radio system during an MCI.

15.7. In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with ODEMSA's Prehospital Patient Care Protocols, as most recently revised and approved by the Old Dominion Medical Control Committee.

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

16. RESPONSIBILITIES--PREHOSPITAL

16.1. Transportation of patients under the MCI Plan during an incident or evacuation will be done by licensed prehospital EMS agencies in the Old Dominion EMS Alliance region and from neighboring regions when necessary and available.

16.2. Units and personnel involved in mutual aid response to a regional MCI or Evacuation will be dispatched through the local emergency communications and/or dispatching center.

16.3. Individual providers will report to their respective agencies and will not self-dispatch to the scene of the incident. 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. **They will not be allowed direct access to the MCI site.**

16.4. All out-of-hospital providers and/or agencies responding to an MCI site in the ODEMSA region agree to operate under the Virginia Mass Casualty Incident Management System, the Virginia START Triage system and the Prehospital Patient Care Protocols of the Old Dominion EMS Alliance.

16.5. Localities affected by an MCI will be responsible for activating mutual aid in the region 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 Old Dominion EMS Alliance is encouraged.

16.6. Prehospital 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 prehospital EMS agencies will be expected to maintain their emergency response capabilities to meet local needs. (See Sections 3.1.2. and 3.1.3.)

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

16.8. The crews of prehospital EMS units responding to an MCI or Evacuation will be responsible for maintaining all medical and operational documentation, and for making that documentation available to IMS officials.

16.9. Prehospital agencies in the ODEMSA region will participate when possible in annual training exercises of the MCI Plan held in various locations within Planning Districts 13, 14, 15 ad 19. (See Section 3.1.5).

16.10 Prehospital 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, hazard awareness programs, terrorism

awareness, and other related MCI skills.

17. MEDICAL DIRECTION, PROTOCOLS AND TRIAGE

17.1. In the absence of on-line or on-scene medical direction, out-of-hospital adult and pediatric patient care will be rendered in accordance with ODEMSA's Prehospital Patient Care Protocols, as most recently revised. Unless otherwise designated, final medical documentation will be done on Virginia Prehospital Patient Care Reports (PPCRs).

17.2. Field triage of patients will conform to the guidelines described in the Commonwealth of Virginia Emergency Operations Plan which involves the Virginia START Triage System as outlined in this MCI Plan Mutual Aid Response Guide. General categories are: Red -- Immediate care required; Yellow -- Care can be delayed; Green -- Minor injuries; Black -- Dead or non-salvageable.

17.3. The numbers and types of patients which member hospitals will be prepared to receive are suggested in predetermined Hospital Triage Levels and Mutual Aid Capability tables. (See Sections 15.2 through 15.5.)

18. SPECIAL CONSIDERATIONS FOR HEALTH CARE FACILITY EVACUATIONS

18.1. When a hospital must evacuate any number of patients on a temporary basis, the following shall apply:

18.1.1. The administrative staff of the evacuating hospital will be responsible for directing the evacuation and transfer of patients to the designated receiving hospital in coordination with MCI Medical Control.

18.1.2. 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.

18.1.3. Each evacuated patient will be accompanied by his/her medical records.

18.1.4. Receiving hospitals will use routine admitting procedures for patients from the evacuated hospital including, if possible, consent for treatment.

18.1.5. Other admitting and billing procedures will be predetermined by the participating hospitals in pre-negotiated protocols and/or agreements

which may be an appendix to this document.

19. FATALITIES AND MASS FATALITIES INCIDENTS

19.1. 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.

19.2. 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.

19.3. The Office of the Chief Medical Examiner can be reached at 804-786-3174.

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

19.5. An MCI also may be a Mass Fatalities Incident.

19.5.1. A Mass Fatalities Incident is any situation where there are more bodies than can be handled using local resources.

19.5.2. 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.

19.5.3. During a mass fatalities incident, extreme stress and grief are natural and expected reactions by emergency responders and EMS providers, as well as survivors. In these events, Critical Incident Stress Management is highly recommended (See Section 25).

20. STANDARD PRECAUTIONS

20.1. All EMS personnel involved in a regional response to an MCI or Evacuation will be expected to observe Standard Precautions (aka Universal Precautions) and other infection control Body Substance Isolation practices as specified by the Centers for Disease Control, OSHA and the NFPA Infection Control Standard 1581, and other applicable state and local infection control regulations.

21. EMERGENCY COMMUNICATIONS

21.1. Radio communication, as provided by the ODEMSA region's enhanced two-channel HEAR system, will remain the primary method of hospital-to-hospital and hospital-to-field communications during a MCI. The enhanced, voice-only VHF system provides a dedicated channel for hospital-to-hospital communications and a dedicated channel for hospital-to-field.

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

21.2.1. 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 and/or material resources in line with the Incident Management System.

21.2.2. The HEAR radio frequency 155.340 is the primary channel for communications between the MCI Medical Control hospital and the EMS Transportation Sector at the incident.

21.2.3. The HEAR radio frequency 155.280 is the primary channel for communications between the MCI Medical Control hospital and other hospitals involved in the incident.

21.3. Unless there is an extreme emergency, prehospital 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.

21.4. 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.

21.5. Because 10-Codes can vary among localities, their use is NOT recommended during an MCI or Evacuation.

21.6. In the case of cellular phones, no cells exclusively 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.

22. EMERGENCY MEDICAL RESPONSE

22.1. 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 its has been determined that a regional MCI exists and the MCI Plan has been activated by the MCI Medical Control.

22.2. 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)

22.3. 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.

22.4. A standardized Incident Management System (IMS), as developed and taught within the ODEMSA 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.

23. TECHNICAL RESCUE OPERATIONS

23.1. MCIs involving extended technical rescue operations (i.e. large transportation extrications, confined spaces, collapsed man-made or natural structures, search and rescue operations, etc.) should use the resources of the local jurisdiction.

23.2. When needs exceed local capabilities or resources, utilize existing methods to locate specialized resources. Several local teams exist in Virginia which have technical rescue capabilities. Local dispatch centers should keep team contact phone numbers available for use during an incident. A regional technical rescue team can be mobilized through fire mutual aid.

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

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

24. HAZARDOUS MATERIALS

24.1. Hazardous materials, as defined in Section 44-146.34 of the Code of Virginia, means substances or materials which may pose unreasonable risks to health, safety, property or the environment when used, transported, stored or disposed of, which may include materials which are solid, liquid or gas. Hazardous materials may include toxic substances, flammable and ignitable materials, explosives, corrosive materials, and radioactive materials and include: those substances or materials in a form or quantity which may pose an unreasonable risk to health, safety or property when transported and which the U.S. Secretary of Transportation has so designated by regulation or order; hazardous substances as defined or designated by law or regulation of the Commonwealth or law or regulation of the U.S. government; and hazardous waste as defined or designated by law or

regulation of the Commonwealth.

24.2. The local Fire Department should be contacted for incidents involving hazardous materials. The local Fire Department will contact Virginia EOC at 1-800-468-8892 for technical assistance or to have a Virginia Department of Emergency Management (VDEM) Regional Hazardous Materials Officer respond to the incident site. The VDEM Hazardous Materials Office can activate one or more regional hazardous materials response teams if required.

24.3. Actions of local emergency response organizations are based on local response plans and Virginia's Emergency Operations Plan (COVEOP), including the Oil and Hazardous Materials annex (COVEOP Volume 4), the Terrorism Consequence Management annex (COVEOP Volume 8), as well as local government and hospital emergency operations plans and terrorism management annexes.

24.4. Decontamination is the process of removing or neutralizing contaminates that have accumulated on personnel and equipment that is critical to health and safety at the scene of any hazardous materials incident, including a terrorism incident**. Whenever possible, decontamination should be accomplished at the incident site by trained personnel.** The process is designed to protect emergency care providers, to prevent mixing of incompatible substances, and to protect the community by preventing uncontrolled transportation of contaminants from the incident site. EMS providers should accept for treatment and transport on those patients who have been at least grossly decontaminated by trained personnel.

24.5. While all hospitals are encouraged to have basic decontamination capabilities to treat patients, VCU/MCV Hospitals in Richmond, Southside Regional Medical Center in Petersburg and Community Memorial Healthcenter in South Hill are the primary hospital decontamination facilities in the ODEMSA region.

24.6. Decontamination of hazmat patients and/or hospital and prehospital EMS providers will be in accordance with established national guidelines by the U.S. Department of Transportation, the Occupational Safety and Health Administration (OSHA), and the National Fire Protection Association (NFPA), as well as local and regional emergency operations plans, including the regional Domestic Terrorism and Hazmat plans that are annexes to this Response Guide.

25. CRITICAL INCIDENT STRESS MANAGEMENT

25.1. Critical Incident Stress Management (CISM) has been determined to be an integral part of any emergency medical response to an MCI or Evacuation. Regional and local teams of mental health and peer debriefers have been trained and are available throughout the ODEMSA region.

25.1.1. The ODEMSA Regional Team can be activated through the Virginia EOC, 804-674-2400 or 1-800-468-8892. Other CISM teams can be activated through local emergency communications centers or through the ODEMSA Regional Team.

26. AIRSPACE RESTRICTIONS

26.1. Airspace over an MCI is regulated by the Federal Aviation Administration (FAA).

26.1.1. Questions or requests concerning the use or restriction of that airspace during an MCI should be referred as early as possible to the FAA's Washington Air Route Traffic Control Center (ARTCC) also known as the Washington Center, at 703-771-3470.

26.1.2. Temporary flight restrictions for disaster areas are designated by the ARTCC which will notify other appropriate FAA facilities. NOTE: The Virginia EOC, at 804-674-2400 or 1-800-468-8892, has contact information to assist in this function.

27 MED-EVAC OPERATIONS

27.1. Two air medical operations serve the ODEMSA region. They are EMS Med-Flight I and VCU Life Evac. EMS Med-Flight 1 is available 24 hours a day through the Virginia Emergency Operations Center (Virginia EOC) at 804-674-2400 or 1-800-468-8892. VCU Life Evac is available 24 hours a day by calling 1-877-902-7779. The caller must provide precise identification of the intersection of highways/roads nearest to the chosen LZ.

27.2. In a large-scale emergency, the Virginia EOC can assist with phone numbers to contact the Virginia Army National Guard and Virginia Air National Guard and the U.S. Coast Guard for possible use of the aviation assets of those organizations.

27.3. Fixed-wing and rotorcraft (helicopters) can be used to evacuate patients from the scene of an MCI. However, other possible uses should be considered. These uses for both types of aircraft include:

27.3.1. 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.

27.4. Specific uses for rotorcraft include:

27.4.1. 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 human or material resources at the scene; use of the helicopter to overcome natural or other physical barriers.

28. HELICOPTER OPERATIONS

28.1. A helicopter landing zone (LZ), if needed, should be designated as early as possible by the Incident Manager or the Manager's designed EMS Air Ambulance

Coordinator.

28.1.1. The LZ should be as near as possible to the MCI scene but should not affect patient care areas.

28.1.2. 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.

28.1.3. Roads or highways, with proper traffic control, make suitable LZs. However, safety considerations must include nearby power lines.

28.2. The overall size of an LZ should be not less than 500 feet by 500 feet.

28.2.1. The helicopter touchdown site in daylight should be not less than 75 feet by 75 feet.

28.2.2. The helicopter touchdown site at and after dusk should be not less than 100 feet by 100 feet.

28.2.3. 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.

28.2.4. The helicopter pilot is the final judge in selecting an appropriate site to land the aircraft, and on deciding whether or not to land.

28.2.5. The LZ should be appropriately staffed, marked and prepared before, during and after landings and takeoffs.

28.2.5.1. 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 not shut down.

28.2.6. Precise marking of the LZ in bright daylight is not essential as long as the intended area is obvious to the helicopter flight crew.

28.2.7. The LZ at dusk and in darkness should be marked with lights (lantern, vehicular, etc.), <u>but not flares.</u> All lighting must be secured against the helicopter's down-draft.

28.2.8. LZ personnel must guard against flashing any lights toward the aircraft. Strobe lights bleed through as white.

28.2.9. 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.

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

28.3.1. In the absence of other directives, the Statewide Mutual Aid radio frequency (155.205) should be used when communicating with the helicopter. Good communications with the flight crew will ensure the prompt and safe landing the aircraft.

28.3.2. 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.

28.3.3. The helicopter flight crew should be advised immediately to abort the landing if any threat develops to the flight crew or to ground personnel.

29. VIRGINIA E.M.S. DISASTER TASK FORCES

29.1. In a declared state of 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 (1800-468-8892 or 804-674-2400).

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

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

29.2.2. **Personnel Package:** Composed of standard Task Force staffing with appropriate transportation. No equipment other than personal kits is carried by providers.

29.2.3. **Augmentation Package:** A standard Task Force with vehicles and personnel tailored to meet the needs of the requesting jurisdiction.

29.3. 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.

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

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

30. DEACTIVATING THE M.C.I. PLAN

30.1. The Medical 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.

30.2. The on-scene Medical 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.

30.3. If appropriate and possible, on-scene contact to MCI Medical Control should be made by phone (804-828-8888 if the MCI Medical Control hospital is VCU/MCV Hospitals). Otherwise, radio communication should be used.

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

31. THE M.C.I. COMMITTEE

31.1. The Central Virginia MCI Committee is a working Committee of the Old Dominion EMS Alliance. It is made up of representatives of the hospital and prehospital components, career and volunteer, that render emergency medical care in Planning Districts 13, 14, 15 and 19. Other members include representatives of health care facilities outside the region which have signed the Central Virginia MCI Plan's Memorandum of Understanding.

31.2. 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.

31.3. Members will be recommended by the Committee and endorsed by the ODEMSA Board of Directors. 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.

32. ADOPTION OF THE M.C.I. PLAN MEMORANDUM OF UNDERSTANDING

32.1. Participation in the plan shall be through the adoption by the appropriate governing body and signing by an authorized representative of the Central Virginia Mass

Casualty Incident Plan Memorandum of Understanding, as most recently revised.

32.1.1. Copies of the Memorandum of Understanding and this Mutual Aid Response Guide shall be provided to each locality and hospital by ODEMSA.

32.1.2. ODEMSA 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).

32.1.3. Copies of the Memorandum and one copy of the Mutual Aid Response Guide shall be filed by ODEMSA with the Virginia Office of Emergency Medical Services.

32.1.4. 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 18).

33. REVISIONS AND AMENDMENTS TO THE M.C.I. PLAN

33.1. The Central Virginia MCI Committee is responsible for reviewing each year the MCI Plan in line with the Central Virginia 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.

33.2. 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.

33.3. Revisions and/or amendments to the Plan will require a two-thirds majority of the members present in a quorum to be enacted

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