



FIRE AND RESCUE DEPARTMENTS
OF NORTHERN VIRGINIA
FIREFIGHTING AND
EMERGENCY OPERATIONS
MANUAL

**Multiple Casualty
Incident Manual**

Third Edition

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PREFACE

The Northern Virginia region has significant potential for multiple casualty incidents and relies on mutual aid from jurisdictional partners to manage these types of incidents. They are low frequency, high demand incidents with the tendency to strain local, regional, and, sometimes, state resources. It is imperative that cooperating jurisdictions have standard operating procedures to identify and establish best practices for multiple casualty incidents.

The following are key changes that are found in this third edition of the *Multiple Casualty Incident Manual*.

1. Based on a review of drills, exercises, and events run in the region, the group reorganized the incident priorities to focus on the creation of the transportation area and its function.
2. Reorganized the manual and all positions to prioritize the rapid transport of critical patients to appropriate medical facilities. **Get the Red Out!**
3. Updated the Multiple Casualty Incident (MCI) response algorithm to include a second alarm; this will bring an additional 10 transport units to the event, but only an additional five suppression units.
4. Updated the EMS Task Force response algorithm.
5. Modified the unit assignments to make the Transportation Group's organization and structure a priority.
6. Position responsibilities have been streamlined in an order of priority, focusing on key aspects that will make the position successful.
7. Identified and developed the structure for MCIs that involve multiple transport areas.
8. Eliminated the Patient Intake Points (PIP).
9. Moved Patient Tracking responsibilities to the Transport Recorder position and identified the required information.
10. Eliminated the Treatment/Transport Liaison.
11. Eliminated the Ground Ambulance Coordinator form.
12. Updated all the forms to meet the new incident priorities
13. Updated the Incident Command Boards to meet the new incident priorities.
14. Updated the communications section.
15. Coordinated with the High Threat Environment Committee to ensure common operations between both groups.
16. Adjusted the MCSU category to correlate with the NIMS resource typing:
 - a. Level 1 – 100 patients,
 - b. Level 2 – 50 patients, and
 - c. Level 3 – 25 patients.
17. Updated the Multiple Casualty Support Unit (MCSU) inventory to meet the current threat environment.
18. Worked with the Regional Hospital Coordination Center (RHCC) to provide hospital availability to on scene resources upon initial contact.
19. Eliminated unnecessary terminology from the manual and glossary.
20. Identified the need for unit-level training on the manual and procedures.

Definitions

The key definitions used in this manual are as follows.

Casualty Collection Point (CCP) – An area where patients are relocated that is outside of the Immediately Dangerous to Life and Health (IDLH)/hostile environment where safe triage can occur. On high-threat incidents, the initial CCP may be in a warm zone while awaiting extraction.

Disaster – Any event of unusual or severe effect, threatening or causing extensive damage to life and/or property and requiring extraordinary measures to protect lives, meet human needs, and achieve recovery. A disaster will demand resources beyond local capabilities and require extensive mutual aid and support needs.

Impact Area – The immediate area of an incident scene where the patients received their injuries and were initially found.

Patient Exit Point (PEP) – The physical location through which the patient exits the scene via the transport unit (air or ground). At the PEP, the transport stub is collected (by the Transport Recorder) from the disaster tag and affixed to the Transport Recorder Form. If available, the departure shall be scanned into the Patient Tracking System.

Patient Tracking System – The electronic system used by NOVA for recording and tracking patients associated with an MCI. By entering information in to this system, users create a database of tracking information that can be used and accessed by all responding agencies to track the movement of patients.

Self-care Kits – Pre-packaged medical kits that are designed to allow for self-care of minor injuries.

OVERVIEW

The *Multiple Casualty Incident Manual* outlines procedures to be used by NOVA jurisdictions in the event of a multiple casualty incident. It establishes consistency throughout the Northern Virginia region on many levels, including resource deployment, organization, communications, accountability, and patient flow.

The Virginia Office of Emergency Medical Services (VOEMS) defines a Multiple Casualty Incident (MCI) as, “any incident that injures enough people to overwhelm resources usually available in a particular system or area.”

Crisis Standard of Care

An MCI in our region is a low-frequency, high-demand event. As a result of the high number of patients at a MCI, emergency responders are not expected to provide normal levels of care for each individual patient as dictated by our respective protocols. Instead, because the number of patients exceeds the available resources, a crisis standard of care will be provided, where the goal is to provide the greatest good for the greatest number of people affected by the incident. The focus of emergency personnel will be to provide limited, life-saving interventions and to transport the most seriously injured patients off the scene as quickly as possible.

Rapid Transport of Critical Patients

The intent of this manual is to create a framework that enables the rapid transport of the most severely injured patients from the scene to appropriate facilities. Rapid triage of those in the impact area identifies the most severely injured patients and provides Incident Command with a count of casualties in each triage category. Patients who receive the Immediate or Red designation can often only be saved by interventions that occur at a hospital; there is very little that can be done on the scene to improve their outcomes. Consequently, this manual calls for the early development of the Transportation Group. By establishing an effective Transportation Group, patients can be transported to appropriate facilities quickly, which will have the greatest positive impact on their outcomes.

Patient Tracking and Family Reunification

Tracking patient destinations during a MCI incident is difficult. This manual establishes a method for emergency personnel to track patient destinations through the use of triage tags, paper forms, and the electronic patient tracking system. The information collected is used by the 2-1-1 Virginia call center which is the statewide system used by hospitals to facilitate family reunification.

MCI Types

This manual is designed to create a framework that is effective for rapidly transporting patients from any type of MCI such as large-scale hazardous materials incidents, High Threat Incidents such as mass shootings, or transportation accidents. In all of these cases, the MCI incident occurs in addition to another emergency. For this reason, all of the positions created are normally filled

by personnel dispatched on the MCI alarm, and not units already on scene mitigating the initial incident. Table 1 lists some special considerations for three MCI types.

Table 1: Special considerations by MCI type.

MCI Type	Considerations
Hazardous Materials Incidents	Patients will go through appropriate decontamination prior to being moved to the Casualty Collection Point. The Casualty collection point should be established at the transition point between the warm and cold zone, where triage and normal MCI operations will begin.
High-threat Environments	The <i>Joint Action Guide for High-threat Environments</i> manual will be followed by initial arriving units. Once evacuation teams remove patients from the structure/warm zone to a casualty collection point, triage and normal MCI operations will begin.
Evacuation of a Medical Facility	<p>Hospitals and skilled nursing facilities should have an evacuation plan; in the event such a facility requires evacuation, command staff should coordinate with facility leadership to execute the plan.</p> <p>It may be necessary to establish a safe Casualty Collection Point early in the incident. Responders should coordinate with RHCC and local emergency management resources to develop appropriate destinations that can include hospitals, nursing facilities, or emergency shelters.</p> <p>The framework outlined in this manual offers a structure and method for resolving emergencies in these facilities.</p>

EMS Task Force and MCI Response Configurations

The EMS Task Force and MCI Alarms are designed to assemble necessary resources for a multiple casualty incident. A unit assigned to an EMS Task Force or MCI Alarm should fill the role designated in the Quick Reference Guide for the MCI (refer to Appendix A) based on their arriving order unless directed to do otherwise by the Incident Commander. In the absence of EMS Supervisors, qualified personnel should be placed into those positions. The incident response resources are outlined in Table 2.

Table 2: Incident response resources.

Type	Dispatch Complement
EMS TASK FORCE – Provides the resources to manage incidents with approximately 10 patients. Patients are assigned directly to EMS units and the incident should not require establishment of a Treatment area.	<ul style="list-style-type: none"> ▪ 5 EMS Transport Units ▪ 1 Battalion Chief ▪ 1 EMS Supervisor/Command Staff ▪ 2 Suppression Units

Type	Dispatch Complement
<p>MCI ALARM – Provides the resources to manage incidents with approximately 25 patients. The initial MCI alarm assignment is designed to complete the structure of the EMS Branch.</p>	<ul style="list-style-type: none"> ▪ 10 EMS Transport Units ▪ 10 Suppression Units ▪ 1 Battalion Chief ▪ 3 EMS Supervisors / Command Staff ▪ 1 Mobile Command Unit ▪ 1 Green (Civilian) Transport Bus ▪ 1 Medical Care Support Unit (MCSU) ▪ 1 Medical Ambulance Bus (MAB)
<p>2ND AND SUBSEQUENT MCI ALARMS – Provides the resources to supplement the initial MCI Alarm and is designed to manage approximately 25 additional patients.</p>	<ul style="list-style-type: none"> ▪ 10 EMS Transport Units ▪ 5 Suppression Units ▪ 1 Medical Care Support Unit (MCSU) ▪ 1 Medical Ambulance Bus (MAB) ▪ 1 Green (Civilian) Transport Bus

INITIAL INCIDENT OPERATIONS

The first arriving unit, on the original incident, is to initiate the Five S's and shall establish command per the [NOVA Command Officer Operations Manual Guidelines](#), Figure 1.

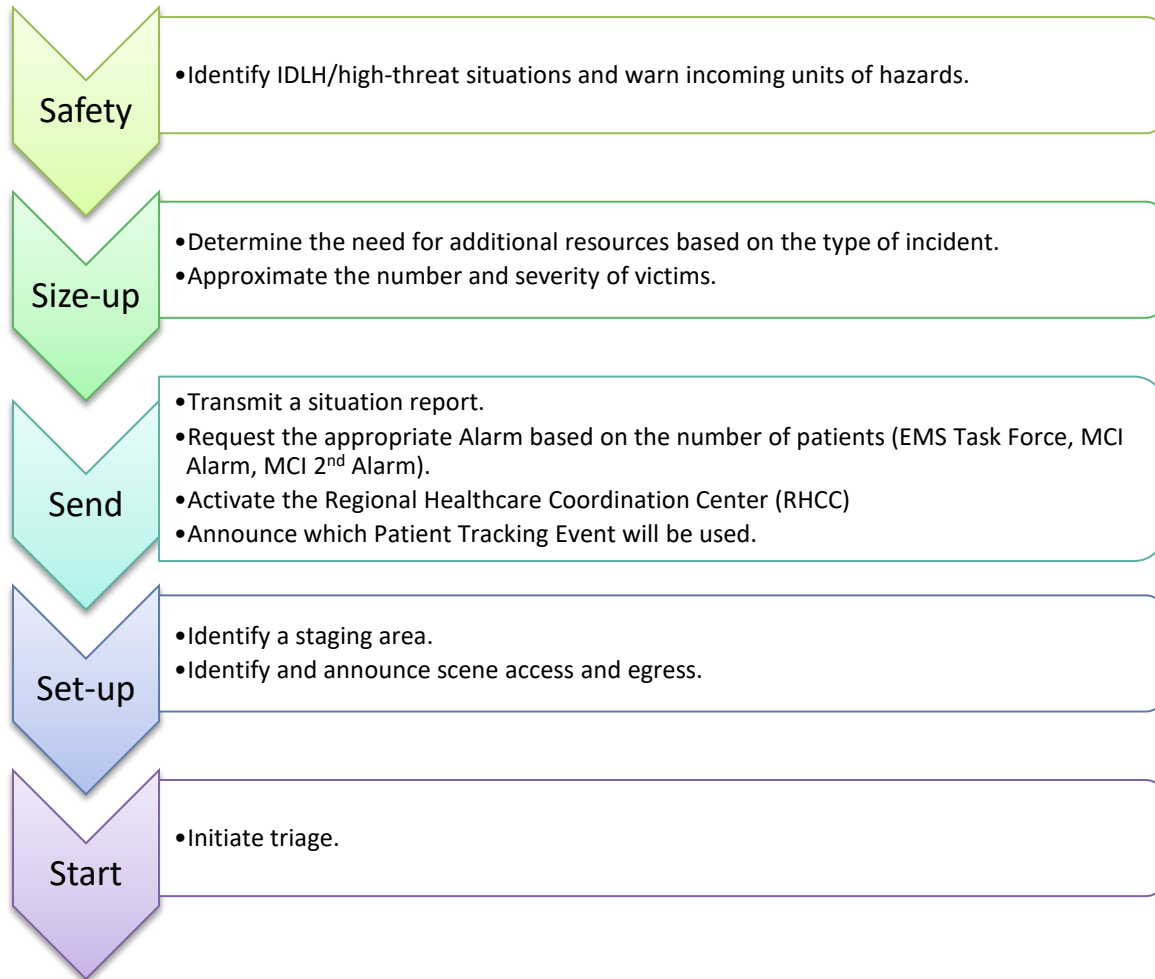


Figure 1: The 5 S's of the multiple casualty incident.

MCI COMMAND STRUCTURE

Incident Commander

An MCI will most likely be one component of a larger event involving multiple priorities. When a large number of patients are encountered, request an appropriate alarm. An EMS Task Force should be requested to treat approximately 10 patients and an MCI Alarm for approximately 25 patients.

Critical responsibilities:

- Early recognition and declaration of a MCI.
- Ensure resources meet incident demands.
- Establish and announce the Staging Area and Incident Entry Point.
- Maintain incident egress for transport units.
- Establish appropriate Branches, Groups, and Divisions.
- Manage and direct the initial MCI Alarm until the EMS Branch Director position has been established by the Battalion Chief on the MCI Alarm.

Additional responsibilities:

- Ensure dedicated MCI tactical channels for the EMS Branch, Transportation Group, and Medical Group have been established.
- Establish and announce a Casualty Collection Point¹ if required.
- Ensures RHCC has been alerted.

Communications:

- Channels: Operations, Command

Staging Manager

The Incident Commander or Operations Chief has the option to assign a Staging Manager (Staging). In the absence of such an assignment, the first suppression unit officer to arrive at the staging area shall assume or assign the role of Staging Manager for the duration of the incident. Depending on the size and complexity of the incident, a single crew member or the entire crew may be used to manage the staging or base functions of the incident. Requests for additional transport units may come directly from the Transportation Group Supervisor.

During an MCI Alarm response, the eighth, ninth, and tenth arriving suppression units are designated to report to staging.

Critical responsibilities:

- Establish staging area.

¹ A CCP is established in IDLH/high threat situations. Patients will be relocated to a CCP when required, where primary triage will be performed.

- Use the [Staging Manager Form \(Appendix F\)](#).
- Respond to requests for resource assignments from IC, Operations, or the Transportation Group Supervisor.
- In the event of multiple Transportation Areas, direct transport units to the appropriate transportation area as directed by the Transportation Group Supervisor.
- Ensure units leaving Staging Area switch to the appropriate channel.
- Advise the Operations Section when apparatus reserves reach minimum levels as established by the Incident Commander.

Communications:

- Channel: Command

Single Transportation Area

Figure 2 depicts the organization of an MCI with a single transportation area.

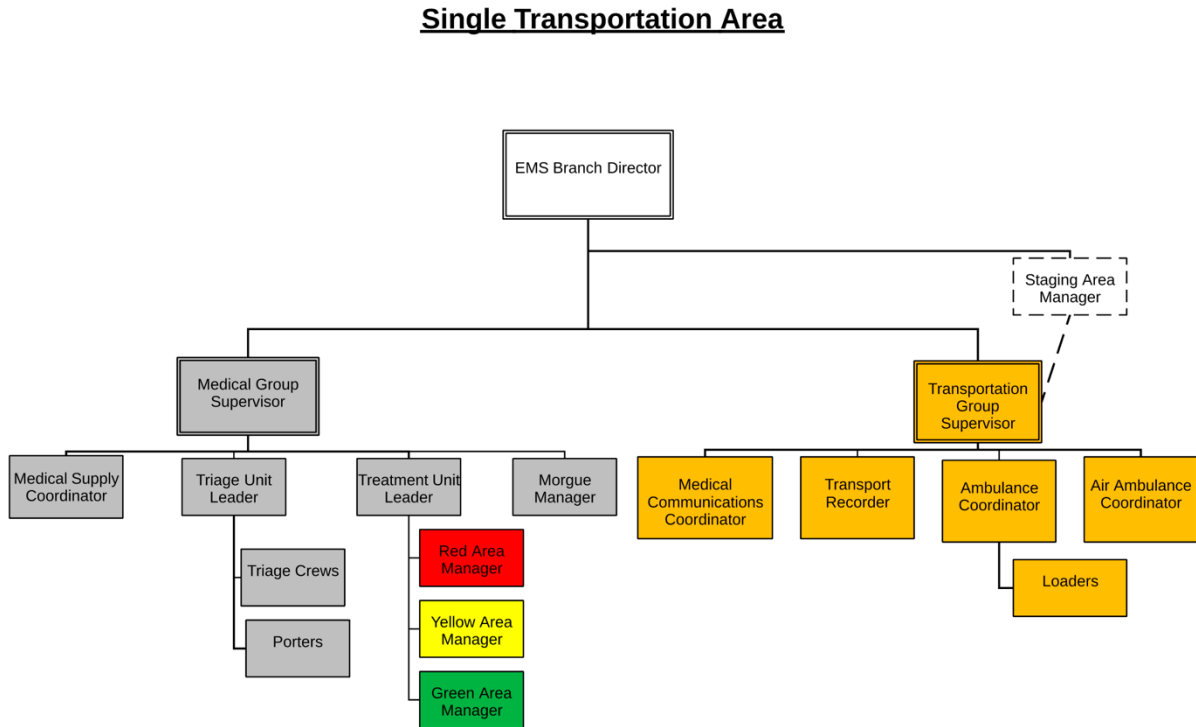
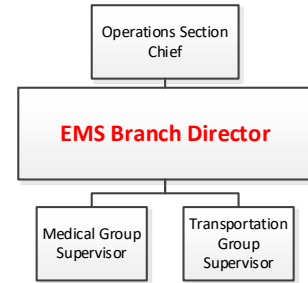


Figure 2: Single transportation area organizational structure.

EMS Branch Director

The EMS Branch Director is established by the first arriving Battalion Chief on the initial MCI alarm and reports to the Operations Section Chief or to the IC. This position manages the Medical Group and Transportation Group Supervisors.



Critical responsibilities:

- Obtain EMS Branch Command Board.
- Ensure dedicated Transportation Group and Medical Group tactical channels have been assigned.
- Assign Units to MCI positions as designated in the MCI Quick Reference Guide included as Appendix A. (Suppression unit assignments may be modified based on incident priorities.)
- Coordinate actions of the Transportation and Medical Groups.
- Request resources from Operations Section Chief or Incident Commander to meet current and anticipated Transport Unit and personnel needs.

Additional responsibilities:

- Anticipate needs of persons not requiring medical transport
- Ensure that a patient tracking event has been announced to responding units

Communications:

- Channels: Operations, EMS Branch

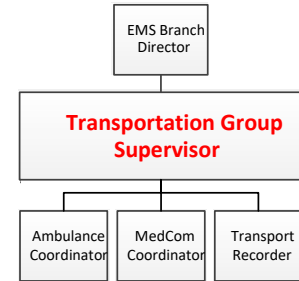
Transportation Group

The Transportation Group is responsible for the set up and operation of the transportation section, to include coordinating and tracking patient transportation. Resources assigned are the first arriving Transport Unit, the first arriving EMS Supervisor, and the second and seventh arriving Suppression Units. The overall goal of the Transportation Group is to expedite transportation for the most critically injured. This group is essential to moving units and patients in and out of the scene efficiently.

Patient transport should not be delayed by the Transport Corridor/Patient Exit Point (PEP) operations. The PEP should be well organized to rapidly identify and assign patients to appropriate transport destinations, while maintaining on scene accountability of the transports.

Transportation Group Supervisor

Transportation Group Supervisor is established by the first arriving Transport Unit Officer/Attendant in Charge (OIC/AIC) and will be assumed by the first arriving EMS Supervisor. The first arriving transport unit OIC/AIC will then become the Medical Communications Coordinator. The Transportation Group Supervisor reports to the EMS Branch Director and supervises the Medical Communications Coordinator, the Transport Recorder, and the Ambulance Coordinator. In the EMS Branch, there shall only be one Transportation Group Supervisor regardless of size or scope of the incident.



Prior to the arrival of the first arriving EMS supervisor the Transportation Group Supervisor will also have to perform the duties of the Medical Communications Coordinator. At the outset of the incident the Transportation Group Supervisor may assign patient destinations prior to receiving bed availability information from RHCC.

Critical responsibilities:

- Obtain Transportation Group Supervisor Command Board.
- Request a dedicated Transportation Group radio channel via the chain of command.
- Ensure designation of the PEP and Transportation Corridor.
- Once established, direct incoming Transport Units to the Transportation Corridor.
- Establish communications with RHCC (1-888-987-7422, or designated radio channel).
- Acquire patient counts from the Medical Group Supervisor and request sufficient Transport Units from Staging.
- Coordinate with EMS Branch to ensure that the appropriate Patient Tracking incident event has been announced.

Additional responsibilities:

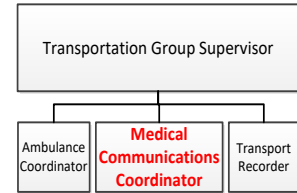
- Determine the need for and request resources for air ambulance operations.
- In the event of multiple transport areas, direct transport units to the area with most critical patients first.
- At the conclusion of the incident, assist with the reconciliation of all casualty records from treatment, triage, and transport.

Communications:

- Channels: Transportation, EMS Branch, Command (Requesting Transport Units from Staging)

Medical Communications Coordinator

The Medical Communications Coordinator (MCC) is established by the AIC/OIC from the first arriving transport unit once relieved from the role of Transportation Group Supervisor. The MCC maintains a count of available beds via communications with the RHCC. In the EMS Branch, there shall only be one MCC regardless of size or scope of the incident.



Critical responsibilities:

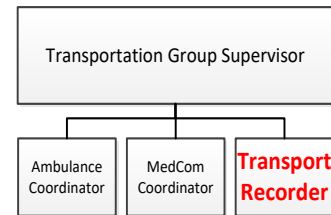
- Establish and maintain communications with RHCC (1-888-987-7422 or designated radio channel).
 - RHCC will provide bed availability for the five hospitals and two trauma centers closest to the incident.
- Advise RHCC if additional beds or hospitals will be required. Use the [Medical Communications Coordinator Form \(Appendix F\)](#) to maintain current status of receiving facility availability and capability.
- Assign patient destination to transport units.

Communications:

- Channels: Transportation, RHCC, Medical Communications Liaison (Only when multiple Transport Areas are established)

Transport Recorder

The Transport Recorder is established by the driver-operator of the first arriving transport unit and reports to the Transportation Group Supervisor or Transportation Unit Leader.² A Transport Recorder must be assigned to each PEP.



Some priority patients may bypass the Treatment Area and arrive at the PEP without having a disaster tag applied. The Transport Recorder must ensure a disaster tag is applied and completed.

Critical responsibilities:

- Ensure a disaster tag is attached to each patient.
- At a minimum, the transport record must have the following fields completed:
 - Patient sex
 - Destination
 - Transportation Agency/Unit
 - Departure Time/ Time Out
 - Triage Status
- Use a separate [Transport Recorder Form \(Appendix F\)](#) for each destination hospital.
- Affix the disaster tag Transport Record stub to the appropriate Transport Recorder Form.

² Only applicable in instances of multiple transportation areas.

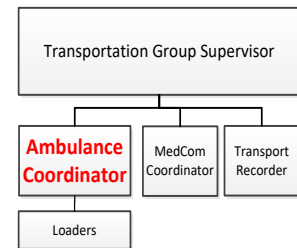
- Enter the Transport Record Stub information into the Patient Tracking System.

Communications:

- Channel: Transportation

Ambulance Coordinator

The Ambulance Coordinator is established by the OIC of the second arriving suppression unit, reports to the Transportation Group Supervisor or Transportation Unit Leader³ and supervises the Transport Loaders. The Ambulance Coordinator manages the access, egress, positioning, and loading of transport units.



Critical responsibilities:

- Designate and clearly mark transportation corridor points of entry, exit, and transport unit loading area.
- Direct transport units where to park to receive patients.
- Ensure efficient traffic flow in the transport corridor.
- Direct Loaders to report to the Treatment Unit Leader to obtain a patient and exit through the PEP.

Communications:

- Channel: Transportation

Air Ambulance Coordinator

The Air Ambulance Coordinator will be a member of the suppression unit assigned to the landing zone and reports to the Transportation Group Supervisor. The Air Ambulance Coordinator is the liaison between the air medical crews and the Transportation Group Supervisor.

Communications:

- Channels: Transportation, Landing Zone

³ Only applicable in instances of multiple transportation areas.

Transport Loaders

Transport Loaders (Loaders) are personnel from the second and seventh arriving suppression units and report to the Ambulance Coordinator. Loaders retrieve patients from treatment areas or the impact area and bring them through the PEP to the loading area.

Critical responsibilities:

- Retrieve patient movement device(s).
- On direction from the Ambulance Coordinator, report to the Treatment Unit Leader who will direct Loaders to a Treatment Area Manager.
- Bring the patient through the PEP and assist transport unit crew with patient loading.

Communications:

- Channel: Transportation

Transport Units

The intent of MCI management is to transport Immediate (red tag) patients as soon as possible. Initial responding Transport Units will be directed to the Transport Corridor.. While transporting, direct communications with the destination hospital is not necessary as the information is relayed by RHCC.

Critical responsibilities:

- AIC/OIC reports to the PEP to receive patients and hospital assignment.
- Ensure that the driver stays with the unit.
- Ensure the completed Disaster Tag Transport Record is given to Transport Recorder.
- Assist Loaders with patient loading.
- Transport patients to assigned receiving facility.
- Complete disaster tag and Patient Tracking System entry.
- When returning to service after transporting a patient, Transport Units will contact the communication center managing the incident for instructions.

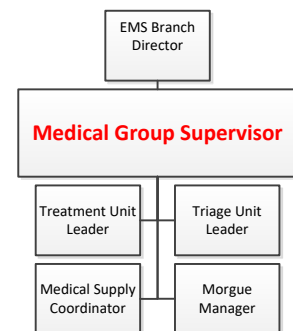
Communications:

- Channel: Transportation

Medical Group Supervisor

Established by the second arriving EMS Supervisor on the initial MCI alarm. The Medical Group Supervisor reports to the EMS Branch Director and supervises the Triage Unit Leader, Treatment Unit Leader, Morgue Manager and Medical Supply Coordinator.

Critical responsibilities:



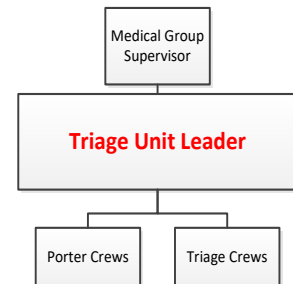
- Obtain Medical Group Supervisor Command Board.
- Request a dedicated tactical channel for the Medical Group.
- Receive patient counts from Triage and Treatment Unit Leaders
- Provide updated patient counts to the Transportation Group Supervisor.

Communications:

- Channels: EMS Branch, Medical Group

Triage Unit Leader

The Triage Unit is responsible for triaging patients within the impact area or Casualty Collection Point (CCP) using [START/JumpSTART \(Appendix G\)](#). Initial triage involves classification of patients, delivery of lifesaving interventions, and application of triage ribbons. Once triage has been completed the unit is responsible for porting patients based on priority to the PEP or treatment area(s) if immediate transport is not available. Resources assigned to the Triage Unit on the initial MCI Alarm are the first and fifth arriving Suppression Units.



The Triage Unit Leader is established by the OIC of the first arriving suppression unit on the initial MCI alarm. The Triage Unit Leader reports to the Medical Group Supervisor and supervises Triage Crews and Porters.

Critical responsibilities:

- Obtain the Triage Unit Leader Command Board.
- Designate the Casualty Collection Point (CCP) if needed.
- Direct walking wounded patients to a defined location.
- If Transport Units are available, direct Porters to move Red Tag patients directly to the Transport Area through the PEP.
- Obtain and frequently communicate patient counts to the Medical Group Supervisor.

Communications:

- Channel: Medical Group

Triage Crews

Triage Crews are assigned by and report to the Triage Unit Leader. Triage Crews are most efficient when comprised of two or three people.

Critical responsibilities:

- Direct walking wounded patients to a defined location.
- Perform START/JumpSTART and attach a colored ribbon to all injured patients.
- Initial treatment should be limited to appropriate lifesaving interventions:
 - Position the airway.

- Deliver five rescue breaths (JumpSTART).
- Control severe bleeding (tourniquet or pressure).
- Chest seals may be applied if available.
- Communicate accurate counts, triage status, and locations of patients to the Triage Unit Leader.

Communications:

- Channel: Medical Group

Porters

Porters are assigned by and report to the Triage Unit Leader.

Critical responsibilities:

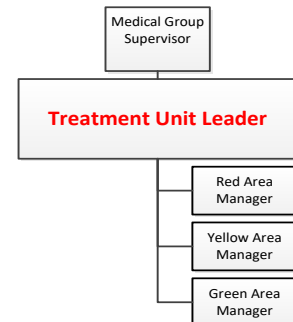
- Coordinate with Triage Unit Leader to determine location of triaged patients.
- Obtain necessary equipment to port patients.
- Port patients, as directed by the Triage Unit Leader, to the PEP or treatment area(s).

Communications:

- Channels: Medical Group

Treatment Unit Leader

The Treatment Unit is responsible for the location, set-up, and operation of the treatment areas. Upon entering a treatment area, patients will undergo secondary triage and have a disaster tag that includes as much patient information as possible, attached to them. Based on a medical assessment, patients will be treated appropriately until a Transport Unit is available. The Treatment Unit shall prioritize patients within a given Treatment Area for transport. Resources assigned to the Treatment Unit on the initial MCI Alarm are the fourth and sixth arriving suppression units. As time and resources permit the Treatment Unit may perform the initial patient tracking scan.



The Treatment Unit Leader is initially established by the OIC of the fourth arriving suppression unit on the initial MCI alarm and assumed by the third arriving EMS Supervisor. The Treatment Unit Leader reports to the Medical Group Supervisor and supervises the Treatment Area Managers. The Treatment Unit Leader will assign Treatment Area Managers, who may be members of their suppression unit or other available personnel.

Critical responsibilities:

- Obtain Treatment Unit Leader Command Board.
- Identify and announce the location of all Treatment Areas.

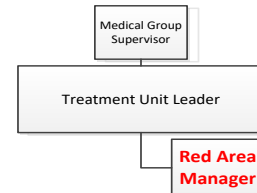
- Maintain communications and coordinate patient movement with the Medical Group Supervisor.
- Maintain a real-time count of all patients within the Treatment Areas.
- Direct Loaders and ambulance crews to appropriate Treatment Area Manager.

Communications

- Channels: Medical Group

Immediate (Red) Treatment Area Manager

The Immediate (Red) Treatment Area Manager is assigned by and reports to the Treatment Unit Leader. The Immediate Treatment Area Manager supervises the setup of the area, treatment of patients assigned to that area, and prioritizes patients for transport.



Critical responsibilities:

- Utilize Treatment Area Manager Worksheets.
- Ensure patients undergo secondary triage, are appropriately treated, and relocated as necessary
- Frequently communicate patient counts to the Treatment Unit Leader.
- Ensure every patient receives a disaster tag and that the transport record stub has been completed as much as possible.
- Direct loaders or ambulance crews to the patient they will transport.

Additional responsibilities:

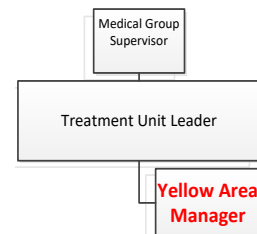
- As time permits, scan and enter patient information into the Patient Tracking System.

Communications:

- Channels: Medical Group

Delayed (Yellow) Treatment Area Manager

The Delayed (Yellow) Treatment Area Manager is assigned by and reports to the Treatment Unit Leader. The Delayed Treatment Area Manager supervises the setup of the area, treatment of the patients assigned to the area, and prioritizes patients for transport.



Critical responsibilities:

- Utilize Treatment Area Manager Worksheets.
- Ensure patients undergo secondary triage, are appropriately treated, and relocated as necessary.
- Frequently communicate patient counts to the Treatment Unit Leader.

- Ensure every patient receives a disaster tag and that the transport record stub has been completed as much as possible.
- Direct loaders or ambulance crews to the patient they will transport.

Additional responsibilities:

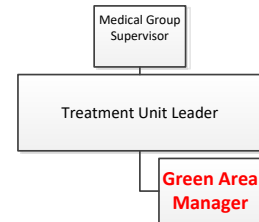
- As time permits, scan and enter patient information into PTS.

Communications:

- Channels: Medical Group

Minor (Green) Treatment Area Manager

The Minor (Green) Treatment Area Manager is assigned by and reports to the Treatment Unit Leader. The Minor Treatment Area Manager supervises the setup of the area, treatment of the patients assigned to the area, and prioritizes patients for transport.



Critical responsibilities:

- Utilize Treatment Area Manager worksheets
- Ensure patients undergo secondary triage, are appropriately treated, and relocated as necessary
- Frequently communicate patient counts to the Treatment Unit Leader.
- Ensure every patient receives a disaster tag and that the transport record stub has been completed as much as possible.
- Direct loaders or ambulance crews to the patient they will transport.

Additional responsibilities:

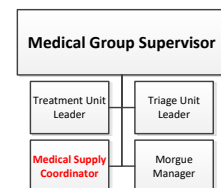
- Distribute self-care kits.
- Anticipate needs for prolonged on-site care and management.
- As time permits, scan and enter patient information into PTS.
- Report needs of uninjured to the Treatment Unit Leader.

Communications:

- Channels: Medical Group

Medical Supply Coordinator

The Medical Supply Coordinator is established by the OIC of the first arriving MCSU on the initial MCI alarm and reports to the Medical Group Supervisor.



Critical responsibilities:

- Set up the MCSU in proximity to the Red and Yellow treatment area(s).
- Distribute supplies to the Triage and Treatment Area(s).

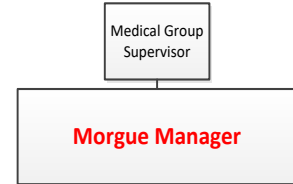
- Request and secure additional medical supplies as necessary

Communications:

- Channels: Medical Group

Morgue Manager

The Morgue Manager is assigned by and reports to the Medical Group Supervisor and assumes responsibility for Morgue Area activities until relieved by law enforcement.



Critical responsibilities:

- Establish a temporary morgue away from viable patients.
- Perform re-triage and ensure those in the morgue are pulseless and apneic.
- Deny access to unauthorized personnel.
- Maintain decedent confidentiality.

Additional responsibilities:

- Ensure a disaster tag has been applied.
- Scan the disaster tag and update decedents triage status and information.
- Obtain a picture of the patient's face and identifying marks if possible and enter it into the Patient Tracking System.

Communications:

- Channels: Medical Group

Transport Area Workflow

Figure 3 shows the single transport area patient flow.

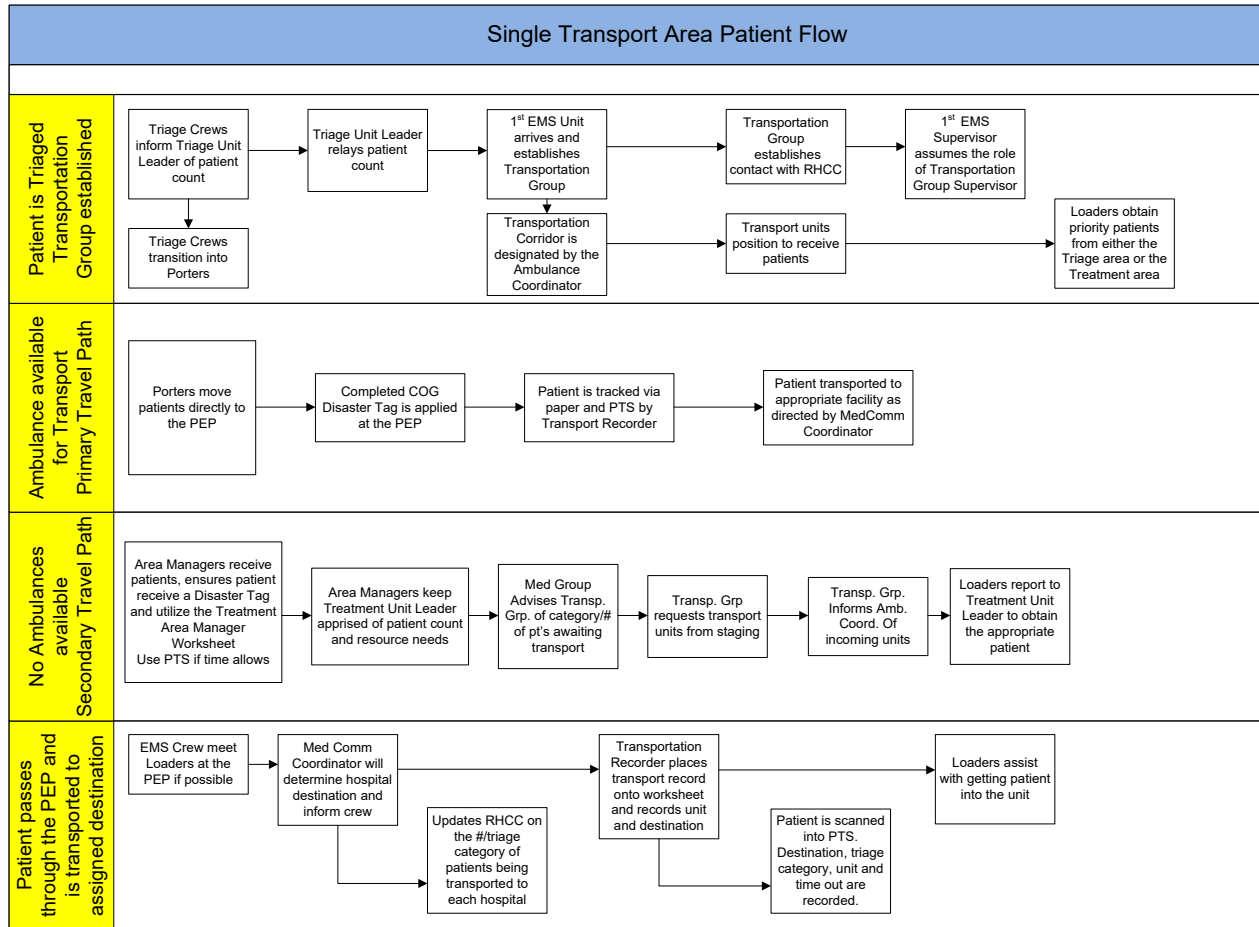


Figure 3: Single transport area patient flow.

Incident Requiring Multiple Treatment and Transportation Locations

Incidents with patients spread widely or separated by physical barriers may require expanding the incident structure to add Medical Divisions and Transportation Units for each geographic area.

If multiple transportation areas are required, the Transportation Group Supervisor shall assume responsibility for overall management of the Transport Group to include all subsequent Transport areas.

A Transportation Unit Leader will then be assigned to each designated Transport Area.

Multiple Transportation Areas

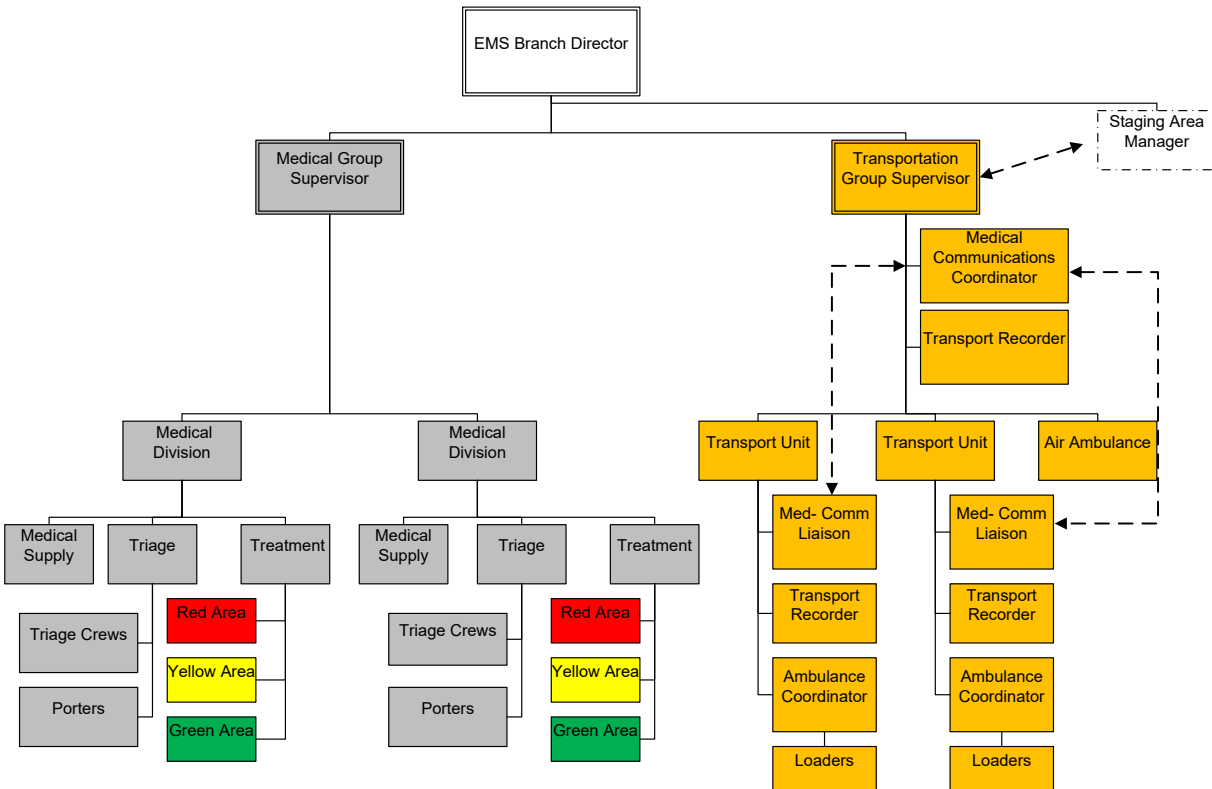


Figure 4: Sample organizational chart for multiple transportation areas.

The “Medical Division” should be renamed as appropriate for each incident. Based on the need, the following positions and responsibilities will be assigned at each transport area.

Transport Unit Leader

The Transport Unit Leader is assigned by the Transportation Group Supervisor and can be filled by any available resource. The Transport Unit Leader fills and supervises their respective Ambulance Coordinator, Medical Communications Liaison, Transport Recorder, and Loaders as needed. The Transport Unit Leader will coordinate with the appropriate Medical Division Supervisor to facilitate the movement of patients.

Critical responsibilities:

- Ensure designation of Division Patient Exit Point (PEP) and Transportation Corridor.
- Obtain Transportation Group Supervisor Command Board
- Establish and maintain communications with Transportation Group Supervisor and the corresponding Medical Division Supervisor

- Acquire patient counts from their corresponding Medical Division Supervisor and determine transport needs.
- Request resources from the Transportation Group Supervisor.
- Coordinate the air and ground transportation of patients in that area.

Communications:

- Channels: Transportation, Medical Division

Medical Communications Liaison

The Medical Communications Liaison (MCL) is appointed by the Transport Unit Leader and coordinates with the Medical Communications Coordinator (MCC) to assign patient transport destinations. A MCL will be assigned for each transport area.

Critical responsibilities:

- Establish and maintain communications with the MCC.
- Assign patient destination to transport units.

Communications:

- Channels: Medical Communications Liaison

Medical Division Supervisor

The Medical Division Supervisor reports to the EMS Branch Director and supervises their respective Triage and Treatment Unit Leaders.

Critical responsibilities:

- Obtain Medical Group Supervisor Command Board.
- Monitor actions of the Triage and Treatment Groups.
- Receives patient counts from Triage and Treatment Unit Leaders and request transport assets from the Transportation Unit Leader

Additional responsibilities:

- Ensure proper security, traffic control, and access for the Medical Division.

Communications:

- Channels: EMS Branch, Transportation Group, Medical Division

Sample Scene Flowcharts

The following figures show pictorial flowcharts of an MCI event, a high-threat MCI event, and a hazardous materials MCI Event.

MCI EVENT

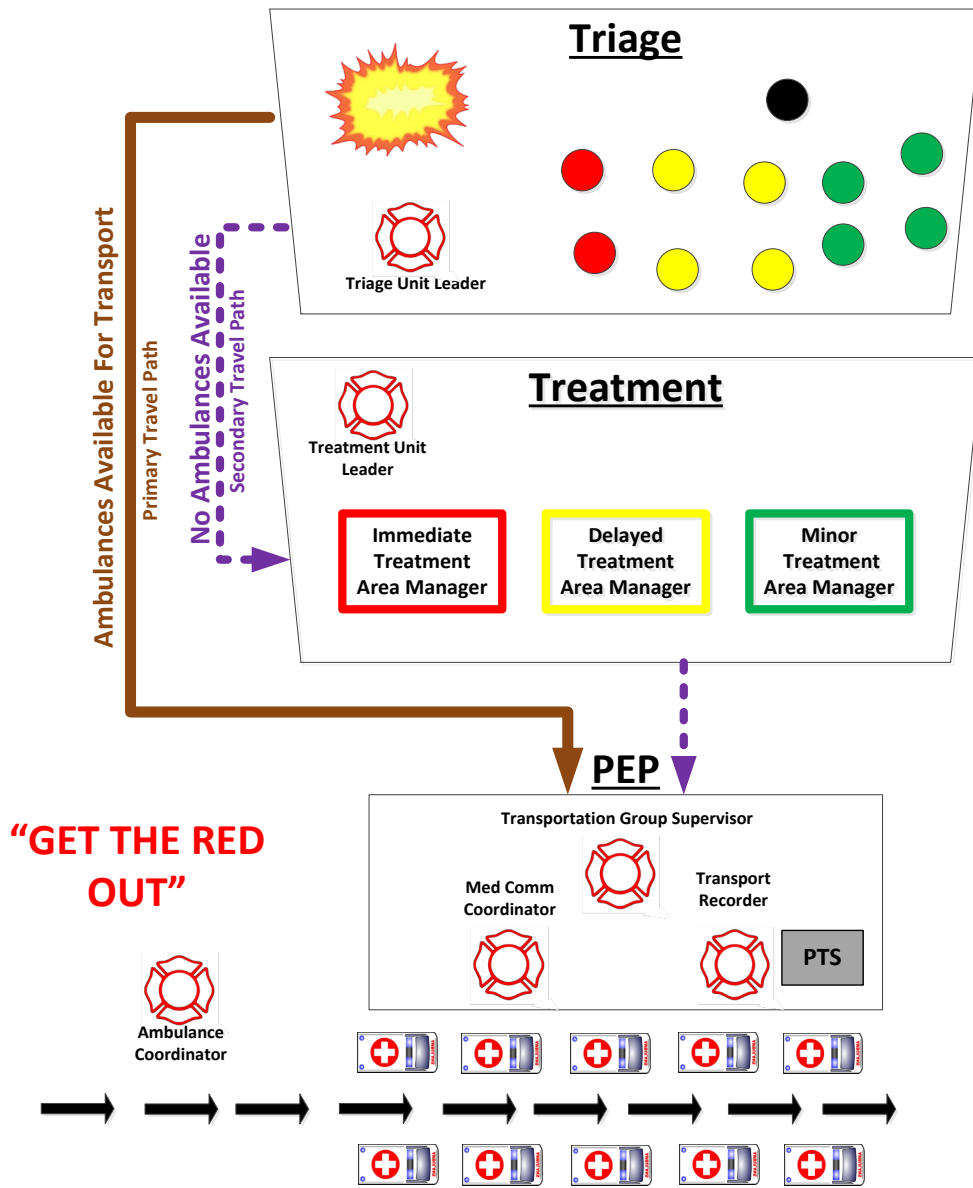


Figure 5: Sample MCI event flowchart.

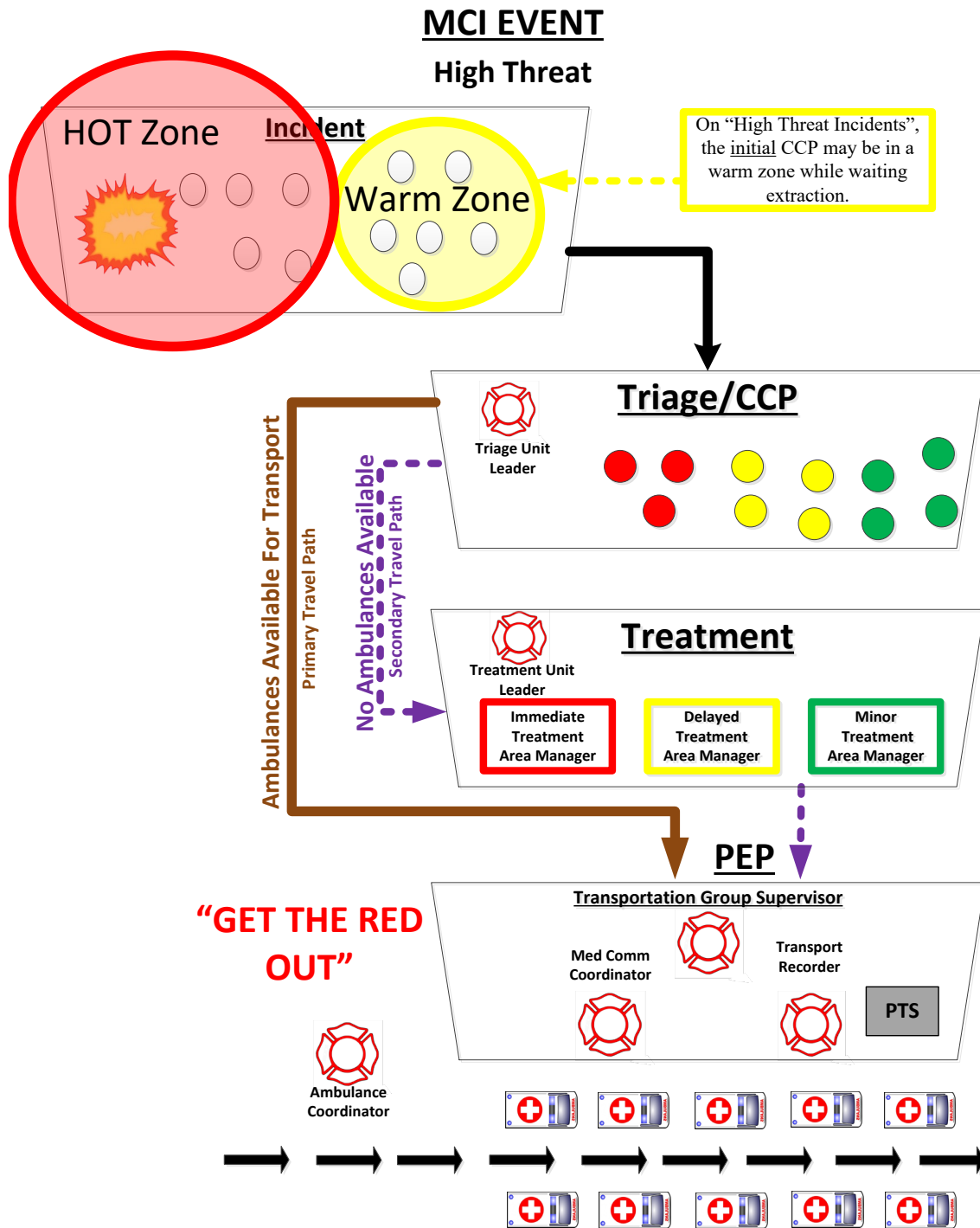


Figure 6: Sample MCI high-threat event flowchart.

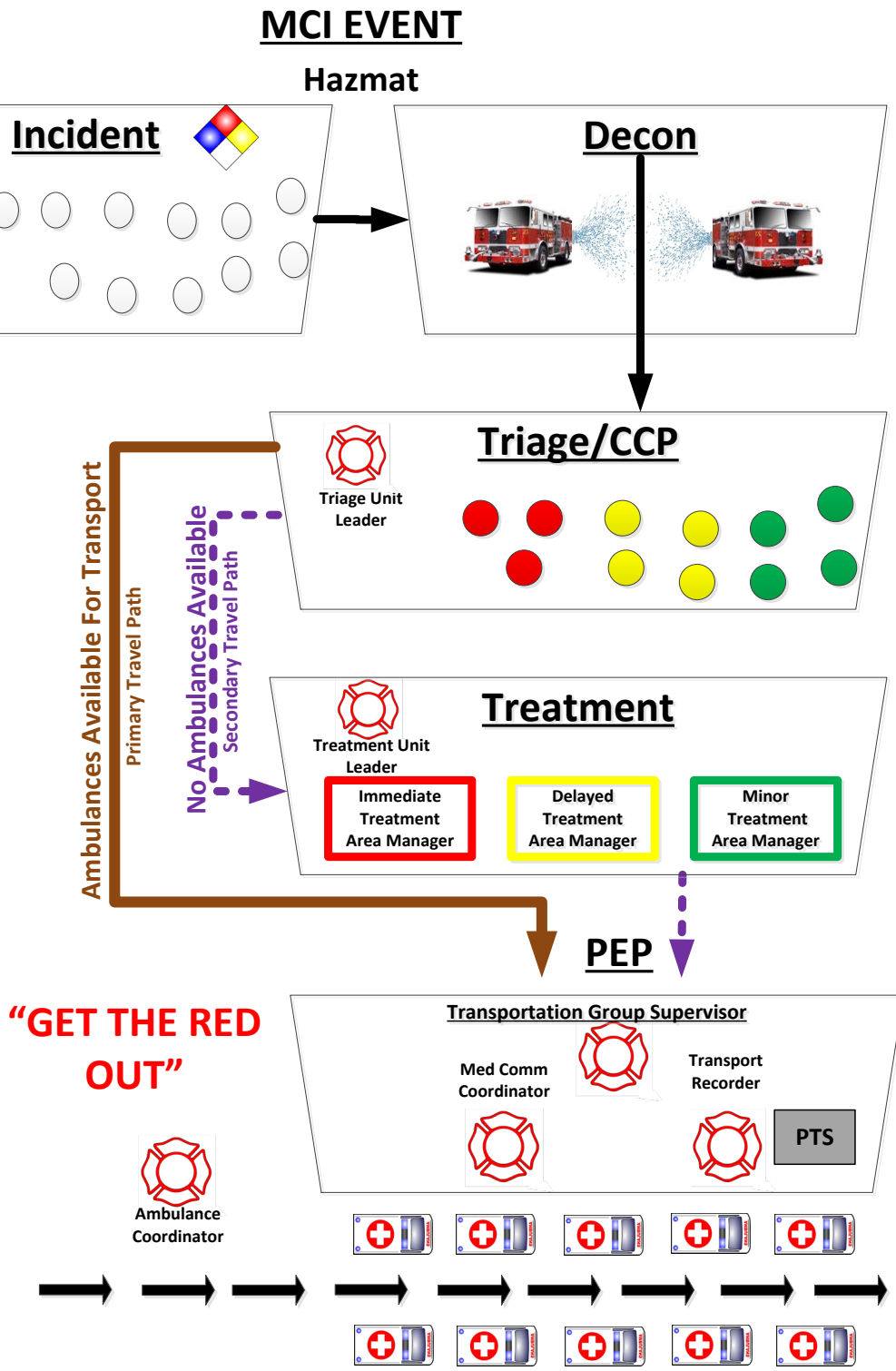


Figure 7: Sample MCI hazardous materials event flowchart.

APPENDIX A: NOVA QUICK REFERENCE GUIDE FOR MCI

MCI assignments are based on the ability of the IC to assign apparatus to the EMS Branch based on incident priorities. In the absence of direction from an IC, units responding on the MCI Alarm will assume these roles.

Suppression Unit = any engine, truck, or squad
PEP = Patient Exit Point

UNIT	Priority of Unit Assignments
1 st Suppression Unit	Triage Unit Leader
2 nd Suppression Unit	Ambulance Coordinator
3 rd Suppression Unit	Report to Triage (porters or triage crew)
4 th Suppression Unit	Treatment Unit Leader
5 th Suppression Unit	Report to Triage (porters or triage crew)
6 th Suppression Unit	Report to Treatment
7 th Suppression Unit	Report to Ambulance Coordinator (loaders)
8 th -10 th Suppression Unit	Report to staging, establish if not done already
1st EMS Transport Unit	Establish Transportation Group (Med Comm and Transport Recorder)
Remaining Transport Units	Report to transportation corridor or Staging as directed by Transportation Group Supervisor
1 st EMS Supervisor	Assume Transportation Group Supervisor
2 nd EMS Supervisor	Establish Medical Group Supervisor
3 rd EMS Supervisor	Assume Treatment Unit Leader
1 st Battalion Chief	Establish EMS Branch

APPENDIX B: NATIONAL CAPITAL REGION MEDICAL CARE SUPPORT UNITS

AGENCY	UNIT DESIGNATION	UNIT LOCATION	LEVEL
Washington, D.C.			
Washington, DC	MCSU 1	Washington DC	1
	MCSU 2	Washington DC	2
	MCSU 3	Washington DC	2
Maryland			
Charles County	MC1016	LaPlata, MD	2
	MC1013	Waldorf, MD	3
Montgomery County	MCSU 722	Germantown, MD	1
	MCSU 726	Bethesda, MD	1
Prince Georges County	MCSU 855	Bunker Hill, MD	1
	MCSU 841	Calverton, MD	2
Virginia			
MWAA	MCSU 302	Dulles	1 (can treat 200 patients)
	MCSU 301	Reagan	1 (can treat 200 patients)
Alexandria	MSU 202	Alexandria, VA	1
Arlington	MC 100	Arlington, VA	1
Fairfax County	MCSU 415	Chantilly, VA	2
	MCSU 442	Vienna, VA	2
	MCSU 435	Springfield, VA	1
Loudoun County	MC 603	Middleburg, VA	2
	MC 615	Sterling, VA	2
	MC 614	Purcellville, VA	1
City of Manassas	MCSU 501	Manassas, VA	2
Prince William County	MCSU 523	Woodbridge, VA	2
	MCSU 524	Haymarket, VA	2
Stafford County	MCSU-12	Berea station (Fredericksburg, VA)	2

NIMS Typing	
Level 1+ = 200 patients	MWAA Tractor Trailer MCSU
Level 1 = 100 patients	
Level 2 = 50 patients	
Level 3 = 25 patients	

Last Update: March 2016

APPENDIX C: NATIONAL CAPITAL REGION MEDICAL AMBULANCE BUSES

AGENCY	UNIT DESIGNATION	UNIT LOCATION
Washington, D.C.		
Washington, D.C.	MAB 1	Washington DC
	MAB 2	Washington DC
	MAB 3	Washington DC
Maryland		
Montgomery County	MAB 726	Bethesda, MD
	MAB 722	Germantown, MD
Prince Georges County	MAB 830	Landover Hills, MD
Virginia		
Arlington	MAB 100	Sta. 2 – 4805 Wilson Blvd.
Fairfax County	MAB 427	Springfield, VA
Loudoun County	MAB 623	Moorefield (Ashburn, VA)
Stafford County	MAB 12	Berea station (Fredericksburg, VA)

APPENDIX D: MCSU EQUIPMENT LIST

2016 MCSU Inventory		
LEVEL 1 Qty.	LEVEL 2 Qty.	ITEM
80	40	Backboards (long)
80	40	Backboard straps (sets)
80	40	Cervical Immobilization Device (CID rolls, headbed, etc.)
80	40	Cervical collars (adjustable – adult)
80	40	Cervical collars (adjustable – pediatric)
40	20	Military type patient litter, mesh, collapsible, with feet, with handles
100	50	Splints, disposable (minimum 12" , recommend 18")
48	24	Splints, disposable, 34"
100	50	Blankets (disposable) 58 x 90, insulated
130	65	Blankets (space type)
100	50	Multi-trauma dressing (sterile, size 12" x 30")
1000	500	Non-sterile 4 x 4 dressing
100	50	Military or "H" style; civilian 4" or 6" compression bandages
100	50	Trauma dressing, 8" x 10"
500	250	Kling 4" rolls
300	150	Cravats (triangular bandage)
200 rolls	100 rolls	Tape 3" x 10 yards, silk
10	5	NP airway kit, latex free, set of 6, sizes 26 to 34 French
50	25	OP airways, set of 6, (Berman kit), size infant to large adult
50	25	Oxygen mask, non-rebreather, with tubing, adult
50	25	Oxygen mask, non-rebreather, with tubing, pediatric
50	25	Oxygen tubing, male connectors, minimum 7 ft.
10 each	5 each	Bag valve mask device, disposable (ea. BVM has adult, & pediatric masks)
20	10	Hand powered portable suction units
40	20	Hand powered portable suction units replacement canisters
2 case of each size	1 case of each size	Gloves (medium, large, extra-large)
100	50	Face masks w/eye shield
20	10	Scissors
36	18	Penlights
20	10	Stethoscopes, adult/ peds
20	10	Blood pressure cuffs, (pediatric, adult, large adult)
48 - 4 cases	24 - 2 cases	1000 cc Normal Saline IV (12 per case)

LEVEL 1 Qty.	LEVEL 2 Qty.	ITEM
80	40	Small bottles irrigation saline
48	24	IV tubing (10 drop sets) (48 per case) at least 100 inches
48	24	IV starter kits
100 each	50 each	IV needles – 16 g., 18 g. 20 g.
10	5	Sharps containers (minimum - 2 gallon size)
12	6	Waterless hand cleaner (antiseptic)
1 box	1 box	germicidal wipes (equipment clean up)
130	65	Patient belonging bags
36	18	Rolls Duct tape
300	150	Zip lock storage bags (gallon size)
250 bags	250 bags	Biohazard bags (10 – 15 gallon size)
2 sets	1 sets	Triage tarps, (red, yellow, green), with grommets, minimum 15' x 20' (recommend heavy canvas) for equipment cache (can be poly coated)
2 each	1 each	Triage flags (base, telescoping min. 8' pole, flag), red, yellow, green
36	18	Traffic cones with reflective stripe
36	18	Step-in posts, fiberglass
4 rolls each	4 rolls each	Rolls barricade tape (red, green, yellow - 3" minimum width)
200	100	Disaster tags (COG tag)
12	6	Triage ribbon kits (red, yellow, green, black)
1 sets	1 sets	MCI Vests (New set includes 13 vests) (old set included 14 vests)
6 boxes	6 boxes	Permanent markers
6 boxes	6 boxes	Ball point pens (12 per box)
18	18	Clipboards
4	4	Oxygen multilator or minilator, minimum 5 ports, adjustable flow rate
4	4	Oxygen hose 50 feet with regulator
4	4	Oxygen bottles, minimum size M cylinder
4	4	Oxygen kits (include Teflon tape, adjustable wrench, 5 Christmas trees – green nipple fitting)

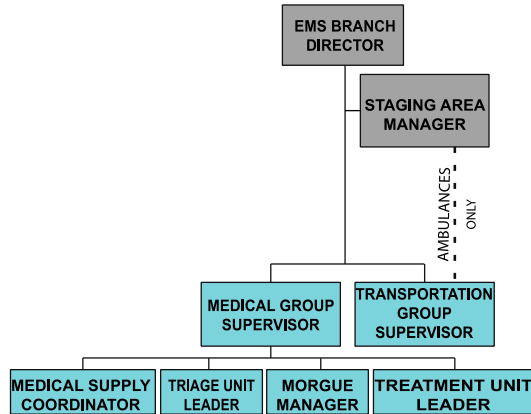
MCI ICS Vest Inventory		
EMS Branch Director (blue)	Air Ambulance (blue)	Transportation Group (blue)
Medical Group Supervisor (blue)	Minor Manager (blue)	Transport Recorder (blue)
Medical Comm. (blue)	Immediate Manager (blue)	Treatment Leader (orange)
Medical Supply (blue)	Delayed Manager (blue)	
Ground Ambulance (blue)	Triage Leader (blue)	

Optional Equipment Listing		
LEVEL 1 Qty.	LEVEL 2 Qty.	ITEM
50	25	Tourniquets
50	25	APLS Thermal Guard Mylar
50	25	Patient self-care kits (gloves, kling, band aid, etc.)
30	15	Nebulizer kits
50	25	Morgan Lenses
2	1	Patient Transport device with wheels
3	1	EZ-UP tents (color coded if possible)
4	2	Skeds (Patient drag system)
15	15	Combi- Nebulizers - Adult
15	15	Combi-Nebulizers - Pediatric
200	100	Eye protection
2	2	Megaphone/bullhorn with extra batteries
12	6	Flashlights with extra batteries
6 cases	6 cases	Bottled water, minimum 12 ounce
80	40	Sheets (white linen – stored in either vacu-package or zip lock bag)
60	30	Towels - cloth
24 each color	24 each color	Cyalume light sticks, box of 24 (red, yellow, green - min. 12 hour)
50 each	50 each	Cyalume light sticks (white – hi intensity – 30 min.) 10 per box

NIMS Typing
Level 1 = 100 patients
Level 2 = 50 patients
Level 3 = 25 patients

APPENDIX E: EMS BRANCH COMMAND BOARDS

NORTHERN VIRGINIA INCIDENT COMMAND SYSTEM WORKBOARD ©		RADIO CHANNEL	
1 EMS BRANCH DIRECTOR		EMS BRANCH	OPERATIONS
INCIDENT LOCATION	STAGING LOCATION		



NOTES



MEDICAL GROUP				
CHANNEL				
LOCATION				
				TOTAL
SITUATION/RESOURCES				

MEDICAL GROUP				
CHANNEL				
LOCATION				
				TOTAL
SITUATION/RESOURCES				

TRANSPORTATION GROUP	
CHANNEL	
GROUND AMBULANCE STAGING AREA	
AIR AMBULANCE LOADING AREA	
NOTES	

RESPONSIBILITIES	
ENSURE DEDICATED TRANSPORTATION GROUP AND MEDICAL GROUP TACTICAL CHANNELS	
ASSIGN UNITS TO MCI POSITIONS (SEE REVERSE SIDE OF THIS BOARD)	
COORDINATE ACTIONS OF TRANSPORTATION AND MEDICAL GROUPS	
REQUEST RESOURCES FROM OPS SECTION/ IC	

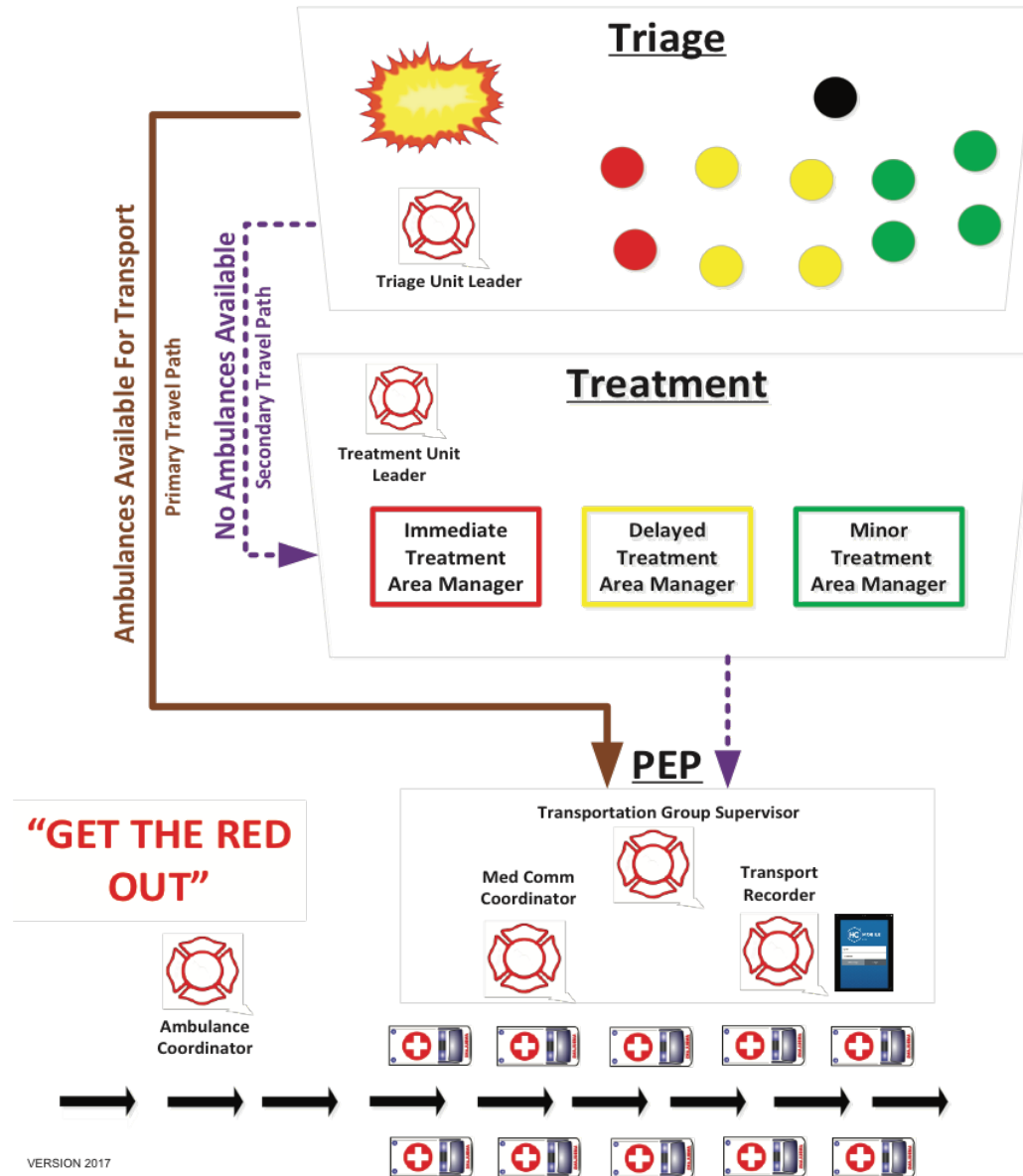
Version 2017

FIRST MCI ALARM		
UNIT TYPE	SUGGESTED LOCATION	UNIT ID/ASSIGNMENT
1ST SUPPRESSION UNIT	TRIAGE UNIT LEADER	
2ND SUPPRESSION UNIT	GROUND AMBULANCE COORDINATOR	
3RD SUPPRESSION UNIT	REPORTS TO TRIAGE (PORTERS)	
4TH SUPPRESSION UNIT	TREATMENT UNIT LEADER	
5TH SUPPRESSION UNIT	REPORT TO TRIAGE	
6TH SUPPRESSION UNIT	REPORT TO TREATMENT	
7TH SUPPRESSION UNIT	REPORT TO GROUND AMBULANCE (LOADERS)	
8-10 SUPPRESSION UNIT	REPORT TO STAGING ESTABLISH IF NOT ALREADY DONE	
1ST TRANSPORT UNIT	ESTABLISH TRANSPORTATION GROUP/MED COMM/ TX RECORDER	
REMAINING TRANSPORT UNITS	REPORT TO TRANSPORT COORIDOR OR STAGING	
1ST EMS SUPERVISOR/ COMMAND STAFF	ASSUME TRANSPORT GROUP SUPERVISOR	
2ND EMS SUPERVISOR/ COMMAND STAFF	ESTABLISH MEDICAL GROUP SUPERVISOR	
3RD EMS SUPERVISOR/ COMMAND STAFF	ASSUME TREATMENT UNIT LEADER	
1ST BATTALION CHIEF	ESTABLISH EMS BRANCH	
MOBILE COMMAND UNIT	EMS BRANCH OPERATIONS	
MCSU	REPORT TO MEDICAL GROUP SUPERVISOR	
MAB	TRANSPORT COORIDOR OR STAGING AS DIRECTED	
GREEN CIVILIAN TRANSPORT BUS	TRANSPORT COORIDOR OR STAGING AS DIRECTED	

SECOND/SUBSEQUENT MCI ALARMS		
UNIT TYPE	SUGGESTED LOCATION	UNIT ID/ASSIGNMENT
1ST SUPPRESSION UNIT	REPORT TO STAGING	
2ND SUPPRESSION UNIT	REPORT TO STAGING	
3RD SUPPRESSION UNIT	REPORT TO STAGING	
4TH SUPPRESSION UNIT	REPORT TO STAGING	
5TH SUPPRESSION UNIT	REPORT TO STAGING	
10 TRANSPORT UNITS	TRANSPORT COORIDOR OR STAGING AS DIRECTED	
MCSU	REPORT TO STAGING	
MAB	TRANSPORT COORIDOR OR STAGING AS DIRECTED	
GREEN CIVILIAN TRANSPORT BUS	TRANSPORT COORIDOR OR STAGING AS DIRECTED	

EMS TASK FORCE		
UNIT TYPE	SUGGESTED LOCATION	UNIT ID/ASSIGNMENT
5 TRANSPORT UNITS	PREPARE TO RECEIVE PATIENTS	
BATTALION CHIEF		
EMS SUPERVISOR/ COMMAND STAFF		
1ST SUPPRESSION UNIT		
2ND SUPPRESSION UNIT		

MCI EVENT

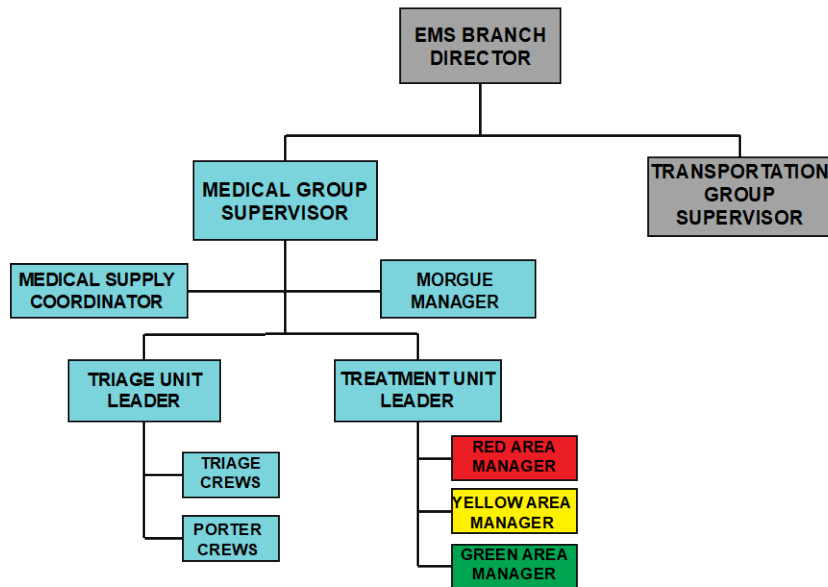


3 MEDICAL GROUP SUPERVISOR <small>NORTHERN VIRGINIA INCIDENT COMMAND SYSTEM WORKBOARD ©</small>		RADIO CHANNEL	
		TRANSPORTATION GROUP	COMMAND/STAGING
INCIDENT LOCATION	STAGING LOCATION	EMS BRANCH	RHCC

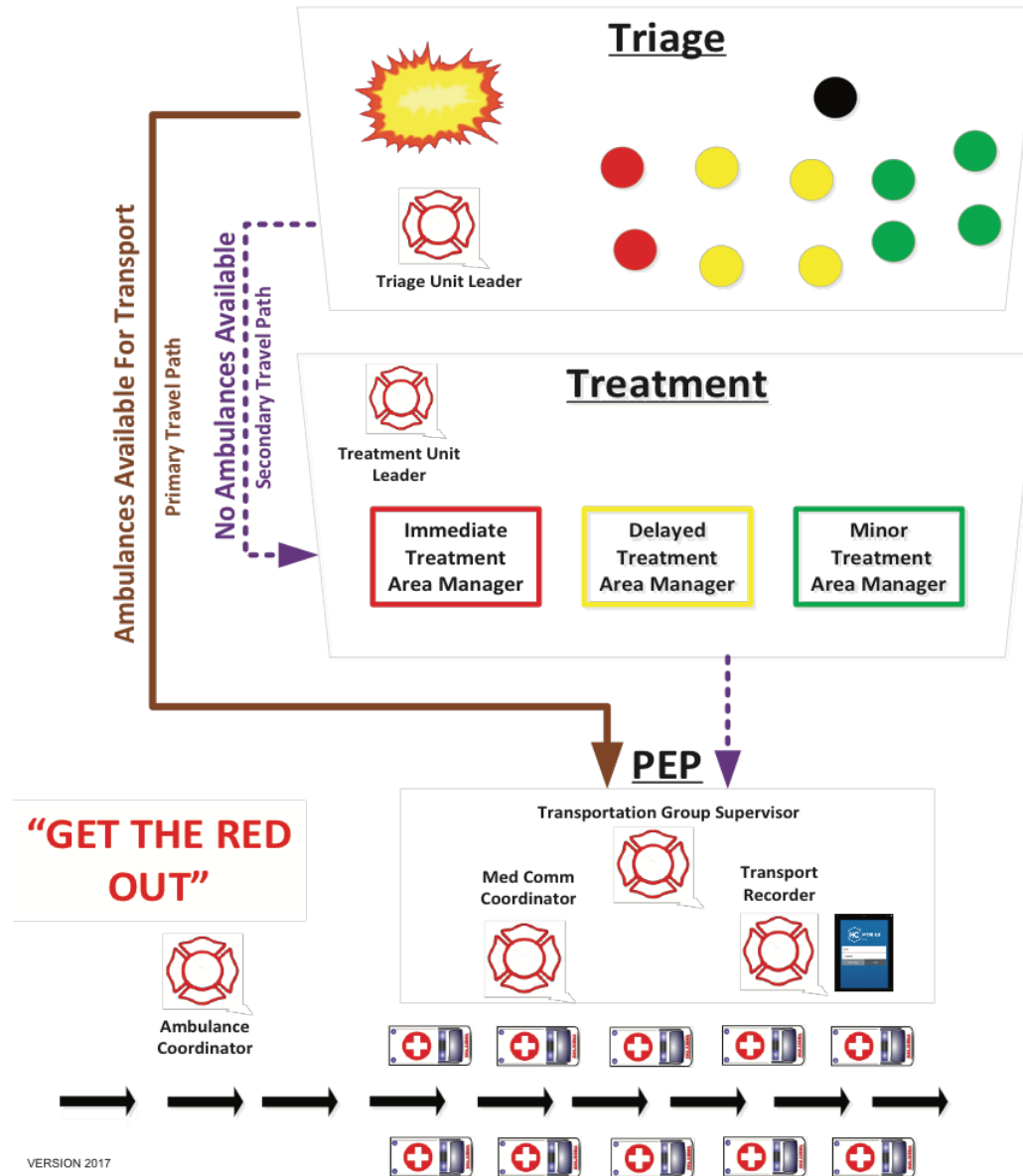
PATIENT COUNTS	TRIAGE	TREATMENT
IMMEDIATE		
DELAYED		
MINOR		
DECEASED		
TOTAL		

RESPONSIBILITIES	TIME COMPLETED
REQUEST DEDICATED CHANNEL FOR MEDICAL GROUP	
OBTAIN PATIENT COUNTS FROM TRIAGE AND TREATMENT	
PROVIDE UPDATED PATIENT COUNTS TO TRANSPORTATION GROUP	
ANTICIPATE THE NEEDS OF THE TRIAGE AND TREATMENT UNITS	
ESTABLISH MEDICAL SUPPLY CACHE	
ESTABLISH A MORGUE AS NEEDED	

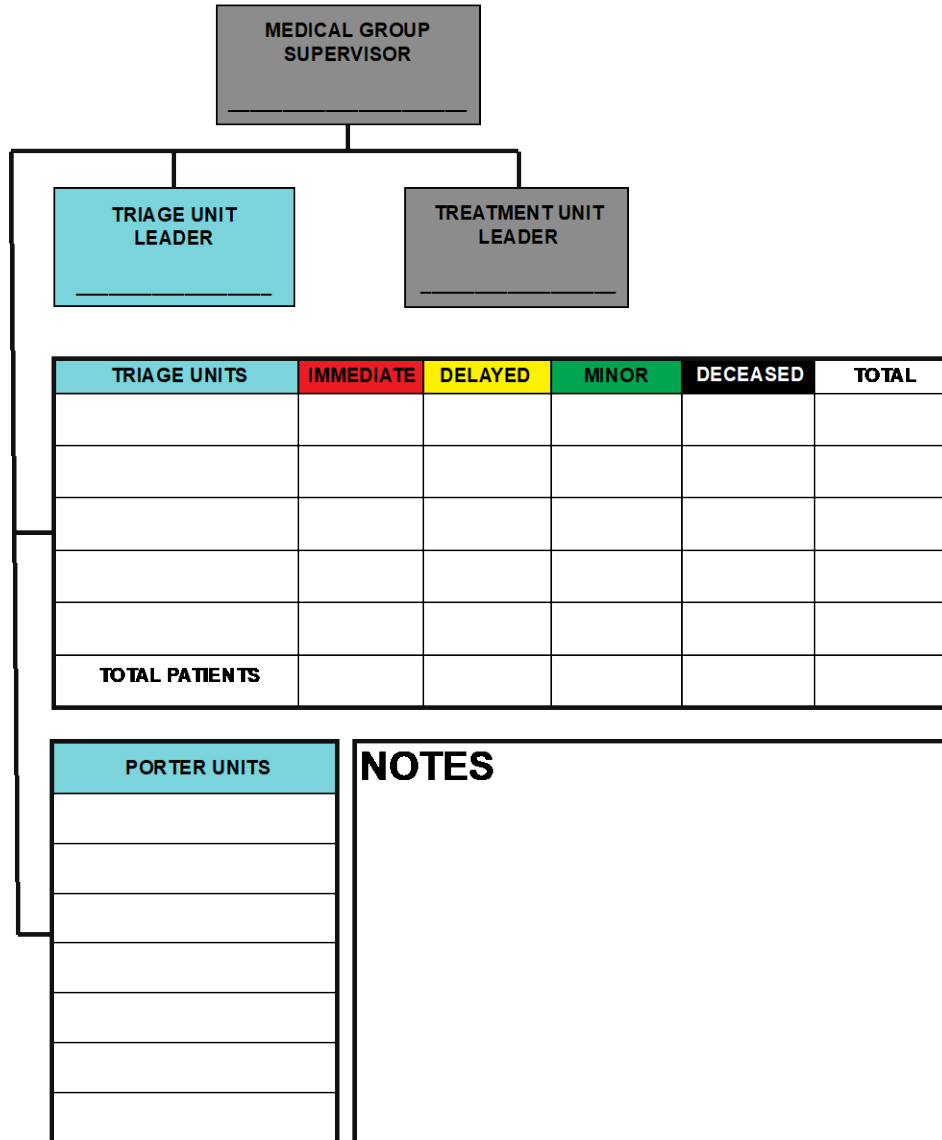
NOTES



MCI EVENT



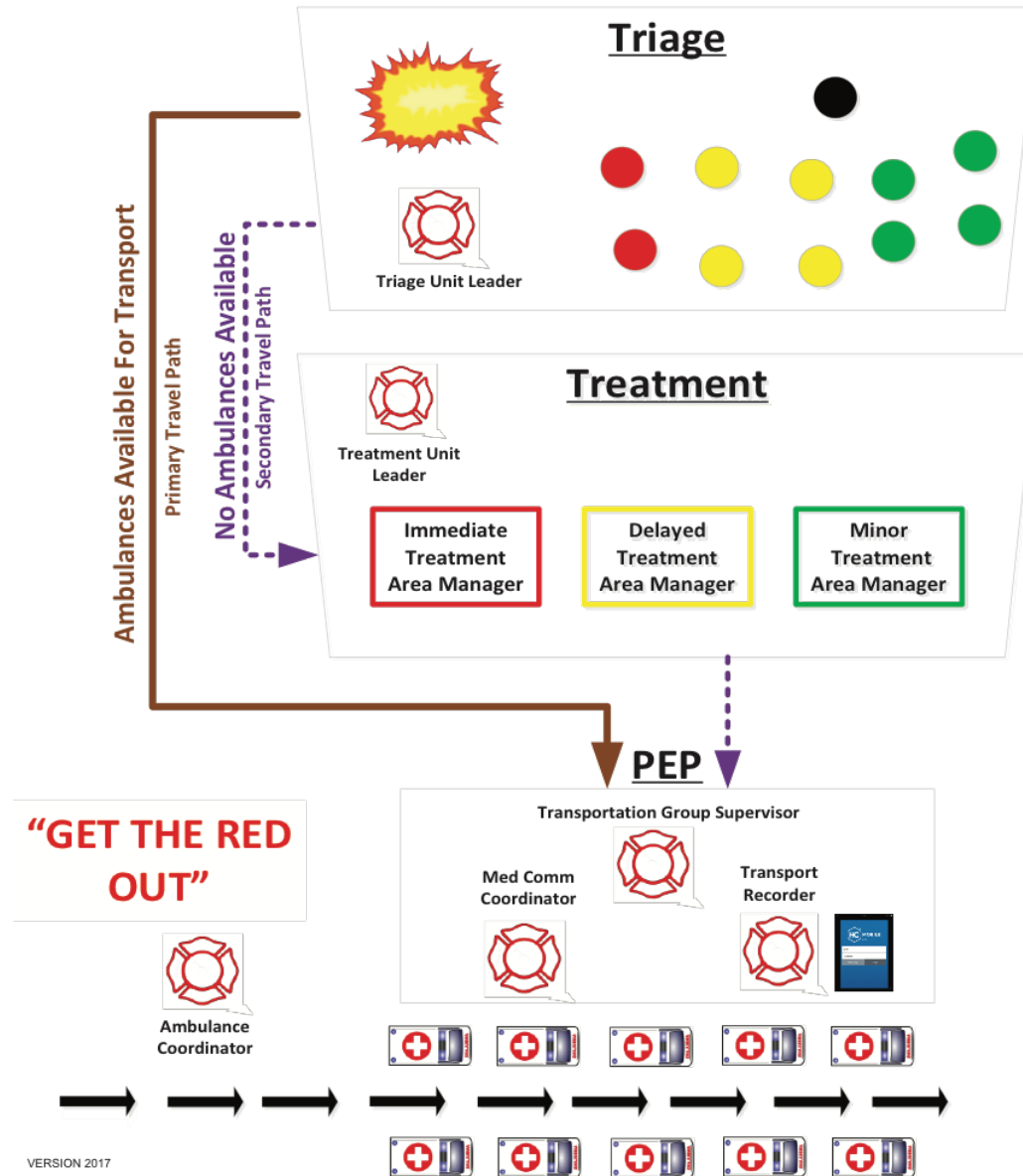
4	TRIAGE UNIT LEADER	RADIO CHANNEL	
	MEDICAL GROUP	EMS BRANCH	



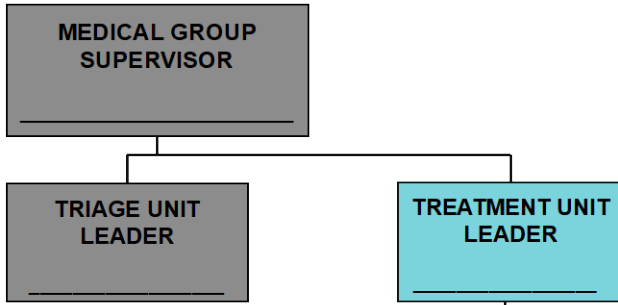
RESPONSIBILITIES	COMPLETED
DESIGNATE THE CASUALTY COLLECTION POINT (CCP) IF NEEDED	
DIRECT WALKING WOUNDED PATIENTS TO A DEFINED LOCATION	
COORDINATE WITH TRANSPORT GROUP SUPERVISOR AND INSTRUCT PORTERS TO BRING IMMEDIATE PATIENTS THROUGH THE PEP TO AWAITING TRANSPORT UNITS	
OBTAIN AND COMMUNICATE PATIENT COUNTS TO THE MEDICAL GROUP SUPERVISOR	
ENSURE ALL DECEASED PATIENTS HAVE A DISASTER TAG APPLIED AND ARE ENTERED INTO PTS	

FIVE S's	COMPLETED
SAFETY: * IDENTIFY IDLH/HIGH THREAT SITUATIONS AND WARN INCOMING UNITS OF HAZARDS	
SIZE UP: * DETERMINE NEED FOR ADDITIONAL RESOURCES	
SEND INFO: * TRANSMIT A SITREP * REQUEST APPROPRIATE RESOURCES * ACTIVATE RHCC	
SET UP: * IDENTIFY A STAGING AREA * IDENTIFY AND ANNOUNCE SCENE ACCESS AND EGRESS	
START TRIAGE: * INITIATE TRIAGE	

MCI EVENT



5 TREATMENT UNIT LEADER <small>NORTHERN VIRGINIA INCIDENT COMMAND SYSTEM WORKBOARD ©</small>	RADIO CHANNEL	
	MEDICAL GROUP	TRANSPORTATION GROUP



NOTES

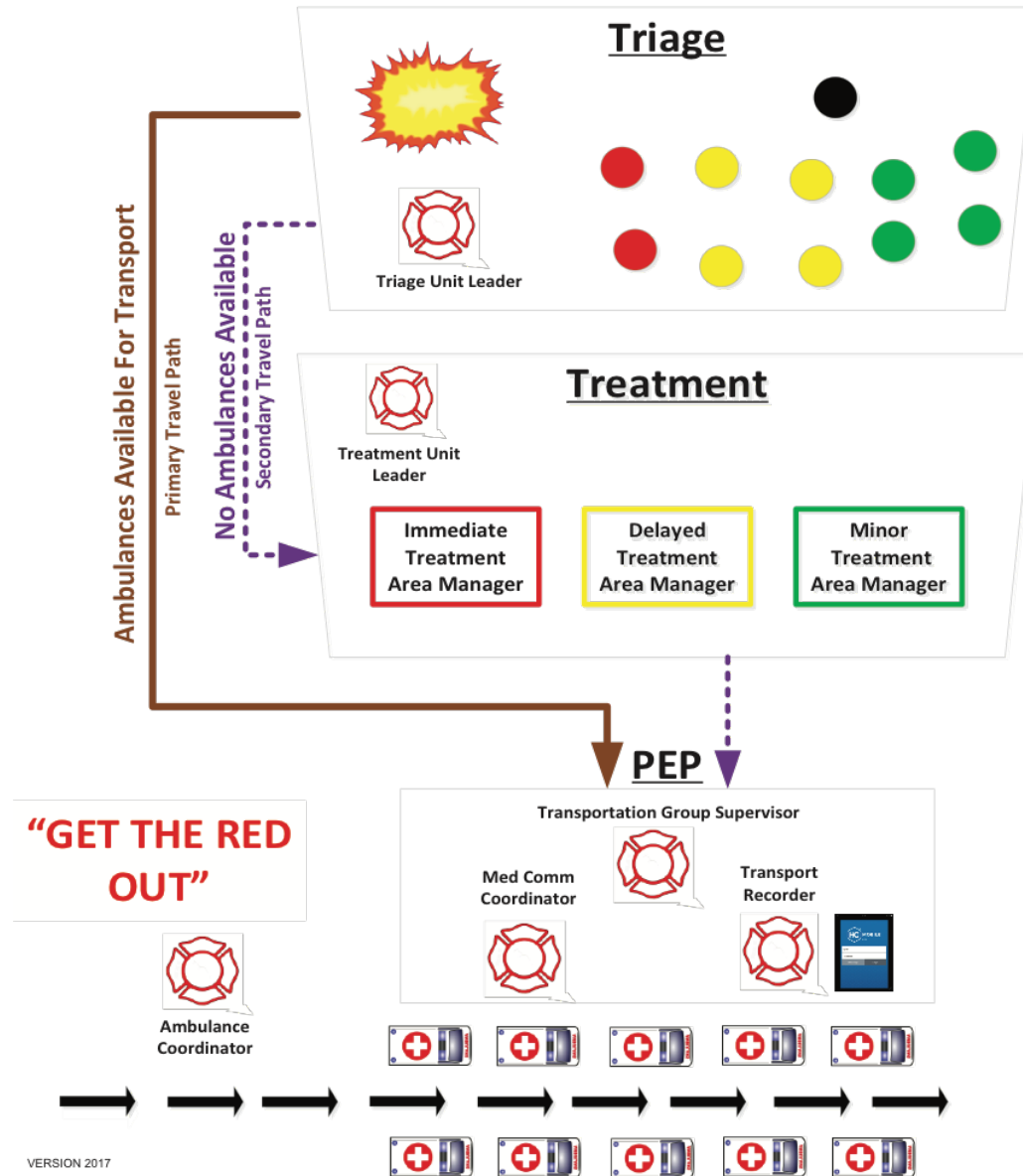
IMMEDIATE TREATMENT AREA	LOCATION	REQUESTED RESOURCES/ PERSONNEL	RECEIVED RESOURCES/ PERSONNEL	PATIENT COUNT
	MANAGER			INITIAL
				FINAL

DELAYED TREATMENT AREA	LOCATION	REQUESTED RESOURCES/ PERSONNEL	RECEIVED RESOURCES/ PERSONNEL	PATIENT COUNT
	MANAGER			INITIAL
				FINAL

MINOR TREATMENT AREA	LOCATION	REQUESTED RESOURCES/ PERSONNEL	RECEIVED RESOURCES/ PERSONNEL	PATIENT COUNT
	MANAGER			INITIAL
				FINAL

RESPONSIBILITIES	COMPLETED
IDENTIFY AND ANNOUNCE THE LOCATION OF ALL TREATMENT AREAS	
MAINTAIN COMMUNICATIONS WITH THE MEDICAL GROUP SUPERVISOR	
COORDINATE PATIENT MOVEMENT WITH THE MEDICAL GROUP SUPERVISOR	
DIRECT LOADERS AND AMBULANCE CREWS TO APPROPRIATE TREATMENT AREA MANAGERS	
MAINTAIN REAL-TIME COUNT OF ALL PATIENTS	

MCI EVENT



APPENDIX F: WORKSHEETS

Treatment Area Manager Form

NORTHERN VIRGINIA INCIDENT MANAGEMENT SYSTEM				PAGE	OF
TREATMENT AREA MANAGER					
TASK OR OBJECTIVES			RESOURCES		
<input type="checkbox"/> REQUEST & ASSIGN PERSONNEL TO PATIENT TREATMENT AREAS <input type="checkbox"/> ENSURE SECONDARY TRIAGE IS COMPLETED <input type="checkbox"/> COMMUNICATE PATIENT COUNTS TO TREATMENT UNIT LEADER <input type="checkbox"/> ENSURE PROPER DOCUMENTATION IS COMPLETED- DISASTER TAG/PTS			<input type="checkbox"/> TARP, FLAG, TENT, AND/OR CONES <input type="checkbox"/> ADMINISTRATION BOX <input type="checkbox"/> PATIENT ASSESSMENT BOX <input type="checkbox"/> IV BOX AND IV FLUIDS <input type="checkbox"/> TRAUMA/BULK BANDAGE BOX <input type="checkbox"/> LITTERS AND BACKBOARDS <input type="checkbox"/> OXYGEN MULTILATOR SYSTEM <input type="checkbox"/> INDIVIDUAL PATIENT CARE KITS		
TIME IN	BAR CODES	AGE/SE X	NOTES	TIME OUT	
	1	M F			
	2	M F			
	3	M F			
	4	M F			
	5	M F			
TIME IN	BAR CODES	AGE/SE X	NOTES	TIME OUT	

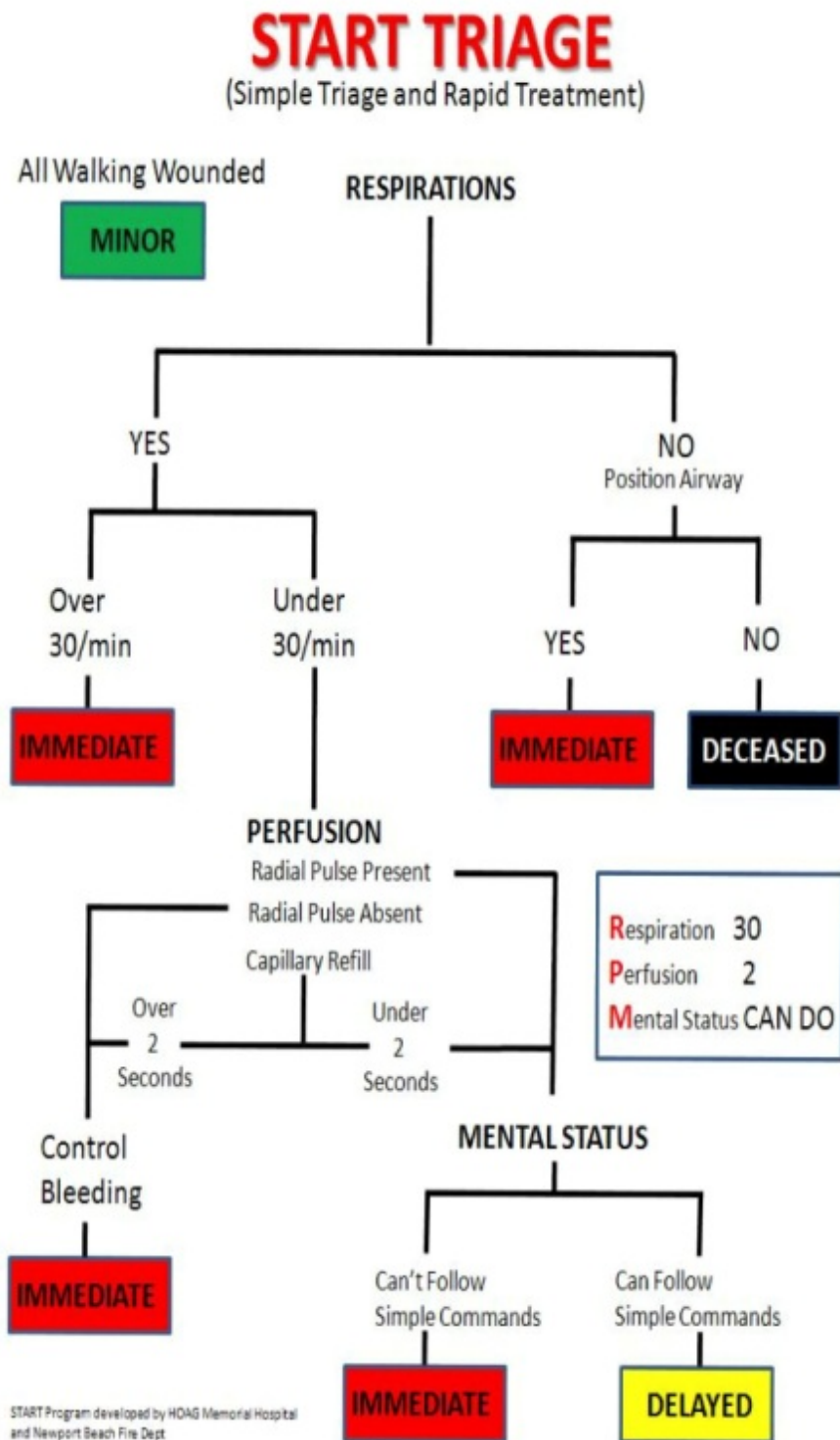
Transportation Recorder Form

NORTHERN VIRGINIA INCIDENT MANAGEMENT SYSTEM TRANSPORT RECORDER FORM		PAGE	OF
1	2	3	
4	5	6	
RECEIVING MEDICAL FACILITY (Hospital)	7	8	
TRANSPORTATION LOCATION (DIVISION)			
DISASTER TAG - TRANSPORT STUBS			

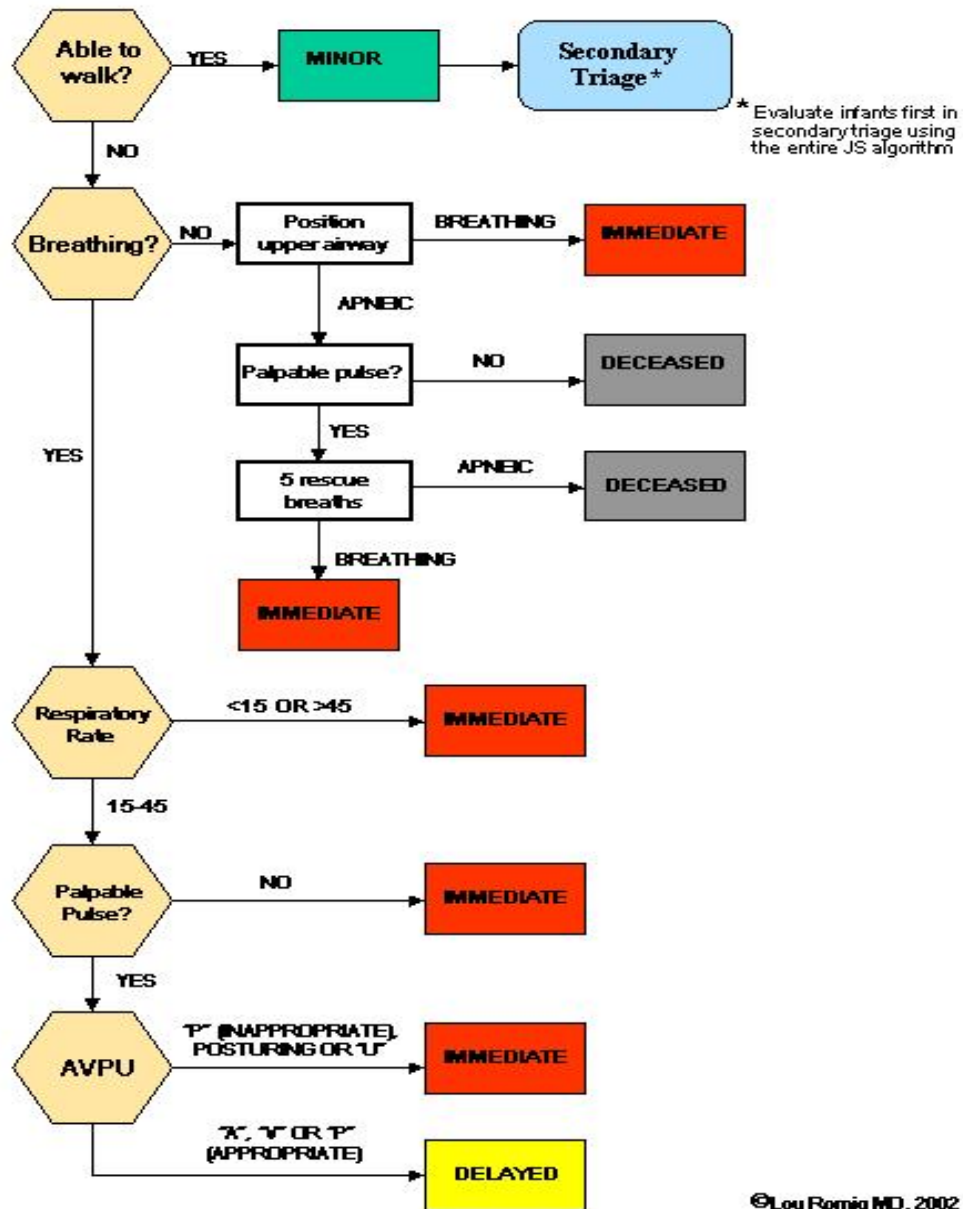
Staging Manager Form

NORTHERN VIRGINIA INCIDENT MANAGEMENT SYSTEM				PAGE	OF
STAGING MANAGER					
TIME IN	TIME OUT	UNIT	ASSIGNMENT	NOTES	
TIME IN	TIME OUT	UNIT	ASSIGNMENT	NOTES	
STAGING MANAGER					


APPENDIX G: START/JUMP START TRIAGE



JumpSTART Pediatric MCI Triage[®]



APPENDIX H: SAMPLE DISASTER TAG



WASHINGTON METROPOLITAN AREA

**DISASTER TAG
DO NOT REMOVE**

PATIENT INFORMATION

AGE WEIGHT

MALE FEMALE

NAME

ADDRESS


CITY STATE PHONE

PATIENT NUMBER

NCR15080001

EVALUATION	TIME	RED	YELLOW	GREEN	BLACK
INITIAL		IMMEDIATE	DELAYED	MINOR	DECEASED
SECONDARY		IMMEDIATE	DELAYED	MINOR	DECEASED
HOSPITAL		IMMEDIATE	DELAYED	MINOR	DECEASED

CHIEF COMPLAINT




EMOTIONAL (uncontrollable)

Head Injury C-Spine
Blunt Trauma
Penetrating Injury
Burn Fracture
Laceration Amputation

Medical _____







Cardiac Respiratory
Diabetic OB/GYN
Haz-Mat Exposure



COMMENTS

TRANSPORTATION AGENCY/UNIT

DESTINATION

TREATMENT	HOSPITAL
 NCR15080001	 NCR15080001
OTHER	OTHER
 NCR15080001	 NCR15080001
OTHER	OTHER
 NCR15080001	 NCR15080001

TRANSPORT RECORD

AGE

MALE FEMALE

NAME

CHIEF COMPLAINT

DESTINATION

TRANSPORTATION AGENCY/UNIT TIME OUT

PATIENT NUMBER

NCR15080001

TRIAGE STATUS

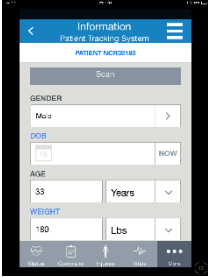
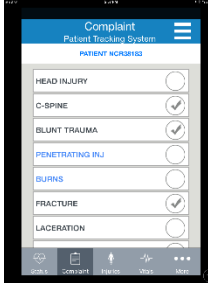

DOB

NCR15080001

LAST NAME, FIRST NAME

APPENDIX I: PATIENT TRACKING DEVICE

PTS Quick Reference	
<p>Step 1</p> <p><u>Login</u></p> <ul style="list-style-type: none"> User = Your current unit ID (e.g. E405, M422) Pass = *novapts <p>First time Login Note</p> <ul style="list-style-type: none"> Module Launcher will appear, select Patient Tracking System Next login will skip this step 	<p>Step 2</p> <p><u>Sync</u></p> <ul style="list-style-type: none"> After login, the app will automatically sync with the server. Then this screen will appear. Tap “Individual”
<p>Step 3</p> <p><u>Incident</u></p> <ul style="list-style-type: none"> On this screen, at a minimum, the Incident and the Position fields <u>must</u> be filled out correctly. For Weekly Triage use “Daily Patients” as the incident On an actual MCI incident, use “Event ###” - The event number is determined by the jurisdictional location of the event (e.g. an incident occurring in Fairfax Co. would be “Event 400”, and an incident occurring within Arlington is “Event 100” etc.). 	<p>Step 4</p> <p><u>Scan</u></p> <ul style="list-style-type: none"> Uncover the camera on the back. Tap scan – a camera view will appear. Align the red line on screen with the triage barcode. A barcode that has been previously scanned and saved will have any information that was entered by that unit/first responder uploaded after it is scanned again. <p><i>(If an engine triages a patient and transfers them to a medic unit; when the medic unit scans that same barcode they will receive all the information previous entered) information will automatically populate.</i></p>
<p>Step 5</p> <p><u>Triage</u></p> <ul style="list-style-type: none"> Select the appropriate triage color for the patient. If a patient’s triage status changes at any time or in any station during the MCI, navigate back to the status tab, and update this screen. 	<p>Step 6</p> <p><u>Transport</u></p> <ul style="list-style-type: none"> All the information on this screen is required for the transporting unit. Scroll down for Arrival Time. A unit that is only doing initial triage does not fill out this screen. Once the jurisdiction is selected, the “unit” drop down menu will populate with a corresponding list of units.

Step 7	Step 8
<p>Information</p> <ul style="list-style-type: none"> Fill in as much information on this screen as you are able. Minimum information (gender, age/dob and first & last name). The scan button on this screen allows you to read the barcode on the back of ID cards and Driver’s licenses, and auto-populate the fields with the information. <p><i>Not all IDs and DLs have a readable barcode, but the scan feature will work with most VA issued IDs and DLs.</i></p> 	<p>Complaint</p> <ul style="list-style-type: none"> Select any complaints that the patient has. Comments are not required but any information that may be useful to pass on can be noted here. 
Step 9	
 <p>This button, found in the upper right hand corner of most of the screens, will give the user a few different options to exit, as well as provide some shortcuts to other features. Almost all options to exit will auto-save the patient information. <i>Close</i> is the only option that will allow you to close out the patient record without auto-saving.</p>	

APPENDIX J: PATIENT TRACKING AND FAMILY REUNIFICATION

The Patient Tracking System (PTS) project was created to address the need to accurately track the location of patients from the scene of an incident to area hospitals within Northern Virginia and the National Capital Region (NCR).

In a Mass Casualty Incident (MCI), the system will be used to record patient distribution as well as reunite patients with their families. The three instances of patient tracking in Maryland, the District of Columbia, and Northern Virginia are integrated for sharing data across state lines, both for special events and for MCIs. During events, hospitals will be alerted of patients that are en route to their facility and system managers will have ability to monitor all activity.

Additionally, PTS is integrated with many agencies' electronic patient care reporting systems, the Virginia Hospital Alerting and Status System (VHASS), 2-1-1 Virginia (Virginia's state-wide system for family re-unification in emergencies), and the Regional Healthcare Coordinating Center (RHCC) that manages patient flow to appropriate receiving facilities.

The Patient Tracking Incident should be dictated by the location of the incident.

- Event 000- DC
- Event 100- Arlington
- Event 200- Alexandria
- Event 300- MWAA
- Event 400- Fairfax
- Event 500- Prince William
- Event 600- Loudoun
- Event 700- Montgomery
- Event 800- PG

2-1-1 Virginia is system that is designed to reunite families after events and is connected to the Patient Tracking System. The RHCC will activate 2-1-1 on a request from hospitals or Incident Commanders. All inquiries about the transport destination of patients involved in and MCI shall be referred to 2-1-1.

2-1-1 relies on information entered into the Patient Tracking System in order to identify patients, so it is important when completing patient records to be as complete and accurate as possible.

APPENDIX L: RHCC

**Northern Virginia Regional Hospital Coordination Center (RHCC) EMS
Activation Protocol**

Purpose: One of the responsibilities of the NoVA RHCC is to coordinate with EMS personnel to ensure the timely and appropriate distribution of patients to Northern Virginia Hospital Alliance member facilities, including both acute-care hospitals and freestanding emergency care centers, and to improve the communication between field personnel and receiving hospitals. The goal of this coordination is to match patients to the most appropriate hospital resources, based on the circumstances of the event, in a timely and efficient manner.

Scope: The RHCC will be notified to activate in support of EMS agencies in Northern Virginia for incidents meeting **ANY** of the following criteria:

1. A single, non-HAZMAT event in NoVA, involves (10) or more patients that will require transportation to a NVHA hospital; and/or where (3) or more NVHA hospitals are to receive patients
2. A single HAZMAT event in NoVA involves (3) or more patients that will be decontaminated in the field by EMS before being transported to a NVHA hospital
3. An event in NoVA involves a suspected or confirmed Category A biological agent
4. A NoVA Fire/EMS agency has activated an Urban Search & Rescue Team for an event occurring in the National Capital Region
5. A NoVA Fire/EMS agency has activated a Mass Casualty Unit, Task Force, or equivalent, for an event occurring in the National Capital Region.
6. A NoVA EMS agency has accessed and/or requested a CHEMPACK or MMRS Rx cache
7. A NoVA Emergency Operations Center (EOC) has activated and staffed the Health & Medical Services (ESF 8) function

Procedures:

1. If an incident occurs that meets the criteria enumerated under the SCOPE, an appropriate Fire/EMS agent will immediately contact the RHCC at;
 - (1) **Phone:** 888-987-RHCC (7422); or
 - (2) RHCC Radio Talk Group
 - Alexandria.....Zone **14** Channel **1** (H1 RHCC4)
 - Arlington.....Zone H RHCC4, Zone H RHCC6
 - Fairfax.....Zone **14** Channel **1** (49A RHCC4), Channel **16** (49P RHCC6)

Prince WilliamZone **11** Channel **1** (9A RHCC4), Channel **16** (9P RHCC6)
LoudounZone **69** B RHCC6
MWAAZone VA Hospital 17 P RHCC4

2. The appropriate agent will request the immediate support of the Regional Hospital Coordination Center (RHCC) via Phone or Radio per the communication mechanisms listed in (1);
3. The appropriate EMS agent will provide RHCC staff the following information, if known:
 - Point of contact and phone number
 - Nature of event, i.e., chemical spill, explosion, etc.
 - Number of patients
 - Types of injuries
 - Special needs, i.e., pediatrics
 - Incident location
 - Lead agency
 - Current Activities
4. The information listed in (3) will be immediately conveyed by the RHCC to regional hospitals as detailed in the RHCC activation procedures outlined in the Northern Virginia Regional Hospital Emergency Operations Plan (RHEOP).
5. The RHCC will gather from all NVHA hospitals their immediate casualty capacity information (i.e., the number of red/immediate, yellow/delayed, and green/minor patients they could manage within the next 30 minutes). This information will be collected and relayed to the appropriate EMS field officer (i.e. Medical Communications Coordinator), within 10 minutes of activation, to assist with patient disposition.
6. Final hospital destination decisions will be decided by an appropriate EMS field officer (i.e. Medical Communications Coordinator) in coordination with the RHCC. At a **minimum**, the EMS field officer will relay to the RHCC the following information for each transporting unit, preferably BEFORE the unit leaves the scene:
 1. Unit Number
 2. Destination facility
 3. Number and Category (Red, Yellow, Green) of patients on unit (with notice for peds)
 4. The RHCC will relay information to the designated receiving facilities via pre-established communication channels.
7. The EMS officer (i.e. Medical Communications Coordinator) will keep the RHCC informed of major developments on the scene that could affect Northern Virginia

Hospitals. Likewise, the RHCC will keep the designated EMS officer apprised of all major changes to the status of Northern Virginia Hospitals. All requests for on-scene support from Northern Virginia Hospitals (i.e., additional equipment, supplies, on-scene physician / nursing support, etc.) will be directed through the RHCC and not individual hospitals;

8. The appropriate EMS officer (i.e. Medical Communications Coordinator) will notify the RHCC when the scene incident has been demobilized and/or the last patient has been transported off-site;
9. At the conclusion of the scene incident the designated Medical Communications Coordinator or designee will cross check their patient transfer information with the RHCC. The RHCC will be responsible for cross checking their patient transfer information with all of the receiving facilities. A copy of the final incident/transport record will be sent to the affected jurisdictional Fire and Rescue Department and a copy maintained in the RHCC records for a minimum of 7 years.

Version 7.3

For additional information contact:

EMS

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Gainesville, VA 20155
877-261-3550
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Hospital

Northern Virginia Hospital Alliance
Regional Hospital Coordination Center
8110 Gatehouse Drive, Suite 600 W
Falls Church, VA 22042
888-987-7422
rhcc@novaha.com