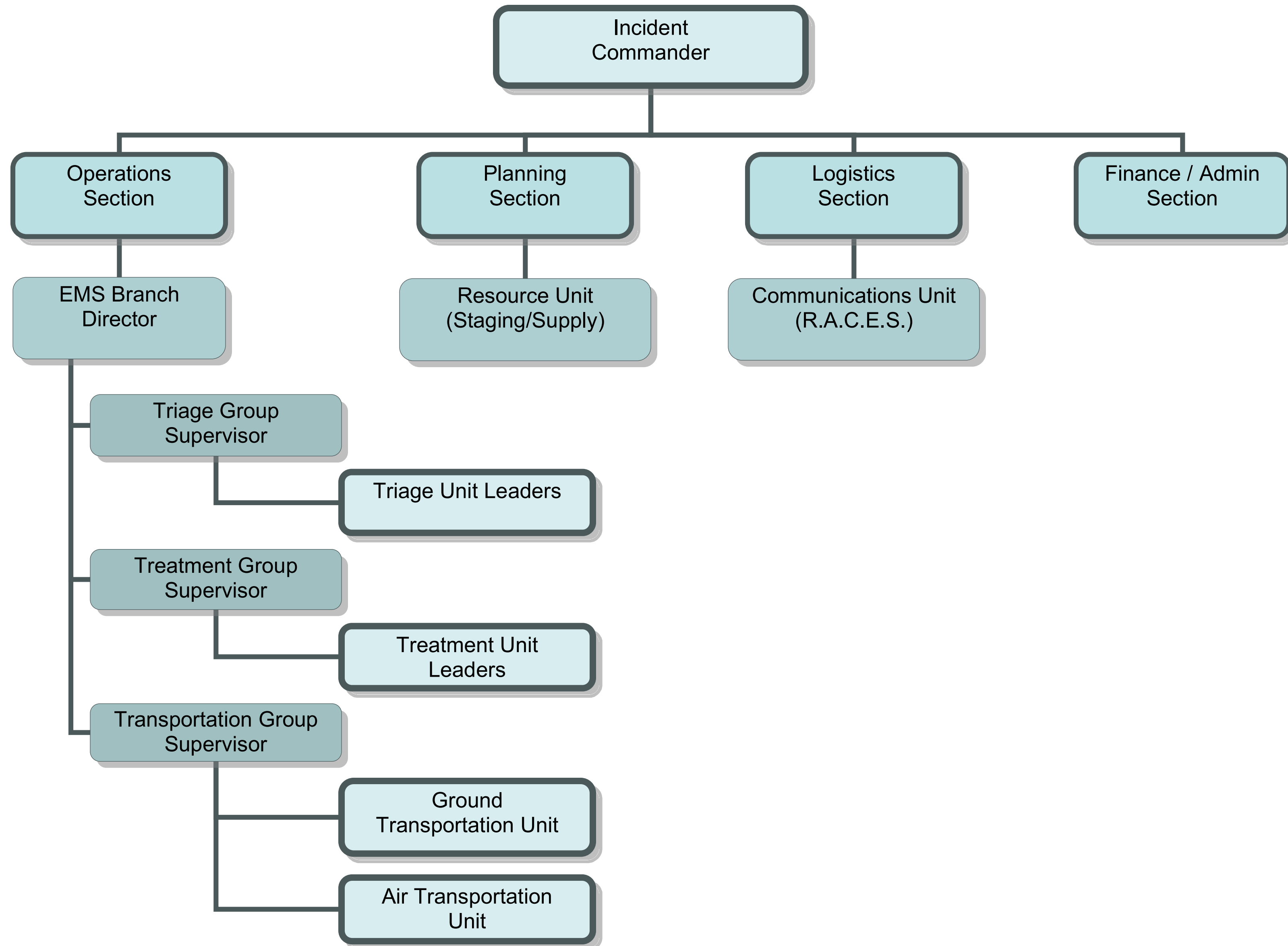
SAINT JOSEPH COUNTY, INDIANA
EMERGENCY MEDICAL RESPONSE PLAN

HOSPITAL CONTROL
01-01-2024 TO 12-31-2025

SAINT JOSEPH HEALTH SYSTEM
MISHAWAKA MEDICAL CENTER
574-335-1199

St. Joseph County Emergency Medical Response Plan
NIMS Compliant Scene Organization



Purpose

The purpose of this document is to establish a plan for an immediate, rapid, and efficient response to a mass casualty incident/medical disaster. This document, in conjunction with the Public Health and Medical Services Emergency Support Function (ESF 8), is intended to serve as the guide for the medical component of the Saint Joseph County Comprehensive Emergency Management Plan. It describes the necessary components for coordinating on-scene triage, treatment, and transportation of injured patients to receiving hospitals, as well as for coordinating the distribution of injured patients to those hospitals.

This document recognizes that many medical and public safety agencies and individuals will be involved in any disaster, and at any one time may be performing some combination of medical, fire, police, military, or other functions. Although it is clearly not the intent of this plan to inhibit such agencies or individuals from performing their assigned tasks, it is intended that all medical functions will be accomplished according to this plan.

Any emergency medical response directed by or related to this plan will follow the National Incident Management System (NIMS) in establishing command structure. All positional titles in this plan reflect those assigned by NIMS and, as such, will be used at all incidents managed in accordance with this plan.

Definitions

The following definitions are critical to the understanding and implementation of this plan. As such, all St. Joseph County emergency medical responders should make themselves familiar with these terms as they apply to this plan. Note that these definitions apply to their use in this plan and do not necessarily represent the informal daily uses of these terms.

Communications Center – Communications Center is defined as the central communications and dispatch agency of the jurisdiction primarily affected by the incident. For the purposes of this plan, the Mishawaka and South Bend Dispatch Centers will serve as the Communications Center for incidents primarily affecting their respective jurisdictions, and St. Joseph County Fire Dispatch will serve as the Communications Center for all other incidents in St. Joseph County.

Mass Casualty Incident – A mass casualty incident is any situation involving the injury or illness of a number of persons, under circumstances clearly and substantially beyond the capability of the usual emergency medical services system to handle in a reasonable period of time. Mass casualty incidents are taxing to local and regional assets but do not require the assistance of federal assets to mitigate the incident. In this document, the terms medical disaster and mass casualty incident are used interchangeably, since the local response provided for in this document is the same for both incident levels.

Medical Disaster – A medical disaster is any mass casualty incident that is extensive enough to require the assistance of federal response assets and/or state level response assets from neighboring states. Involvement of federal agencies for regular law enforcement purposes does not necessarily constitute a medical disaster. In this document, the terms medical disaster and mass casualty incident are used interchangeably, since the local response provided for in this document is the same for both incident levels.

Response Agencies – Response agencies are considered to be all agencies, public or private, that provide resources and/or personnel to act in the mitigation of a mass casualty incident in accordance with this plan. Response agencies may include, but are not limited to, hospitals, firefighters, police officers, EMS responders, Emergency Management Agency representatives and teams (local, state, or federal), federal law enforcement, military resources, and urgent care centers.

EDUCATION AND TRAINING STANDARDS

Each SJCEMSC sponsoring hospital is responsible for providing Emergency Medical Response education to its own staff, as well as for overseeing medical education programs and mass casualty incident training for SJCEMSC sponsored response agencies in St. Joseph County.

Response agencies will be responsible for ensuring command personnel, or those who may potentially fill command roles, are educated in all command positions provided for in this plan. Training shall follow the roles and responsibilities outlined in the position manuals provided with this plan.

Mass casualty incident medical component drills and tabletop exercises will be held as determined by the SJCEMSC, and may be incorporated into more comprehensive St. Joseph County Emergency Management Agency practice scenarios. Since a medical disaster may overwhelm county assets, drills may include agencies from throughout the region. Drills should not only include scene operations, but also simulate the administrative processes of identifying, requesting, mobilizing, assigning, replacing, and demobilizing resources, as well as forming and utilizing a unified command system. These administrative and command processes are as important as on-scene operations.

The purpose of tabletop exercises will be to familiarize representatives with the administrative, command, and paperwork functions necessary in a mass casualty incident response. Tabletop exercises will also focus on the processes and documentation necessary to request resources from all levels of response agencies, as well as the inventory, mobilization, assignment, maintenance, demobilization, and return to service of all resources. During the briefing at the end of each tabletop exercise, attending representatives will evaluate and design or redesign standardized forms for use by all agencies operating under this plan.

All response agencies and hospitals that operate under this plan will comply with all current and future NIMS training requirements as mandated by the Department of Homeland Security. This training is available online from the Federal Emergency Management Agency (FEMA) Emergency Management Institute at http://training.fema.gov. Failure to meet NIMS training requirements may affect the ability of response agencies and local governments to receive federal and state compensation after a disaster.

HOSPITAL CONTROL

Hospital Control shall serve as the ultimate authority for medical operations and treatments during any incident regulated by this plan. While Hospital Control will usually be run out of the Emergency Department of the responsible hospital, it's location is not mandated to be at that location. Hospital Control may be moved to any location deemed appropriate by the personnel serving as Hospital Control. This location may be elsewhere in the hospital, in another building, or even on the incident scene. Hospital Control staffing shall include at least one Emergency Nurse but may require additional personnel, with varied credentials, depending on the size and scope of the incident. The role of Hospital Control staffing is only to operate Hospital Control. This staffing shall not be used to provide medical care to patients at any time, as doing so would distract them from fully performing the duties of Hospital Control.

Hospital Control shall maintain regular voice communication with the on-scene EMS Branch Director during the entire incident or until EMS operations cease, whichever comes first. This communication may be accomplished through any form of telephonic or radio method necessary. Whenever possible, the EMS Branch Director will contact Hospital Control every thirty minutes in order to provide an update on the current situation. If the EMS Branch Director does not contact Hospital Control, it shall be Hospital Control's duty to initiate contact and request that update.

The responsibilities of Hospital Control shall be rotated between ***Memorial Hospital of South Bend*** and ***Saint Joseph's Regional Medical Center*** every two years. Hospital Control shall be responsible to:

- Direct medical care for victims and other patients.
- Designate a licensed physician, or physicians, to serve as the contact point for all online medical requests, including treatment authorizations and general consultations. If possible, the physician(s) shall be provided with a phone line that is accessible from outside the facility. This phone number shall be provided to the EMS Branch Director and used exclusively for online medical consultations.
- Oversee the training and education of medical personnel prior to and, if necessary, during the incident.
- Monitor IHERN and RACES radio traffic to stay informed of transported patients.
- Provide resources and online medical direction for response personnel as well as for on-scene command personnel, including the Incident Commander, EMS Branch Director, Triage Group Supervisor, Treatment Group Supervisor, and Transportation Group Supervisor.
- Monitor bed availability at receiving hospitals, as well as the availability of other pertinent medical resources. Hospital Control shall communicate resource availability to the on-scene Resource Unit at regular intervals; when possible, this communication should occur at least every 30 minutes.
- Identify the treatment capabilities of all receiving hospitals and provide this information to the Resource Unit.

- When necessary, request the establishment of decontamination operations at all receiving hospitals for incoming patients who may have been exposed to hazardous materials and were not decontaminated the scene.
- Maintain contact with Poison Control in any incident requiring that service, especially in a hazardous materials incident.

ON-SCENE COMMAND POSITIONS

As mentioned earlier in this document, the National Incident Management System (NIMS) will be used in all incidents managed under this plan. The federal government mandated the implementation and use of NIMS by all emergency response agencies and governments by October 1, 2007. All response agencies utilizing this plan should be familiar with and using NIMS on a regular basis.

All personnel filling command roles on the scene of an incident managed under this plan shall wear a reflective vest with their position printed on the vest in black letters. This vest is to be worn at all times while on the scene of the incident.

The National Incident Management System dictates the command positions and titles that will be used in the case of a medical disaster. These positions are shown on the command chart on page two of this document. The responsibilities of these positions are as follows:

INCIDENT COMMAND

Incident Command is the ultimate authority at the incident scene. As such, in the case of a disagreement between off-scene personnel or Hospital Control and Incident Command, the Incident Commander will have the final say in what course of action is followed. This rule does not apply if the current situation dictates otherwise because of written laws or the National Response Plan, or in the instance of treatment(s) ordered by on-line medical consultation. Directives by online medical consultation shall be followed unless those actions would place the on-scene provider in an unacceptable degree of danger.

Incident Command may be comprised of one individual at smaller incidents or several individuals from multiple agencies working in a unified command structure. This structure may grow larger or smaller as the incident progresses.

Incident Command is responsible to:

- Establish an incident command post that will provide the necessary tools to assess, plan, and review the incident, as well as provide the space and infrastructure necessary for a unified command structure.
- Schedule periodic briefings with command personnel. These briefings will be used to update all personnel on the situation, evaluate progress, create or modify plans of action, and collect information to be used for press releases. Whenever possible, Hospital Control shall be included in these briefings through phone and/or video conferencing.
- Provide signature authority to command positions as needed. For example, provide ordering signature authority to the Resource Unit Leader.
- When necessary or desirable, replace command personnel with new personnel, ensuring that incoming personnel are briefed by outgoing personnel.
- Review and sign off on press releases prior to release by the Public Information Officer (PIO).

EMS BRANCH DIRECTOR

The EMS Branch Director shall be appointed by Incident Command and will report to the Operations Section Chief. In the absence of this position, the EMS Branch Director will report directly to Incident Command. The EMS Branch Director is responsible for all on-scene EMS operations, including triage, treatment, and transportation of victims.

The EMS Branch Director will serve as an on-scene representative for Hospital Control and is responsible for maintaining communication with Hospital Control at all times. The EMS Branch Director shall be certified to at least the EMT-Intermediate level, have completed FEMA Emergency Management Institute certification through at least the ICS-300 level, and shall be a commissioned officer of a fire or EMS department operating under this document. The EMS Branch Director is responsible to:

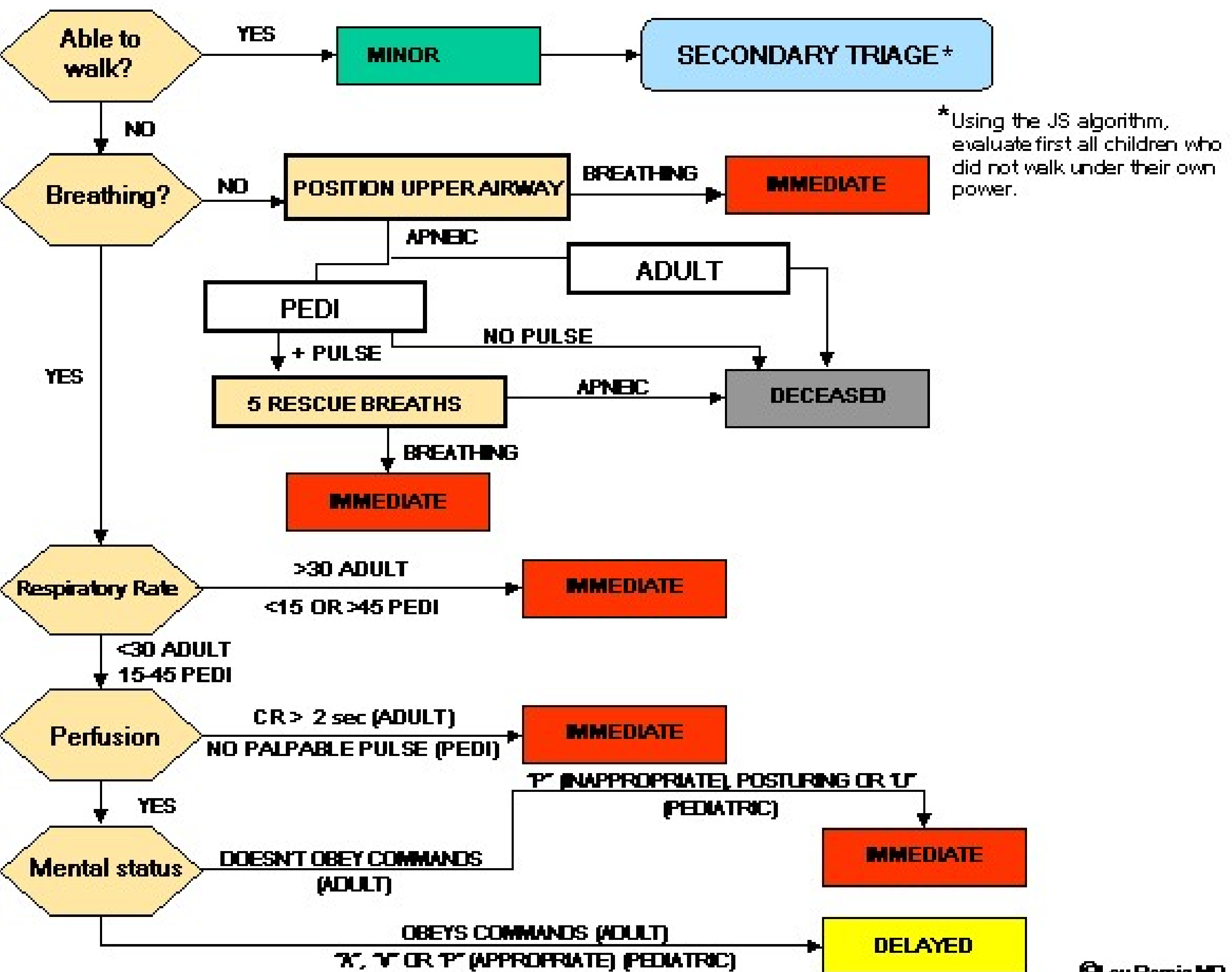
- Ensure the setup of all medical operations at the scene. If any setup is deemed inadequate, the EMS Branch Director may rearrange operations as he/she deems appropriate.
- Perform continuous assessment of the scene and medical operations, and make any adjustments necessary.
- Maintain communications with Hospital Control and provide regular situation updates. When necessary, the EMS Branch Director shall confer with Hospital Control to resolve situations or questions that may arise.
- Implement directives given by Hospital Control.
- Serve as the resource for relaying online medical requests. At the EMS Branch Director's discretion, this role may be delegated to the Treatment Group Supervisor.
- Maintain control over all on-scene medical operations.
- Ensure the safety of all on-scene medical personnel.
- Appoint personnel to fill all needed command roles under the EMS Branch Director's authority.

TRIAGE GROUP SUPERVISOR / UNIT LEADERS

The Triage Group Supervisor, who reports to the EMS Branch Director, is responsible for overseeing the safe, rapid, and efficient triage of all injured or ill patients on the scene of a multi-casualty incident, as well as the removal of victims from the scene to the Treatment Area. If not yet begun, the Supervisor will begin the triage process until provided with personnel to form into units. Once units are formed, each unit will have a Triage Unit Leader, who will report to the Triage Group Supervisor.

The Triage Group Supervisor is responsible to:

- Request and organize sufficient personnel and resources to handle all necessary triage functions in a reasonable amount of time.
- Initiate and manage the triage process, ensuring all patients are triaged utilizing the START/Jump START triage algorithm (next page).
- Ensure all patients on scene are located and triaged, and that their locations are reported to the EMS Branch Director for rescue, extrication, and/or removal.
- Ensure all patients are triaged prior to their removal from the scene to the Treatment Area
- Coordinate, with the Treatment Group Supervisor, the removal of all triaged patients to the Treatment Area.
- Provide periodic status reports to the EMS Branch Director that include estimated number of patients, their severity, and the number of personnel currently working triage.
- Maintain security and control of the areas in which triage is being performed.
- Maintain an accounting, and proper ratios, of triage personnel and victims.
- Ensure safety of triage personnel.
- Establish and maintain an inventory of resources and supplies.
- Maintain communication at all times with the EMS Branch Director, Treatment Group Supervisor, and Communications Unit Leader.


Combined START/JumpSTART Triage Algorithm
Able to walk?
YES
MINOR
SECONDARY TRIAGE *
NO
Breathing?
NO
POSITION UPPER AIRWAY
BREATHING
IMMEDIATE
APNEIC
ADULT
PEDI
NO PULSE
+ PULSE
5 RESCUE BREATHS
APNEIC
DECEASED
BREATHING
IMMEDIATE
YES
Respiratory Rate
>30 ADULT
<15 OR >45 PEDI
IMMEDIATE
<30 ADULT
15-45 PEDI
Perfusion
CR > 2 sec (ADULT)
NO PALPABLE PULSE (PEDI)
IMMEDIATE
YES
Mental status
DOESN'T OBEY COMMANDS
(ADULT)
"P" (INAPPROPRIATE), POSTURING OR "U"
(PEDIATRIC)
IMMEDIATE
OBEYS COMMANDS (ADULT)
"A", "V" OR "P" (APPROPRIATE) (PEDIATRIC)
DELAYED
*Using the JS algorithm, evaluate first all children who did not walk under their own power.
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TREATMENT GROUP SUPERVISOR / UNIT LEADERS

The Treatment Group Supervisor, who reports to the EMS Branch Director, is responsible for verifying the proper triage assignment of all victims, as well as the provision of medical care to those victims. The Treatment Group Supervisor is also responsible for the efficient use and rationing of medical supplies and personnel, inventory, and requesting of resources through the Resource Unit.

The Treatment Group Supervisor will maintain communications with Hospital Control at all times and will be responsible for relaying all requests from EMS personnel for online medical consultation, including requests to administer medications and perform interventions requiring online medical approval.

TRANSPORTATION GROUP SUPERVISOR

The Transportation Group Supervisor, who reports to the EMS Branch Director, is responsible for ensuring safe, timely, and efficient transportation of patients from the incident scene to receiving hospitals or medical care facilities. Transportation methods may include ground ambulances, rotary-wing ambulances, fixed wing ambulances, mass transit vehicles, or other vehicles capable of transporting patients. The Transportation Group Supervisor shall work in concert with the Treatment Group Supervisor and Hospital Control to ensure that patients are transported according to the severity of their injuries/condition and hospital capabilities. The Transportation Group Supervisor will work with Hospital Control to determine to which facility each patient is transported.

GROUND TRANSPORTATION UNIT

The Ground Transportation Unit Leader, who reports to the Transportation Group Supervisor, shall be responsible for the requesting, accounting, and assigning of ground-based resources for patient transportation. The Ground Transportation Unit Leader shall be responsible to:

- Establish staging and patient loading area(s) for ground transportation resources. The Leader will also establish a single route into and out of the loading area.
- Request additional ground transportation units, from the EMS Branch Director, as necessary.
- Maintain an accounting of ground transportation units and their patient capacity based on number and status.

AIR TRANSPORTATION UNIT

The Air Transportation Unit Leader, who reports to the Transportation Group Supervisor, is responsible for the request and coordination of rotary-wing ambulances and, in concert with the Ground Transportation Unit Leader, the coordination of ground transportation of patients to and from the landing zone of any rotary-wing ambulance.

The Air Transportation Unit Leader is responsible to;

- Request any needed air ambulance resources from the EMS Branch Director, if not already requested.
- Establish and appropriately mark landing zone(s) for air ambulances, and relay the location(s) to the Ground Transportation Unit Leader, Transportation Group Supervisor, EMS Branch Director, and Incident Command.
- Coordinate the movement of patients to the landing zone(s) in concert with the Transportation Group Supervisor and the Ground Transportation Unit Leader.
- Establish communication with all responding air ambulances and provide them with any necessary information. At a minimum, the Air Transportation Unit Leader should provide the incident location (in GPS coordinates if requested), radio frequency for air units, situation updates, landing zone location(s) and hazards, and brief status reports about those patients already designated for loading into each air ambulance.
- Determine the patient capacity of all air ambulances responding to the scene and relay that capacity to the Transportation Group Supervisor.
- Determine safe routes of travel for air ambulances coming to and leaving from the incident scene. Whenever possible, these routes should avoid the incident itself, as well as any Treatment Area, medical supply stockpile, and the Decontamination Area, if one is in operation.

RESOURCE UNIT

The Resource Unit Leader is responsible for the procurement, inventory, deployment, accountability, and demobilization of all incident scene resources, excluding communications equipment and medical transportation resources. This includes completing requests for equipment and supplies, performing initial and periodic inventories of available supplies, issuing and recollecting durable equipment, staging response resources (not including ambulances), and maintaining records of expended equipment to be forwarded to the Finance/Administration Section Chief. The Resource Unit Leader is also responsible for overseeing the rationing of expendable supplies to ensure that inventory is not wasted and that supplies are available for the duration of the incident. The Resource Unit Leader will report to the Planning Section Chief. In the absence of that position, the Resource Unit Leader will report directly to Incident Command.

All requests for equipment and supplies will be made to the Resource Unit Leader. These requests will be recorded by the Resource Unit and filled as rapidly and completely as possible. The Resource Unit is also responsible for the acquisition and distribution of command identification vests,

COMMUNICATIONS UNIT

The Communications Unit Leader, who reports to the Planning Section Chief, is responsible for the establishment and maintenance of communications between all units on and off scene. The Communications Unit Leader is also responsible for receiving all RACES resources and deploying them as necessary. The Communications Unit Leader

will receive all communication resources that arrive on scene and be responsible for inventorying, issuing/deploying, and recovering all communications equipment.

FINANCE / ADMINISTRATION SECTION

The Finance/Administration Section, which reports to Incident Command, is responsible for maintaining accurate financial records and controlling expenses associated with the incident. This section is also responsible for receiving, processing, and archiving all documentation completed during the incident. All documentation and reports will be submitted to the Finance/Administration Section as soon as possible after completion.

PLAN IMPLEMENTATION

Implementation of this plan shall be performed in accordance with the guidelines that follow. This plan is only intended to regulate the medical response to mass casualty incidents. All other on-scene actions (i.e. - rescue, hazardous materials mitigation, law enforcement actions, etc.) shall be performed in accordance with the policies and guidelines established by the response agencies that cover the affected jurisdiction.

With the exception of the response units specifically identified in these guidelines, all mutual aid and assistance requests shall be done in accordance with the response agencies operating guidelines and/or response cards established by the Mutual Aid Box Alarm System (MABAS), if applicable. Requests for additional local, state, and federal resources, shall be conducted through the Saint Joseph County Emergency Management Agency unless otherwise specified by a member of that agency, or by previously arranged permission.

1. ACTIVATION

The Saint Joseph County Emergency Medical Response Plan (EMRP) may be activated at any time, based on information received from either an emergency caller or from on-scene emergency response personnel. There are two stages: Standby and mobilization.

Standby

Standby is the time period extending from the time the first emergency call is received until the completion of a size-up by arriving emergency response personnel. The goal of this period is to notify response agencies of the potential for a medical disaster and to prepare assisting agencies and Hospital Control for potential mobilization. During this time period, the following events should be completed:

- Upon receiving reliable information about a possible mass casualty incident (i.e. plane crash, multi-vehicle pile-up, large occupancy structure collapse, etc.), the Communications Center will contact the Emergency Department of the currently designated Hospital Control to alert of an incident having the potential to require activation of the EMRP.
- The Communications Center will, if other than St. Joseph County Fire Dispatch, contact St. Joseph County Fire Dispatch to request that RACES be put on standby.
- The Communications Center will, if other than St. Joseph County Fire Dispatch, contact St. Joseph County Fire Dispatch to request that Clay Fire CV-1 be placed on standby.
- All response agencies with county-funded mass casualty incident trailers (South Bend Fire Department, Mishawaka Fire Department, and Clay Fire Territory) will be notified of the event and shall prepare the trailers for response, including connecting them to their tow vehicles.

- The Communications Center will contact MedFlight and notify them of the incident and the potential for activation, to allow for pre-flight checks to be completed and GPS coordinates, if available, to be plotted. If the incident dictates a high likelihood of critically injured patients, for example a plane crash or school collapse, MedFlight shall be activated at this time and begin flight to the scene as soon as possible. If deemed necessary, other regional rotary-wing ambulances may also be placed on standby. MedFlight will be kept apprised of any other rotary-wing ambulances responding.
- SBFD Unit 1660 will be contacted and notified of the incident and the potential need for a multi-vehicle ground ambulance response.
- As necessary, the Communications Center will notify private ambulance companies of the potential need for additional ground ambulances.
- The Communications Center will notify Incident Command when all notification steps have been completed.

Mobilization

The mobilization stage of the EMRP extends from the time of the first scene size-up by an emergency responder until the time the EMRP is fully activated. If possible, all standby steps should be completed prior to the beginning of the mobilization phase of the EMRP. If, based upon scene assessment, mobilization of the EMRP is deemed unnecessary, the Communications Center will advise all entities notified during the standby stage to stand down. During the mobilization stage, the following events should be completed:

- On-scene emergency medical personnel, after scene assessment, will notify the Communications Center to confirm activation of the Emergency Medical Response Plan.
- The Communications Center will contact the Emergency Department of the currently designated Hospital Control and advise them of the activation of the EMRP. Hospital Control will be established at this time and will be the point of contact for any further communications from the Communications Center.
- Hospital Control will notify all St. Joseph County hospitals of the activation, as well as other hospitals and medical facilities, as necessary. If deemed necessary, this notification will include all local urgent care facilities as well.
- The Communications Center will transmit a message over the assigned operations frequency stating, "Attention all units: Under the authority of Incident Command, the incident at [*Location*] has been declared a mass casualty incident. The Emergency Medical Response Plan has been activated."
- The Communications Center shall notify the St. Joseph County Emergency Management Agency and the Red Cross of the activation of the EMRP.
- The Communications Center will contact St. Joseph County Fire Dispatch to request RACES activation
- The Communications Center will contact St. Joseph County Fire Dispatch to request that Clay Fire CV-1 respond to the incident.
- Unless clearly unnecessary, all agencies with county-funded medical disaster response trailers will respond those vehicles to the incident.

- If not already launched, MedFlight and any other needed rotary-wing ambulances shall be mobilized to the incident area.

Once the above tasks have been completed, the Communications Center shall contact Hospital Control, Incident Command, and the SJCEMA to inform them of the completed activation. Hospital Control will confirm at this time that their responsibilities have also been completed. At this time, the St. Joseph County EMRP is considered fully activated.

2. INITIAL ARRIVING UNIT RESPONSIBILITIES

The first arriving emergency responder – whether fire, police, or EMS – will perform a scene size-up and report to the appropriate Communications Center. At a minimum, this information should include: incident location, type of incident, approximate number and severity of the victims involved, geographic size of the incident and, if applicable, the number of scenes involved. If more than one scene is involved, the first arriving responder will stay with the first scene, and subsequent arriving units will proceed to investigate the other scenes.

The first arriving unit will establish Incident Command. As additional units arrive, Incident Command should be relinquished to personnel more qualified to provide Incident Command for a particular response scenario. For example, if a police officer is the first to arrive on a plane crash, he will turn Incident Command over to the first arriving fire unit. Note that most medical disaster scenes involve multiple agencies and types of responders, so even if Incident Command is relinquished, that first arriving responder may be asked to remain at the command post as part of a unified command structure.

3. TRIAGE

The first arriving EMS unit is responsible for initiating triage once scene safety is established. In the initial stages of response, the same unit may be responsible for Incident Command and triage. The goal is to triage patients and provide rapid life-saving aid. Triage will be performed using the START algorithm for adult patients and the JumpSTART algorithm for pediatric patients (see page 11). During the triage process, only two medical interventions may be performed. These include:

- OP/NP Airway – EMS personnel performing triage may insert an OP or NP airway device to maintain the airway of an otherwise viable patient who is unable to control his/her own airway, even after being placed in the recovery position.
- Life-Threatening Bleeding Control – EMS personnel may apply a pressure dressing or tourniquet to stop life-threatening bleeding from an otherwise viable patient. Commercially manufactured or military pressure dressings are recommended for this function. Tourniquets should be rapidly applied to open mangled limbs, limbs exhibiting signs of arterial bleeding, or amputated limbs. The Combat Application Tourniquet (CAT) is recommended. While improvised tourniquets may be used, they have proven to be less effective and more likely to

cause "pinching" tissue damage under the device.

Patients will be triaged into one of the following four categories:

- Green "Minor" – Minor injuries that may wait for extended periods of time without comprehensive medical care, may be seen at an urgent care center for medical care, and may not necessarily require care at a hospital; some may only require treatment from on-scene EMS personnel and then can return home to follow up with a personal physician.
- Yellow "Delayed" – Moderate injuries that may wait several hours for comprehensive medical care after receiving care from EMS personnel but will need to be evaluated and treated at a hospital prior to being released home.
- Red "Immediate" – Severe injuries that may not wait for any extended period of time prior to receiving comprehensive medical care at a hospital and will require treatment at an Emergency Department and/or surgery to mitigate serious/permanent disability or death; and acute medical conditions requiring immediate care (i.e. possible ACS, status asthmaticus minimally responsive to EMS treatment, CVA, etc.).
- Black "Expectant" – Dead or imminent death; overwhelming odds against survival or already deceased.

Upon initial triage, a SMART triage tag will be applied to the patient. Once the tag is applied, the serial number on the tag will be used for patient identification. The tag will also be used to record treatments, as necessary.

When sufficient manpower arrives, triaged patients will be evacuated to the Treatment Area entrance where they will be reevaluated. This is intended to verify initial triage as well as identify changes in patient condition between initial triage and arrival at the Treatment Area. After triage at the Treatment Area entrance, the affixed SMART triage tag will be updated as necessary and completed.

After all patients have been triaged and evacuated to the Treatment Area, the Triage Group Supervisor and Triage Unit positions may be dissolved and personnel reassigned as needed.

4. TREATMENT

Rapid establishment of a Treatment Area is essential to establishing and maintaining control of the incident scene and affected victims. Delaying establishment of the Treatment Area will result in confusion and an eventual loss of patient control as ambulatory triaged victims are much more likely to begin self-transportation to the hospital if there is not a clearly identified/readily available Treatment Area to seek care. This self-transportation can be detrimental to the operations of the Emergency Departments of receiving hospitals.

In order to quickly establish a Treatment Area and prevent patient self-transportation, the second arriving EMS unit will immediately establish the Treatment Area. The

Treatment Area will be established in a location that is readily visible, within easy walking distance of the incident, provides safety for responders and victims, provides easy access for ground transportation pick-up, and is large enough to accommodate the number of injured or ill victims. If weather conditions are adverse or shade cannot be provided from the sun, an indoor location should be used if available. If a structure is used, the structure should be clearly marked to identify it as the Treatment Area.

The Treatment Area will be divided into four treatment zones marked with colors corresponding to the above noted triage categories: Green, yellow, red, and black. The Treatment Area will have one entrance and one exit, both of which are to be clearly marked. All patients will be received at the entrance, where they will be re-triaged and a SMART triage tag will be applied. The patient will then be placed in the appropriate colored zone for medical care and to await transport.

Each Treatment Area zone will be staffed with ALS and/or BLS personnel according to the approximate number of patients to be treated and the severity of the incident. Staffing ratio goals will follow the guidelines in the table below. Each Treatment Area zone will have one person designated by the Treatment Group Supervisor as the Unit Leader for that zone. The Unit Leader will update the Treatment Group Supervisor on patient quantity and status every 20 minutes. Unit Leaders will also prepare lists of needed medical supplies, equipment, and resources to the Treatment Group Supervisor, who will request additional supplies through the Resource Unit. When not performing these duties, the Unit Leaders will provide medical care to patients in their zones.

Treatment Area Staffing Goals	
Mass Casualty Operations (Less than 30 Patients)	
Immediate Care/Red Tag	1 ALS and 1 BLS provider/2 patients and 4 litter bearers
Delayed Care/Yellow Tag	1 BLS provider/3 patients; 1 ALS provider per 5 patients and 4 litter bearers
Minor Care/Green Tag	1 BLS provider/10 patients
Medical Disaster Operations (30+ Patients)	
Immediate Care/Red Tag	1 ALS provider/3 patients; 1 BLS provider/5 patients, and 4 litter bearers
Delayed Care/Yellow Tag	1 BLS provider/5 patients; 1 ALS provider/10 patients, and 4 litter bearers

If any response personnel are injured, they will receive immediate care and, if necessary, transportation to a receiving hospital.

5. TRANSPORTATION

While transportation of patients is important, it must be done in a controlled manner to ensure that all necessary patient-tracking measures are in place, all hospitals are

prepared to receive patients, and all transportation resources are prepared to operate in such a way as to make the flow of traffic to and from the scene safe and efficient.

In order to maintain an organized transportation process, the transportation of patients should be delayed until sufficient transportation resources are on scene, Hospital Control has been notified by sufficient receiving hospitals that they are prepared to receive patients, and the Treatment Group Supervisor advises that his/her group is prepared to begin patient transport. The only exception to this rule is for extremely acute trauma patients who, while salvageable enough to be triaged Red, require immediate transportation to a trauma center in order to save their lives. These patients MUST have an injury that can only be treated with immediate surgical intervention, such as penetrating torso trauma with shock. Such patients will be transported to Memorial Hospital of South Bend to receive definitive trauma care or, if their condition continues to deteriorate to the point where transportation is considered futile, be considered for re-triage to Black-Expectant.

Hospital Control is responsible for assigning patients to receiving hospitals and relaying that information to the Transportation Group Supervisor. Whenever possible, Hospital Control will provide hospital assignments for multiple patients at once in order to reduce radio traffic and allow for better coordination of transportation. The Transportation Group Supervisor will then assign those patients to available transportation assets and contact the Treatment Group Supervisor to arrange patient loading. Ambulance personnel will be notified of which patients they are to receive, what the status of each patient is, and to which hospital or clinic the patients are being transported. Whenever possible, patients going to the same hospital should be loaded in the same transportation asset to cut down on transportation times and improve efficiency.

When ambulances leave the scene, the Transportation Group Supervisor will contact the destination hospital(s) and provide a report on incoming patients. At a minimum, this report should include ambulance unit number, number of incoming patients, triage status of the patients, and a report of general injuries. An example of proper radio report is shown below:

Example: "Memorial Hospital, this is Transportation. South Bend Fire Department Medic 2 is enroute to your facility with three patients, all triaged red. Two have blunt trauma to the chest, one has penetrating trauma to the head. Do you require any additional information?"

Once patients have been delivered to the hospital, transportation assets will notify the Ground/Air Transportation Unit Leader(s) that they are clear of the hospital and returning to the scene. Transportation vehicles may, in some instances, be loaded with supplies for use at the scene prior to returning to the scene. If such supplies are loaded, the ambulance should first proceed to the Resource Unit to deliver those supplies. Otherwise, the ambulance will return directly to the transportation staging area or landing zone to await patient assignment.

If there are multiple patients with serious injuries and limited ambulance resources, the use of a bus, other form of mass public transportation, or other form of transportation

should be considered for evacuation of such patients. Staffing levels of non-ambulance forms of transportation should be based on patient number, injury severity, urgency of evacuation, and available personnel. Staffing decisions should be made by the Ground Transportation Unit Leader in conjunction with the Transportation Group Supervisor.

If there are a large number of ambulatory patients with minor injuries, the use of a bus or other form of mass public transportation vehicle should be considered for these patients after patients with more serious injuries have been evacuated. When a public transportation vehicle is used, an individual licensed for that purpose by the State of Indiana must drive the vehicle. Preferably, the agency from which the vehicle is borrowed from will provide a driver. Vehicles used for patient transportation should be made of materials that may be easily decontaminated. Seating surfaces should be made of vinyl or plastic and flooring should be made of rubber or vinyl. Vehicles with cloth seating or carpeted flooring is discouraged, due to the risk of staining, damage, and the potential for disease transmission.

6. DEMOBILIZATION

Demobilization is the calculated process of releasing response personnel and units from the incident scene and returning them to regular service. A properly planned demobilization will return units to regular service as rapidly as possible while maintaining a complete accounting of issued resources and full re-supply of returning units.

Before the release of units is begun, Incident Command will assign personnel to establish a Demobilization Area. The Resource Unit Leader, or his/her designee, will be responsible for the establishment and operation of the Demobilization Area.

The Demobilization Area should be a central location that all response personnel must pass through prior to being released from the incident scene. The Demobilization Area should be equipped with tables, chairs, and containers for the collection of issued equipment and resources. All completed inventory logs of issued materials and equipment will be provided to the Demobilization Area personnel, in order to log the collection of those materials and equipment. The Demobilization Area should be provided with enough personnel to accomplish all necessary collection, logging, and other demobilization processes.

There are five stages to the demobilization process. These steps, in order, include:

1) Approval for demobilization by Incident Command
2) Recording of released personnel, which should include name, agency, response unit assigned to, time of release from scene, and destination released to (i.e. home department, standby at another station, etc.).
3) Receipt and logging of all issued materials and equipment. Some examples are cellular phones, radios, gas detection equipment, and durable medical goods.
4) Determination and logging of any injuries and/or exposures to possibly harmful substances. Injured, ill, or potentially exposed personnel should be encouraged

to receive medical treatment at a hospital or urgent care clinic and will not be considered released until treatment is complete or the member signs a refusal of care form. Personnel who may have been exposed to a harmful substance should have the exposure logged, submit to a full physical exam by a licensed physician as soon as possible, and undergo medical surveillance for a time period to be determined by a licensed occupational medicine physician.

5) Provision of information regarding any scheduled follow-up meetings, including upcoming critical incident stress debriefings (CISDs) and post-incident analyses. Personnel should also be provided with contact information for available counselors, religious personnel, and psychologists in case of acute grief, post-traumatic stress, or other mental health disturbances.

Mass casualty incidents are dangerous environments filled with graphic injuries, undue hardship, and the deaths of many patients, including children. While many medical care personnel are used to dealing with individual deaths, the deaths of many people in one incident is much more stressful. These images and situations will place response personnel under severe stress and will cause some level of psychological injury to all responders. In order to deal with this stress, CISDs should be held immediately after the incident, as well as one to three days after the incident. During the incident, Hospital Control will contact religious personnel, counselors, and psychologists from within the hospitals and health systems who can respond to the scene and provide mental health care to all response personnel. Use of these resources is recommended and encouraged for all personnel involved in the response to an incident regulated by this plan, including on-scene, communications, hospital, and other personnel. These religious and mental health resources will remain available in the demobilization area until on-scene operations are complete, after which they will be available at the CISDs and at their regular offices.

SPECIAL SITUATIONS

Many special situations may exist or arise when a mass casualty incident occurs. These include a hazardous materials release, continuing violent acts, or the risk of explosive devices.

HAZARDOUS MATERIALS

If the release of hazardous materials is reported or suspected, that release should be dealt with prior to initiating patient care. Hazardous materials responses should be mitigated in accordance with the policies and/or guidelines of the agency having jurisdiction. Agencies and response personnel should only perform mitigation actions to the level at which they are trained and equipped. Triage and removal of patients from the hot zone will only be performed by properly trained and equipped personnel. Hospital Control must be notified as soon as possible of the involvement or potential involvement of hazardous materials.

Hazardous materials exposure must be considered in triaging patients who may have been in contact with the material. For example, extremely toxic materials may warrant triaging patients with confirmed exposure as "Expectant" even though their current condition might otherwise result in their triage as "Immediate" or "Delayed." All patients must be stripped of all clothing and thoroughly decontaminated prior to being sent to the Treatment Area. The Treatment Group Supervisor should contact Hospital Control as soon as the hazardous material is identified to request guidance on the triage and care of exposed patients.

Hospitals receiving patients who may have been exposed to hazardous materials will establish a decontamination zone outside the Emergency Department. Incoming patients will be received at this location and evaluated for contamination. Secondary decontamination will be performed as deemed necessary prior to the patient being admitted into the Emergency Department.

CONTINUING VIOLENT ACTS

As several incidents in recent years have shown, there is a high likelihood that those committing violent acts resulting in a high number of casualties will still be performing those acts upon the arrival of emergency response personnel. When a violent act is reported, such as a mass-shooting event, only law enforcement personnel will report directly to the scene. EMS personnel will respond to a safe location away from the incident scene and standby until law enforcement personnel have secured the scene.

If law enforcement personnel can evacuate victims from the scene, EMS personnel will establish a temporary Treatment Area in a safe location to receive evacuated patients. Law enforcement personnel will be responsible for the evacuation and search of those patients as well as their transportation to the Treatment Area. These patients will be triaged at the entrance to the Treatment Area and then sent to the proper colored treatment section.

It is important to note that in an active-shooter/hostile party type scenario, law enforcement will be engaged in suspect apprehension or threat elimination, with little, if any, focus on patient care. It must be understood by all EMS responders that the law enforcement aspect of this type of event may be time consuming.

EXPLOSIVE DEVICES

Explosive devices have become more common in the commission of mass-casualty violent crimes. The use of secondary devices has also become more prominent in recent years. EMS personnel should be alert for any suspicious bags, boxes, vehicles, or any other signs of potential explosive devices. Parking lots full of vehicles, dumpsters, and bushes should be avoided whenever possible. EMS personnel should be especially alert when responding to an incident at which there has already been an explosion or where a mass-casualty violent crime has occurred.

If any potential explosive device is detected or expected, EMS personnel will immediately evacuate to a safe distance and notify law enforcement. EMS personnel will remain clear of the area until law enforcement has identified the scene as secure. Even then, EMS personnel should continue to remain alert for any potential device.