15 'TIL 50...

Mass Casualty Incident Guide

For Healthcare Entities

COUNTY OF LOS ANGELES CALIFORNIA

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Henry Mayo Newhall Hospital

PROVIDENCE
Little Company of Mary Medical Center
Torrance

C&A
Constant & Associates

CASE STUDY

The Emergency Department was operating at full capacity with another 30 patients in the waiting room when the initial call came in. It was 2:30 in the afternoon when staff were notified of a cruise ship explosion at the Port. The initial report indicated that there were potentially 2,500 victims. Details were vague about the cause and types of injuries and whether or not decontamination of victims would be required. The emergency department Director and the Nurse Supervisor were immediately alerted to the unfolding events. With the hospital located just 20 minutes from the Port, the decision was made to initiate a Code Triage External. The Code was paged overhead and with minimal guidance the external treatment areas were set up.

The pilot MCI response plan of "15 Minutes `til 50 Patients" was less than two months in development and about to get its first test. Roles were assigned and with only five available staff, four untrained in the process, the treatment areas were established in under 20 minutes. The first victim was received within 35 minutes of the initial notification. Although the initial casualty report was greatly exaggerated the "15 Minutes 'til 50 Patients" rapid response plan proved to be the answer for quickly responding to a mass casualty incident.

Acknowledgements

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Acronyms

ACLS	Advanced Cardiac Life Support
BLS	Basic Life Support
CDC	Center for Disease Control and Prevention
CMIST	Communication, Medical, maintaining Independence, Supervision, Transportation
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
FE	Functional Exercise
FEMA	Federal Emergency Management Agency
FSE	Full Scale Exercise
HICS	Hospital Incident Command System
HCC	Hospital Command Center
HSEEP	Homeland Security Exercise and Evaluation Program
IAP	Incident Action Plan
IC	Infection Control
ICS	Incident Command Center
JIT	Just In Time
LMFT	Licensed Marriage and Family Therapist
MCI	Mass Casualty Incident
MT Specialist	Medical Technician
OR	Operation Room
PLCMMCT	Providence Little Company of Mary Medical Center Torrance
PsySTART	Psychological Simple Triage and Rapid Treatment
RN	Registered Nurse
TTX	Tabletop Exercise

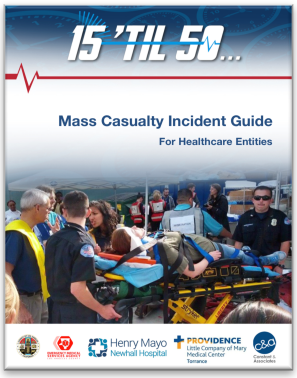
Owner's Manual

Introduction

Today, mass casualty disaster scenarios that once seemed merely theoretical have become a disturbing reality. Hospital disaster preparedness has therefore taken on increased importance at local, State, and federal levels. Hospital staff are taking renewed interest in disaster preparedness and reexamining their disaster plans with the goal of preparing hospital personnel to respond to a Mass Casualty Incident (MCI).

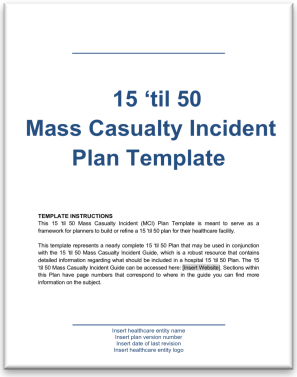
In support of MCI readiness efforts, the 15 'til 50 model was developed. It is designed to enable hospital staff to receive a surge of 50 or more patients within 15 minutes of notification of a MCI. The model can be readily implemented through a series of resources made available as part of the 15 'til 50 MCI Toolkit: a comprehensive MCI Guide, a MCI Plan Template, videos, training materials, sample plans and several other tools. Flexible, scalable and adaptable, the 15 'til 50 Toolkit takes what was a daunting planning task and streamlines the steps of MCI Plan development and application. This Toolkit allows health care personnel—clinicians, medical staff, health system leaders, and policymakers — to familiarize themselves with their roles and responsibilities, make more informed decisions, and maintain the quality of healthcare services.

The 15 'til 50 Mass Casualty Incident Toolkit



MCI Guide

The Guide provides a comprehensive explanation of the 15 'til 50 model. It offers a step-by-step walkthrough for developing a 15 'til 50 Program.



MCI Plan Template

The Plan Template provides an easy-to-populate document that can be used to create a MCI Plan for your facility.

MCI Multimedia

MCI Multimedia connects the user to all media files (photos, video and audio) relating to 15 'til 50 MCI planning.

MCI Toolkit Library

MCI Toolkit Library provides a comprehensive suite of supplemental materials to aid with the design and implementation of the 15 'til 50 program. It includes a train the trainer program, a healthcare responder training program, presentation material, patient care forms, Job Action Sheets, sample plans, executive briefing materials, and more.

Internet Access to Toolkit

As of the date of publication, the toolkit is available at the following websites. You may also locate the Toolkit by entering "15 'til 50" in an internet search engine.

http://dhs.lacounty.gov/wps/portal/dhs/ems/
http://constantassociates.com/our-work
http://cdphready.org
http://calhospital.org

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Section I: Introduction

Overview

A MCI has the ability to throw a wrench in the finely tuned engine of a hospital. For those caught unprepared, it can overwhelm staff and drain resources. The 1994 Northridge Earthquake in Los Angeles killed 60 people and wounded over 7,000, many of whom crowded hospitals that had been crippled by the earthquake. Immediately following the Boston Marathon Bombing in 2013, six trauma facilities saw three dead and over 264 wounded surged to surrounding hospitals.

What is 15 'til 50?

The innovative and award winning 15 'til 50 program is designed to enable hospital staff to receive a surge of 50 or more patients within 15 minutes of notification of a mass casualty incident. This includes the rapid deployment of staff, supplies, and equipment to successfully active and operate MCI triage and treatment areas.

The program utilizes the Hospital Incident Command System and can be initiated using existing hospital supplies and equipment.

Most MCI Plans focus on the activities that take place after the first patient arrives, such as utilizing special equipment or alternate care arrangements. This guide goes further, by outlining what staff need to do before the arrival of the first patient – specifically within the first 15 minutes of notification of an MCI. It's based on the pioneering work done by emergency planners at Providence Little Company of Mary Medical Center Torrance and Henry Mayo Newhall Hospital in California. They developed the 15 Minutes Until 50 Patients MCI Program, or "15 'til 50" for short. 15 'til 50 concentrates on the planning process and pre-positioning of supplies in addition to operations upon activation. This model provides an all-inclusive process that identifies what each department should do to increase capacity and successfully manage a MCI.

Purpose

The purpose of this Guide is twofold: (1) to explain the 15 'til 50 model and (2) to provide planners with a step-by-step resource for developing a 15 'til 50 Plan. The Guide, along with the accompanying Plan Template, covers activation, operation, and transition to either ongoing emergency operations or demobilization. It is designed to increase capacity and rapidly screen patients during a no-notice/short-notice incident. The 15 'til 50 MCI Planning model is applicable to events that test medical surge capacity.

The planning framework falls within what the Center for Disease Control and Prevention (CDC) describes as the "Dual Wave Phenomenon" in which the larger group of less severely injured walking wounded typically arrive within 15-30 minutes of an incident, followed within an hour or two by a second wave of more severely injured who will require pre-hospital emergency transportation.

Scope

15 'til 50 was developed to supplement existing MCI Plans and functions as a transition program that can help your hospital through the initial waves of a medical surge, after which you can phase into your emergency operations plans or demobilize to normal operations. The program is distinct in that it covers hospital activity 15 minutes before the first patient arrives and through the first two hours of response.

Frequently Asked Questions (FAQ)

What Is A Mass Casuality Incident?

The Federal Emergency Management Agency (FEMA) defines an MCI as one in which the number of people killed or injured in a single incident is large enough to strain or overwhelm the resources of local medical service providers.

When planning for a MCI, 50 patients can be a useful benchmark for hospitals of a certain size however the number that qualifies as a surge will change depending on the hospital and its resources. The standard assumption put forward by the CDC is 20% above licensed bed capacity.

What Is 15 'til 50?

The original "15 Minutes 'til 50 Patients" Mass Casualty Incident (MCI) response program was conceptualized by a multidisciplinary team within the Emergency Department at Providence Little Company of Mary Medical Center Torrance (PLCMMCT), California. The premise of this model was the rapid deployment of staff, supplies and equipment. The goal was to prepare hospital personnel to respond to an MCI by familiarizing them with their roles and responsibilities. Under the leadership of Emergency Management Officer Christopher Riccardi and Bradford Baldridge, M.D., Emergency Department Physician, the process was developed, tested and modified over the past ten years to create a plan that is flexible, scalable, and adaptable to the needs of any hospital or healthcare facility.

The program concept came about as a solution to a problem that exists in many hospitals. Working at full capacity on a daily basis, PLCMMCT noticed that there wasn't a place to treat arriving victims from a MCI. During exercises it could take up to one hour for the treatment areas to be established and supplies to be deployed. The role of the Emergency Department was underutilized in the response plan and it was obvious that the plan required some modification. As such, a Planning Team was established to create a model, now known as "15 'til 50", that would allow for the rapid triage and treatment of patients from an MCI.

Upon convening a Planning Team, the following questions were asked:

- Where can treatment supplies be set up?
- How is a safe and secure location to treat victims established?
- How would supplies be deployed?
- Who can deploy the equipment?
- Who is best suited to staff the external treatment areas?
- How is staff mobilized?
- How can staff surge to an alternate location when the emergency department is full?
- What logistical challenges need to be overcome?

From these questions, some resolutions emerged:

- Identify a location that can be secured and favorable to the flow of pedestrian and ambulance traffic.
- Identify essential resources needed for deployment.
- Identify key personnel to respond to an MCI.
- Identify a storage location for supplies.
- Identify key departments that need to be part of the immediate response.
- Develop a process to integrate support and ancillary departments into response.
- Create a process to ensure equipment and personnel were deployed to a common location.

These solutions evolved into the 15 'til 50 response framework and ensuing plan. The rapid deployment process ensured an achievable, consistent and coordinated response utilizing staff on hand. From concept to application, this program has been tested, modified and retested at least 30 times in four different hospitals. This plan has been adopted and integrated by trauma and pediatric hospitals as their MCI response. The program is designed to equip staff for success at a time when failure is not an option.

What Does A 15 'til 50 Activation Look Like?

The following timeline should help you get a sense of what 15 'til 50 looks like within a hospital with an external triage/treatment structure:

00:00:00 – 00:15:00 Minutes

- The Emergency Operations Plan and 15 'til 50 Plan is activated by the appropriate authority, e.g., the nursing supervisor
- Internal notification/communication, such as an overhead "Code Triage, External" page to alert staff of a 15 'til 50 incident and impeding arrival of a surge of patients
- Staff callback protocols such as email, text, phone trees to alert staff not in the hospital of the incident. During the time period covered by the 15 'til 50 program, operations will be mostly handled by staff already on duty. Human resources is prepared to activate their labor pool as needed
- Activation of the Hospital Command Center (HCC)
- Staff accesses 15 'til 50 go-kits, which include vests, job action sheets, and special 15 'til 50 admissions forms with active medical identification
- Resource management system to distribute, track, and allocate supplies
- Radios signed out and distributed to the appropriate staff members
- Case management begins to coordinate the rapid discharge of inpatients and emergency department patients with physicians in order to accommodate the influx of survivors, to include preparation for transportation
- Security will set up barriers, cones, and signage outside the hospital to control traffic. Security will direct traffic to include guiding ambulances to their appropriate routes
- HCC establishes operational period and begins development of the Incident Action Plan (IAP)
- A holding area for arriving patients waiting for triage and treatment is set up

- Activation of triage treatment areas to include: signage, review of Job Action Sheets, staffing, equipment and supplies, patient tracking/medical records, and stored materials such as cots, canopies, and medical carts
    - Staff sets up green, yellow, red, and black triage tarps
    - Staff sets up cots on each tarp
    - Medical carts are wheeled out
    - Spaces designated for where staff can access the needed admissions paperwork, and where they can deposit requests directed at ancillary/support departments such as lab work
    - Spaces designated for where medical waste will be deposited
    - Generators are checked to ensure they are in working order

- Ancillary and support staff report to their pre-designated staging areas or report directly to the triage and treatment site according to their protocols. Pharmacy arrives with pharmaceutical supply carts for medication dispensing. Anesthesiologist/ surgical representative evaluates survivors and communicates to the HCC the potential burden on the operating room
- Ancillary departments without an immediate role on standby. An example would be the blood bank which will have a tech standing by to supply the external triage and treatment area as requested by logistics, or radiology which would be available to deploy with portable x-ray for rapid radiological diagnostics
- Case management establishes a patient discharge area away from the emergency department where discharged patients can be processed and await transportation
- Emergency department doors and all points of ingress/egress are secured
- Radio check in between the Incident Management Team and the HCC

- Liaison Officer communicates with local external agencies to determine extent of damage to critical infrastructure and services
- Coordinate with regional patient transport center equivalent as appropriate
- Safety Officer begins to provide an assessment of facility structures and systems condition (if necessary)
- Staff sets up triage tents over the cots/tarps

00:015:00 Minutes – 02:00:00 Hours

- First wave of survivors arrive at the hospital within 15 – 30 minutes, depending on the hospital's proximity to the incident. The CDC estimates that most of the initial patient load will be minor/moderately wounded, as they're able to ambulate on their own. Patients are triaged
- Patients are processed through the rapid admissions/discharge system
- Public Information Officer receives information at HCC in order to provide situation briefing to patients, visitors, and staff
- Inventory of all supplies, equipment, food and water conducted
- As per the CDC Mass Casualty Predictor, the number of survivors arriving in the first hour multiplied by two is used to estimate the overall size of the surge
- Logistics/Human Resources projects any labor shortfalls

02:00:00 Hours – Beyond

- Ongoing incident management, transition to either disaster operations or demobilization to normal hospital operations
- Infrastructure Branch performs a detailed assessment of structure and systems (if necessary)

Using This Guide

The Guide is a resource to help you and other hospital emergency planners complete the accompanying 15 'til 50 MCI Plan Template.

The guide provides a high-level overview of the hospital's planning considerations, emergency operations, and response to a no-notice or short-notice MCI and is organized into three sub-sections:

- Section I: Introduction. The introduction includes a description of the document's purpose, definition of key terms, scope, instructions on how to use the guide, and assumptions
- Section II: Getting Ready for 15 'til 50. This section will walk you through the steps for implementing the 15 'til 50 concept in your hospital including the creation of buy-in for the model, the process of creating the actual plan, coordination and pre-positioning of resources, and creating a training and exercise strategy to test your plan.
- Section III: Creating the 15 'til 50 Plan. After providing a broad outline of how to bring the 15 'til 50 concept to your hospital this section provides step-by-step information regarding how your plan should be constructed. An overall plan blueprint is provided along with a walkthrough of each section that can be connected back to the 15 'til 50 Plan Template.

The supplemental materials contained in the appendices of this Guide and the accompanying Toolkit include functional and support annexes that clearly state the policies, processes, roles, and responsibilities within critical operational sections. It also contains tools that might be helpful for implementing 15 'til 50 in your hospital, like training materials, a presentation/talking points for creating executive buy-in, and Job Action Sheets specific to incidents involving Chemical, Biological, Radiological, Nuclear, or Explosive materials. In contrast to the broad strokes found within the basic guide, supplemental materials are targeted to specific roles within the emergency operations structure or unusual circumstances.

Assumptions

This guide is not intended to be prescriptive. Emergency planning doesn't take place in a vacuum and no guide can account for every possible scenario. When you put together your plan, use your own discretion and professional judgment as to what will work for your hospital during an incident or event. A MCI will place stress on your entire facility so seek to involve multiple departments and gather input from other members of your hospital team.

While every incident is unique and every hospital is different, there are some basic assumptions that were made in the development of this Guide:

- Hospitals already have emergency plans, procedures and policies in place. This Guide is meant to supplement, not replace existing plans
- "15 minutes" is counted from the moment the plan is activated, not from the moment the incident starts
- Your 15 'til 50 MCI Plan will involve multiple departments in your hospital, not just the emergency department
- For the first 15 minutes, and perhaps longer, response will have to be conducted by staff on duty using existing equipment and supplies
- Less seriously injured casualties who self-transport, or are transported by friends and family typically arrive before those who are most seriously injured

Section II: Getting Ready For 15 'til 50

Creating Buy-In

One of the first steps towards implementing the 15 'til 50 program in your hospital is creating buy-in both at the executive level and within the departments that will be participating in the planning process. As part of the Toolkit, a "one-liner" card and brief slide deck have been developed to provide planners with talking points that describe what 15 'til 50 model is and the benefits to any participating hospital.

The Planning Process

The planning process is incredibly important. Often gathering various departments into a room and creating a sense of ownership for the process is as important if not more so than the actual written plan itself. The planning process itself is well established and described below.

Designate A Project Leader

While there might be many candidates for leadership in your hospital, make sure you choose someone with knowledge of all operational areas of the healthcare facility, including patient admissions, record keeping, and emergency operations.

Organize A Working Group

Too few participants won't provide a deep pool of knowledge to draw on, too many can weigh down the process and impede progress. Keep your working group to whatever a manageable number is for you and your facility. Creating buy-in across all departments is crucial, so make sure to include representatives from all departments that will be directly or indirectly involved in plan implementation.

Review Existing Policies And Procedures

Have the group review your facility's existing policies regarding admissions, patient tracking, and emergency operations. Take the time to review the Joint Commission or the other accrediting organizations to understand what is required.

Review The 15 'til 50 Guide

Your working group should review the Guide in detail and determine how the recommendations contained in the Guide apply to your facility.

Develop And Maintain The 15 'til 50 Plan

Using the guide and the template prepare your 15 'til 50 Plan. Provide any department within your hospital responsible for response operations a draft document for review and comment. Then revise/finalize the plan as needed and submit it to the appropriate facility authority(s) for approval as required.

Designate a unit or person by position title to be responsible for plan maintenance making sure they are scheduled to review it at least annually. Update the plan as necessary following every exercise or event by preparing and implementing an After Action Report/Improvement Plan (AAR/IP). In the interim the plan should be the foundation for a 15 'til 50 exercise or training program within your hospital and updated to incorporate lessons learned.

Coordinate and Pre-Position Supplies

One of the hallmarks of the 15 'til 50 program is the organized multi-departmental effort to pre-position supplies and equipment for a mobile triage site. This is not just a matter of making sure your storage room is full of backup supplies. 15 'til 50 features a number of prepositioned caches specifically for 15 'til 50 activation. These include:

- 15 'til 50 "Go-Kits"
- Mobile Storage Units/Trailers
- Command Center Supplies

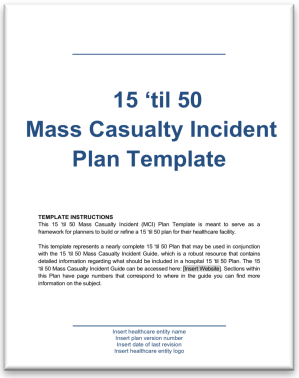
Go-kits are boxes that can be easily deployed to mobile triage, ideally one for each triage area (minor, immediate, etc.). Along with go-kits, mobile storage units or trailers should be used for larger equipment, such as traffic cones, tents, and signs. Additional boxes of supplies for the HCC and the Family Information Center with relevant 15 'til 50 MCI Plan materials are also recommended.

A detailed, sample list of supplies and equipment for each element above can be found in Appendix E. Your facility will need to create your own 15 'til 50 supplies and equipment list based on your hospital's capacity and the details of your plan. For example, if your facility plans to utilize an outdoor mobile triage site in the parking lot, you may want to have your 15 'til 50 storage units located in trailers or buildings easily accessible from the parking lot. If your facility plans to use an existing department or ward as your triage location, you will need to store your supplies according to the layout of the department.

Section III: Writing The 15 ‘til 50 Plan

15 ‘til 50 Plan Blueprint

Once you’ve designated a project leader, formed your working group, and reviewed relevant policies and procedures, it will be time to create your 15 ‘til 50 Plan. This section provides you with blueprints, or table of contents, to build out your plan, including an explanation of the information that should be provided in each section.


15 ‘til 50
Mass Casualty Incident Plan Template

TEMPLATE INSTRUCTIONS
This 15 ‘til 50 Mass Casualty Incident (MCI) Plan Template is meant to serve as a framework for planners to build or refine a 15 ‘til 50 plan for their healthcare facility.

This template represents a nearly complete 15 ‘til 50 Plan that may be used in conjunction with the 15 ‘til 50 Mass Casualty Incident Guide, which is a robust resource that contains detailed information regarding what should be included in a hospital 15 ‘til 50 Plan. The 15 ‘til 50 Mass Casualty Incident Guide can be accessed here: [Insert Website]. Sections within this Plan have page numbers that correspond to where in the guide you can find more information on the subject.

Insert healthcare entity name
Insert plan version number
Insert date of last revision
Insert healthcare entity logo

Use the accompanying 15 ‘til 50 Plan Template to create your plan. Here is a sample table of contents for your plan, taken directly from the15 ‘til 50 Plan Template.

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Appendices

15 'til 50 Plan Blueprint Walkthrough

Acknowledgements

Acknowledge your planning team members, the hospital, or any group that provided feedback, editing, or direct input.

Table of Contents

The table of contents should be logically organized and consist of the major sections and subsections of your document. The above 15 'til 50 Blueprint is essentially your table of contents for the plan.

Acronyms

Acronyms are a functional way for people within a profession to communicate commonly used phrases in shorthand. Try to use acronyms sparingly, and include an acronym list at the beginning of the plan.

Introduction Section

Overview

The overview serves as the foundation of the rest of the document. It tells your audience why the plan has been written, what the plan offers, who has written the plan, the plan's scope, assumptions, and how the plan will be maintained.

Purpose

The purpose is important as it provides guidance for the rest of the plan. It answers the question "what is this plan offering" and provides a brief description of the plan's contents.

Scope

The scope defines the boundaries of the emergency response activities for the plan. For example, if you represent a multi-site organization, does the plan apply to several hospitals, or just one? Does the plan apply to one department, or all of them?

Assumptions

Many decisions made in daily life are based on assumptions. When you make plans to meet someone for lunch, you're assuming that you'll have reliable transportation to get you where you need to go, that there won't be a crisis situation that will disrupt your schedule, or that you won't suddenly come down with the flu.

Sample assumptions for this plan may include:

- Staff and responders will follow the plan
- The plan will follow the Hospital Incident Command System (HICS)
- Patients may need decontamination
- Patients may report with pre-existing Access and Functional Needs (AFN)

Pre-Incident Section

Identify the area within your facility that will be used for triage and treatment in the event of an MCI. Select the individuals and alternates who will fill key positions in the event of an MCI including those who can fill positions after normal business hours. Determine the 15 'til 50 MCI set-up strategy. Pre-position supplies and equipment (Appendix E).

Prepare for the accommodation of at-risk populations including children and those with access and functional needs. Perform a gap analysis to identify any additional equipment or supplies needs. If purchasing medical surge resources is prohibitively expensive, consider a Memorandum of Understanding (MoU) with a neighboring healthcare facility.

Training and Exercise Schedule

Once you've written the 15 'til 50 Plan, it's important to train your staff to ensure they understand their roles and responsibilities. It's equally important to test your plan for "holes" with regular exercises.

Training

Two types of training are of key importance:

Advance training for those pre-identified for key staff positions. The curriculum should include a review of the 15 'til 50 Plan and walkthrough of all aspects of your hospital's response operations from activation to either demobilization or transition to continued incident management.

Just in Time (JIT) Training. The purpose of JIT Training is to refresh the knowledge of those persons who have been pre-trained, and to provide persons with no prior training with the tools to perform their assigned functions. JIT Training should cover all aspects of 15 'til 50 operations.

A unit or individual, identified by position title, should be designated to coordinate training activities. Training should be conducted on a regularly scheduled basis, and documented.

Exercises

A progressive exercise program will allow your facility to test critical capabilities related to your plan. In accordance with the 2013 FEMA Homeland Security Exercise and Evaluation Program (HSEEP), there are seven different types of exercises grouped as either discussion-based or operations-based.

Discussion-Based Exercises. Discussion-based exercises test policy-oriented and strategic issues. They're a good forum to make sure that everyone is aware of their role and responsibilities during a MCI.

Seminars. Seminars may provide an orientation to your hospital's policies and procedures that are the foundation of your 15 'til 50 Plan as well as available resources.

Workshops. Workshops are similar to seminars except there is more active participation on behalf of your staff and the end result is a product such as job aids or revised procedures.

Tabletop Exercises (TTX). A TTX uses a hypothetical emergency scenario to test your staff's understanding of roles and responsibilities, validate plans and procedures, and identifying strengths as well as areas for improvement.

Games. A game simulates a hypothetical scenario and divides staff into two or more teams that are competing according to a pre-determined metric. An example of a game might be pitting different teams against one another to see who can set up the external staging area the fastest (hopefully within 15 minutes).

Operations-Based Exercises. In operations-based exercises, you and your staff will be physically interacting with and reacting to an exercise scenario rather than talking through it. They're best for validating your plan and identifying resource gaps. For example, until you run a drill setting up your external staging area you don't realize you had your supplies prepositioned and ready…but didn't include a barrier for traffic control.

Drills. A drill runs through a specific component of a plan within one agency or organization. Drills are an excellent way to test new equipment, procedures, or practice one component of your plan without involving the entire hospital.

Functional Exercises (FE). Functional exercises usually test command, management, and control functions. You might use this sort of exercise to test operational communications between your HCC and incident management team.

Full-Scale Exercises (FSE). The most resource-intensive and complex, these exercises usually involve more than one agency or organization and tests multiple aspects of preparedness.

At a minimum, tabletop and other discussion-oriented exercises should be used to familiarize staff with plans, including recent updates. Drills, functional and full-scale exercises will provide opportunities to test plan functionality in a tactical manner and may include interaction with external partners, such as your local Emergency Medical Services Agency. For more information on HSEEP exercises visit www.fema.gov.

Supplies and Equipment

All prepositioned supplies and equipment for the 15 'til 50 program should not be used for day-to-day operations. All staff should be notified about supplies and equipment designated for this type of emergency, and where they are located. Staff should be trained not to use these supplies or equipment unless the Plan has been activated.

You and your staff will need to establish storage locations, obtain needed supplies, and re-evaluate supplies after each and every exercise or incident. The "15" in 15 'til 50 refers to the small window of time your hospital will have to setup all prepositioned supplies, so staff need to exercise setup and takedown as often as possible. The more you exercise, the quicker your response will be during a real incident.

Finally, review supplies and equipment needed to activate the MCI Plan. For each resource, identify:

- Number
- Type
- Location
- If in a secure storage area, who has keys and /or 24/7 access
- Who is responsible for securing
- Who is responsible for positioning
- Restrictions or authorization requirements
- How the resource will be acquired
- How the resource will be tracked
- Prioritize the order in which supplies and equipment should be set up

Activation Section

Activation involves the processes that transition a hospital from a normal mode of operations to that of incident management. The 15 'til 50 MCI Plan should establish a "trigger" point for activation, such as notification that the facility is expecting to receive patients from the incident. Planners should use their existing activation protocols to activate their 15 'til 50 response. Patient triage and treatment, either internal or external to the hospital facility, should be activated as soon as your facility is made aware of an incident with notification such as a "Code Triage" page. Initial activation should include minimum staffing for 15 'til 50 functions and provide for escalation of staffing as required.

Authorization to Activate

Confirm who is responsible for 15 'til 50 operations at your facility. The person responsible may be the person who is authorized to activate the plan and lead 15 'til 50 operations as described in this Guide.

Notification

When designing your 15 'til 50 MCI Plan, describe how staff will be notified and the notification process used at your facility. Consider mechanisms for notifying staff at the hospital, not at the hospital, and external agency/organizations.

Staff at the facility.

Staff will be notified by overhead page such as "Code Triage, External", emergency notification text system, or pager.

Staff not at the facility.

Staff will be notified through either an emergency notification text system, or phone call using a pre-determined notification procedure

External agencies and organizations.

External agencies are notified through either a dedicated medical emergency communication network software or through the phone. In preparation for an MCI, create a contact list consisting of a table with a description of services, name of provider/organization and contact information. Include e-mail addresses, and most important, a 24/7 access telephone number for each. Key stakeholders you will want to contact include:

- Local emergency management department
- Local public health department

- Local emergency medical services agency
- Hospitals, clinics, and other facilities within your healthcare community
- Law enforcement (if necessary)

Clearly identify what types of information needs to be relayed, with special consideration paid to:

- Type of incident, including specific hazard/agent, if known
- Location of incident
- Number and types of injuries
- Any special populations (e.g. a large number of children)
- Special actions being taken (e.g. decontamination, transporting by bus)
- Estimated time of arrival of first-arriving EMS unit

Coordinate Staffing and Prepare Staff for Activation

Critical staff during the initial stages of an MCI will likely come from the emergency department, Operating Room, and Intensive Care Units. However, a hospital is a large organization with many moving parts and dependencies. When making decisions on staffing, it's important to consider the scope and nature of the incident and match them with needed capabilities. Consider how the types of injuries your hospital will see can change based on the category of event. As an example, in comparing a wildfire to a flood: a burn unit, general surgeon, and plastic surgeon will probably be needed for the wildfire, but not the flood. For the most part, services provided by Mental Health, Pediatrics, Obstetrics and Gynecology, and Internal Medicine will be consistently necessary. Table (1) below provides some suggested considerations for which departments would play a role in response by incident type and can help you in planning staff deployment accordingly.

JIT Training should be conducted for all staff at the beginning of each shift and/or when any new staff member is assigned. This is important not only for staff unfamiliar with MCI operations, but also for previously trained staff that may need refresher training. You will need to create a JIT Training program that is tailored for your facility. The plan should outline who is responsible for JIT Training conduct. Overall JIT Training should address: objectives, organizational structure, patient flow, and key functions.

Specific position JIT Training should address:

- Job Action Sheets
- Organization chart with names, positions and missions, to include reporting relationships
- Fact Sheet regarding MCI operations
- Hospital Layout, with a detailed map of triage operations and the emergency department
- Documents and forms that will be utilized by the position
- Talking points for the JIT instructor
- Develop JIT Training materials

Table (1): Staffing Considerations by Incident Type

MCI Scenario	Trauma Surgeon	General Surgeon	Orthopedic Surgeon	Neuro Surgeon	Plastic Surgeon	Thor Surgeon	Vascular Surgeon	Internal Medicine	Pulmonary	Infectious Disease	Pediatric	OB -GYN	Hem - Oncology	Radiation Oncology	Behavioral Health
Chemical								X			X	X			X
Biological								X	X	X	X	X			X
Radiologic								X			X	X			X
Nuclear	X	X						X			X	X	X	X	X
Explosive	X	X	X	X	X	X	X	X	X		X	X	X	X	X
Tornado	X	X	X	X	X		X	X	X		X	X			X
Hurricane								X			X	X			X
Flooding								X			X	X			X
Earthquake	X	X	X	X	X	X	X	X			X	X			X
Wildfire		X			X			X			X	X			X
Transporta -tion Crash	X	X	X	X	X	X	X	X			X	X			X

Deploy Supplies and Equipment

In this section, describe how material, equipment, supplies and personnel resources will be deployed to their assigned locations. Schematics and diagrams depicting the deployment location of all materials, supplies and personnel should be developed and tested pre-incident. Lists or spreadsheets showing quantities should accompany schematics. Personnel deployment schematics should depict the number of staff in each job category to be deployed. See Job Action Sheets provided as part of this toolkit for information that should be included in your deployment strategy.

Hospital Command Center

Here describe how Hospital Command Center (HCC) staff will be informed of activities happening in the triage and treatment areas and other areas supporting MCI efforts. This should include status updates, resource requests, security issues and media management.

ACTIVATION ACTION ITEMS SUMMARY

Authorize Action

- ✓ **Specify who is authorized to order your hospital's 15 'til 50 MCI Plan activation by HICS position. This can be the Incident Commander or other designated individual**

Coordinate Staffing

- ✓ **Work with your human resources department to develop a strategy for determining staffing needs**
- ✓ **Staffing needs can be based on the number of patients, resources available, etc.**

Make Notifications

- ✓ **Identify who is responsible for notifying and organizing staff**
- ✓ **Determine mechanisms for issuing notifications and document the strategy for issuing alerts**

Coordinate Supplies and Equipment

- ✓ **Identify who is responsible for securing and positioning supplies**
- ✓ **Review supplies and equipment needed to activate the MCI Plan**

Prepare Staff for Activation and Operation

- ✓ **Activate the method for conducting staff registration**
- ✓ **Conduct training**
- ✓ **Provide staff briefings and updates**
- ✓ **Prepare staff for successful MCI operations**

Operations Section

The operations section describes how your facility will carry out key 15 'til 50 MCI activities.

Triage

The Dual Wave Phenomenon serves as the foundation of the 15 'til 50 program philosophy. In most cases, unless your facility is located extraordinarily close to the incident, the patient load in the first 15 – 30 minutes will consist mostly of mild or walking wounded followed by the more severely injured within an hour. Also part of the Secondary Surge will be those patients or worried well that initially sought treatment with their primary physician and are decompensating to your facility after they've found their doctor's office closed. A system for triage, such as START, is vital in order for your Incident Management Team to decongest the emergency department and clear survivors with minor injuries before the potentially more severe second wave hits. Depending on the type of MCI there may be higher or lower patient volumes, varied pediatric casualties, and different acuity levels. In a typical MCI with a 20% surge, literature suggests that 20% of patients will be categorized as red, 30% yellow, and 50% green. The initial goal will be to prioritize red-tagged patients for immediate care and life saving interventions.

Table (2): START Color Coding System

Color	Acuity	Need for Treatment	Level of Care at Triage Area
Red	Emergency - Threat to life, limb or organ	Immediate	Critical Care, Advanced Cardiac Life Support (ACLS)/ Basic Life Support (BLS)
Yellow	Urgent - Significant injury or illness but can tolerate a delay in care	Delayed	ACLS if necessary, BLS, specialty experience if needed
Green	Non-Urgent - Can safety wait for treatment	Minimal/Non-Urgent	BLS, specialty care if needed
Black	Expired or expected to expire – palliative care	Care and Comfort Measures	Palliative/comfort care. Pain medication, hydration, psychological support, care of deceased

Treatment

During response, the emergency department must work closely with ancillary and support departments. As an example, of the total patient surge population, planners should assume 20% will be children, so it should be assumed that pediatric staff will be heavily involved. Another example is that of surgical planning. Of red-tagged patients, 10% will require stat, emergency

resuscitative surgery. A number of patients may require one or more surgical interventions during their hospital stay. You may consider a coordinated approach to surgical care to avoid bottlenecks in the operating room such as assigning a member of the surgical staff to the Incident Management Team to monitor the situation.

Security

In the aftermath of a no-notice/short-notice incident, the environment within your facility might be chaotic. The role of security staff will be to provide some measure of order by providing traffic control and maintaining the integrity of internal security.

Support departments such as your security staff should be trained within their 15 'til 50 responsibilities as thoroughly as your physicians or nurses. Because they are often the first people that staff or patients will come across, they should be familiar with the 15 'til 50 Plan and understand where staging areas will be located. When every minute counts you don't want congestion in the parking lot or frequent questions over the radio cluttering your communications because a member of your security team doesn't know if the emergency department is still open or where patients with minor injuries are directed.

Traffic Control

The security unit will be responsible for establishing a traffic flow pattern for both pedestrians and vehicles. A detailed map of the hospital should be used to plan separate areas of ingress and egress for emergency vehicles that will guide them towards the designated triage area. Particularly if your campus is large, your traffic flow diagrams should include locations to place cones, barriers, signs, and other indicators so staff know where to place signage during an incident.

Internal Security

Your plan should detail whether your staging area is internal or external to your facility and if certain areas of your hospital will be closed or involve controlled access. Your security plan should include details of where staff will be posted and how unit communications will be maintained.

In the case of terrorist acts, the hospital itself may be a secondary target. If terrorism is suspected hospital security should establish a secure perimeter around the hospital and hospital staff should be advised to watch for suspicious behavior.

Coordinating With Law Enforcement

If the mass casualty event triggering activation of the 15 'til 50 Plan is known or suspected to have resulted from a criminal act, law enforcement will most likely arrive at the hospital soon after the first patients arrive to take witness statements and gathering evidence. In addition to local law enforcement, the FBI may arrive if the incident is suspected of being a terrorist act.

It is also possible that the perpetrators of the event have themselves sustained, or pretended to have sustained injuries. Therefore, the facility's 15 'til 50 Plan should include procedures for coordinating with and assisting law enforcement agencies and for securing items that may be needed as evidence in the ensuing investigation and/or legal proceedings.

The specifics of the section of the plan concerning coordinating with law enforcement will vary by hospital, but should include the following elements at a minimum:

- Provision should be made for ingress, egress and parking of law enforcement vehicles. This may include designated space for a mobile command post vehicle.
- A room should be provided for use by law personnel.
- No statements or information should be released to the media unless approved by law enforcement.

Hospital personnel should be made aware that clothing, personal effects, or other items accompanying victims may be needed for evidence. Therefore, it is important that personal items be treated as potential evidence. This includes ensuring that items are described and/or photographed; labeled to identify the associated victim; and a "chain of evidence" record maintained to track their transfer from one person/unit to another.

It is recommended that hospital emergency management and security personnel confer with local law enforcement in the development of this portion of the Plan.

Patient Processing

During an MCI response it may not be practical to follow normal procedures for admission, tracking and discharge of patients. When you are developing this section of the plan, consider the following points:

- Make sure you involve staff from the admitting and discharge department(s) in the planning process
- Benchmark how your departments operate normally and how those processes will differ during a 15 'til 50 incident
- Make a detailed flow diagram detailing patient processing from intake to discharge, paying special attention to how the operations will occur, who will perform them, and where in the hospital they take place
- Determine if normal forms and record keeping procedures will be used, or if special forms and procedures will be designed specifically for 15 'til 50 situations

- If forms processing will be conducted outside the hospital, or in a space not normally used for that purpose (such as an auditorium), make sure that the appropriate electronic equipment is included on the 15 'til 50 equipment list, including electronic translation devices
- Make sure that all locations that will electronically process admissions, tracking and discharge have wireless or landline connections to hospital networks
- Develop procedures for merging 15 'til 50 records into normal hospital records systems
- Make sure that any hard copy forms (including triage tags), charts or other materials are acquired ahead of time and prepositioned with other 15 'til 50 supplies

Communications

Communications, both internally and externally to your facility, are critical for all of the units, departments, and agencies to work together as fluidly as possible. Communications plans should designate who is responsible for communications, where equipment is located, what equipment and sources are utilized, communications etiquette and protocol, and a list of key stakeholders.

Examples of communication methods include:

- 2 Way Radio Channels (UHF, VHF, etc)
- Internet/Email
- Fax
- Landlines
- Cell Phones
- GETS cards
- Satellite Radio

Communications with Hospital Command Center (HCC)

If an MCI occurs and the healthcare facility receives, or expects to receive a number of injured patients, it is probable that the HCC will have been activated. The Plan should specify responsibility for communications with the HCC and the entity that coordinates the transfer of patients from hospitals and tracks the bed availability and diversion status hospitals.

The Command Center should be notified when:

- The Incident Management Team is activated and ready to receive patients
- Resources are needed
- Deactivation of the 15 'til 50 Plan
- Occurrence of any unusual or significant unexpected event
- Any breach, or suspected breach of security (also notify the facility security and/or law enforcement agency with jurisdiction as necessary)
- Discovery of any safety hazard or other condition that could compromise operations

Communication via Public Media

Your hospital's Public Information Officer should handle all communications with public media. All staff should be instructed not to provide information to any media representative without specific authorization from the Public Information Officer.

Communications via Social Media

Communications via social media have become increasingly important in our society. While extremely valuable for communications purposes, communication via social media is virtually impossible to control, and is subject to misunderstanding and dissemination of misinformation. Social media is also a common source of rumors and speculation. Your staff should adhere to your facility's established social media policy.

Communications Regarding Incidents Resulting From Intentional Acts

If an incident is known or suspected to have occurred as a result of an intentional act, the designated representative should coordinate with the law enforcement agency having jurisdiction prior to release of any information.

Provide detailed information about how communications will occur with respect to:

- General procedures
- Staff
- Command Center, Local EOC, Multi Agency Coordination Center
- Public Media
- Social Media
- Incidents resulting from intentional acts

At-Risk Populations

During a medical surge some groups might have difficulty in accessing public health or medical services. Children, people with Access Functional Needs (AFN), whom English is a second language, are chemically dependent, or mentally ill are all potentially at-risk populations. Minnesota has for some time utilized a definition that included thinking of those considered "at risk" as having concerns with Communication, Medical, Independence, Supervision, and Transportation services, otherwise know as CMIST. CMIST is just a starting place and it cannot be assumed that at-risk populations can be readily identified, or vice versa, that the appearance of being at risk means the individual is at risk.

Generally, at-risk populations suffer from low socio-economic status, lack a strong support network, or both. It's important to note that "at-risk" can be a subject to change and is defined by the individual's status during the particular crisis. Pregnancy or recent immigrants are examples of this term's fluid property.

Your facility should have protocols and considerations for at-risk populations as part of your general existing hospital plans and policies. The following are examples of some at-risk population planning considerations that might be particularly germane to a MCI:

- Ensure that your staging area, especially if external to your facility, is ADA accessible
- Consider the need for transportation services so that individuals may be rapidly discharged if cleared
- If possible, plan to have a licensed mental health professional at the staging site
- Pre-identify auxiliary aids and services necessary to meet the communications needs of all persons and include them as part of your plan or 15 'til 50 go-kit including translation services, visual language translation cards, or materials in braille
- Identify back-up strategies for translation services for non-English speaking patients. For example, if the phone system is unavailable during an incident, the 15 'til 50 MCI Plan

should address or refer to the provision of back-up interpreter services, which should also be a part of your facility's larger emergency plans. Strategies could include emergency MOUs with interpreter services or wireless access or battery powered translation equipment

- Post messages and signage in centralized locations
- Have a protocol for how you will handle patients that arrive at the staging area with service animals
- Consider how your facility would handle a pediatric surge. Refer to Los Angeles County Department of Health Services Pediatric Surge for assigned Pediatric capacity in a disaster

Family Information Center (FIC)

The FIC provides a secure and controlled area for families of patients as well as many of the at-risk populations listed above where information can be shared to facilitate family reunification and to provide access to support services (social services/mental health, spiritual care). In most hospitals, Case Management and Social Services staff will activate the FIC and staff the Patient Family Assistance Branch under Operations, but other possible departments include Pediatrics or Patient Registration. Supplies, job action sheets, sign in sheets, toys and materials for children and other items should be easily accessible and ready for deployment near the location of the FIC in your hospital. Refer to FIC Planning Guide for Healthcare Entities, June 28, 2013.

Clinics and smaller hospitals can tailor their FIC staffing strategies based on their organizational structure. For example, marketing or administration staff typically have access to contact information and could be used to contact family members. Office staff can help check-in families and help provide care services for children and unaccompanied minors.

Key operations of the FIC include:

- Performing Family Registration – All non-staff persons entering the FIC should be appropriately registered and issued a badge or wristband that offers authorized entry. Unaccompanied Minors should receive a special registration badge or other identification.
- Facilitating Reunification – FIC staff will coordinate, to the best of their ability, reunification of admitted patients with family members within their facility or at other facilities through Reddinet searches.

- Performing Family Notification – If a missing patient has been located at the hospital, the patient's family members at the FIC should be notified of the patient's status in private.
- Offering Support Services – FIC staff should provide whenever possible social services, childcare, mental health services, and spiritual care for family members within the FIC as well as for FIC or other response staff as appropriate.

Unaccompanied Minors FIC Sign-in and Tracking Form

The FIC Sign-In and Tracking Form is given to each family that enters the FIC in order obtain information about the patient that the family is looking for, as well as family information, to include the number of people in the FIC per family.

In any mass casualty incident, you likely will have unaccompanied minors presenting at your healthcare facility seeking information or whereabouts of loved ones (e.g. their parent/guardian is the patient). These unaccompanied minors require special considerations. Your facility should have an Unaccompanied Minors Sign-In and Tracking Form included in the FIC supplies and/or go-kit. An Unaccompanied Minors sample checklist for FIC staff is included in the Template. For sample tracking forms and additional resources for your Family Information Center, you can refer to the Family Information Center Guide for Healthcare Entities (2013) produced by the Los Angeles County Emergency Medical Services Agency and available online at their website.

Mental/Behavioral Health

Mental health must be considered as part of your 15 'til 50 MCI Plan. During a crisis event, everyone is psychologically affected whether survivors, first responders, hospital staff, or bystanders. Oftentimes, the victims of traumatic stress are more numerous than the number of casualties, and even for survivors, psychological wounds can persist long after their physical injuries have healed.

During a crisis, a range of mental health issues can surface, either pre-existing conditions that have been aggravated by stress (such as anxiety disorders), or novel symptoms. Staff can be highly susceptible to compassion fatigue, also referred to as secondary traumatic stress, from treating those that are themselves traumatized or suffering. Staff should be trained to recognize signs of traumatic stress that can include anger, fear, hopelessness, disconnect, diminished self-care, and temporary cognitive impairment. Your 15 'til 50 MCI Plan should include mental health staff as well strategies for providing stress management and psychological first aid. Self-monitoring can be done by staff through the Anticipate, Plan and Deter program.

PsySTART, or Psychological Simple Triage and Rapid Treatment, was developed by Dr. Merritt Schreiber from University of California, Los Angeles (UCLA). It is a rapid mental health triage and management strategy designed for use during a crisis event. It provides a situational awareness of "at risk" individuals and a linkage to follow on care. PsySTART uses a "floating triage algorithm" to prioritize those individuals who need to be seen first and those who need to be seen next or can be referred for assessment after the initial surge. Psychological first aid includes identification of those exhibiting acute stress reactions with immediate needs and establishing safe areas, facilitating stress-symptom reduction, linking persons to critical resources, and connecting them to social support.

Staff Support Services

Any MCI incident will create stress and anxiety among both victims and victims' families. People will need more than medical attention, in addition to mental health support as described in the previous section. Such support services may include things such as:

- Childcare for unaccompanied minors that are victims or family members
- Family reunification specialists
- Spiritual care
- Social services
- Transportation assistance
- Replacement for lost medications
- Care for service animals
- Meals and water
- Temporary sleeping arrangements

Most of these services are provided in some form during normal operations. In your planning process, try to figure out how the need for these services can escalate, and where you will find the personnel, equipment and supplies needed. As with other 15 'til 50 functions, equipment and supplies should be prepositioned if possible. Provide information on staff support services such as dependent care, transportation, mental health/spiritual care, or sleeping accommodations.

OPERATION ACTION ITEMS SUMMARY

Triage

- ✓ Plan for a 20% surge with 20% red tagged, 30% yellow, and 50% green (source: CDC)
- ✓ Ensure your plan involves ancillary and support units such as pediatrics or surgical staff

Security

- ✓ Work with your security staff to create diagrams of traffic flow, with special consideration for ingress and egress points for emergency vehicles. Mark signage, barriers, and cones
- ✓ Ensure that security personnel are thoroughly trained on the 15 'til 50 Plan, including the location of staging areas and whether certain entrances will be controlled or closed
- ✓ Have a plan for how your staff will coordinate with Law Enforcement in the event that the triggering MCI is a criminal act

Patient Processing

- ✓ Involve intake and case management staff as part of planning rapid admission, patient tracking, and discharge during an MCI

Communications

- ✓ Designate who is responsible for communications, where equipment is located, and what equipment and sources are utilized
- ✓ Outline basic communications etiquette and protocol
- ✓ Create a list of key stakeholders
- ✓ Designate a flow for communications, including the circumstances for when certain groups must be contacted

At-Risk Populations

- ✓ Plan for the needs of at-risk populations such as children, people with access and function needs (AFN)
- ✓ Especially if located outside, ensure your staging area is ADA accessible, with attention paid to providing clear pathways, utilizing space effectively, exposed power cords, etc.

Mental/Behavioral Health

- ✓ Include mental health staff as part of your 15 'til 50 planning process
- ✓ Identify a system like PsySTART to rapidly identify mental health issues in survivors
- ✓ Consider as part of your plan training staff in basic psychological first aid
- ✓ Include as part of your plan a system of supporting your staff's mental wellness

Support Services

- ✓ Plan for continuous staff support services such as dependent care, sleeping arrangements, food, and mental wellness

Transition Section

15 'til 50 operations are intended to get your organization through the first crucial hours of an MCI, long enough for you to either demobilize to normal operations or transition to ongoing incident management. Language regarding transition in your plan should include information on who has the authority to deactivate the 15 'til 50 Plan, triggers that determine deactivation, and notifying your stakeholders of the transition.

Demobilization procedures should follow the HICS Demobilization Checklist (HICS 221) or a modified version tailored for your facility. If your facility does not already have a Demobilization Checklist as part of its other emergency operations plans and policies, HICS 221 offers a useful tool to begin planning and outlining your facility's demobilization procedures in any incident. The HICS Demobilization Checklist is included as Appendix C.

Authority to Transition

The 15 'til 50 Plan should state directly, by HICS position title, who is responsible for making the decisions associated with deactivation. This could be the Incident Commander, Safety Officer, or other designated HICS authority. If your facility designates a specific hospital position as the demobilization or activation authority, include their contact information and designated replacements if they are not available. The deactivation authority could also be the same individual authorized to trigger the initial plan and response activation.

State, by position title, who has the authority to make decisions regarding the transition from 15 'til 50 to ongoing incident operations or normal hospital operations.

15 'til 50 Deactivation Trigger

The trigger for deactivation will depend largely on the type of incident and the resources you have available to you. Below are some possible triggers for 15 'til 50 deactivation:

- Your hospital no longer needs to transfer patients to other hospitals and can handle patient inflow internally
- The incident is over and no additional incident-related patients are appearing at the hospital
- The hospital has become unsafe, and must halt surge operations and transition into evacuation and/or facility shutdown
- Incident-related patients have all been diverted to another facility

While your possible trigger(s) will be included in your 15 'til 50 MCI Plan, it should be explicitly stated that often, the decision to enter deactivation is a subjective one. This is why designating the

proper decision-making authorities for deactivation is the most crucial step in your plan. The decision to deactivate your plan will always depend on the nature of the incident, the resources available, and the safety of your staff.

Notification Stakeholders

As with Activation, you will need to describe how internal staff and external stakeholders will be notified that you're transitioning to ongoing incident management or normal operations. Is there a code that you will use in your hospital? Are you coordinating with the local Emergency Operations Center(s) to let them know you're entering a new phase of your response? Be consistent with the communication protocols established for Activation.

Transition Operations

HICS Form 221 in Appendix C outlines a full checklist that should be completed as part of your 15 'til 50 Demobilization operations. This includes gathering all completed paperwork, disseminating final messages or incident summaries to staff members, completing final media and staff briefings, updating social media, notifying partner agencies, completing an inventory of remaining equipment and supplies, and completing a safety check.

TRANSITION ACTION ITEMS SUMMARY

Designate Authority

- ✓ **Specify who is authorized to order MCI demobilization. This will most likely be the individual who authorized the plan activation or another designated individual if response spans multiple labor shifts**

15 'til 50 Deactivation Trigger

- ✓ **Specify the trigger for 15 'til 50 deactivation and the transition to normal or other operations**

Stakeholder Notification

- ✓ **Review your hospital's communications protocols for notifying all staff and coordinating partner agencies that the facility has transitioned to either normal or continued emergency operations**

Demobilization Operations

- ✓ **Refer to HICS 221 (Appendix C) for a full checklist of Demobilization Action Items**

Appendix A: JIT Training Materials

JIT training materials have been provided as part of this toolkit. This includes Job Action Sheets, slide decks, videos and more.

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Appendix B: 15 'til 50 Activation Checklist

The purpose of an activation checklist is to ensure that in a crisis environment all critical functions are in place and ready to receive victims. The checklist below is an example of an activation checklist that may be used to activate the 15 'til 50 process. Using this checklist as a guide, each hospital should prepare an activation checklist appropriate to their situation and include the Activation Checklist in their plan.

Following the checklist, an explanation is provided for each checklist step.

- ☑ Decision to activate the 15 'til 50 Plan is made by the Incident Commander
- ☑ Incident Commander notifies all personnel via PBX paging "Code Triage External"
- ☑ Departments self activate according to Job Action Sheets for 15 'til 50. Add positions to checklist: Emergency Department Charge Nurse, Emergency Department External Change, Immediate Team, Delayed Team, Internal Emergency Department Charge Nurse
- ☑ Predestinated areas are set up with equipment, supplies and medications
- ☑ Incident Commander reviews Quick Start Form (incident action plan) with incident Command and General staff
- ☑ Section Chiefs distribute Job Action Sheets and conduct Just-in-Time Training as required
- ☑ Safety Officer inspects physical configuration and reviews procedures. If any safety deficiencies are identified these are reported to the Incident Commander
- ☑ Security establishes and marks ingress and egress routes for vehicles and pedestrians, and other security arrangements.
- ☑ Incident Commander or designee conducts communications check
- ☑ Unit leaders/Section Chiefs report to Incident Commander when their units/sections are "ready"
- ☑ Incident Commander declares that activation is complete, notifies participating staff, and the HCC

Decision to Activate. The Plan should clearly indicate, by position title, who is authorized to activate the Plan. This may be the HCC if activated, the Incident Commander if identified, or other appropriate authority. Keep in mind that activation may be required during evening hours, weekends or holidays; or the designated authority may not be present, so the plan should provide for alternative authorities. Persons with designated activation authority should be provided with a copy of the Plan, including the Activation Checklist on a flash drive or smart phone app so that it is readily available.

Personnel Notifications. It is recommended that all personnel who have assigned duties under the plan be notified directly, using an emergency notification system, phone tree, text, or blast email. If possible, the notification procedure should include an acknowledgement feature, so that Command Staff will know who to expect to report, and if any vacant positions need to be filled. Staff, on duty, can also be notified through the overhead paging system with a pre-determined code, such as "Code Triage External".

Support Unit Notifications. While in most instances the emergency department staff will initially fill most of the positions involving direct contact with patients, other units in the hospital, such as Patient Transportation, Mental Health, Pharmacy, Laboratory, or Admissions, will play important support roles in the 15 'til 50 process. It should be automatic upon hearing Code Triage External, MCI that support units initiate, or be prepared to initiate, their assigned support functions.

Configuration of Facilities. The Plan should include diagrams of how the various areas (triage, treatment, etc.) should be configured. Configuration diagrams should include the location of equipment, location and content of signage, and supply storage. Configuration diagrams should also indicate patient flow through the area. Upon announcement of Code Triage External, Mass Casualty Incident that each department that has a role in an MCI activate their plan and begin set up of the pre-designated areas. Note that configuration should also include all forms or other recordkeeping tools.

Review Quick Start Form. It is recommended that an Incident Action Plan be prepared in advance using the HICS "Quick Start Form." The Incident Commander should review the form with the Safety Officer, Liaison Officer, and Section Chiefs to ensure that key players have a common understanding of objectives and tactics. The Quick Start Form prepared in advance can be modified at this time if required by the nature of the incident.

Distribute Job Action Sheets and Conduct Just-in-Time Training. Section Chiefs should distribute Job Actions Sheets to Unit Leaders, who in turn distribute to participating staff. It is recommended that personnel who may perform leadership roles be trained and exercised in advance so that they are fully familiarized with their role. Pre-trained Section and Unit leaders will provide JIT training to their assigned staff as needed, using the JIT training material included in the Plan.

Safety Inspection. The safety of patients and hospital personnel is of primary importance; it is the responsibility of the Safety Officer to conduct a safety inspection prior to receiving patients, identify any unsafe conditions, and bring these to the attention of the Incident Commander for correction. The safety inspection should include physical safety, safe and secure storage of supplies, and procedures. The facility should not be declared "ready" until the Safety Officer is satisfied that operations can be conducted safely for patients and staff.

HICS 215A – IAP Safety Analysis form should be used to document the safety inspection and mitigation.

Traffic Control and Security. In most cases, the Security unit will be responsible for establishing a traffic flow pattern for both pedestrians and vehicles. Cones, barriers, signs, and other indicators should be used to direct pedestrians including points of ingress and egress, staging areas, parking, and speed restrictions. The Plan should include a detailed plan for traffic flow including diagrams. Separate ingress and egress should be established for emergency vehicles if possible, and arrangements should be made to accommodate multiple emergency vehicles simultaneously. The Security unit is also responsible for establishing and maintaining security for staff and patients. The Plan should also include a detailed security plan, including posting locations.

"Ready Status" Reporting. Upon determining that their functions are ready to receive patients, unit leaders should report up to Section Chiefs, who in turn will advise the Incident Commander.

"Ready" Declaration/Notifications. Once the Incident Commander is satisfied and all units are "Ready" and the operation can be conducted safely, she/he should declare activation complete and transmit both "up' and "down" notifications – down to all participating staff, and up to the HCC or other designated authority. Communication flows up and down the HICS chain of command structure.

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Appendix C: HICS Demobilization Checklist (221)

HICS 221- DEMOBILIZATION CHECK-OUT

1. Incident Name	2. Operational Period (#)
	DATE: FROM: ______ TO: ______
	TIME: FROM: ______ TO: ______

3. Section Demobilization Checks
Use as positions and resources are demobilized. The position and the resources may only be released when the checked boxes below are signed off, all equipment is serviced and returned, and all paperwork turned in to the Documentation Unit Leader. Respective Section Chiefs must initial their sections showing approval for demobilization.

COMMAND STAFF

INCIDENT COMMANDER	REMARKS	INITIALS
☐ All units, branches, and sections have been demobilized. ☐ All paperwork has been gathered for review and development of After Action Report. ☐ Final message to staff, media, and stakeholders has been developed and disseminated. ☐ All clinical operations have returned to normal or pre-incident status. ☐ Hospital Command Center and Emergency Operations Plan are deactivated.		

PUBLIC INFORMATION OFFICER	REMARKS	INITIALS
☐ Final media briefing is developed, approved, and disseminated. ☐ Final staff and patient briefings are developed, approved, and disseminated. ☐ Social media is updated with current status.		

LIAISON OFFICER	REMARKS	INITIALS
☐ All stakeholders and external partners are notified of Hospital Command Center deactivation/return to normal operations.		

SAFETY OFFICER	REMARKS	INITIALS
☐ Final safety review of facility is completed and documented. ☐ All potential hazards have been addressed and resolved. ☐ All sites/hazards have been safely mitigated/repaired and are ready to be used. ☐ Appropriate regulatory agencies are notified. ☐ All safety specific paperwork is completed and submitted.		

MEDICAL / TECHNICAL SPECIALIST (TITLE) ______	REMARKS	INITIALS
☐ Position-specific roles and responsibilities have been deactivated. ☐ Response-specific paperwork is completed and submitted to Documentation Unit Leader.		

MEDICAL / TECHNICAL SPECIALIST (TITLE) ______	REMARKS	INITIALS
☐ Position-specific roles and responsibilities have been deactivated. ☐ Response-specific paperwork is completed and submitted to Documentation Unit Leader.		

MEDICAL / TECHNICAL SPECIALIST (TITLE) ______	REMARKS	INITIALS
☐ Position-specific roles and responsibilities have been deactivated. ☐ Response-specific paperwork is completed and submitted to Documentation Unit Leader.		

HICS 221- DEMOBILIZATION CHECK-OUT

OPERATIONS SECTION		
STAGING AREA	**REMARKS**	**INITIALS**
☐ All supplies and equipment staged for response are returned to storage or pre-response state. ☐ All personnel are debriefed and returned to daily work site.		
MEDICAL CARE BRANCH	**REMARKS**	**INITIALS**
☐ All procedures and appointments are rescheduled. ☐ All evacuated patients have been repatriated and family members notified. ☐ All clinical information/procedures/interventions have been documented in the electronic medical record. ☐ Alternate care sites have been deactivated and physical sites returned to pre-response operations. ☐ Medical supplies and equipment utilized in the response have been returned to pre-response state. ☐ Staffing patterns have returned to pre-response state. ☐ All units within the branch are debriefed and deactivated.		
INFRASTRUCTURE BRANCH	**REMARKS**	**INITIALS**
☐ All damage assessments are completed and final report submitted to Operations and Planning Section Chiefs. ☐ Repairs to infrastructure and equipment are complete or a new state of readiness is established by Operations Section Chief. ☐ Utility services are in pre-response state. ☐ Resupply of critical resources is underway. ☐ All units within the branch are debriefed and deactivated.		
SECURITY BRANCH	**REMARKS**	**INITIALS**
☐ Facility and/or campus lockdown is suspended. ☐ Hopspital personnel used to augment security staff are debriefed and demobilized. ☐ Additional security measures used in the response are now discontinued. ☐ All units within branch are debriefed and deactivated.		
HAZMAT BRANCH	**REMARKS**	**INITIALS**
☐ Decontamination operations are concluded and all supplies, equipment, and personnel are returned to a pre-response state. ☐ Water collected in decontamination operations is collected and disposed of safely. ☐ Authorities are notified of the decon operations, including water collection. ☐ Personnel involved in decon are referred to Employee Health for surveillance. ☐ All units within branch are debriefed and deactivated.		
BUSINESS CONTINUITY BRANCH	**REMARKS**	**INITIALS**
☐ All supplies and equipment used in relocated services have been returned. ☐ Interruptions in data entry have been resolved and documentation recovered. ☐ All units within branch are debriefed and deactivated.		

HICS 221- DEMOBILIZATION CHECK-OUT

PATIENT FAMILY ASSISTANCE BRANCH	REMARKS	INITIALS
☐ All supplies and equipment used in relocated services have been returned. ☐ All units within branch are debriefed and deactivated.		
PLANNING SECTION		
RESOURCES UNIT	**REMARKS**	**INITIALS**
☐ All tracking forms are complete and submitted to Documentation Unit Leader. ☐ All tracking tools are demobilized and returned to storage.		
SITUATION UNIT	**REMARKS**	**INITIALS**
☐ All tracking forms are complete and submitted to Documentation Unit Leader. ☐ All tracking tools are demobilized and returned to storage.		
DOCUMENTATION UNIT	**REMARKS**	**INITIALS**
☐ All paperwork created or used in the response has been submitted. ☐ All paperwork is catalogued and correlated for review.		
DEMOBILIZATION UNIT	**REMARKS**	**INITIALS**
☐ All paperwork, including the approved Demobilization Plan, is submitted to Documentation Unit Leader.		
LOGISTICS SECTION		
SERVICE BRANCH	**REMARKS**	**INITIALS**
☐ All communications equipment is returned to readiness. 1. Radios and batteries are placed in charging stations. 2. Voice and text messages are reviewed and deleted. 3. Extra disaster telephones are returned to storage. 4. Satellite phones are returned and placed on chargers. 5. Hospital Command Center communication equipment is returned to storage. ☐ All deployed information technology (IT) equipment is returned and inspected; all event specific data is removed and archived. ☐ All food/water stores are returned to daily operations levels. ☐ Disposable food preparation and delivery supplies are removed from service. ☐ All units within branch are debriefed and deactivated.		
SUPPORT BRANCH	**REMARKS**	**INITIALS**
☐ Supplies and equipment used in response are inspected, cleaned, and returned to storage or daily use. ☐ All equipment requiring calibration or repair is entered into preventive maintenance/service program. ☐ All units within branch are debriefed and deactivated.		
FINANCE / ADMINISTRATION SECTION		
TIME UNIT	**REMARKS**	**INITIALS**
☐ All timesheets and other documentation tools are collected and provided to Documentation Unit Leader.		
PROCUREMENT UNIT	**REMARKS**	**INITIALS**
☐ All order forms, expense sheets, and other documentation tools are collected and provided to Documentation Unit Leader.		

HICS 221- DEMOBILIZATION CHECK-OUT

COMPENSATION / CLAIMS UNIT	REMARKS	INITIALS
☐ All timesheets and other documentation tools are collected and provided to Documentation Unit Leader. ☐ All insurance forms are completed and submitted per policy.		
COST UNIT	**REMARKS**	**INITIALS**
☐ All time sheets and other documentation tools are collected and provided to Documentation Unit Leader. ☐ All expense reports are completed. ☐ All outstanding expenses, bills, purchase orders, check cards, bank cards have been resolved.		
ALL POSITIONS	**REMARKS**	**INITIALS**
☐ All paperwork generated during the response and recovery is submitted to the Documentation Unit Leader. ☐ All response and recovery equipment related to your role has been repaired, charged, restocked, and returned to storage. ☐ Daily supervisor is notified of your deactivation and return to normal duties.		

4. Prepared by

PRINT NAME: _____ SIGNATURE: _____

POSITION: _____ FACILITY: _____

DATE/TIME: _____

HICS 221- DEMOBILIZATION CHECK-OUT

PURPOSE: The HICS 221 - Demobilization Check-Out ensures that resources utilized during response and recovery has been returned to pre-incident status.

ORIGINATION: The HICS 221 is completed by Hospital Incident Management Team (HIMT) personnel designated by the Incident Commander.

COPIES TO: Delivered to the applicable Command Staff and Section Chief(s) for review and approval then forwarded to the Demobilization Unit or the Planning Section. All completed original forms must be given to the Documentation Unit Leader. Personnel may request to retain a copy of the HICS 221.

NOTES: HIMT personnel are not released until form is complete and signed by their Section Chief. If additional pages are needed, use a blank HICS 221 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period**	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	**Section Demobilization Checks**	As demobilization actions are taken, check off each appropriate box (or indicate "N/A"), and ensure Section Chief signs or initials approval before resource is released.
4	**Prepared by**	Enter the name, Hospital Incident Management Team (HIMT) position, and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

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Appendix D: Job Aids

Job aids are included on the following pages for biological, chemical, or radiological incidents. Additional job aids are also provided for an MCI involving trauma/burn victims.

BIOLOGICAL EMERGENCIES JOB AID

A Summary Guide for the Management of Biological Emergencies

	PHASE	PERSONNEL	JOB ACTION
D	Detection	ED Nurse or Physician	• The most common findings which should help lead to the detection of a biological disaster from an intentional event or from an emerging infectious disease may include: (A) ILI (Influenza-Like Illness) – Most cases of ILI are not caused by influenza but by other viruses; (B) A single case of an unusual illness or an unexplained outbreak of a known illness; (C) A rapid increase in the number of otherwise healthy individuals exhibiting common symptoms, seeking medical treatment; (D) A cluster of previously healthy individuals exhibiting similar symptoms who live, work, or recreate in a common geographic area; (E) An unusual presentation of a known infectious disease; (F) An increase in reports of dead or sick animals or (G) Any individual with a recent history (within 2-4 weeks) of international travel who presents with symptoms of high fever, rigors, delirium, unusual rash, extreme myalgia, prostration, shock, diffuse hemorrhagic lesions or petechiae, and/or extreme dehydration related to vomiting or diarrhea with or without blood loss.
I	ICS	Incident Commander	• Upon determination of a multiple casualty biological event, activate HICS positions and emergency operations plan (EOP) as needed
S	Safety and Security	Employee Health and Well-being Unit Leader	• If appropriate, monitor all in-coming employees for signs/symptoms of illness • Ensure that all personnel who could potentially be exposed to a contaminant are protected by appropriate level of PPE. (All personnel must have completed a medical evaluation before donning PPE if it includes APR or PAPR respirators) • Ensure all persons using PPE are evaluated after doffing of Level C PPE and receive appropriate rehabilitation, according to policy
		Security Branch Director	• Assess security needs and capabilities and follow guidance from Operations Section Chief regarding possible victim screening and visitor restriction (e.g., no children under 16 years of age; no visitors with influenza-like illnesses)
		Safety Officer	• Monitors and ensures the appropriate isolation procedures are followed • Monitors staff use of appropriate personal protective equipment and infection control procedures
A	Assessment	Medical/Technical Specialist	• Assesses and/or monitors situation updates from: Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), state Department of Public Health (DPH), local Department of Public Health and facility-based (inpatient and staff) sources • Provides guidance to the Command Staff regarding: method of transmission, risks for cross-contamination or infection to others and methods designed to limit the spread of the infection
		Operations Section Chief	• Works with Medical/Technical Specialist, Safety Officer and Logistics Section Chief to develop infection control guide to limit the spread of the infection • Shares information and plans with Branch and Unit Leaders to assure safety and infection control plans are properly and completely implemented
		Casualty Care Unit Leader	• Assesses ongoing patient needs and capacities, and ongoing infection control needs and resources, and reports to Medical Care Branch Director • Assesses need for additional bed capacity due to patient surge
S	Support	Casualty Care Unit Leader	• Ensures appropriate infection control procedures are followed by all staff, patients, and visitors • Establishes area(s) for the cohorting of patients with the signs and/or symptoms associated with the presumed or known infectious agent • Requests assistance from the laboratory department for evidence collection, if necessary
		Inpatient Unit Leader	• Ensures appropriate infection control procedures are followed by all staff, patients and visitors • Establishes area(s) for the use of cohorting of patients with the signs and/or symptoms associated with the presumed or known infectious agent. • Manages and promotes rapid admission to appropriate inpatient care areas as well as early patient discharge, if indicated
		Logistics Section Chief	• Ensures an adequate supply of all resources necessary for patient care activities
T	Triage and Treatment	Operations Section Chief	• Works with Medical/Technical Specialist, Safety Officer and Logistics Section Chief to develop infection control guidelines to limit the spread of the infection. • Shares plans and information with department managers to ensure infection control and treatment plans are properly and completely implemented
		Casualty Care Unit Leader	• Ensures appropriate infection control procedures are followed by all staff, patients and visitors • Uses established triage guidelines to prioritize patients according to severity of injury or illness • Ensures appropriate treatment of patients based on appropriate treatment guidelines
		Inpatient Unit Leader	• Manages and promotes rapid admission to appropriate inpatient care areas and provides continuity of care for all inpatients • Provides for early patient discharge, if indicated
E	Evacuate	Casualty Care Unit Leader	• In consultation with the senior emergency department physician prepare the ED by making prompt disposition decisions: discharge to home, or admission to hospital or secondary distribution to another facility for continued care (e.g., pediatric, long term care patients)
		Inpatient Unit Leader	• In consultation with the Medical Care Branch Director, prepare the various inpatient units by making prompt disposition decisions: discharge to home, or admission to hospital or secondary distribution to another facility for continued care (e.g., pediatric, long term care patients) • Implement internal surge plans as necessary
R	Recovery	Mental Health Unit Leader	• Aid recovery by addressing the behavioral health needs of patients, visitors, and health-care personnel (see Behavioral Health EOP). If needed, enlist the services of social services, pastoral care, psychiatry, child life, employee assistance services, and external behavioral health services
		Casualty Care Unit Leader	• Monitors and/or relieves staff for signs/symptoms of illness, exposure or signs of excessive fatigue, stress • Ensure all unneeded equipment and supplies are cleaned and returned to its original location
		Section Chiefs	• Maintain a continuous level of readiness by monitoring staffing patterns, relieving staff showing signs of excessive fatigue or stress, monitoring staff for signs/symptoms of illness, directing used or unneeded equipment and supplies to be cleaned and returned to original location, and maintaining an accurate accounting of all staff time and other expenses

Center for Emergency Preparedness and Disaster Response
YALE NEW HAVEN HEALTH

BIOLOGICAL EMERGENCIES JOB AID

A Summary Guide for the Management of Biological Emergencies

Isolation, placement and transport of patients with probable biopathogens

	Biological Agents									Viral Agents				Biotoxins			Misc. Biologicals				
CDC Bioterrorism Agents/Diseases by Category **A – Agents with high risk to National Security** **B – Agents easy to disseminate with high morbidity/low mortality**	Anthrax (A)	Bubonic Plague (A)	Pneumonic Plague (A)	Tularemia (A)	Brucellosis (B)	Q Fever (B)	Glanders (B)	Food/Water Safety Threats (B)	Meliodosis (B)	Smallpox (A)	Viral Hemorrhagic Fever (A)	Viral Encephalitis (B)	SARS-CoV	Botulism (A)	Ricin and Abrin (B)	Trichothecene (T2) Mycotoxin	Influenza	Bacterial Meningitis	Methicillin Resistant Staphylococcus aureus (MRSA)	Vancocillin Resistant Entrococci (VRE)	Unprotected abcess or draining wound
Isolation Precaution																					
Contact	❶				❶		❷	X		X	X		X						X	X	X
Droplet			X							X	❸		X				X	X			❹
Airborne										X			X								
N95 Required										X			X								
Patient Placement																					
No Restriction	X			X		X						X		X	X	X					
Private Room		X	X		X		X			X	X		X					X	X	X	X
May Cohort		X	X				X	X					X				X		X	X	
Negative Pressure Room										X	❸		X								
Patient Transport																					
No Restriction	X			X		X		X				X		X	X	X					
Essential movement only		X	X		X		X		X	X	X	X	X								X
Mask patient to minimize droplet contamination			X							X	❸		X				X	X		❺	
Notify receiving unit before transport	X		X		X		X	X		X	X		X				X	X	X	X	X

❶ Contact precautions with extensive skin involvement or lesions than cannot be covered
❷ Contact precautions required when skin involved
❸ Airborne Precautions with for prominent cough, vomiting, diarrhea or hemorrhage
❹ Add Droplet Precautions for the first 24 hours of appropriate antibiotic therapy if invasive Group A streptococcal disease is suspected.
❺ Patient must wash hands with antibacterial soap, wear a gown, avoid touching common surfaces (elevator or TV buttons).

NOTE: ALL PATIENTS receive ***STANDARD PRECAUTIONS*** in addition to any recommended transmission based (airborne, droplet, contact) precautions.

Center for Emergency Preparedness and Disaster Response
YALE NEW HAVEN HEALTH

TRAUMA / BURN EMERGENCIES JOB AID

A Summary Guide for the Management of Trauma or Burn Emergencies

	PHASE	PERSONNEL	JOB ACTION
D	Detection	ED Nurse or Physician	• Obtain as much information as possible regarding potential source of contamination • Notifies the Administrator on Duty (AOD) and the regional EMS communications center
I	ICS	Incident Commander	• Upon determination of a multiple casualty trauma/burn event, activate HICS positions and emergency operations plan (EOP) as needed
S	Safety and Security	Security Branch Director	• Assess security needs and capabilities and follow guidance from Operations Section Chief regarding possible victim screening and visitor restriction • Establishes secure ingress and egress for vehicles delivering victims
		Safety Officer	• Assign a safety officer to the Emergency Department as necessary • Monitors staff use of appropriate safety and infection control procedures
A	Assessment	Medical/Technical Specialist	• Provides guidance to the Incident Commander and Operations Section Chief regarding: ○ Appropriate methods of treating casualties based on their severity ○ Number of casualties needing immediate surgery or other treatments and the number of casualties that could have delayed surgery or other treatments ○ Number of pediatric casualties ○ Determination of criteria for transferring casualties to other facilities (trauma centers, burn centers, pediatric centers, etc.)
		Operations Section Chief	• Shares information and plans with Branch and Unit Leaders to assure emergency treatment plans and victim dispositions are properly implemented
		Casualty Care Unit Leader	• Assesses ongoing patient needs and capacities, and ongoing trauma/burn specific needs and resources, and reports to Medical Care Branch Director • Assesses need for additional bed capacity due to patient surge
S	Support	Casualty Care Unit Leader	• Maintains contact with the regional EMS communications centers • Establishes area(s) for the cohorting of patients based on triage categories
		Inpatient Unit Leader	• Manages and promotes rapid admission to appropriate inpatient care areas as well as early patient discharge, if indicated
		Logistics Section Chief	• Ensures an adequate supply of all resources necessary for patient care activities
T	Triage and Treatment	Operations Section Chief	• Shares plans and information with Branch and Unit Leaders and department managers to ensure treatment plans are properly and completely implemented
		Casualty Care Unit Leader	• Uses established triage guidelines to prioritize patients according to severity of the injury • Ensure that contaminated victims with immediate life-threatening injuries receive life-saving treatments • Assesses and treats traumatic and or burn injuries based on appropriate treatment guidelines
		Inpatient Unit Leader	• Manages and promotes rapid admission to appropriate inpatient care areas and provides continuity of care for all inpatients • Provides for early patient discharge, if indicated
E	Evacuate	Casualty Care Unit Leader	• In consultation with the senior emergency department physician, prepare the ED by making prompt disposition decisions: discharge to home, or admission to hospital or secondary distribution to another facility for continued care (e.g., pediatric, burn, long term care patients)
		Inpatient Unit Leader	• In consultation with the Medical Care Branch Director, prepare the various inpatient units by making prompt disposition decisions: discharge to home, or admission to hospital or secondary distribution to another facility for continued care (e.g., pediatric, burn, long term care patients) • Implement internal surge plans as necessary
R	Recovery	Mental Health Unit Leader	• Aid recovery by addressing the behavioral health needs of patients, visitors, and health-care personnel (see Behavioral Health EOP). If needed, enlist the services of social services, pastoral care, psychiatry, child life, employee assistance services, and external behavioral health services
		Casualty Care Unit Leader	• Relieve staff showing signs of excessive fatigue or stress • Ensure all unneeded equipment is cleaned and returned to the staging area, or returned to its original location
		Section Chiefs	• Maintain a continuous level of readiness by monitoring staffing patterns, relieving staff showing signs of excessive fatigue or stress, directing unneeded equipment and supplies to be cleaned and returned to original location, and maintaining an accurate accounting of all staff time and other expenses

Center for Emergency Preparedness and Disaster Response
YALE NEW HAVEN HEALTH

TRAUMA / BURN EMERGENCIES JOB AID

A Summary Guide for the Management of Trauma or Burn Emergencies

Blast Injuries

Pearls for Clinical Practice

- Expect an "upside-down" triage - the most severely injured arrive after the less injured, who by-pass EMS triage and go directly to the closest hospitals
- If structural collapse occurs, expect increased severity and delayed arrival of casualties
- Clinical signs of blast-related abdominal injuries can be initially silent until signs of acute abdomen or sepsis are advanced.
- Standard penetrating and blunt trauma to anybody surface is the most common injury seen among survivors. Primary blast lung and blast abdomen are associated with a high mortality rate. "Blast Lung" is the most common fatal injury among initial survivors
- Isolated tympanic membrane rupture is not a marker of morbidity; however, traumatic amputation of any limb is a marker for multi-system injuries.
- Air embolism is common, and can present as stroke, MI, acute abdomen, blindness, deafness, spinal cord injury, or claudication. Hyperbaric oxygen therapy may be effective in some cases
- Determinants of Injury from Blasts
  - Size of the explosion – larger blasts create a larger pressure differential which cause injury and structural damage
  - The initial pressure wave from a high energy explosive is a sharp overpressure, followed by a slight negative pressure before returning to baseline
  - Distance from the blast – the further the victim from the center of the blast, the less injury they might experience
  - Protection – solid walls can provide protection from the pressure wave, shrapnel, and heat
    - If the victim is in front of the wall, the pressure wave will hit them in the front, bounce off the wall and hit them again in the back
    - If in a corner of two walls, the pressure wave may hit the victim three times
  - Casualties may have increased chances of survival if they are in an open field, rather than being in a confined room

Body armor may increase the amount of trauma to lungs

Parkland Formula

IV fluid

Lactated Ringer's Solution

Fluid calculation:

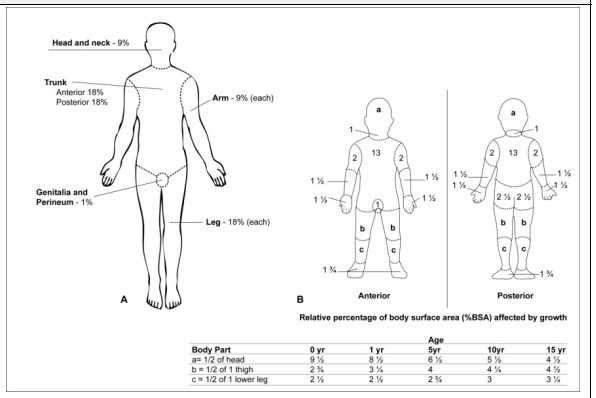
4 x weight in kg x %TBSA burn
Give 1/2 of that volume in the first 8 hours
Give other 1/2 over next 16 hours

Warning: *Despite the formula suggesting cutting the fluid rate in half at 8 hours, the fluid rate should be gradually reduced throughout the resuscitation to maintain the targeted urine output,(i.e., do not follow the second part of the formula that says to reduce the rate at 8 hours, adjust the rate based on the urine output).*

Example of Fluid Calculation

100-kg man with 80% TBSA burn
Parkland formula:
4 x 100 x 80 = 32,000 ml
Give 1/2 in first 8 hours = 16,000 ml in first 8 hours
Starting rate = 2,000 ml/hour

Rule of Nines



Center for Emergency Preparedness and Disaster Response
YALE NEW HAVEN HEALTH

RADIOLOGICAL EMERGENCIES JOB AID

A Summary Guide for the Management of Radiological Emergencies

	PHASE	PERSONNEL	JOB ACTION
D	**Detection**	ED Nurse or Physician	• Obtain as much information as possible regarding potential source of contamination • Notifies the Radiation Safety Officer, the Administrator on Duty (AOD) and the regional EMS communications center
I	**ICS**	Incident Commander	• Upon determination of a multiple casualty radiological event, activate HICS positions and emergency operations plan (EOP) as needed
S	**Safety and Security**	Medical/Technical Specialist (Radiation Safety Officer)	• Provide radiation specific guidance regarding: (A) establishing perimeters for areas used for triage, treatment, decon, and storage of contaminated items; (B) Distribution of personal radiation monitoring devices and instructions for use; (C) preventive measures against cross-contamination • Ensures safety of all persons through oversight of radiation survey, decontamination and monitoring of radiation exposure limits • Ensures all staff and victims are surveyed with Geiger counter before leaving the Decontamination Zone • Ensures that personnel (ED staff) who may treat potentially contaminated patients use Modified Level D PPE appropriately
		Employee Health and Well-being Unit Leader	• Ensure that all personnel on the decontamination team have completed a medical evaluation and screening before donning Level C PPE • Ensure all persons using PPE are medically evaluated after doffing of Level C PPE and receive appropriate rehabilitation, according to policy
		Security Branch Director	• Assess security needs and capabilities and follow guidance from Operations Section Chief regarding possible victim screening and visitor restriction • Establishes secure ingress and egress for vehicles delivering victims • Ensures that a security officer, donned in Modified Level D PPE is stationed inside the Hospital Decontamination Zone
		Safety Officer	• Monitors the integrity of the decontamination unit and related equipment • Ensures that all personnel including decontamination team members appropriately use personal protective equipment and control procedures • Ensures that perimeters of all areas used to triage, treat, or decontaminate victims, or used to store contaminated items are clearly demarcated • Based on guidance from the Radiation Safety Officer, ensures all staff and victims are surveyed with Geiger counter before leaving the Decontamination Zone
A	**Assessment**	Medical/Technical Specialist	• Ensures assessment and/or monitoring for potential radiation contamination in victims and staff • Assess the need for preventive measures to protect against cross-contamination of staff, patients, visitors, equipment, and hospital areas
		Operations Section Chief	• Works with Medical/Technical Specialist, Safety Officer, and Logistics Section Chief to develop safety plan designed to limit the risk of cross-contamination • Shares information and plans with Branch and Unit Leaders to assure safety and control plans are properly and completely implemented
		Casualty Care Unit Leader	• Assesses ongoing patient and resource needs and capacities and reports to Medical Care Branch Director • Assesses need for additional bed capacity due to patient surge
S	**Support**	Casualty Care Unit Leader	• Maintains contact with the regional EMS communications centers • Ensures appropriate contamination control procedures are followed by all staff, patients, and visitors • Requests assistance from the laboratory department for laboratory analysis, and evidence collection, if necessary
		Inpatient Unit Leader	• Manages and promotes rapid admission to appropriate inpatient care areas as well as early patient discharge, if indicated
		Logistics Section Chief	• Ensures an adequate supply of all resources necessary for patient care activities
T	**Triage and Treatment**	Operations Section Chief	• Works with Medical/Technical Specialist, Safety Officer and Logistics Section Chief to develop contamination control guidelines to provide for safety • Shares plans and information with department managers to ensure treatment plans are properly and completely implemented
		Casualty Care Unit Leader	• **Ensure that the administration of life-saving treatment to potentially contaminated victims is NEVER delayed in favor of decontamination** • Administer radiation countermeasures, including internal decontamination agents, as soon as possible • Assess all potentially radiation-exposed patients for acute radiation syndrome
		Inpatient Unit Leader	• Ensure the continued assessment of all potentially radiation-exposed patients for acute radiation syndrome • Manages and promotes rapid admission to appropriate inpatient care areas as well as early patient discharge, if indicated
E	**Evacuate**	Casualty Care Unit Leader	• In consultation with the senior emergency department physician prepare the ED by making prompt disposition decisions: discharge to home, or admission to hospital or secondary distribution to another facility for continued care (e.g., pediatric, long term care patients)
		Inpatient Unit Leader	• In consultation with the Medical Care Branch Director, prepare the various inpatient units by making prompt disposition decisions: discharge to home, or admission to hospital or secondary distribution to another facility for continued care (e.g., pediatric, long term care patients) • Implement internal surge plans as necessary
R	**Recovery**	Mental Health Unit Leader	• Aid recovery by addressing the behavioral health needs of patients, visitors, and health-care personnel (see Behavioral Health EOP). If needed, enlist the services of social services, pastoral care, psychiatry, child life, employee assistance services, and external behavioral health services
		Casualty Care Unit Leader	• Monitors and/or relieves staff for signs/symptoms of injury, exposure or signs of excessive fatigue, stress • Ensures all staff coming from a decontamination zone must complete technical decon, surveyed with Geiger counter and evaluated in the rehab area • Ensure all unneeded equipment and supplies are cleaned and returned to its original location
		Section Chiefs	• Maintain a continuous level of readiness by monitoring staffing patterns, relieving staff showing signs of excessive fatigue or stress, directing unneeded equipment and supplies to be cleaned and returned to original location, and maintaining an accurate accounting of all staff time and other expenses

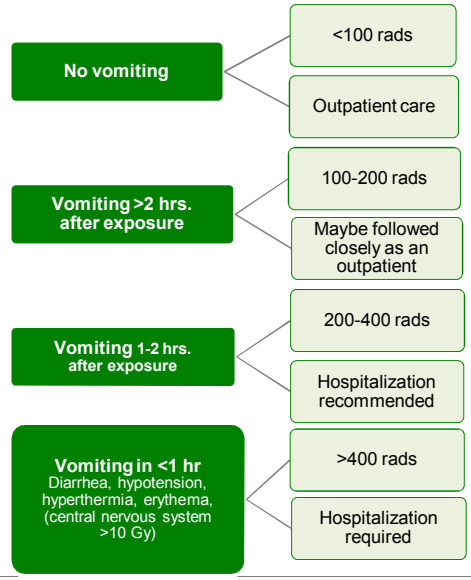
Center for Emergency Preparedness and Disaster Response
YALE NEW HAVEN HEALTH

RADIOLOGICAL EMERGENCIES JOB AID
A Summary Guide for the Management of Radiological Emergencies

Treatment Principles in Radiation Emergencies

Unit	Treatment Principles
Radiation injury and other traumatic injury	• Patient may require spinal immobilization or analgesics for server pain prior to decontamination • All open wounds are contaminated until proven otherwise by radiation survey • If surgery is indicated, it should be performed within 48 hours of severe whole-body radiation exposure • Serial CBCs should be obtained every 6 hours and absolute lymphocyte counts monitored over a 24-48 hour period to estimate radiation injury, if resources permit
Radiation injury without traumatic injury	• Supportive care is the mainstay of emergency treatment of acute radiation injury • Serial CBCs should be obtained every 6 hours and absolute lymphocyte counts monitored over a 24-48 hour period to estimate radiation injury, if resources permit • Ingestion of certain radioactive agents may require that internal decontamination be initiated in the ED
Radiation exposure	• Serial CBCs should be obtained every 6 hours and absolute lymphocyte counts monitored over a 24-48 hour period to estimate radiation injury, if resources permit
Acute radiation illness	• Hospitalization may be required for management of radiation sickness

Management of Radiation Sickness Based on Early Symptoms



Components of Modified Level D Personal Protective Equipment

Item	Rationale
Double Gloving	Contaminated outer gloves are easily removed, leaving the healthcare worker "clean" and protected by inner gloves
Two layers of surgical gowns	Contaminated outer gown is easily removed, leaving the healthcare worker "clean" and protected by inner gown
Goggles	Standard Precautions item
Cap	Standard Precautions item
Face shield or mask	Standard Precautions item
Plastic shoe covers	Protects footwear from contamination
Personal dosimeters (e.g., pen or thermoluminescent dosimeters)	Provides a measure of radiation dose to the upper body
Ring dosimeters	Provides a measure of radiation dose to the hands

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CHEMICAL EMERGENCIES JOB AID

A Summary Guide for the Management of Chemical Emergencies

	PHASE	PERSONNEL	JOB ACTION
D	Detection	ED Nurse or Physician	• Obtain as much information as possible regarding potential source of contamination • Notifies the Administrator on Duty (AOD) and the regional EMS communications center
I	ICS	Incident Commander	• Upon determination of a multiple casualty chemical event, activate HICS positions and emergency operations plan (EOP) as needed
S	Safety and Security	ED Charge Nurse	• Establish contaminated and non-contaminated triage areas • Assign medical Decon Team for contaminated triage unit and for ambulatory and non-ambulatory decontamination areas as needed • Ensure all personnel who may be exposed to contaminated patients don Level C PPE
		Employee Health & Well-Being Unit Leader	• Ensure that all personnel on the decontamination team have completed a medical evaluation and screening before donning Level C PPE • Ensure all persons using PPE are medically evaluated after doffing of Level C PPE and receive appropriate rehabilitation, according to policy
		Security Branch Director	• Assess security needs and capabilities and follow guidance from Operations Section Chief regarding possible victim screening and visitor restriction • Establishes secure ingress and egress for vehicles delivering victims
		Safety Officer	• Monitors the integrity of the decontamination unit and related equipment • Ensures that all personnel including decontamination team members appropriately use personal protective equipment and control procedures • Ensures that perimeters of all areas used to triage, treat, or decontaminate victims, or used to store contaminated items are clearly demarcated
A	Assessment	Medical/Technical Specialist	• Once the chemical agent is known, use at least three authoritative references to determine the risks/hazards • Provides guidance to the Incident Commander and Operations Section Chief regarding potential of injury from the chemical agent, preventive measures to protect against cross-contamination of staff, patients, and visitors and hazard-specific patient treatment guidance
		Operations Section Chief	• Works with Med/Technical Specialist, Safety Officer, and Logistics Section Chief to develop safety plan designed to limit the risk of cross-contamination • Shares information and plans with Branch and Unit Leaders to assure emergency treatment plans and victim dispositions are properly implemented
		Casualty Care Unit Leader	• Assesses ongoing patient needs and capacities, and ongoing contamination-specific needs and resources, and reports to Medical Care Branch Director • Assesses need for additional bed capacity due to patient surge
S	Support	Casualty Care Unit Leader	• Maintains contact with the regional EMS communications centers • Ensures appropriate personal protection procedures are followed by staff, victims, and visitors • Requests assistance from the laboratory department for evidence collection, if necessary
		Inpatient Unit Leader	• Manages and promotes rapid admission to appropriate inpatient care areas as well as early patient discharge, if indicated
		Logistics Section Chief	• Ensures an adequate supply of all resources necessary for patient care activities
T	Triage and Treatment	Operations Section Chief	• Works with Med/Technical Specialist to develop contamination control guidelines designed to provide safety for staff, patients, visitors, and victims • Shares plans and information with Branch and Unit Leaders and department managers to ensure treatment plans are properly and completely implemented
		Casualty Care Unit Leader	• Uses established triage guidelines to prioritize patients according to severity of the injury • Ensure that contaminated victims with immediately life-threatening injuries receive life-saving treatments based on appropriate algorithms • Ensures appropriate treatment of patients based on appropriate treatment guidelines
		Inpatient Unit Leader	• Manages and promotes rapid admission to appropriate inpatient care areas and provides continuity of care for all inpatients • Provides for early patient discharge, if indicated
E	Evacuate	Casualty Care Unit Leader	• In consultation with the senior emergency department physician prepare the ED by making prompt disposition decisions: discharge to home, or admission to hospital or secondary distribution to another facility for continued care (e.g., pediatric, long term care patients)
		Inpatient Unit Leader	• In consultation with the Medical Care Branch Director, prepare the various inpatient units by making prompt disposition decisions: discharge to home, or admission to hospital or secondary distribution to another facility for continued care (e.g., pediatric, long term care patients) • Implement internal surge plans as necessary
R	Recovery	Mental Health Unit Leader	• Aid recovery by addressing the behavioral health needs of patients, visitors, and health-care personnel (see Behavioral Health EOP). If needed, enlist the services of social services, pastoral care, psychiatry, child life, employee assistance services, and external behavioral health services
		Casualty Care Unit Leader	• Monitors and/or relieves staff for signs/symptoms of injury, exposure or signs of excessive fatigue, or stress • Ensures all staff coming from a decontamination zone must complete technical decon, and evaluated in the rehab area • Ensure all unneeded equipment and supplies are cleaned and returned to its original location
		Section Chiefs	• Maintain a continuous level of readiness by monitoring staffing patterns, relieving staff showing signs of excessive fatigue or stress, directing unneeded equipment and supplies to be cleaned and returned to original location, and maintaining an accurate accounting of all staff time and other expenses

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CHEMICAL EMERGENCIES JOB AID

A Summary Guide for the Management of Chemical Emergencies

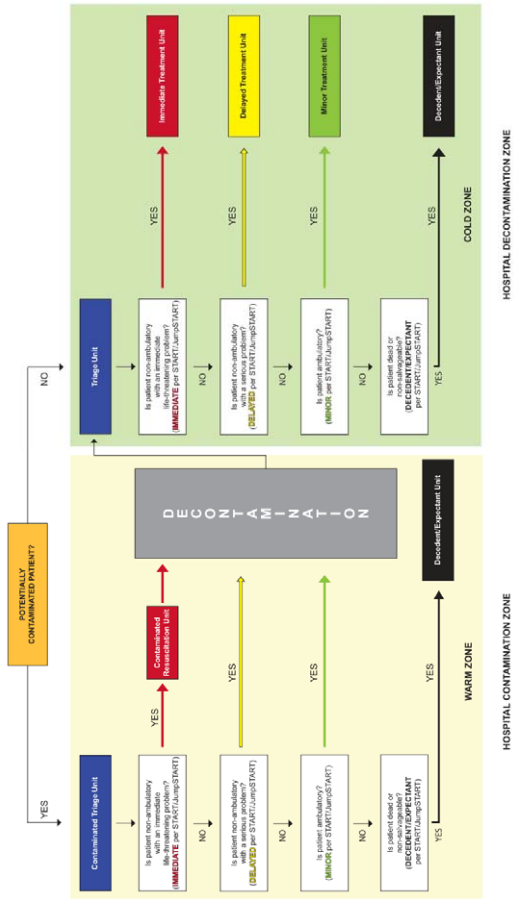
Hazard Risk Assessment Worksheet

Instructions: Using the scenario provided, use three (3) chemical information resources to complete this worksheet. Use this worksheet to determine the appropriate level of PPE required to protect an individual from the stated chemical.

Product: _____ **Physical State:** _____

Hazards	Values
Flash Point/Flammability *Definition: Minimum temperature which liquid forms enough vapor to ignite/ease with which substance will ignite*	
IDLH *Definition: Immediate danger to life and health – maximum exposure which person could escape within 30 minutes without ill effects*	
Vapor Density *Definition: Density of gas relative to the density of air which by definition is 1 at 68° F (may be referred to as RGasD in some references)*	
Water Solubility *Definition: Solubility in water at 68° F, % by weight (i.e., g/100mL)*	

Physical Properties	**Description**
Health Effects	**Inhalation**
	Ingestion
	Skin Contact
	Eye Contact
	Other
Personal Protection	**Respiratory Protection**
	Skin Protection
	Eye Protection
	Level of PPE necessary



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Appendix E: Equipment And Supplies Checklist

Below is a sample list of equipment and supplies for 15 'til 50 deployment. This is not prescriptive, only an example provided to work from. Hospital administrators and staff will need to tailor each list depending on the extent of your mobile triage site and your expected capacity.

Table (3): Go-Kit Equipment

#	Item	Quantity	Location	Status	✓
1.	Clipboard	5 per go-kit	Inside go-kit box	Accounted for	Clipboard
2.	Copy of the 15 'til 50 Plan	5 per go-kit	Inside go-kit box	Accounted for	Copy of the 15 'til 50 Plan
3.	Extra directional signage (left, right, up, down arrows, space to write in locations)	10-20 copies	Inside go-kit boxes for Triage and Treatment areas	Accounted for	Extra directional signage (left, right, up, down arrows, space to write in locations)
4.	Job Action Vest Inserts for each section (including a few blanks)	5-10 per go-kit	Inside go-kit box	Accounted for	Job Action Vest Inserts for each section (including a few blanks)
5.	Job Action Vests for each section	5-10 per go-kit	Inside go-kit box	Accounted for	Job Action Vests for each section

#	Item	Quantity	Location	Status	✓
6.	Mobile Triage Layout Maps (laminated)	5 per go-kit	Inside go-kit box	Accounted for	Mobile Triage Layout Maps (laminated)
7.	Pens	10	Inside go-kit box	Accounted for	Pens
8.	Personal Protective Equipment (Safety Goggles, Gowns, Latex and non-latex gloves, shoe covers, and N95 masks)	Extra supplies for at least 5 people	Inside go-kit boxes for relevant areas	Accounted for	Personal Protective Equipment (Safety Goggles, Gowns, Latex and non-latex gloves, shoe covers, and N95 masks)
9.	PsyStart Triage Evaluations	50 per go-kit	Inside go-kit box	Accounted for	PsyStart Triage Evaluations
10.	Quick Triage Flow-charts and/or Medication Algorithms	10-20 Laminated copies of common complaint/treatment algorithms	Inside go-kit boxes for Triage and Treatment areas	Accounted for	Quick Triage Flow-charts and/or Medication Algorithms
11.	Radios (For Trained Staff)	2 per go-kit	Located in the 1st floor storage room – Locked Cabinet #4	Must be retrieved and placed into go-kits before deployed	

#	Item	Quantity	Location	Status	✓
12.	START Triage Tags	50 per go-kit	Inside go-kit box	Accounted for	
13.	Triage Tape	1 roll of each color (Red, Green, Yellow)	Inside go-kit box	Accounted for	
14.	Triage Tarps (Fire Marshall Approved)	1 of each color (Red, Green, Yellow)	Inside go-kit box	Accounted for	

Table (4): Mobile Triage Setup Equipment

#	Item	Quantity	Location	Status	✓
1.	Assorted Bandage Packs	10 boxes	Inside Storage Unit 1	Accounted for	
2.	Batteries (Non-rechargeable lithium manganese dioxide)	5	On the "Other Materials" shelf in Storage Unit 1	Accounted for	

#	Item	Quantity	Location	Status	✓
3.	Bleach	3 buckets of Clorox Bleach	Inside Storage Unit 3	Accounted for	
4.	Bottled Water	10 packs of 12 per pack	Inside Storage Unit 2	Accounted for	
5.	Bungee Cords	5 packs of 3 per pack	On the “Other Materials” Shelf in Storage Unit 1	Accounted for	
6.	Cadaver Bags	30	Inside the bin labeled “Post Mortem”	Accounted for	
7.	Canopies	5-10	Inside the Mobile Triage Storage Unit 2	Accounted for	
8.	Canvas Stretchers	10	Inside the bin labeled “Canvas Stretchers” in Unit 1	Accounted for	

#	Item	Quantity	Location	Status	✓
9.	Caution Tape	5 rolls	Inside the bin labeled "Traffic Control"	Accounted for	
10.	Chalk	2 packs of 10 pieces per pack	On the "Other Materials" Shelf in Storage Unit 1	Accounted for	
11.	Cleaning Tissues	10 boxes – 100 per box	Inside the bin labeled "Treatment supplies"	Accounted for	
12.	Clipboards	10-20	Inside the box labeled "Clipboards, Pens, Paper"	Accounted for	
13.	Copy of the 15 'til 50 Plan	10 copies per storage unit	Inside the "Documents" Storage Bin or at Patient Check-In Desk	Accounted for	
14.	Decon Doffing Bins	3	Inside Storage Unit 3	Accounted for	

#	Item	Quantity	Location	Status	✓
15.	Decon Wash Kits for Patients	6 boxes of 3 kits per box	Inside the Decon Doffing Bins	Accounted for	
16.	Directional Signs (large pop-up easels)	5-10	Inside the Mobile Triage Storage Unit 1	Accounted for	
17.	Directional Signs (printed and laminated)	20	Inside the bin labeled “Signs”	Accounted for	
18.	“Doff-it” Personal Privacy Kits	10 packs	Inside the Decon Doffing Bins	Accounted for	
19.	Drinking Water Packets	50	Inside the bin labeled “Water and Food”	Accounted for	
20.	Dry Erase Markers	5 packs of 10 per pack	On the “other materials” shelf in Unit 1	Accounted for	

#	Item	Quantity	Location	Status	✓
21.	Flashlights / Lanterns	25	Inside the bin labeled “Flashlights / Lanterns”	Accounted for	
22.	Floodlights	3	Inside Storage Unit 3	Accounted for	
23.	Gurneys	10-20	Borrowed from ED and other departments	Must be retrieved during deployment	
24.	Injection Needles (various sizes)	7 boxes (50 per box)	Inside Storage Unit 2	Accounted for	
25.	IV Lines	20	Inside the bin labeled “IV supplies”	Accounted for	
26.	Job Action Vest Inserts for all positions (and blank extra copies)	2-5 for each position	Inside the bin labeled “Inserts”	Accounted for	

#	Item	Quantity	Location	Status	✓
27.	Job Action Vests for all sections (except Command)	50 total (ensure enough to cover org chart and extras)	Inside the bin labeled “Vests”	Missing from the storage unit	
28.	Meals for all	9 cases (125 servings per case)	Inside Storage Room 503	Must be retrieved if needed	
29.	Medical Waste Disposal Bags	5 packs of 100 per pack	Inside the Medical Waste Disposal Buckets in Storage Unit 1	Accounted for	
30.	Medical Waste Disposal Buckets (Red)	3	Inside Storage Unit 1	Accounted for	
31.	Mobile Generators	3	Inside Storage Unit 2	Accounted for	
32.	Mobile Triage Layout Maps (laminated)	10 copies per storage unit	Inside the bin labeled “Documents”	Accounted for	

#	Item	Quantity	Location	Status	✓
33.	Oxygen Tanks	20	Located within Room 134	Must be retrieved during deployment	
34.	Powered Air Purifying Respirator (PAPR) Vests	5	Inside the bin labeled “PAPR” in Unit 2	Accounted for	
35.	Pop-up Cots	30-50	Inside Mobile Triage Storage Units 1 and 2	Some are stored in basement level Storage room – need to be retrieved	
36.	Portable Mini-Refrigerators	2	Inside Storage Unit 1	Accounted for	
37.	Portable Shower	3	Inside the Mobile Triage Storage Unit 2, in the “Extra Equipment Bin”	Accounted for	
38.	Post Mortem Kits	5	Inside the bin labeled “Post Mortem”	Accounted for	

#	Item	Quantity	Location	Status	✓
39.	Power Cords	10 (3-4 of various lengths)	On the "Other materials" shelf in Unit 1	Accounted for	
40.	PPE – Eye Protection Goggles	10 boxes – 2 pairs per box	Inside the bin labeled "PPE"	Accounted for	
41.	PPE – Face Shields	10 boxes – 5 face shields per box	Inside the bin labeled "PPE"	Accounted for	
42.	PPE – Gloves (Large)	5 boxes – 200 gloves per box	Inside the bin labeled "PPE"	Accounted for	
43.	PPE – Gloves (Non-latex, small and large)	5 boxes – 200 gloves per box	Inside the bin labeled "PPE"		
44.	PPE – Gloves (Small)	5 boxes – 200 gloves per box	Inside the bin labeled "PPE"	Accounted for	

#	Item	Quantity	Location	Status	✓
45.	PPE – Gowns	10 boxes – 10 gowns per box	Inside the bin labeled “PPE”	Accounted for	
46.	PPE Guidelines (Instructional Sheets and Posters for each piece)	10 copies of each instructional page	Inside the bin labeled “PPE”	Accounted for	
47.	PPE – Head Covers	10 boxes – 10 head covers per box	Inside the bin labeled “PPE”	Accounted for	
48.	PPE – Helmets	15	On the shelf above the “PPE” bin	Accounted for	
49.	PPE – N95 Masks	5 boxes – 10 masks per box	Inside the bin labeled “PPE”	Accounted for	
50.	PPE – Respirators (Disposable)	10 boxes – 10 disposable respirators per box	Inside the bin labeled “PPE”	Accounted for	

#	Item	Quantity	Location	Status	✓
51.	PPE – Respirators (Half Mask)	10	Inside the bin labeled "Respirators"	Accounted for	
52.	PPE – Shoe Covers	10 boxes – 10 shoe covers per box	Inside the bin labeled "PPE"	Accounted for	
53.	Procedural Packs / Trays (Angiographic Tray, Biopsy / Centesis Basic Kit, Medication Delivery Packs, Spinal Procedure Kit, Vein Closure Tray, and Myelogram Tray)	2-3 of each	Inside the bin labeled "Procedural Kits" in Storage Unit 2	Accounted for	
54.	Radios	10-20 radios, depending on staffing plans	Located in the 1st floor storage room – Locked Cabinet #4	Must be retrieved during deployment	
55.	Sheets	50	Inside the bin labeled "Sheets"	Accounted for	
56.	Shovels	3	Inside Storage Unit 3	Accounted for	

#	Item	Quantity	Location	Status	✓
57.	Shower Trailer / Decontamination Trailer	1	Located behind the Hoover Memorial Clinic	Must be moved and setup next to the staging area	
58.	Soiled Linens Cart	1	Located in the Laundry Room in the Basement	Must be retrieved during deployment	
59.	Supply Carts	10	Located within the ED	Must be retrieved during deployment	
60.	Traffic Cones	50	Inside Storage Unit 3	Accounted for	
61.	Trailer-Pull “Power Mover”	1	Located to the left of the Decontamination Trailer	Accounted for	
62.	Trash Bags	5 boxes of 10 bags per box	On the “Other Materials” shelf in Unit 1	Accounted for	

#	Item	Quantity	Location	Status	✓
63.	Triage Tape	5 rolls of each color (Red, Green, Yellow)	Inside the bin labeled "Tarps"	Accounted for	
64.	Triage Tarps (Red, Green, Yellow)	3 of each color	Inside the bin labeled "Tarps"	Accounted for	
65.	Water Bottles (5 Gallon)	5	Inside Storage Room 503	Must be retrieved during deployment	
66.	Water Pumps (Manually operated)	5	Inside Storage Room 503	Must be retrieved during deployment	
67.	Wheelchairs	10-20	Borrowed from ED and other departments	Must be retrieved during deployment	
68.	Whiteboards	4 Large	Borrowed from ED and other departments	Must be retrieved during deployment	

#	Item	Quantity	Location	Status	✓
69.	Ziploc Bags (small and large)	10 packs of 100 per pack	On the "Other materials" shelf in Unit 1	Accounted for	

Table (5): Command Center Equipment

#	Item	Quantity	Location	Status	✓
1.	Blank HICS Forms	5 copies of each	Inside the "Forms" bin	Accounted for	
2.	Blank Job Action Vest Inserts	10	Inside the bin labeled "Vests"	Accounted for	
3.	Copies of EOPs, Incident Response Guides, other hospital plans and policies	1 copy of each	Should be readily available in the Command center	Accounted for	
4.	Copy of the 15 'til 50 Plan	10 copies	Inside 1st drawer of Cabinet #2 in the Command Center	Accounted for	
5.	Folders	1 for each Command position	Inside the bin labeled "Folders and Job Action Sheets"	Accounted for	
6.	Job Action Sheets	1 copy for each HICS position	Inside the folders in the "Folders and Job Action Sheets" bin	Accounted for	
7.	Job Action Vest Inserts - Finance/Admin	10	Inside the bin labeled "Vests"	Accounted for	

#	Item	Quantity	Location	Status	✓
8.	Job Action Vest Inserts - Command	10	Inside the bin labeled "Vests"	Accounted for	
9.	Job Action Vest Inserts - Planning	10	Inside the bin labeled "Vests"	Accounted for	
10.	Job Action Vest Inserts – Logistics	10	Inside the bin labeled "Vests"	Accounted for	
11.	Job Action Vest Inserts – Operations	10	Inside the bin labeled "Vests"	Accounted for	
12.	Job Action Vests – Command (Blue)	10	Inside the bin labeled "Vests"	Accounted for	
13.	Job Action Vests – Finance/Admin (Orange)	10	Inside the bin labeled "Vests"	Accounted for	
14.	Job Action Vests – Logistics (Green)	10	Inside the bin labeled "Vests"	Accounted for	
15.	Job Action Vests – Operations (Red)	10	Inside the bin labeled "Vests"	Accounted for	
16.	Job Action Vests – Planning (Yellow)	10	Inside the bin labeled "Vests"	Accounted for	
17.	Mobile Triage Layout Maps (laminated)	10 copies	Inside 1st drawer of Cabinet #2 in the Command Center	Accounted for	
18.	Radios	10-20 radios, depending on staffing plans	Located in the 1st floor storage room – Locked Cabinet #4	Must be retrieved during deployment	

Appendix F: Mass Causality Predictor

Every facility is different in terms of size, assets, and function within the healthcare community. In order to accurately determine logistical needs specific to the event and your facility, the CDC created a Mass Casualty Predictor formula predicated on the Dual Wave Phenomenon. Think of the phenomenon truly like a tsunami. The further away the impact, the more time you'll have before the first wave hits your shores. If the event happens within a mile of your facility, expect the waves to come crashing down on your facility in quick succession. The window of time between the two waves is a vital period for your staff to clear less wounded patients through your hospital in order to make room for the more resource intensive critically injured.

According to the CDC, when trying to determine how many casualties to expect, it is important to remember that casualties present quickly and that approximately half of all casualties will arrive at the hospital within a 1-hour window. The 1-hour window begins when the first casualty arrives at your hospital. To predict the total number of casualties you can expect, double the number of casualties received in the first hour. That total will be an estimate. There are many factors that may affect the accuracy of this prediction such as: transportation difficulties and delays, security issues that may hinder access to victims, and multiple impacts or secondary impacts (e.g. building collapse after an explosion).

CDC MASS CASUALTY PREDICTOR

Total Expected Casualties = # of casualties arriving in a one hour window multiplied by 2. Approximately 50% of acute casualties may arrive at closest medical facilities within 60 minutes. 50-80% may arrive within 90 minutes. Most arrive within 1-4 hours.

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Appendix G: What Are The Staffing Requirements for 15 ‘til 50?

The 15 ‘til 50 program is a flexible and modular system that fits easily within the HICS incident management structure. As such, the number of personnel required to achieve the objective of increased capacity during a surge is dictated by available resources and the severity of the incident. The following table represents how you might structure your 15 ‘til 50 staffing plan. The activation criteria for each level should be determined by your own hospital’s resources and environment.

Table (6): Sample 15 ’til 50 Staffing Levels

Staffing	Minimum Activation	Level I (10-30 patients)	Level II (30-50 Patients)	Level III (50 + Patients)
Clinical/Licensed	5	10	15	20
Support	15	20	25	30

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Appendix H: How Is Each Department Involved In 15 'til 50?

The 15 'til 50 model emphasizes the strong role that ancillary and support departments play in a mass casualty incident. The table below lists various departments within hospitals, their role during a 15 'til 50 MCI, staff, supplies, and role within HICS.

Table (7): Department roles in 15 'til 50

Department	Role	Staff	Supplies	HICS
Behavioral Health	Provide PsySTART services in the Triage and Treatment areas	Any available staff, social services, chaplains	PsySTART triage forms	Behavioral Health Unit Leader and/or Social Services Appointee
Blood Bank	Fill supply orders as requested	Blood Bank Tech on duty or designee	Blood Products	N/A
Case Management	Increase bed surge capacity from a low of 10% of the current bed inventory to a high of 35% of the current bed inventory to accommodate an influx of patients resulting from a mass casualty incident Coordinate discharge of patients meeting criteria for rapid discharge for inpatients and emergency department patients with physicians Establish a patient discharge area to free beds until patients can be discharged or transferred and transported in a lobby or other lounge area Coordinate activities to expedite discharge including transportation Assist in the Family Information Center by providing psychological first aid Provide PsySTART assessments	Case managers on duty	Phones Laptops Additional supplies for the FIC	Director may be assigned to the role of Medical Care Branch Director or Inpatient Care Unit Leader
Central Supply/Supply Chain	Restock supplies as requested	Staff on duty or as requested	Per request	Logistics and/or Planning Sections
Chaplain	Provide mental health and spiritual care services Support Family Information Center activities and Expectant or Palliative Care services	Staff on duty or on call	N/A	Patient and/or Family Assistance

Department	Role	Staff	Supplies	HICS
Emergency Department	Organize a coordinated emergency department response and fill all Code Triage treatment functions	All available as assigned	Pre-designated supply caches and/or treatment supply carts	N/A – Only if available
Engineering	Conduct facility assessments (as needed) Assist with setup of triage and treatment areas Perform utilities assessments	Any available as assigned	Facility blueprints Maps Appropriate tools	Infrastructure Branch Director Safety Officer Operations Chief Subordinate roles
Environmental Services	Respond to waste and/or spill management requests Assist with room and/or bed turnover	Any available as assigned	N/A	Director
Food and Nutrition	Ensure food and water supplies are available for staff, patients, and visitors throughout the MCI event	Any available as assigned	As ordered / as needed for the event	Food Services Unit Leader / Director
Health Information	Reconcile disaster forms and input into computerized records and/or electronic health records	Any available as assigned	N/A	Director / Document Leader
Hospital Command Center	Coordinate deployment of staff, internal/external operational communications, and the procurement and management of all resources and equipment	All available as assigned	Per designated caches: Job Action Sheets Writing Materials All relevant hospital plans (EOPs, 15 'til 50, etc.)	Incident Commander Command Staff
Human Resources	Manage the labor pool and the health and well-being of responding staff	Any available as assigned	Labor pool supplies Resources for staff	Director or Supervisor as assigned to Support Branch Director
Infection Control	Discuss infection control measures that need to be implemented for the protection of all	IC Nurse	N/A	Medical Technical Specialist. Biological/Infections
Inpatient Nursing	Assist Case Management staff in assessing patients who meet the criteria for rapid discharge and or downgrade to a lower level of care Setup and oversee patient discharge areas. Report to the Emergency Department for care of patients arriving	Available RNs and CNAs from each Nursing unit. Some RNs and CNAs from each unit should remain to handle transports	Job Action Sheets Writing Materials Extra Forms	Triage and/or Treatment Unit staff under Casualty Care Unit Leader

Department	Role	Staff	Supplies	HICS
Laboratory	Provide all necessary functions for blood and fluid analysis	Any available as assigned	Transport supplies	N/A
Nursing	Serve as the IC or MT Specialist	Admin on call, Admin in charge, or House Supervisor on Duty	Radio(s) Bed Status Report	Incident Commander Med Tech Specialists
Pharmacy	Provide pharmaceutical services using satellite carts to external triage sites.	Pharmacist to Triage Pharmacy Tech to ED	Pre Stocked Med Carts Deploy to: Mobile Triage Area Internal Treatment Areas	Director may be assigned a Medication Staging Unit Leader position
Public Relations	Provide communications to staff, media, visitors, patients, and external agencies	Personnel on call	N/A	Public Information Officer
Radiology	Provide all necessary radiological diagnostic services for an MCI	Management Supervisor Techs	C-Arms Portable X-Rays PACS Carts Deploy to: Mobile Triage Area, Internal Treatment Areas	N/A
Registration	Ensure registration of all incoming patients during an MCI event	Any available as assigned	Registration supply boxes	Director or Designee for Patient Tracking
Respiratory	Provide RC to patients PRN	Any available as assigned	N/A	Director Med Tech Specialists
Safety and Security	Provide safety and security measures and ensure they are maintained during the event, ensuring the safety of all involved responders, patients, visitors, etc.	Any available and on duty	N/A	Safety Officer and/or Manager
Social Services	Provide PsySTART evaluation to patients Assist at the Family Information Center and with Expectant and/or Palliative Care	Any available as assigned	Supplied by Case Management	Patient or Family Assistance and Family Reunification
Staffing Office	Continue staffing office functions to coordinate staffing needs as requested by Incident Command	N/A	N/A	N/A

Department	Role	Staff	Supplies	HICS
Surgery	Identify available physicians, anesthesiologists,first assists and other surgery staff Obtain estimated ending times of each surgical procedure in progress Obtain time estimated of available recovery beds Cancel all elective cases on schedule when directed Check with each surgeon in the unit for their availability should they be needed Provide direct patient care based on acuity and medical necessity Establish accurate vacant bed list Establish patient assessment for discharge, transfer to lower level of care Assign appropriate staff to Labor Pool Activate telephone tree upon request of Command Center or request notification of staff through Emergency Notification System	Charge Nurse to emergency department Anesthesiologist to mobile triage or internal treatment areas	N/A	N/A
Transport	Provide transportation services to all areas of external triage and assist with internal transport of patients transferring to a lower level of care	All available transporters	Find all available gurneys and wheelchairs Deploy to: Staging Area or Mobile Triage Area	N/A
Trauma	Expand quickly the capacity and capability beyond normal operations to meet an increased demand for medical care in the event of a multiple casualty incident (MCI), bioterrorism or other large-scale public health emergencies Assist inpatient triage – to identify patients who can be downgraded, transferred to other healthcare facilities, or discharged Assist Emergency Department triage to identify patients who meet criteria for intensive care or surgery Facilitate patient movement utilizing the triage criteria	All available trauma staff	N/A	N/A
Volunteers	Assist management of an MCI incident by accepting an alternate assignment	Volunteers on duty	N/A	Runners

Appendix I: Sample Unaccompanied Minors Action Items Checklist

The following checklist was taken from the Family Information Center Planning Guide for Healthcare Entities:

- ☑ Assign an Unaccompanied Minors Specialist in the FIC
- ☑ Establish an Unaccompanied Minors Safe Area
- ☑ Establish security measures to ensure the safety and security of the Safe Area
- ☑ Consider instances that the minor may need to be escorted out of the FIC, such as to use the restroom
- ☑ Ensure that there is a plan for assessing mental health needs of unaccompanied minors
- ☑ Implement enhanced procedures to document the identity of unaccompanied minors, including physical description; information provided by the minor; description of clothing and jewelry; distinguishing scars, birthmarks, and tattoos; and photographs.
- ☑ Take a photograph of the unaccompanied minor and attach it to his/her medical record
- ☑ If not already in place, establish protocols and safeguards for the release of unaccompanied minors to adults
- ☑ The following considerations may be implemented with regard to the registration and badging of unaccompanied minors:
    - Document identification information including name, gender, age, triage tag number, and the location of the unaccompanied minor within the facility
    - Provision of an identifying wristband attached in addition to the FIC identification badge

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Appendix J: HICS Incident Action Plan Quick Start

The following pages contain IAP Quick Start forms.

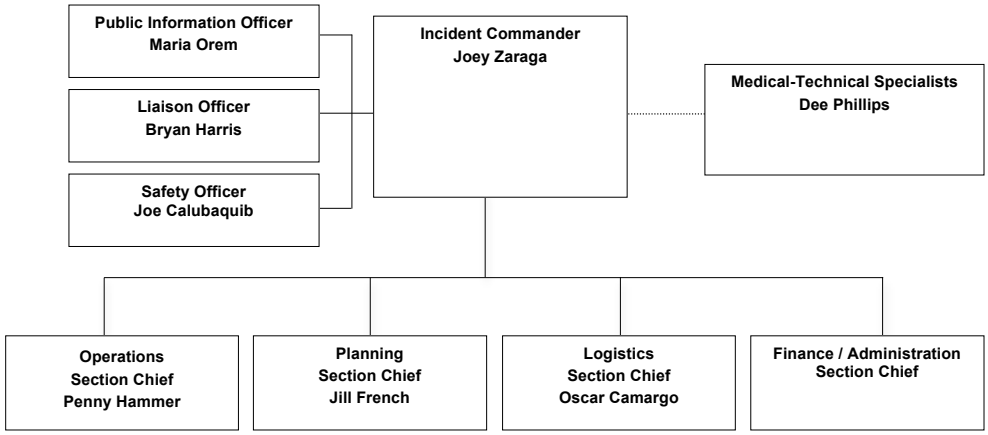
HICS INCIDENT ACTION PLAN (IAP) QUICK START
COMBINED HICS 201—202—203—204—215A

1. Incident Name	2. Operational Period (#1)
2015/10/15 Mass Casualty Incident	DATE: FROM: 2015/11/19 TO: 2015/11/19 TIME: FROM: 1000 to 1400

3. Situation Summary **HICS 201**

Santa Clarita Sheriff report 5 active shooters at 6 Flags Magic Mountain amusement park. Survivors are being transported to HMNH. HMNH EOP activated. Overhead page for Code Triage External drill. 15 Til 50 for Mass Casualty Incident initiated. HCC activated by IC.

4. Current Hospital Incident Management Team (fill in additional positions as appropriate) **HICS 201, 203**



HICS INCIDENT ACTION PLAN (IAP) QUICK START
COMBINED HICS 201—202—203—204—215A

5. Health and Safety Briefing Identify potential incident health and safety hazards and develop necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards. **HICS 202, 215A**

Obtain situational awareness for incident from SCV Sheriff (# casualties), scope, effect, or potential effect of the disaster to the facility and to the facility safety and operational systems.

Coordinate with law enforcement responding to HMNH campus.

Provide local law enforcement with critical HMNH information with per-staged information packet and equip.
Security institutes:

a. Traffic and pedestrian plan implemented by security
b. All ED entrance's locked down
c. Internal Triage is closed

Coordinate with the Hospital Command Center's Liaison Officer and the local law enforcement agency to establish protocols for providing evidence, interviewing patients, and collecting forensic information or data. These protocols should be briefed to ALL triage and treatment area staff once established

Coordinate with the Hospital Command Center's Liaison Officer and Public Information Officer about the need for any joint media coverage, messaging, or press conferences with local law enforcement

Safety Officer will evaluate areas for MCI triage and treatment to ensure they are safe and follow health and safety standards. Safety practices (e.g., sharps disposal, linen control, trash control, biohazard materials control, electrical safety, water, temperature, etc.) in nontraditional areas are followed.

Traffic and pedestrian flow for MCI implemented by Security. Barriers and signage set up to prevent entry into area

Identify PPE needed for the incident or decontamination needed for the incident.

Identify if a chain of custody the survivors is needed for the incident.

Assess: size (# casualties), scope, effect, or potential effect of the disaster to the facility and to the facility safety and operational systems.

6. Incident Objectives **HICS 202, 204**

6a. OBJECTIVES	6b. STRATEGIES / TACTICS	6c. RESOURCES REQUIRED	6d. ASSIGNED TO
Confirm/validate incident	Validate the incident.	Reddinet, LA County Public Health Department, News media, Departments involved, Law enforcement, other trusted sources	Incident Commander
Determine notifications and HICS assignments	Medical Alert Center Levels of notification: AOD and Admin, Triage Alert group Staff, Patients/visitors, Sheriff Assign needed HICS positions	Emergency Notification System Command Aware or telephone	IC, who can instruct scribe to do notification on Everbridge Incident Commander

HICS INCIDENT ACTION PLAN (IAP) QUICK START
COMBINED HICS 201—202—203—204—215A

6a. OBJECTIVES	6b. STRATEGIES / TACTICS	6c. RESOURCES REQUIRED	6d. ASSIGNED TO
Maintain patient tracking	Registration staff initiate patient tracking on HICS 254 and submit copies to HCC every 10 minutes	HICS 254, registration forms	Registration
Provide continuity of care for non-incident patients	Diversion Rapid Discharge	Rapid discharge, diversion for ED for non incident related patients, discharge staging area	ED Case Management
Maintain communications with healthcare and public safety response partners	Provide Sheriff with HMNH critical information	Give Critical Incident kit to law enforcement. HMNH 2 way radio on IC 1 channel, master key, maps/floor plans, location of security CCTV monitoring room, phone/contact list of key hospital personnel, location of HCC, copy of notification sent to staff	Security Branch Director
Ensure the safety of patients, staff, and visitors	Notification of patients and visitors	Traffic barriers, signs	Security Branch
Coordinate the hospital response with the law enforcement incident command system	See safety plan above	HMNH radio channel for Sheriff Traffic barriers and signage Security directing traffic	Security Branch
Return to normal operations as quickly as possible	Demobilization triggers may include: Patient inflow has reached within 5%-10% of the day-to-day average Hospital no longer needs to transfer patients to other hospitals and can fully handle patient inflow internally Incident has stabilized and no additional incident-related patients are arriving at the hospital All remaining incident-related patients have been diverted to another facility	Communication to all unit leaders from the HCC that transition to normal operations will begin. Schedule a debrief	All Unit Leaders Incident Commander

7. Prepared by PRINT NAME: _____ SIGNATURE: _____

DATE/TIME: _____ FACILITY: _____

HOSPITAL INCIDENT COMMAND SYSTEM

Purpose: Short form combining HICS Forms 201, 202, 203, 204, and 215A
Origination: Incident Commander or Planning Section Chief
Copies to: Command Staff, Section Chiefs, and Documentation Unit Leader

HICS INCIDENT ACTION PLAN (IAP) QUICK START
COMBINED HICS 201—202—203—204—215A

PURPOSE: The Incident Action Plan (IAP) Quick Start is a short form combining HICS Forms 201, 202, 203, 204 and 215A. It can be used in place of the full forms to document initial actions taken or during a short incident. Incident management can expand to the full forms as needed.

ORIGINATION: Prepared by the Incident Commander or Planning Section Chief.

COPIES TO: Duplicated and distributed to Command and General staff positions activated. All completed original forms must be given to the Documentation Unit Leader.

NOTES: If additional pages are needed for any form page, use a blank HICS IAP Quick Start and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period**	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	**Situation Summary**	Enter brief situation summary.
4	**Current Hospital Incident Management Team**	Enter the names of the individuals assigned to each position on the Hospital Incident Management Team (HIMT) chart. Modify the chart as necessary, and add any lines/spaces needed for Command staff assistants, agency representatives, and the organization of each of the General staff sections.
5	**Health and Safety Briefing**	Summary of health and safety issues and instructions.
6	**Incident Objectives**	
	6a. Objectives	Enter each objective separately. Adjust objectives for each operational period as needed.
	6b. Strategies / Tactics	For each objective, document the strategy/tactic to accomplish that objective.
	6c. Resources Required	For each strategy/tactic, document the resources required to accomplish that objective.
	6d. Assigned to	For each strategy/tactic, document the Branch or Unit assigned to that strategy/tactic.
7	**Prepared by**	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

15 'TIL 50...

COUNTY OF LOS ANGELES CALIFORNIA

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Henry Mayo Newhall Hospital

PROVIDENCE
Little Company of Mary Medical Center
Torrance

c&a
Constant & Associates