15 ‘til 50

Mass Casualty Incident

Plan Template

TEMPLATE INSTRUCTIONS

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

This Plan Template should be used in conjunction with the companion 15 ‘til 50 MCI Guide. The Guide offers step-by-step instruction on how to develop your plan. For each section and subsection within this Plan Template, corresponding page numbers are provided to the Guide with tips and an explanation of the information that should be provided in that area. Bracketed text is provided where healthcare facility specific information should be inserted.

Acknowledgments

See Guide, p. 20

Development of the 15 ‘til 50 MCI Plan was sponsored by [Insert Sponsoring Organization or Individual] and developed by [Insert Name].

Project Contributors provided strategic guidance regarding guide development, validation, and implementation.

[Include Names of Contributing Agencies, Organizations and Individuals]

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Acronyms

See Guide, p. 20

Introduction

## Overview

See Guide, p. 20

Working at full capacity on a daily basis, hospitals around the country often find that there isn’t a comprehensive plan in place that specifies what will happen within the first 15 minutes of a MCI. [Insert Hospital Name] convened a Planning Team to address this gap at our facility and as part of the research phase came across the “15 ‘til 50” MCI response program. The 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 MCI.  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 (HICS) and can be initiated using existing hospital supplies and equipment.

## Purpose

See Guide, p. 20

The purpose of this 15 ‘til 50 Plan is to prepare [Insert Hospital Name] to rapidly deploy staff, supplies, and equipment in the event of an MCI. The plan covers pre-incident measures such as coordination and procurement of equipment. It also covers the phases of incident management: activation, operation, and transition into either ongoing emergency operations or demobilization. It is applicable to events that test medical surge capacity. The planning framework falls within what the 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

See Guide, p. 20

This plan is intended to supplement pre-existing Emergency Operations Plans (EOP), which have been created using an all-hazards model. Therefore, this plan may be used for any type of incident, whether the cause is natural, human-induced, or a technological event. This plan applies to all departments, personnel, and agents of [Insert Hospital Name].

## Assumptions

See Guide, p. 21

Assumptions that the Planning Team made when constructing the plan include:

* [Insert Hospital Name] already has emergency plans, procedures and policies in place. This plan is meant to supplement, not replace existing plans
* “15 minutes” is counted from the moment the plan is activated/initiated, not from the moment the incident starts
* Your 15 ‘til 50 MCI response plan will involve multiple departments [Insert Hospital Name], 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
* The Hospital Command Center (HCC) and HICS will be activated immediately following notification of an MCI

Pre-Incident

## Training and Exercise Schedule

See Guide, p. 22

[Insert Hospital Name] Multi-year Training and Exercise Schedule [Year]

| **Department** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Department 1** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Department 2** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Department 3** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Department 4** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Department 5** |  |  |  |  |  |  |  |  |  |  |  |  |

## Supplies and Equipment

See Guide, p. 24 and 63

[Insert Hospital Name] has procured and prepositioned caches specifically for 15 ‘til 50 activation. These include:

* 15 ‘til 50 “Go-Kits”
* Mobile Storage Units/Trailers
* Command Center Supplies

A detailed list of supplies and equipment for each element above can be found in [Insert Appendix Number]. The lists were created based on [Insert Hospital Name]’s capacity. Supplies are located [Insert Locations of Supply Caches]. A map of the facility with caches marked is included as [Insert Appendix Number] within this plan. All prepositioned supplies and equipment for the 15 ‘til 50 program will not be used for day-to-day operations. [Position Within Hospital] will re-evaluate supplies [annually/bi-annually/monthly] as well as after each and every exercise and incident.

See Supplies and Equipment Appendix for a full list of resources.

Activation

The notification of a MCI may come to the hospital in any one of numerous formats; ‘walking wounded’ arriving at the hospital, a staff member noticing a breaking news story on the television, or messaging from a regional government agency. It might be immediately obvious that [Hospital Name] will be handling an MCI, or the scope of the MCI might not be clear for some time. Regardless of how [Hospital Name] is informed of an MCI, the decision must be made to activate the 15 ‘til 50 Plan.

## Authorization to Activate

See Guide, p. 25

Regardless of time or staffing, the decision to activate the 15 ‘til 50 plan will be made by the [designate position title that ultimately determines to activate the MCI. This may be the Incident Commander or other designated HCC staff] in conjunction with [insert the title of any other personnel who should also be involved in determining the plan should be activated]. Information to consider when determining whether the 15 ‘til 50 Plan should be activated includes:

* Location of the incident and its proximity to [Hospital Name] and other healthcare facilities
* Type of incident
* Number of persons injured in the incident, and the severity of those injuries
* The need to quickly triage injured persons and/or the need to coordinate their transportation to other healthcare facilities

## Notification

See Guide, p. 25

When the [position title] and [position title] have determined that an MCI has occurred and that the hospital must prepare for surge capacity, [position title] will announce the activation to all department heads via [intercom, verbally, via the established phone tree, etc.].

As the 15 ‘til 50 Plan involves all hospital departments, it is important that all departments be made explicitly aware that the 15 ‘til 50 Plan is being activated. To accomplish this, the code over the intercom will explicitly state “Attention all staff, a [code triage] has been called. All staff are to report to their positions and prepare to support [code triage].”

In addition to hospital personnel who must be notified that the plan has been activated, the following external partners should be notified that the hospital is responding to an MCI and that surge plans have been activated:

[Tailor the following chart for organizations, departments, or personnel outside the hospital that must be notified that the 15 ‘til 50 and/or surge plans have been activated.]

|  |  |  |  |
| --- | --- | --- | --- |
| **Organization/Department** | **Point of Contact** | **Contact Information (phone, email, etc.)** | **Position Responsible for Notifying** |
| [Fire Department] |  |  |  |
| [Hospital CEO] |  |  |  |
| [Police Department] |  |  |  |
| [City or Special District EMS] |  |  |  |
| [Hospitals with which we have mutual aid] |  |  |  |
| [Other area hospitals] |  |  |  |
| [Ambulance company] |  |  |  |

## Coordinate Staffing and Prepare Staff for Activation

See Guide p. 26

Upon announcing that the 15 ‘til 50 Plan is activated, staff assigned 15 ‘til 50 responsibilities should grab their activation kits, which contain [vests, job action sheets, and admissions forms]. Staff should also immediately begin following their specific protocols and procedures, including reporting to their assigned location/supervisor, and carrying out tasks that directly support the 15 ‘til 50 effort.

As the Plan is activated, [Case Management] will immediately begin working with physicians and nursing staff to begin the rapid discharge of inpatients and Emergency Department patients. The goal of this step is to free up as much hospital space as possible in order to accommodate the influx of survivors expected related to the MCI.

Upon activating the 15 ‘til 50 Plan, the process of recalling key hospital staff and personnel must also begin. After internal notification to all departments and on-site personnel, the [Planning and Logistics Section Chiefs] should quickly assess the current staffing and determine the need for additional personnel. Considerations when determining the number and type of staff to recall include:

* Type of incident
* Type of injuries
* Anticipated number of patients
* Anticipated length of incident response
* Anticipated role of ancillary and support departments

Using established procedures for recalling hospital staff (see [Insert Appendix Number]) the [Logistics Section Chief] will make notifications and ensure adequate personnel are recalled to support ongoing surge capacity in the Hospital. While the initial 15 ‘til 50 response will likely be handled by staff already at the Hospital, it is important to begin making notifications and requesting additional personnel as soon as the decision is made to activate the plan. [Logistics] will also keep a list of key contact information for all personnel involved in incident response.

[Tailor this chart for to show which positions shift into a new role under the 15 ‘til 50 Plan. Include position titles during daily operations, position titles during 15 ‘til 50, and physical location they are to report to.]

|  |  |  |
| --- | --- | --- |
| **Daily Position Title** | **15 ‘til 50 Position Title** | **15 ‘til 50 Location** |
| [Charge Nurse] | [Triage Unit Leader] | [Triage and Treatment Area] |
| [Facilities Supervisor] | [Logistics Section Chief] | [HCC] |
| [Nurse Supervisor] | [Incident Commander] | [HCC] |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Deploy Supplies and Equipment

See Guide, p. 27

Upon activation of the Plan, the [Logistics Section] will begin distributing, deploying, allocating, and tracking resources. [Logistics] must deploy staff to [location where 15 ‘til 50 supplies are stored] and unlock containers, release necessary materials, track which resources are being sent to the triage site, and ensure the proper flow and tracking of all resources released. [Logistics] will set up direct lines of communication to the Incident Commander and the [Triage Unit Leader].

## Hospital Command Center

See Guide, p. 28

Upon activation of the 15 ‘til 50 Plan, the HCC will be activated. [Position title] is responsible for activating the HCC following procedures set forth in the HCC Plan. Logistics will supervise the distribution of radios, ensuring each radio is signed out and tracked before being released. Upon arriving at and activating the HCC, [position title] will notify the [position title, likely Triage Unit Leader] that the HCC is open and that resource requests and information will be sent to the HCC.

#

Operations

## Triage

See Guide, p. 29

Some special challenges faced in MCI triage could include:

* Mixed Chemical, Biological, Radiological, Nuclear, or Explosive (CBRNE) casualties
* Responder protection and safety
* Crime scene management and evidence preservation

Therefore, all 15 ‘til 50 triage staff will abide by the following actions during triage:

* Evaluate each patient individually before making decisions
* Determine any possible hazards associated with each patient (i.e. CBRNE hazards)
* Use appropriate Personal Protective Equipment (PPE) as necessary
* Remain in the appropriate areas (do not leave your assigned zone unless directed otherwise)
* Never make a triage decision based on a perception that there are too many “Reds” or not enough “Greens,” no matter what your capacity is
* Always lean on the side of higher priority. For example, if unsure of whether the patient is green or yellow, the patient should be tagged yellow
* Preserve items as much as possible, including the patient’s personal items or clothing, for use in later evidence processing if necessary

The basics of your S.T.A.R.T. Triage process include the following:

* Separate the patients into ambulatory and non-ambulatory
	+ If not already included in your triage site setup, triage staff might want to demarcate a separate line for nonambulatory patients coming in on gurneys, using traffic cones and caution tape
* Initial Patient Assessment (should take less than one minute for each patient)
	+ Interview each patient (or accompany EMT or paramedic) for the main complaint and the location from which the patient is coming from
	+ Tag each patient (omit personal information on the tag for now and concentrate only on the main complaint, the need for decontamination, and the type of injury) according to the following:
		- Confirmed deceased – Tag Black
		- Unresponsive – Tag Red
		- Severe bleeding or severe injury – Tag Red
		- Minor injuries – Tag Yellow or Green
		- Walking Wounded – Tag Green
		- Possibility of CBRNE-related injury – Note for Primary or Secondary Decon
* Secondary (Advanced) Patient Assessment
	+ Depending on the surge of patients, the 15 ‘til 50 triage staff may have the resources and time to perform a full assessment for better triaging during their initial assessment. However, if there is a large surge of patients, triage staff will separate into two groups: those who conduct initial triage and tagging, and those who make the rounds of the tentative treatment areas to measure the following:
		- Respiratory Status
			* No respiration – check for obstruction
			* Still no respiration – Tag Black
			* R > 30 – Tag Red
			* R < 30 – Check perfusion
		- Perfusion
			* No pulse – Tag Black
			* P > 2 seconds – Tag Red
			* P < 2 seconds – Check mental status
		- Mental Status
			* Those who cannot follow simple commands – Tag Red
			* Those who can follow simple commands – Tag Yellow or Green
			* Be sensitive to those who:
				+ Don’t speak English
				+ Have hearing deficiencies
				+ Have mental impairment
	+ Re-tag patients as necessary and direct them to the appropriate treatment area

See the following page for a depiction of triage.



## Treatment

See Guide, p. 29

Once patients have moved past the Triage area and have been directed to either Immediate, Delayed, Minor, or the Morgue, treatment will follow the orders/discretions of the treatment area MD.

[All 15 ‘til 50 Treatment staff will complete the following priority items before moving on to administrative items:

* Direct or move the patient to an available cot, chair, or section of the treatment area
* Take vital signs and record on the triage tag
* Open the airway and insert any necessary Oropharyngeal Airways (OPA)
* Stop the bleeding
* Elevate the legs for shock
* Administer oxygen
* Identify necessary specialties (i.e. general surgery, anesthesiology, radiology) who may need to consult on the patient
* Identify necessary medications or treatment recommendations and report to the Treatment Unit Leader
* Identify patients recommended for transport to other areas of the hospital or other facilities and report to the Treatment Unit Leader

Once initial treatment has been made, staff can complete the following items for each patient:

* Ask the patient for their name, age, and personal information
* Fill out the [Insert your hospital’s appropriate quick admit form] and assign a patient ID #
* Bag all personal items in a Ziploc bag and label with the patient’s ID # and include the tear-off Personal Property Receipt from the Triage Tag (if available)
* Fill out any necessary x-ray or test request forms and drop into the appropriate box
	+ Radiology or x-ray staff should have a box or boxes in the treatment areas designated for quick test requests. These staff should periodically check the boxes and assign staff to transport those patients to the appropriate areas
* Provide the patient with water or food if necessary
* Provide patient privacy if possible and/or appropriate. Staff can use tents, sheets, portable showers, or whatever is on hand to provide privacy
* Refer separated family members to the Family Information Center (FIC) or hotline]

The Treatment Unit Leader will regularly report the status of Treatment Area capacity, recommended patient transports, treatment area resource requests, staffing capacity, and security issues.

## Security

See Guide, p. 30

Upon activation of the 15 ‘til 50 Plan, hospital security staff will immediately begin the process of setting up traffic control, internal security, and law enforcement coordination, before assisting with setup of the mobile triage site.

One of the most important aspects of MCI response is the management of ingress and egress routes to the mobile triage area. Hospital security will first coordinate with the HCC
to confirm the location of the mobile triage area, and which ingress and egress routes will
be used. The egress route used to evacuate patients from existing departments must be separate from the ingress routes used to process incoming patients when the MCI Plan
is active. Initial actions for hospital security staff are categorized and outlined in more detail below:

### Traffic Control

* Confirm the location of the mobile triage site with the HCC
* Confirm the lockdown and/or evacuation of hospital departments in coordination with the HCC, ED staff, and Triage and Treatment Unit Leaders
	+ For example, the ED should be locked to incoming patients (who will now be redirected to the mobile triage site) and the waiting room evacuated and redirected to the mobile triage location
* Retrieve traffic cones, caution tape, and directional signage from the [mobile triage equipment storage (located in Storage Unit 3)]
* Establish ingress routes for emergency vehicles arriving at the mobile triage site and demarcate with appropriate signs and equipment
* Establish ingress routes for incoming pedestrians and “walking wounded” arriving at the mobile triage site and demarcate with appropriate signs and equipment
* If not already existing, create a traffic flow map and send a copy to the HCC and the Triage and Treatment Unit Leaders

### Internal Security

* Post security staff according to the established ingress and egress routes, taking into consideration the safety of the facility (i.e. if the hazard was an earthquake that affected the integrity of hospital facilities) and estimates of incoming surge amounts. Coordinate with the HCC and Engineering
* Ensure that all security staff are equipped with radios
* Ensure that security personnel are posted in the Family Information Center,
the Treatment Area, and the Triage Area
* Establish a secure perimeter around the hospital
* Advise all hospital staff to be on the alert for suspicious behavior [use “Code Alert” on the Intercom to notify staff]

### Law Enforcement Coordination

* Activate any existing MOU agreement with local law enforcement to call in additional security personnel, especially if the hospital may be considered a secondary target of terrorist attacks
	+ Contact [insert local law enforcement agency] to activate the MoU and request an additional [six deputies] to assist with triage and treatment
	area security
	+ Ensure incoming law enforcement personnel have parking and identification
	+ The Security Branch Director will be in charge of debriefing incoming law enforcement personnel on internal processes, flow maps, radio protocols, and role assignments
* Coordinate with the HCC’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 HCC’s Liaison Officer and Public Information Officer (PIO) about the need for any joint media coverage, messaging, or press conferences with local law enforcement

## Patient Processing

See Guide, p. 31

Patient processing involves the ongoing efforts of intake and case management staff to facilitate rapid admission, patient tracking, and discharge throughout triage. Intake and case management staff in the Treatment Unit will complete the following priority items for each patient:

* [Ensure that the [insert your hospital’s appropriate rapid admission form] forms have been completely and accurately completed for each patient
* Fill out PsySTART triage tags for each individual to evaluate possible mental health crises or emergencies
* Ensure that personal property is tagged and stored in an appropriate location
* Facilitate the discharge process for minor or delayed treatment patients
* Monitor the treatment areas for possible HIPAA violations (i.e. forms lying out where other patients can easily read or view them)
* Monitor for low quantities of admit forms or triage tags
* Follow-up with patients regularly and check for patients who can be moved to a lower treatment area or discharged
* Report intake or discharge information to the Treatment Unit Leader]

## Communications

See Guide, p. 32

HCC staff is in charge of overall communications throughout all areas of the hospital. The Triage and Treatment Unit Leaders will serve as the main points of contact between the mobile triage area and the command center. As such, both of these positions will need to be equipped with radios as early as possible in the 15 ‘til 50 activation process. If radios are not deemed appropriate or viable based on the needs of the incident, the Incident Commander at the HCC must establish an alternate means of communication and notify all hospital staff immediately.

The Liaison Officer will serve as the primary point of contact for other agencies, including the local public health department, the local Emergency Operations Center (EOC), the entity that coordinates the transfer of patients, local fire and law enforcement personnel, and the FBI for federal investigations or the CDC for specific public health emergencies. The Liaison Officer will notify relevant agencies when the 15 ‘til 50 process has been activated, and when it has been deactivated. The Liaison Officer will schedule regular status update phone calls with each agency to keep them apprised of the incident and any requests for assistance.

The [Planning Section Chief] is responsible for collecting regular [(at least every 5 minutes during site setup, and every 10-20 minutes during triage and treatment operations)] radio status updates from the Triage and Treatment Unit Leaders, the on-duty staff in each hospital department, and hospital security staff. Status updates will include:

* The status of site setup
* The status of any missing equipment
* The number of incoming patients
* Safety issues
* Security violations
* Requests for assistance

The PIO will take charge of all communications with the public and the media,
in coordination with the FIC. All other staff need to refrain from speaking with the media or posting incident details to social media. Requests regarding patient information or missing family members will be directed to the Family Information Center’s hotline. As soon as 15 ‘til 50 has been activated, the Public Information Officer will coordinate with the Liaison Officer and other PIOs at other agencies to draft media messaging, notify internal staff of policies for speaking to the media, and begin rumor control.

## At Risk Populations

See Guide, p. 34

During a medical surge some patients might have difficulty in accessing public health or medical services. Children, people with access or functional needs, those for whom English is a second language, those who are chemically dependent or mentally ill are all potentially at-risk populations.

All Triage and Treatment staff should look out for potential at risk individuals within the arriving patient population, and in addressing them accordingly or referring them to the appropriate staff.

*Children or unaccompanied minors* will be referred to treatment specialists as well as the Family Information Center for family reunification. If a child is with a parent, they will not be separated unless the child is interfering with treatment. The Family Information Center will be supplied with toys, books, and coloring books to keep children occupied while waiting for family members. Staff at the Family Information Center will fill out Unaccompanied Minors forms when applicable and assist with family reunification. See the “Family Information Center” section below for more information.

For those with *access and functional needs*, staff will make every effort to accommodate their needs. The Triage and Treatment Area will take every reasonable action to achieve full accessibility. The Treatment Unit Leader and Triage Unit Leader are responsible for evaluating the site for accessibility issues during site set-up, and providing solutions or recommendations. If extra equipment is necessary, requests will be communicated to the Command Center through the Unit Leaders.

Portable translator equipment and/or volunteer staff translators are included in the 15 ‘til 50 setup for *those for whom English is a second language.* If a patient arriving at triage does not speak English, sign language will be utilized when possible, and translation (through equipment or personnel) will be requested through the Unit Leaders.

Those *who are chemically dependent or those with existing mental impairments* will also need to be accommodated. Case management staff that have been appropriately trained [insert relevant hospital experience and/or training for your facility] will be activated as part of surge staffing to consult on patients with these pre-existing conditions and to check on them regularly.

*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, away from medical treatment areas, where information can be shared to facilitate family reunification, and to provide access to support services (social services/mental health, spiritual care). Case Management and Social Services staff will activate the FIC under the Operations Section as the Patient Family Assistance Branch, in coordination with Pediatrics and/or Patient Registration department personnel. Supplies, job action sheets, sign in sheets, toys and materials for children and other items are located in the FIC go-kit and are ready for deployment in any 15 ‘til 50 activation. [Insert location of FIC supplies/go-kit here].

Immediately following activation of the 15 ‘til 50 Plan, the FIC will be activated. Any medical surge incident will call for family information and reunification resources.

### FIC Activation

Initial activation includes minimum staffing for FIC functions and provide for escalation of staffing as required. Activities listed herein are part of coordinated emergency operations as directed by the Incident Commander or designee.

The Incident Commander, along with other Command staff, will determine based on the nature of the incident, the extent of staffing needed to support the activation and operation of the Family Information Center. The FIC is supported by departments across the healthcare facility, including facility maintenance, procurement, security, and others. Activities such as patient tracking and next of kin (NOK) notification will be conducted in accordance with existing policies and procedures.

Sample FIC Checklist (from: Family Information Center Planning Guide for Healthcare Entities)

* Command center initiates call down of pre-identified FIC Staff
* Logistics Section secures pre-identified FIC location and prepares for occupancy
* Logistics Section obtains and positions equipment and supplies
* A call center is established as part of the FIC or existing center is augmented to handle increased volume. The healthcare facility operator is given the extension for the call center and staff are prepped to begin receipt of telephone inquiries
* The FIC is inspected for safety issues; identify and correct any safety hazards. FIC staff report to the FIC, register, and obtain authorized entry badges, forms and supplies
* Security established security procedures
* Position directional signage at the facility entrance and elsewhere as needed to direct family members to the FIC
* Designated JIT Trainer conducts JIT Training if necessary and available
* The Family Reunification Unit Leader (or equivalent position) notifies hospital administration and the Command Center that the FIC and call center are activated
* The Command Center notifies all staff that the FIC and call center are activated
* The Command Center notifies the local EMS Agency or Emergency Management Agency EOC, and local media (if necessary) that the FIC is activated

Sample Unaccompanied Minors Action Item Checklist (from: *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

## Mental and Behavioral Health

See Guide, p. 36

15 ‘til 50 utilizes the PsySTART triage system to rapidly triage mental health status during an MCI. This triage strategy will help identify individuals who are experiencing a mental health crisis or emergency, and those who are at risk for chronic mental health disorders.

Triage staff (those assigned to Secondary Assessment or those from Case Management) will use the PsySTART triage forms to measure the following:

* Impact of severe/extreme stressors
* Severe or extreme exposure to traumatic incidents (i.e. death, suffering, delays in treatment or evacuation, exposure to toxic agents)
* Traumatic loss (loss of family, including missing family members)
* Secondary impacts (home loss, relocation, job loss, decreased social support)
* Injury or illness (missing limbs, extended health risks)
* Expressed peri-traumatic severe panic (subjective risk)
* Practical considerations for case management (housing, unaccompanied minors)

## Staff Support Services

See Guide, p. 37

MCI incidents will create a significant amount of stress on responders and staff. Case management staff should monitor the triage and treatment area staff for the following and report cases to the appropriate Unit Leaders:

* Responder fatigue, panic, or depression
* Confusion or tension among Triage or Treatment staff
* Supplies of food and water for staff as well as patients
* Responder injuries and safety issues
* Fears about contamination and/or CBRNE-related dangers
* Concerns from staff about the safety and well-being of family members
* Lack of adequate staff leading to responder stress and difficulties prioritizing treatment

Transition

Transition marks the time that hospital operations move from triaging and treating a surge of patients back into more standard operations. The transition period allows for resources to be demobilized and personnel to return to their normal positions. The following steps will be taken in order to ensure a measured demobilization and transition into standard hospital operations, and is a crucial step in proper surge response.

## Authority to Transition

See Guide, p. 39

The decision to transition from surge/MCI response into normal daily operations will be made by [the Incident Commander, or other designated authority] based upon information received from the HCC and the Triage Unit Leader. The decision to transition will be made based on information about the MCI, the ongoing threat or hazard, the inflow of patients to the triage and treatment area, and the availability of resources and space in the hospital. In most situations, the decision to transition to normal operations will be a subjective decision based on available information. However, depending on the size, type, and scope of the situation, “demobilization triggers” may be used to determine that a transition to normal operations should take place. These “demobilization triggers” include:

* [Patient inflow has reached within 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 incident-related patients have been diverted to another facility]

Upon deciding that transitioning to normal operations is in the best interest of the hospital and patients, [the Incident Commander] will set a specific time to begin demobilization, and communicate this time to all unit leaders and the HCC. It should be noted that not all areas will necessarily transition at the same time. If establishing staggered transition times, a list of areas and times should be developed and distributed to all unit leaders and the HCC.

## Notify Stakeholders

See Guide, p. 40

Notification of internal hospital personnel will follow much the same procedures as activating the 15 ‘til 50 Plan. Upon the decision to begin Transition, [the Incident Commander] will verbally, either in person or over the radio, tell all unit leaders that the operation is moving into transition at the designated time. If Transition is staggered at different times for different units, a written schedule should be developed and distributed to all unit leaders in a timely manner. Regardless of whether Transition times are staggered or not, all unit leaders should be reminded that they must officially notify the [Incident Commander] when their unit has ‘closed’ and fully transitioned to normal operations. As such, the [Incident Commander] will be the last position to demobilize.

External stakeholders must also be notified of transitioning operations and demobilization. The HCC will notify external stakeholders, via the [Liaison Officer] position, that operations are transitioning back to normal status. All external stakeholders that were involved in response efforts or coordinating with the hospital will be notified. This includes, but is not limited to, [local ambulance companies, County Emergency Medical Services, and hospital executives].

Lastly, off-duty hospital personnel should also be informed of the changing status of hospital operations. Staff not at the facility should be notified via the phone tree that hospital operations are transitioning at the designated time, and that at that time normal schedules and responsibilities will be back in place. [Logistics] is responsible for activating the phone tree and ensuring that all personnel are notified of the changing status of operations.

## Transition Operations

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Demobilization procedures will follow the [HICS 221 Demobilization Checklist]. All units and personnel should follow demobilization procedures, including tracking and returning resources, demobilizing personnel back to their regular positions and responsibilities, and collecting all paperwork. All resources must be received and tracked by [Logistics]. The [HCC] should collect all paperwork. [Note: If your facility does not already have a Demobilization Checklist as part of its other emergency operations plans and policies, use the HICS 221 Demobilization Checklist provided in the 15 ‘til 50 Toolkit as a starting point.]

Upon the decision to begin Transition and notification of stakeholders, the [Public Information Officer] should be briefed on hospital operations and response to the MCI. The [Triage Unit Leader] and [Incident Commander] should work with the PIO to prepare a message detailing overall patient intake, ongoing family information and next-of-kin notification efforts and the successes of the response. The public message during or immediately following Transition should specify that hospital operations are returning to normal, and that regular appointments and intake procedures will be followed henceforth. During and immediately following Transition, the PIO should receive a full briefing on all elements of hospital response, in order to ensure that they are fully able to answer questions in the future.

As part of transition, a designated time and place for a staff debrief or hot wash should be detailed. If the MCI response effort has been short and involved only one operational period, this hot wash should take place immediately after the end of operation. If the MCI response has spanned multiple shifts or days, a designated debrief time should be set with sufficient notice so as to ensure that as many staff participants can attend as possible. The [Incident Commander] will set the date, time, and location of the debrief or hot wash, and will communicate this to all unit leaders. [Logistics] will also set up a conference call line for those who need to participate in the hot wash/debrief but are unable to attend in person. The [Incident Commander] will lead the hot wash/debrief. Depending on the size and scope of the incident, it may be necessary to schedule more than one hot wash/debrief.

Appendices

The appendices can be tailored to your medical center’s specific needs. Below are sample appendices that might be considered.

**JIT Training**

**Activation Checklists**

**Demobilization Checklist**

**Job Aids for CBRNE Incidents**

**Equipment and Supplies Checklist**

**Staffing Requirements**

**Departmental Roles**

**Unaccompanied Minors Checklist**

**Job Action Sheets**

**Surge Intake Forms**

**Organization Chart**

**Hospital Map**

**Equipment and Supplies Map**

**Triage and Treatment Map**