MASS CASUALTY PROTOCOL
&
PROCEDURE MANUAL

Version 3.0 2013

CHARLES COUNTY

CHARLES COUNTY
EMERGENCY SERVICES

MASS CASUALTY

PROTOCOL & PROCEDURES MANUAL

VERSION 3.0

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Approved by:

William Stephens, Director of Emergency Services

James Mitchell MD, Medical Director

Bill Deer, President; Charles County Association of EMS

George Hayden, President; Charles County Volunteer Firemen's Association

Wally Danielson, Fire Chief; Charles County Volunteer Firemen's Association

Doug Hutchins, Special Operations Chief; Charles County Volunteer Firemen's Association

Brent Huber, EMS Chief; Charles County Association of EMS

Authored by:

John Filer, EMS Chief

Contributions by:

Ronnie Burns, EMS Chief 12B
Andrew Spalding, EMS Chief 14
Roberta Spalding, EMS Chief 58
Doug Hutchins, Chief 1B
Stephen Finch, Asst. Chief of EMS DES
Kelly Layfield, Intern

Table of Contents

Table of Figures

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I. Introduction

A. General

1. Charles County, Maryland is at risk from a variety of hazards that may affect the citizens that live, work and commute here. Tornadoes, floods, blizzards and other natural disasters can, and do, affect the area. In addition, major disasters such as transportation accidents, explosions, accidental releases of hazardous materials, nuclear power plant emergencies, biological hazards, acts of domestic terrorism, disease outbreaks and national security emergencies pose a potential threat to public health and safety of Charles County.

2. Realizing the vast variety of hazards that the region is potentially exposed to; The Charles County Department of Emergency Services in conjunction with the Charles County Volunteer EMS Association and the Charles County Volunteer Fire Association have developed these guidelines to assist in the planning, response and mitigation of Mass Casualty Incidents and Major Hazardous Materials Incidents in and around Charles County.

3. In the event of a MCI disaster, the need for a well-coordinated response is paramount to the successful mitigation of the incident. By utilizing these guidelines and training personnel to respond and operate in a standardized format, the stress, confusion and chaos of this type of disaster can be greatly reduced. Standardizing the response increases the safety of the responding personnel, ensures consistency in response Countywide; allows for smooth transition of incoming mutual aid units and provides for the highest competency of patient care possible.

B. Purpose

1. The purpose of the Charles County Department of Emergency Services *Mass Casualty Incident Protocol & Procedures Manual* is to inform, direct and advise personnel of the Charles County Department of Emergency Services, Charles County Volunteer EMS Association and the Charles County Volunteer Fire Association of the proper performance standards and procedures when operating in or around mass casualty incidents. The following is a set of guidelines and procedures adopted by the Charles County Department of Emergency Services, Charles County Volunteer EMS Association and the Charles County Volunteer Fire Association and approved by the Jurisdictional Medical Director's Office. While each incident is unique

in its own creation, operation and mitigation; every effort should be afforded to follow these recommended guidelines.

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II. Operations

A. Policy

1. The primary concern for all personnel operating on the scene of a MCI shall be the immediate life, health and safety of the responder and the public.

2. Scene stabilization will be the secondary concern of responding personnel so long as it does not endanger the life, health or safety of said responders.

3. Property preservation will be the tertiary concern of responding personnel followed by any environmental concerns so long as it does not endanger the life, health or safety of said responders.

4. Upon the occurrence and/or declaration of a Mass Casualty Incident, all personnel involved shall operate under the **National Incident Management System & Incident Command System** model.

5. In most incidents where a MCI has occurred, an appropriate Command structure will be established with participating command elements of the (Fire, EMS, Public Works/Highway and Law Enforcement agencies, etc.) responding agencies present.

6. Command and Control personnel shall be visible and functionally defined by the use of *Color Coded Vests with Bold Identifying Titles*.

7. Communications performed on or around incidents involving a MCI will be verbalized in plain, clear and concise language. The use of "10" codes and slang are prohibited for such operations.

8. Personnel responding to a MCI shall display and utilize the **Personal Accountability System.**

9. Response personnel shall possess the following;

    a) Appropriate credentials for their performance function.

    b) Proper PPE ensemble for the type of incident.

    c) An approved Personal Accountability Tag.

10. No person shall operate within the set parameters of the MCI unless they are in full possession of the above-mentioned items.

11. Those persons attempting to do so will be detained and possibly face criminal prosecution by Law Enforcement.

12. Any injured, ill or deceased persons from such incidents will be triaged utilizing the **Maryland START Triage System**.

13. Only State of Maryland approved, color coded triage tags shall be used when triaging and treating patients.

14. Personnel operating at a MCI Incident shall be organized in two (2) person teams with at least one (1) portable radio for communication.

15. At the end of every incident, all participating personnel may be debriefed for stress and crisis intervention purposes. (If requested)

16. No MCI Operation shall be terminated until all participating personnel have been accounted for and every Personal Accountability Tag has been returned to its rightful owner.

B. Terminology

1. For the purposes of uniformity and standardization, the following classifications of MCI Incidents shall be recognized and communicated as;

   a) **Multi Casualty Incident:** Any illness or trauma-related event that meets at least one of the following criteria:

      (1) Kills five (5) or more persons

      (2) Affects or injures 3-9 persons

   b) **Mass Casualty Incident:** Any illness or trauma-related event that meets at least one of the following criteria:

      (1) Kills ten (10) or more persons

      (2) Affects or injures 10-99 persons

c) **Catastrophic Mass Casualty Incident:** Any illness or trauma-related event that involves one hundred (100) persons or greater.

2. The abbreviation *MCI* may be used to describe any of the above listed incidents however verbalization/communications and actual statutory required incident reports must be described in full during life scenarios and operations.

C. Types of Events or Incidents

1. There are three (3) categories of an incident that may require the use of mutual aid plans. Although these are described below in general terms, there may not be a clear demarcation between categories. Assessment of the need for any resource is the responsibility of any incident commander.

   a) Short Term Active Events (1-2 days in duration)

      (1) These are events requiring an individual unit responding to a single patient up to a multiple casualty event requiring multiple units to assist a jurisdiction in a response. It may require a jurisdiction providing mutual aid to request assistance from other jurisdictions. It may also require the use of commercial services that lie in proximity to the incident. This configuration of response could potentially be supported for 1 to 2 days.

   b) Sustained Events (more than 2 days in duration)

      (1) These are events that will extend beyond a couple of days or are expected to activate more than 3-4 mutual aid agreements. In this case additional resources and/or management or support teams may be requested from distant jurisdictions, state, out of state or federal agencies.

   c) Planned Events

      (1) These events are those that have some notice on the specific needs for a response and resources can be scheduled to be in place prior to its occurrence. These may include mass gatherings, reception of refugees from a distant event or the formal National Disaster Medical System patient reception.

III. Definitions

Advanced Life Support:	An ambulance capable of delivering advanced skills performed by Emergency Medical Services (EMS) practitioners.
Advanced Life Support Provider:	A practitioner credentialed by a State to function at the advanced life support (ALS) level in the State Emergency Medical Services (EMS) system.
Air Ambulance:	A rotary-wing aircraft configured, staffed, equipped to respond, care for, and transport patients. A rotary-wing aircraft must be approved/licensed by a State to do so.
Assigned Resource:	Resource checked in and assigned work tasks on an incident.
Assisting Agency:	An agency or organization providing personnel, services, or other resources to the agency with direct responsibility for incident management. See Supporting Agency.
Available Resources:	Resource assigned to an incident, checked in, and available for a mission assignment, normally located in a Staging Area.
Base:	The location at which primary logistics functions for an incident are coordinated and administered. There is only one Base per incident. The Incident Command Post may be collocated with the Base.
Basic Life Support (BLS) Ambulance:	An ambulance capable of delivering basic emergency interventions performed by Emergency Medical Services (EMS) practitioners trained and credentialed to do so.
Cache:	A predetermined compliment of tools, equipment, and or supplies stored in a designated location, available for an incident use.
Camp:	A geographical site within the general incident area (separate from the Incident Base) that is equipped and staffed to provide sleeping, food, water, and sanitary services to incident personnel.
Casualty Collection Point (CCP):	Serves as a location near the incident site, which provides areas to triage, treat and transport victims in a MCI. Usually located in the “Cold Zone”.

Cold Zone:	An area of the incident that has been determined free/safe of harm, relative danger and health risk to operational personnel and victims. Usually upwind from an incident.
Command Staff:	The staff who report directly to the Incident Commander, including the Public Information Officer, Safety Officer, Liaison Officer, and other positions as required. They may have an assistant or assistants, as needed
Command Mode:	Certain incidents, by virtue of size, shape, complexity or potential for rapid expansion require immediate, strong and direct overall command. In such cases the Company Officer will initially assume a stationary command position and maintain that position until relieved by a higher authorized rank.
Command Post:	The location from which primary command functions are executed.
Commercial Ambulance Services:	Private ambulance companies who are recognized and currently licensed by MIEMSS State Office of Commercial Ambulance Licensing and Regulation, who collectively have a large fleet of transport ambulances, EMS Providers and administrative staff. Primary responsibilities include providing inter-facility medical transportation.
Crew Transport:	A vehicle capable of transporting a specified number of crew personnel in a specified manner.
Critical Incident Stress Management (CISM) Systems:	A wide range of programs and services designed to prevent and mitigate the effects of traumatic stress on public safety personnel and first responders. These resources include a Critical Incident Stress Management Team which is responsible for the prevention and mitigation of disabling stress among emergency responders in accordance with the standards of the International Critical Stress Foundation (ICISF).
Dispatch:	The ordered movement of a resource or resources to an assigned operational mission, or an administrative move from one location to another.
Dispatch Center:	A facility from which resources are assigned to an incident.

Division:	Divisions are used to divide an incident into geographical areas of operation. A Division is located within the ICS organization between the Branch and the Task Force/Strike Team. (See Group) Divisions are identified by alphabetic characters for horizontal applications and, often, by floor numbers when used in buildings.
Emergency:	Any incident, whether natural or manmade, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.
Emergency Management Assistance Compact (EMAC):	A congressionally ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster-affected State can request and receive assistance from other member States quickly and efficiently, resolving two key issues up front: liability and reimbursement.
Emergency Medical Task Force:	Any combination of resources assembled for a medical mission, with common communications and a leader.
EMS Ambulance Strike Team:	A team comprised of five (5) resources of the same type with a Group Supervisor and common communications capability.
EMS Ambulance Task Force:	A team comprised of any combination of ambulances, within the span of control, with common communications, and a leader of five (5) resources.
Emergency Operations Plan:	An ongoing plan for responding to a wide variety of potential hazards.

Emergency Operation Center (EOC):	The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., Federal, State, regional, tribal, city, county), or by some combination thereof.
Facility Resource Emergency Database (FRED):	A web-based communication system that allows connectivity among all Maryland agencies and health care entities responding to a significant incident.
Field Operations Support Team (FOST):	The MIEMSS Rapid Response Team consisting of a representative from MIEMSS that will respond to the incident area, the Local Emergency Operations Center (LEOC) or the State Emergency Operations Center (SEOC) and coordinate state functions related to the incident.
Fast Attack/Rescue Mode:	Situations that require immediate action to stabilize and require the company officer assistance and direct involvement in the attack/rescue. In these situations the company officer goes with the crew to provide the appropriate level of supervision utilizing the portable radio to maintain command until transferred to another officer.
Group:	Groups are established to divide the incident into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. (See Division) Groups are located between Branches (when activated) and Resources in the Operations Section.
Helibase:	The main location for landing, fueling, maintenance and loading of helicopter operations in support of and incident. It is usually located at or near the Incident Base.

Incident:	An occurrence, natural or manmade, that requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wild land and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.
Incident Action Plan:	An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.
Incident Command:	The Incident Command System organizational element responsible for overall management of the incident and consisting of the Incident Commander (either single or unified command structure) and any assigned supporting staff.
Incident Commander (IC):	The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. Identified by a Blue Vest.
Incident Command System (ICS):	A standardized on-scene emergency management construct specifically designed to provide an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Information Officer:	A member of the Command Staff responsible for interfacing with the public and media or with other agencies requiring information directly from the incident. There is only one Information Officer per incident; The Information Officer may have assistants.
Initial Action:	The action taken by resources those are the first to arrive at an incident.
Initial Response:	Resources initially committed to an incident.
Investigation/Size-up Mode:	These situations generally require investigation or size-up from the initial arriving company. The officer should go with the company to investigate while utilizing a portable radio and retaining command of the incident. Units shall follow Standard Operating Guidelines specific to the type of incident. All findings and observations should be relayed to communications as well as additional equipment/resource requests and allocations.
Level I Accountability:	Officers shall insure that all Accountability Tags are placed on the Unit Designator Card (UDC) before arriving on the scene of an emergency. When needed a runner will deliver the UDC's to the Command Post. During emergency operations it is the responsibility of both the Company Officer/Group Officer to maintain accountability of the exact numbers of emergency workers they are supervising.
Level II Accountability:	The next level of accountability ordered by the Incident Commander. Whenever the Incident Commander orders Level II Accountability, all Unit Designator Cards (UDC's) are to be collected from the apparatus and delivered to the Command Post immediately. This will usually be done by the apparatus driver/operator.
Level III Accountability:	The next level of accountability as determined by the Incident Commander when he/she identifies that the incident requires more stringent accountability and to implement access and egress control measures i.e. hazardous materials, technical rescue and or explosive hazards incidents.

Liaison Officer:	A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies or organizations.
Logistics Section:	The Incident Command System Section responsible for providing facilities, services, and material support for the incident.
Mass Casualty Support Unit:	A unit stocked/equipped with inventory which is based on the Washington Metropolitan Council of Governments Mass Casualty Support Unit inventory list, or the Baltimore Metro Chiefs Mass Casualty Support Unit inventory list.
Mutual Aid Agreement:	Written or oral agreement between and among agencies/organizations and/or jurisdictions that provides a mechanism to quickly obtain emergency assistance in the form of personnel, equipment, materials, and other associated services. The primary objective is to facilitate rapid, short-term deployment of emergency support prior to, during, and/or after an incident.
National Incident Management System (NIMS):	Provides a systematic, proactive approach to guide departments agencies at all levels of government, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment.
Operations Section:	The Incident Command System (ICS) Section responsible for all tactical incident operations and implementation of the Incident Action Plan. In ICS, the Operations Section normally includes subordinate Branches, Divisions, and/or Groups.
Planning Section:	The Incident Command System Section responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the Incident Action Plan. This Section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.

PPE:	Personal Protective Equipment
Public Information Officer:	A member of the Command Staff responsible for interfacing with the public and media and/or with other agencies with incident-related information requirements.
Safety Officer:	A member of the Command Staff responsible for monitoring incident operations and advising the Incident Commander on all matters relating to operational safety, including the health and safety of emergency responder personnel.
SCBA:	Self-contained Breathing Apparatus
Section:	The Incident Command System organizational level having responsibility for a major functional area of incident management (e.g., Operations, Planning, Logistics, Finance/Administration).
Section Chief:	Titles that refer to a member of the Command Staff, i.e., Planning Section Chief, Operations Section Chief, Logistics Section Chief and so on.
Single Command:	The method of command with one person as the Incident Commander responsible for developing strategy, action plans and objectives.
Specialty Care Transport:	An ambulance transport of a patient from a scene or a clinical setting whose condition warrants care commensurate with the scope of practice of a physician or registered nurse and/or as defined within COMAR Title 30 and the Maryland Medical Protocols.
START Triage:	Simple Triage and Rapid Treatment
Supporting Agency:	An agency that provides support and/or resource assistance to another agency. See Assisting Agency.
TEMS:	Tactical Emergency Medical Services
TRT:	Tactical Response Team, Charles County's HAZMAT entity.

Unified Command:	An Incident Command System application used when more than one agency has incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior persons from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single Incident Action Plan.

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IV. Responsibilities

A. MEDICAL BRANCH DIRECTOR (Blue Vest)

1. COMMANDED BY: Operations Chief or Incident Commander

2. SUBORDINATES: Medical Communications Group Supervisor, Triage Group Supervisor, Treatment Group Supervisor, Medical Transportation Group Supervisor, and the Medical Material Resource Group Supervisor.

3. FUNCTION: Establish command and control the activities within the medical branch to assure the best possible emergency medical care to patients during a MCI.

4. RESPONSIBILITIES:

    a) Manage all Medical Branch activities.

    b) Establish a Medical Command Post and security for treatment.

    c) Control resources and maintain records.

    d) Develop a command organization based on the incident size in order to handle the medical emergency.

5. Special Assignments Liaison/Involvement

    a) Triage Group Supervisor /Team

    b) Fire Service Branch Director

    c) Medical Communication Group Supervisor

    d) Medical Transportation Group Supervisor

    e) Staging Group Supervisor

    f) Air Medical Team Leader

    g) Treatment Group Supervisor

    h) Treatment Team Leaders

    i) Medical Materials Resource Group Supervisor

j) Law Enforcement

k) Coroner's Office

l) Private Ambulance Services

m) Department of Health

n) Local and Area Hospitals

6. ESTABLISH LOCATIONS:

a) Command Locations

(1) Safe area remote from Triage/Treatment areas with law enforcement perimeter control.

(2) Adjacent to the Transportation Group Supervisor location if possible.

b) Ambulance Staging – consider size, accessibility, traffic pattern, etc.

c) Treatment Areas

(1) Immediate Care – Priority 1 – RED

(2) Urgent Care – Priority 2 – YELLOW

(3) Delayed Care – Priority 3 – GREEN

(4) Deceased – Priority 4 – BLACK

d) Consider appropriate morgue area, should be…

(1) Remote from treatment area.

(2) Cool and Dry, if possible out of the elements.

(3) Secured for crime scene evidence.

B. TRIAGE GROUP SUPERVISOR (Yellow Vest)

1. COMMANDED BY: Medical Branch Director

2. SUBORDINATES: Triage Team

3. FUNCTION: Assume responsibility for providing triage management and coordination of all casualties. When triage is completed, personnel may be reassigned as needed.

4. RESPONSIBILITIES:

    a) Manage all triage activities at incident scene.

    b) Acquire sufficient personnel to manage assignment.

    c) Coordinate medical treatment and movement of injured.

    d) Provide direction and guidance to personnel working on scene.

    e) Establish location outside of the incident but adjacent to triage areas.

5. STRATEGY/TACTICS:

    a) Assess resource needs

        (1) Command and communications

        (2) Personnel

        (3) Equipment and Supplies

        (4) Relief units

    b) Inform Medical Branch Director of minimum needs.

    c) Consult with triage Team

    d) Delegate job assignments

        (1) Safety

        (2) Records

        (3) First-aiders

(4) Transporters

(5) Morgue

NOTE: Do not allow deceased victims to be moved from their original locations unless absolutely necessary. If possible, take pictures and mark victim locations prior to moving. This information is essential to the Coroner/Medical Examiner and Law Enforcement Investigators.

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C. TREATMENT GROUP SUPERVISOR (Red Vest)

1. COMMANDED BY: Medical Branch Director

2. SUBORDINATES: Immediate Treatment Team Leader, Delayed Treatment Team Leader and the Minor Treatment Team Leader.

3. FUNCTION: Assume responsibility for treatment and coordination of all casualties in the treatment areas.

4. RESPONSIBILITIES:

   a) Implement and supervise immediate, delayed and minor treatment areas.

   b) Assign team leaders to immediate, delayed and minor treatment areas.

   c) Request sufficient treatment teams and qualified emergency medical personnel to staff treatment areas.

   d) Coordinate with the Triage Group Supervisor and Medical Transport Group Supervisor.

   e) Request medical supplies as needed.

   f) Request use of medical standing orders without obtaining on-line medical control.

   g) Maintain triage assessment of patients throughout treatment areas.

   h) Assure appropriate use of other medical personnel.

   i) Coordinate with the Medical Examiner to manage fatalities and keep the scene secured.

   j) Coordinate with the Red Cross and volunteer personnel through Agency Liaison.

D. MEDICAL COMMUNICATIONS GROUP SUPERVISOR (Blue Vest)

1. COMMANDED BY: Medical Branch Director

2. SUBORDINATES: Personnel as required.

3. FUNCTION: Maintain communications with the hospital alert system and other resource medical facilities to coordinate proper patient transportation and destination.

4. RESPONSIBILITIES:

   a) Establish and maintain medical communications with the hospital alert system through the Emergency Medical Resource Center (EMRC) and use the system to communicate patient disposition.

   b) Receive hospital resource availability information from EMRC.

   c) Obtain use of medical standing orders, without use of on-line medical control, and inform the Treatment Group Supervisor.

   d) Arrange for additional communications resources to be used for specialized, individual case medical instructions, if necessary.

   e) Maintain appropriate records.

   f) Maintain close liaison and information coordination with the Medical Transportation Group Supervisor.

   g) Establish location remote from the triage area.

      (1) Adjacent to medical Command Post

      (2) Utilize first ambulance crews on scene

      (3) Utilize EMRC as needed

      (4) Keep EMRC updated on the MCI and apprised of any changes especially changes concerning the number of victims.

5. STRATEGY/STATISTICS

   a) Maintain close coordination of efforts and liaison with the Transportation Group Supervisor.

b) Provide medical input into the decision making process at the EMS Branch Command Post.

c) Anticipate potential casualty numbers.

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E. MEDICAL TRANSPORTATION GROUP SUPERVISOR (Green Vest)

1. COMMANDED BY: Medical Branch Director

2. SUBORDINATES: Ambulance Staging Team Leader and Air Medical Team Leader.

3. FUNCTIONS: Coordination of patient transportation and maintenance of records, as required.

4. RESPONSIBILITIES:

   a) Acquire sufficient personnel to manage assignments.

   b) Maintain record of hospitals being utilized and their capabilities for patient disposition.

   c) Control all ambulance loading activities and movement. Maintain an accurate count of victims, where they were transported and their classification.

   d) Coordination with Air Medical Team Leader regarding helicopter transportation of victims.

   e) Coordinate responsibilities with Ambulance Staging Team Leader and Treatment Group Supervisor.

   f) Assure that Crews remain with their unit until called upon for transport. Crews and units should be ready for action at a moment's notice.

   g) Patient destination will be determined after consultation with EMRC hospital alert system, which has been notified through the Medical Communications Group Supervisor.

   h) Establish Location

      (1) Adjacent to treatment areas

      (2) Keep accessibility in mind

      (3) Develop a traffic pattern to avoid confusion

      (4) Security

F. MEDICAL MATERIALS RESOURCE GROUP SUPERVISOR (Orange Vest)

1. COMMANDED BY: Medical Branch Director

2. SUBORDINATES: Personnel as required.

3. FUNCTION: Acquire and stage appropriate medical equipment and supplies from units assigned to the Medical Branch.

4. RESPONSIBILITIES:

   a) Acquire, distribute and maintain medical equipment and supplies within the EMS Section.

   b) Request additional medical supplies as needed through the Medical Branch Director.

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G. STAGING GROUP SUPERVISOR (Green Vest)

1. COMMANDED BY: Operations Chief
2. SUBORDINATES: Personnel as required
3. FUNCTION: Manage the staging area.
4. RESPONSIBILITIES:
    a) Acquire sufficient personnel to manage assignments.
    b) Develop organization sufficient to handle assignments.
    c) Coordination activities with the Medical Transportation Group Supervisor.
    d) Plan layout of Staging Area. Consider immediate and future needs.
    e) Recommend additional resources as necessary.
    f) Establish location
5. Apparatus
    a) Control apparatus parking
    b) Law Enforcement assistance
6. Staging Command Location
    a) Control
    b) Communications
7. STRATEGY/TACTICS
    a) Assess resource needs
        (1) Command, communications
        (2) Equipment, supplies
        (3) Apparatus

(4) Personnel

(5) Relief personnel

(6) Law enforcement

b) Consult with Medical Transportation Group Supervisor

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H. AIR MEDICAL TEAM LEADER (Green Vest)

1. COMMANDED BY: Medical Transportation Group Supervisor
2. SUBORDINATES: Personnel as required
3. FUNCTION: Manage the air medical evacuation area.
4. RESPONSIBILITES:
    a) Establish a safe and well-marked landing zone.
    b) Provide air medical transportation for Medical Transportation Group Supervisor.
    c) Establish immediate contact with air medical personnel at the scene.
    d) Act as a liaison between ground transportation and air medical transportation.
    e) Recommend additional air medical resources as needed.

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I. TREATMENT TEAM LEADERS (Red Vest)

1. COMMANDED BY: Treatment Group Supervisor

2. SUBORDINATES: Treatment Team Members

3. FUNCTION: Responsible for managing treatment and continuing triage assessment of victims assigned to treatment area.

4. RESPONSIBILITIES

   a) Manage all activities within their treatment area.

   b) Acquire sufficient personnel to manage assignment.

   c) Establish treatment unit locations and plan layout. Isolate delayed treatment area from urgent and immediate treatment areas.

   d) Provide direction and guidance to subordinates.

   e) Keep areas off limits to all personnel except those needed.

   f) Acquire law enforcement assistance when required/available.

   g) Coordinate transportation needs with Treatment Group Supervisor.

   h) Establish location accessible to transporters.

5. STATEGY/TACTICS

   a) Assess resource needs.

      (1) Command, communications

      (2) Equipment, supplies

      (3) Personnel, Fire Fighters, Paramedics and EMT's

      (4) Relief personnel

   b) Assure most critical victims to be transported first.

J. TREATMENT TEAM MEMBER

1. COMMANDED BY: Treatment Team Leader

2. FUNCTION: Provide treatment on-scene

3. RESPONSIBILITIES:

   a) Report to Immediate, Urgent or Delayed Treatment Team Leaders as assigned.

   b) Provide rapid, appropriate and professional treatment to victims and record vital patient information.

   c) Report changes in victim status to appropriate Treatment Team Leader.

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K. TRIAGE TEAM MEMBER

1. COMMANDED BY: Triage Group Supervisor

2. FUNCTION: Triage patients' on-scene and assign them to the appropriate treatment areas.

3. RESPONSIBILITIES:

   a) Report to designated on-scene triage location.

   b) Triage and identify (with approved color coded triage tags) injured, ill or deceased patients. Classify these patients as either…

      (1) Immediate – Red Tag

      (2) Urgent – Yellow Tag

      (3) Delayed – Green Tag

      (4) Deceased – Black Tag

   c) Direct movement of patients to proper treatment areas.

   d) Provide appropriate medical treatment (ABC's) to victims prior to movement, as incident conditions dictate.

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L. FIRE SUPPRESSION BRANCH DIRECTOR (Blue Vest)

1. COMMANDED BY: Operations Chief or Incident Commander

2. SUBORDANANTS: Suppression Branch Group Supervisors, Suppression Material Resource Group Supervisor, and Fire Communications Group Supervisor.

3. FUNCTION: Establish, command, and control the activities within the responsibilities of the Fire Suppression Branch. Collaborate with the Medical Branch for both material assets and personnel resources.

4. RESPONSIBILITIES:

   a) Manage all Fire Suppression group activities.

   b) Establish a Fire Suppression Command Post

   c) Control resources and maintain records.

   d) Develop a command organization based on incident size to handle any fire suppression tasks at hand.

   e) Cooperate with the Medical Branch Director to insure that the adequate amount of materials and personnel resources are available for the appropriate and prudent treatment of ill or injured patients.

   f) Secure strategic placement of fire suppression apparatus.

   g) Manage the swift, safe and proper mitigation of any current and or potential fire threats.

   h) Insure an appropriate amount of material resources are available for proper decontamination procedures.

   i) Deploy appropriate resources for the proper and safe establishment of a Helibase.

   j) Special Assignments

      (1) Decontamination Corridor

      (2) Rapid Intervention Rescue Teams

      (3) Rapid Extrication

(4) Forcible Entry

(5) Swift Water Rescue

(6) Confined Space Rescue

(7) High and Low Angle Rescue/Operations

(8) Structural Collapse & Trench Rescue

(9) Alternate EMS Resources

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M. HAZARDOUS MATERIALS BRANCH DIRECTOR (Blue Vest)

1. COMMANDED BY: Operations Chief or Incident Commander

2. SUBORDINATES: Charles County Tactical Response Team, Fire Suppression Group Supervisor, Decontamination Division/Group Supervisor, and Haz-Mat Communication Group Supervisor.

3. FUNCTION: Establish command and control the activities of the Charles County Tactical Response Team and all hazardous materials related incidents. Insure the best possible outcome and proper mitigation of all Haz-Mat Incidents.

4. RESPONSIBILITES:

   a) Manage all Haz-Mat Branch activities.

   b) Establish a Haz-Mat Command Post.

   c) Control resources and maintain records.

   d) Develop a command organization based on incident size.

   e) Insure the swift, safe and proper mitigation of any and all Haz-Mat related incidents.

   f) Overall safety and management of hazardous materials/WMD related incidents.

   g) Minimal staffing requirements are met for the proper and safe mitigation of said incident. Assurance and placement of a qualified RIT.

   h) Insure that the appropriate and swift decontamination of victims is performed.

   i) Prevent further contamination of surrounding areas/regions.

   j) General safety and health of the citizens and operations personnel of any and all WMD/Haz-Mat Incidents.

5. ESTABLISH LOCATIONS:

   a) Command Locations

      (1) Safe area remote from but in view of incident.

(2) Adjacent to rehab.

b) Decontamination Division/Group(s)

(1) Location in a safe region between the “Warm Zone” and “Cold Zone” as well as upwind.

(2) Insure adequate staffing.

(3) Provide proper and adequate equipment and resources.

c) “Hot Zone” Treatment and Rescue

(1) Rapid extrication and treatment of salvageable victims.

(2) Appropriate Rapid Intervention Teams prepped and ready for immediate action.

d) Evacuation/Safety Parameters

(1) Insure that safe and appropriate evacuation parameters are set and established.

(2) Insure all victim/operational treatment and or sections/sectors are functioning at a safe and appropriate distance from the incident.

e) Egress and Escape Routes

(1) All egress and escape routes are well planned and marked.

(2) Materials and resources are available for adequate egress and evacuation procedures.

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N. SAFETY OFFICER (Green Vest)

1. COMMANDED BY: Operations Chief or Incident Commander, Branch Director.

2. SUBORDINATES: All personnel under the above listed.

3. FUNCTION: Serve as the overall safety authority of the incident for their respective assigned sectors/sections.

4. RESPONSIBILITY:

   a) The primary responsibility of the Safety Officer with respect to their assigned section/branch is the general health and safe operations of the scene and personnel involved.

   b) The Safety Officer has the authority to correct any and all unsafe practices on the incident scene as long as they relay said corrections to their respective Operations Chief or Incident Commander.

   c) Should immediate action not be required, the Safety Officer shall inform the Operations Chief or Incident Commander as soon as possible of any discrepancies in safety protocol and procedures.

   d) Appoint assistant/technical Safety Officers as directed by the incident objectives.

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V. Initial Response Units

Arrival

Upon initial arrival at the scene of a suspected or confirmed MCI, the lead unit should…

1. Strategically place the unit with respect to the type of call (utilize dispatched intelligence reports and information obtained on the **initial size-up**) and in complete compliance with scene safety protocols.

2. Take all necessary universal and personal protective precautions. If a WMD attack has been suspected, Don proper PPE now!

3. Perform a **complete scene "size-up"** and communicate to Dispatch the following vital information.

    a) Type of MCI

    b) Approximate number of casualties/victims with severity correlations.

    c) Approximate number of Ambulances (ALS & BLS), Helicopters, Engines, Squads, Specialty Units and Law Enforcement requested to mitigate the scene.

    d) Most prudent and safest approach to the scene.

    e) Any particular hazards or concerns at the scene.

4. Initiate the proper mode of operation for the initial response

    a) Fast Attack/Rescue Mode

    b) Investigation/Size-up Mode

    c) Command Mode

5. Set up an initial Triage and Treatment Area with safe ingress and egress routes.

6. Implementation of Level II Accountability.

7. Seal off area if possible with the assistance of Law Enforcement.

8. Remove the unit's MCI Kit and follow the MCI Task Cards.

9. Transfer and/or relinquish Command to a Superior Officer when he/she arrives on scene, brief him/her of the timeline of events to that point and transfer Personal Accountability Tags to their possession.

B. Responding/Late Arriving Units

Responding and or late arriving units should operate at a MCI in the following manner…

1. Strategically stage your unit/apparatus as directed.

2. Don PPE or SCBA as needed and/or directed to do so.

3. Collect your unit and crews' Personal Accountability Tags and report to the Incident Commander.

4. The Incident Commander will assign a duty/task for your particular unit to perform.

5. Report to your assigned branch or group and check in with the supervisor of that particular area.

6. DO NOT "Freelance". Perform the duty/task your unit was assigned, every job is important in these critical situations whether they are considered "good ones" or not.

7. Use clear and concise communications at all times.

8. Refer to your unit's MCI Kit and appropriate MCI Task Cards for further instructions.

C. Command Elements

First arriving Officers at a MCI/WMD and or Haz-Mat Incident should perform their duties as follows …

1. Establish **Command** and perform a thorough and complete scene size-up.

2. Stage your unit where you feel that the Command Post will be uphill and upwind from the incident.

3. Brief the initial response units.

    a) Who

    b) What

    c) When

    d) Where

    e) How

    f) What you plan to do about it

4. Collect the Personal Accountability Tags of responding units.

5. Mitigate any and all immediate dangers or health risks to victims and or providers (fires, entrapment, water, electrical hazards, etc.) so long as there are…

    a) Proper personnel/equipment to do so.

    b) It is safe to do so.

6. Re-assess the scene and “Up-grade” or “Down-grade” the incident as needed.

7. Assess the following safety considerations.

    a) Is the scene safe?

        (1) Are there hazardous materials involved?

        (2) Units and command staged upwind from incident?

        (3) Are there active or live wires that need to be neutralized?

        (4) Do streets and or waterways need to be shut down?

        (5) Are there unexploded or possibly secondary explosive devices involved?

(6) Does the scene or surrounding region need to be evacuated?

b) Is there a large enough police presence?

c) Are personnel operating under safe conditions with the proper level of PPE and or SCBA?

8. Assess the following logistical considerations.

a) Is there a need for the Mobile Command Unit?

(1) Safe and appropriate command and control materials/facilities?

(2) Adequate communications capabilities?

b) Does the EOC need to be activated?

(1) Always with a Unified Command.

(2) Major incident?

(3) People need to be evacuated?

(4) Serious environmental or commercial hazards possible/present?

9. Establish the following groups as needed.

a) Ambulance/Apparatus Staging Area with assigned supervisor.

b) Incident Communications Group with Supervisors.

(1) EMS

(2) Fire

(3) Police

(4) Haz-Mat

c) Triage Group with supervisor.

d) Treatment and Transport Group with supervisors.

e) Materials and/or Resources Group with supervisor.

f) Helicopter

g) Decontamination Corridor if needed.

h) Safe access and egress pathways.

i) Alternate patient collection, triage and treatment points.

D. Established Command Officers

1. Coordinate with Safety Officer to insure that all personnel are operating under safe and effective conditions with the proper level of PPE and or SCBA.

2. Ensure proper and current communications are effective with the Incident Commander as well as all other sections/sectors and the personnel operating in them.

3. Constantly reassess the incident and current operation to insure that the appropriate quantity of qualified providers and personnel are in place and performing their jobs effectively.

4. Ensure and communicate that all victims are being properly treated in the following fashion…

   a) Safe

   b) Appropriate

   c) Effective

   d) Efficient

5. If not done so in that fashion, coordinate with the other supervisors in alternate groups and divisions to ensure that the tasks and treatment will be done so in the approved fashion.

6. Maintain any and all appropriate records and logs.

E. Support & Rehabilitation Units

Units arriving on scene that have been designated as "support" and or "rehabilitation" crews/units should operate in the following manner…

1. Strategically stage your unit/crew in the pre-designated area.
2. Don all appropriate PPE and or SCBA for the incident at hand.
3. Report to the Staging Group Supervisor, once assigned to a task remit PAT Tag to that supervisor according to the proper level of accountability.
4. Remain in said staging area until called upon for assignment by the Staging Group Supervisor.
5. Crews/units shall not stray from their pre-designated staging area or "freelance"; rather they should maintain a constant state of readiness.
6. Personnel being "rehabbed" who do not meet physical qualifications to return to duty should not be allowed to do so.
7. Rehabilitation units should ensure that there are enough refreshments for all personnel and or victims on scene; re-hydration is crucial for these types of incidents. (Re-hydration keeps providers from turning into patients.)

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VI. INCIDENT SITE MANAGEMENT

A. Mass Casualty Incident

1. Always establish patient care areas in "safe" geographical regions that are upwind from the incident with ample room for expansion if necessary as well as routes of rapid egress.

2. Triage and treat patients in order of severity not convenience.

3. Keep "like" patients together until ready for transport,

    a) Immediate Patients should be kept in the Red Treatment Area,

    b) Urgent Patients should be kept in the Yellow Treatment Area,

    c) Delayed Patients should be kept in the Green Treatment Area, and

    d) Deceased Patients should be left on scene or transported to the morgue.

4. Patients should not be allowed to "mill" around.

5. Keep the treatment area secured with Law Enforcement. Bystanders and "Good Samaritans" should not be permitted into the treatment areas without the expressed permission of the Safety Officer. This includes all press and media personnel.

6. Triage and treatment areas should be laid out in a ***Prioritized Linear Fashion***; do not allow the two areas to become "confusing" or over complicated.

7. Keep Groups close enough to be effective. The Resources and Supply Group should not be located too far from the Treatment Group.

8. If the influx of patients or victims is too great in one division then it is prudent to establish alternate sites for triage, treatment and transport.

9. Do not overwhelm your personnel; call in support staff/materials if needed.

10. It may be necessary at times to establish a Patient Collection Point close to the scene so that initial and critical patient care may not be delayed. A shuttle system may be enacted to aid in this application.

11. Crews MUST remain with their units who are assigned to the Transportation Group until utilized.

12. Always keep in mind environmental concerns for both patients and providers.

B. MCI's Involving WMD/Haz-Mats

1. Always establish patient care areas in "safe" (Cold Zone) geographical regions that are upwind from the incident with ample room for expansion if necessary as well as routes of rapid egress.

2. Safety and Operations of an incident of this magnitude will fall on the Haz-Mat Branch Director until mitigated.

3. A Patient Collection Point may be established in the Warm Zone until they can be properly decontaminated. This is an area where minor and immediate life threatening treatment may be performed.

4. All personnel operating in this type of environment must do so with the proper level of PPE, there are NO EXCEPTIONS to this rule.

5. A Decontamination Group should be established between the Warm and Cold Zones with no one entering or leaving without proper decon.

6. Triage and treat patients in order of severity not convenience.

7. DO NOT allow victims to leave the incident site without first being decontaminated. Utilize law enforcement when necessary.

8. Keep "like" patients together until ready for transport

    a) Immediate Patients should be kept in the Red Treatment Area,

b) Urgent Patients should be kept in the Yellow Treatment Area,

c) Delayed Patients should be kept in the Green Treatment Area, and

d) Deceased Patients should be left on scene or transported to the morgue.

e) Patients should not be allowed to "mill" around.

9. Keep the treatment area secured with Law Enforcement. Bystanders and "Good Samaritans" should not be permitted into the treatment areas without the expressed permission of the Safety Officer. This includes all press and media personnel.

10. Triage and treatment areas should be laid out in a ***Prioritized Linear Fashion***; do not allow the two areas to become "confusing" or over complicated.

11. Most patient care should be performed in the Cold Zone.

12. All access and egress to and from the Warm Zone will be strictly contained through the Decontamination Group.

13. Keep divisions close enough to be effective. Your Resources and Supply Group should not be located too far from the Treatment Group.

14. If the influx of patients or victims is too great in one sector then it is prudent to establish alternate sites for triage, treatment and transport.

15. Do not overwhelm your personnel; call in support staff/materials if needed.

16. It may be necessary at times to establish a Patient Collection Point close to the scene so that initial and critical patient care may not be delayed. A shuttle system may be enacted to aid in this application.

17. Crews MUST remain with their units who are assigned to the Transportation Group until utilized.

18. No patient may be transported without first being decontaminated. NO EXCEPTIONS!

19. Always keep in mind environmental concerns for both patients and providers.

C. MCI's Involving Explosive Ordnances

1. Always establish patient care areas in "safe" (away from the blast zone) geographical regions that are upwind from the incident with ample room for expansion if necessary as well as routes of rapid egress in consideration for distance and shielding with units in staging.

2. Devastating incidents like this one are to be managed under the strict control of Law Enforcement and the EOD Unit.

3. Untrained and unarmored personnel will not be permitted to enter and triage/treat any victim until the scene has been deemed "safe" or "clear" by the EOD Team. (Precautionary measures for Secondary IED's).

4. Major triage and treatment may not begin until victims have been tactically evacuated from the imminent danger zones.

5. Once allowed into the casualty incident area, DO NOT USE RADIO OR CELLUALR PHONE/NEXTEL COMMUNICATIONS over or around suspicious objects or packages. (These items may be unexploded IED's and could be detonated via radio/cellular wave transmissions.)

6. Mark and notify the EOD Unit immediately if personnel stumble upon such an object.

7. Triage and treat patients in order of severity not convenience.

8. Keep "like" patients together until ready for transport,

    a) Immediate Patients should be kept in the Red Treatment Area,

    b) Urgent Patients should be kept in the Yellow Treatment Area,

    c) Delayed Patients should be kept in the Green Treatment Area, and

    d) Deceased Patients should be left on scene or transported to the morgue.

    e) Patients should not be allowed to "mill" around.

9. Keep the treatment area secured with Law Enforcement. Bystanders and “Good Samaritans” should not be permitted into the treatment areas without the expressed permission of the Safety Officer. This includes all press and media personnel.

10. Triage and treatment areas should be laid out in a *Prioritized Linear Fashion*; do not allow the two areas to become “confusing” or over complicated.

11. Keep divisions close enough to be effective. The Resources and Supply Group should not be located too far from the Treatment Group.

12. If the influx of patients or victims is too great in one division then it is prudent to establish alternate sites for triage, treatment and transport.

13. Do not overwhelm your personnel; call in support staff/materials if needed.

14. It may be necessary at times to establish a Casualty Collection Point close to the scene so that initial and critical patient care may not be delayed. A shuttle system may be enacted to aid in this application.

15. Crews MUST remain with their units who are assigned to the Transportation Division/Group until utilized.

16. Always keep in mind environmental concerns for both patients and providers.

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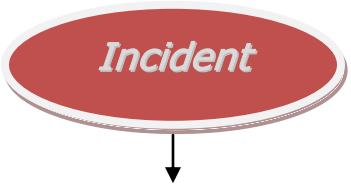
VII. PROCEDURES

A. MCI Procedures



First Arriving Unit/s

1. Stage or park where you expect the Triage/Treatment Area to be located.
2. Perform immediate tasks: Fast Attack/Rescue Mode, Investigation/Size-up Mode, and Command Mode.
3. Declare type of MCI and all pertinent information to Dispatch.
4. Establish Command and collect PAT tags.
5. Remove MCI Kit and begin to triage patients keeping open communications with dispatch.

Command Established

1. Establish a Single or Unified Command Post, call for Mobile Command Post if needed.
2. Reassess incident and Upgrade or Downgrade as necessary.
3. Establish appropriate Groups and secure resources.
4. Activate the EOC if necessary.

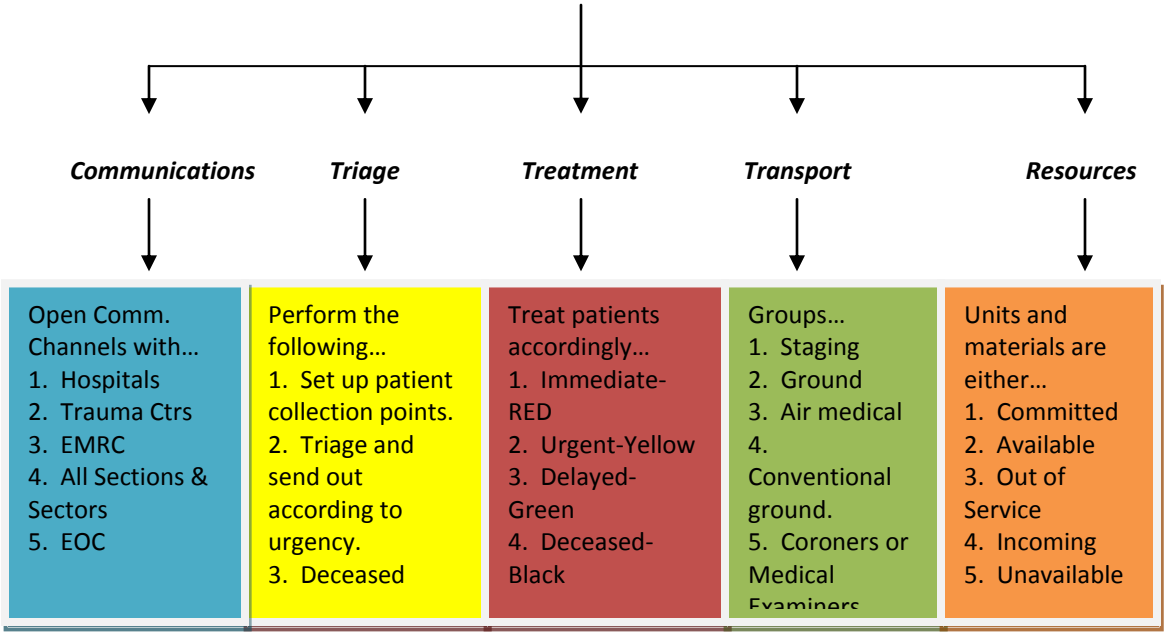


Figure VII-1 MCI Procedures

B. WMD/Major Haz-Mat Procedures

First Responding Units

1. Stage or park upwind and at a safe distance from the incident.
2. Don all proper PPE/SCBA precautions.
3. Perform immediate tasks: Fast Attack/Rescue Mode, Investigation/Size-up Mode, and Command Mode.
4. Declare type of incident and relay all pertinent information to TRT and Dispatch.
5. Establish Command and collect PAT tags.
6. Attempt to contain travel into and from incident.
7. Remove MCI Kit and wait for arrival of Tactical Response Team.

Command Established

1. Establish a Single or Unified Command Post, call for Mobile Command Post if needed.
2. Reassess incident and Upgrade or Downgrade as necessary.
3. Establish appropriate Groups and secure resources.
4. Activate the EOC if necessary.

Hazmat Branch Established

1. Hot Zone, Warm and Cold Zones declared. Evacuate if necessary.
2. Establish Patient Collection Point in the Warm Zone, close to where Decon will be.
3. Establish and construct Decontamination Division//Group.
4. Establish a Unified Command Post and activate the EOC.
5. Reassess incident and Upgrade or Downgrade as necessary
6. Establish all appropriate Sections and Divisions as needed.

Communications

1. Open communication channels with the following…

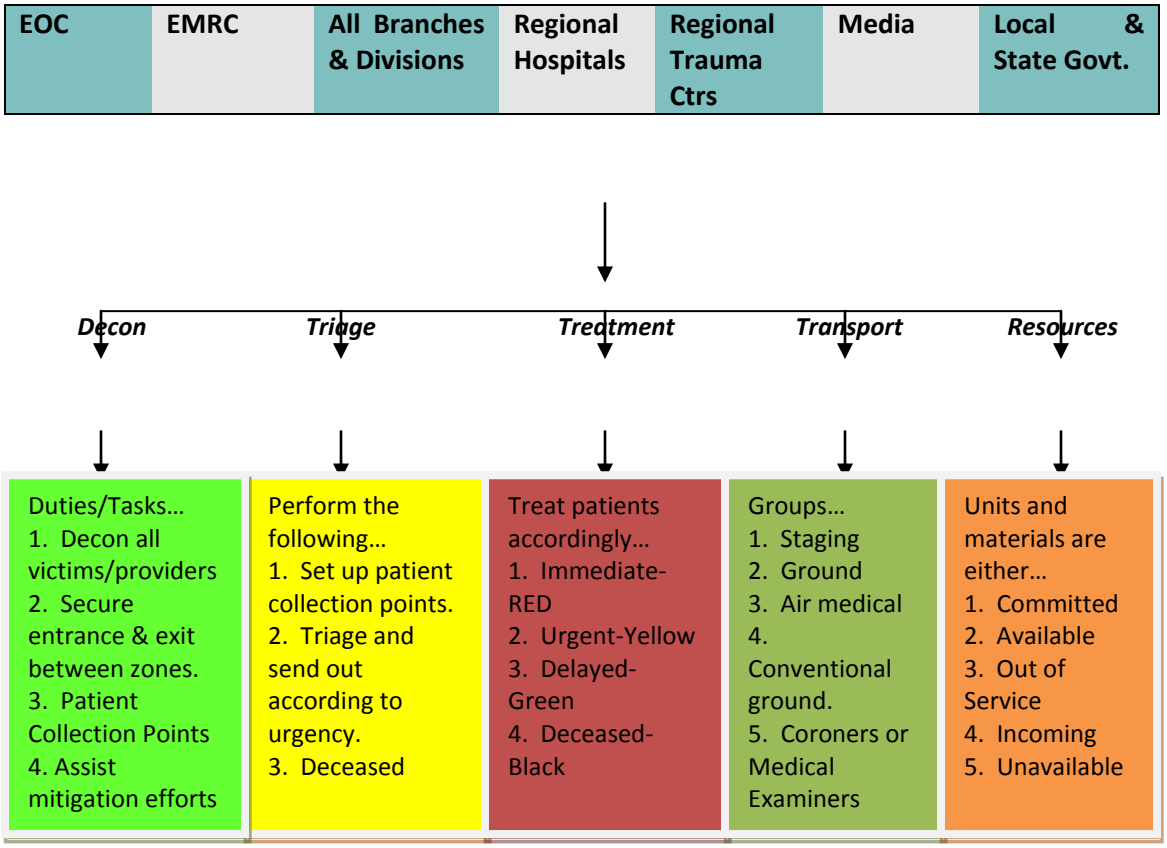


Figure VII-2 WMD/Major Haz-Mat Procedures

C. Lines of Communications

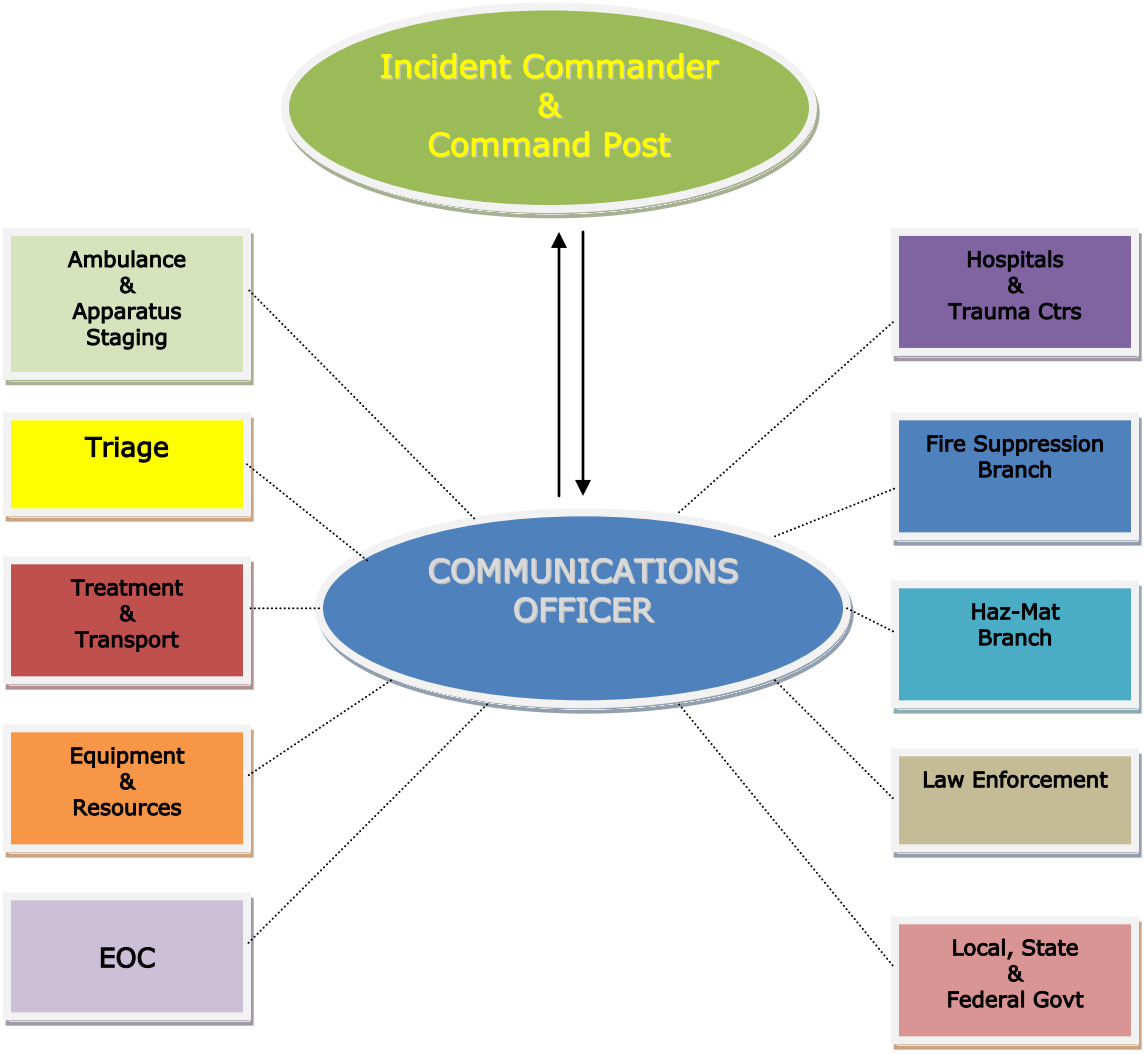


Figure VII-3- Lines of Communication

A. After primary communication responsibilities have been accomplished, all area hospitals and trauma centers should be contacted and the following information obtained…

1. Hospital Status
2. Number of open beds.
3. Number of Priority 1 Patients able to accept.
4. Number of Priority 2 Patients able to accept.
5. Any other special concerns.

B. EMRC should also be brought up for open communications as well as immediate contact with the Medical Director so "Open Medical Treatment Orders" may be obtained.

D. Decontamination Procedures

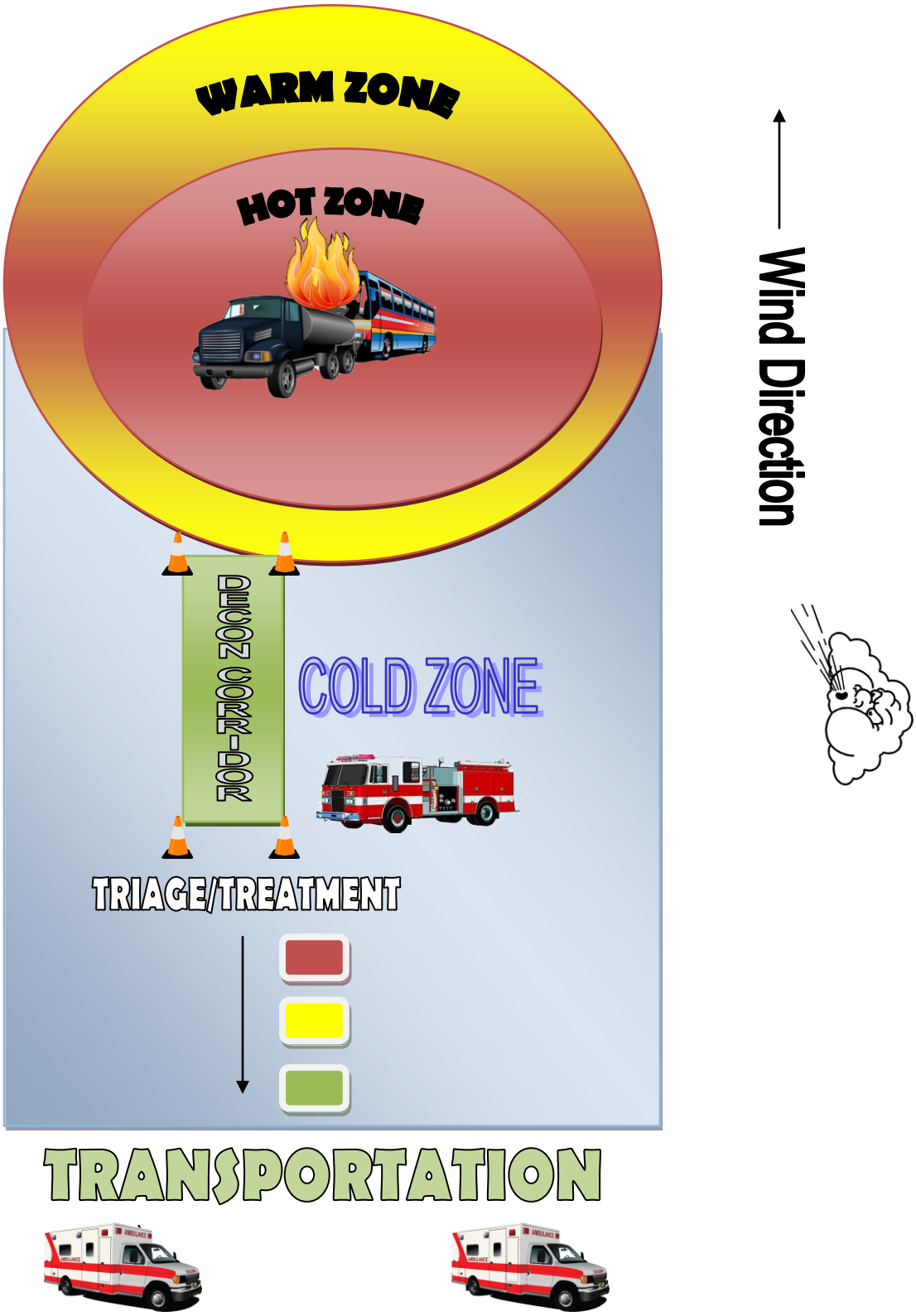


Figure VII-4 - Decontamination Procedures

E. Gross Decontamination Procedures (Prior to Complete Decon)

1. If **Vapor Contamination** has been determined, victims should be placed outside the affected area in a *breeze*. In most cases those victims exposed to *vapor only* need not require gross decontamination.

    a) Victims exposed to Biological Weapons that have been aerosolized absolutely **require** decontamination with soap and water.

    b) Remove **all clothing** and follow with a lukewarm shower utilizing soap and water.

2. If Liquid Contamination is suspected…

    a) Remove victim from the scene.

    b) Remove **all clothing** and rinse patient with copious amounts of water.

    c) Decontaminate patient with a lukewarm shower utilizing soap and water.

    d) Make sure to scrub all body parts well with soap and water – this includes the scrotum, armpits, and gluteal cleft.

    e) Eyes should be rinsed thoroughly with water.

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3. **Contaminated Providers** should remove themselves from the incident immediately and report to the Decon Corridor.

    a) Large chunks or pieces of contaminate may be removed with a tongue depressor, credit card, or stick.

    b) Use **absorbent material** to soak up liquid agents if water is not readily present (Powder detergent, flour, dirt).

    c) At Decon Corridor, remove **all clothing** and flush body with copious amounts of water.

    d) Shower using lukewarm water and scrub all body parts with soap.

    e) Eyes should be flushed with copious amounts of water.

    f) Report to medical personnel for evaluation after a complete decon has been performed.

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Figure VII-5 - Ladder Pipe Decon System

F. Transport Procedures

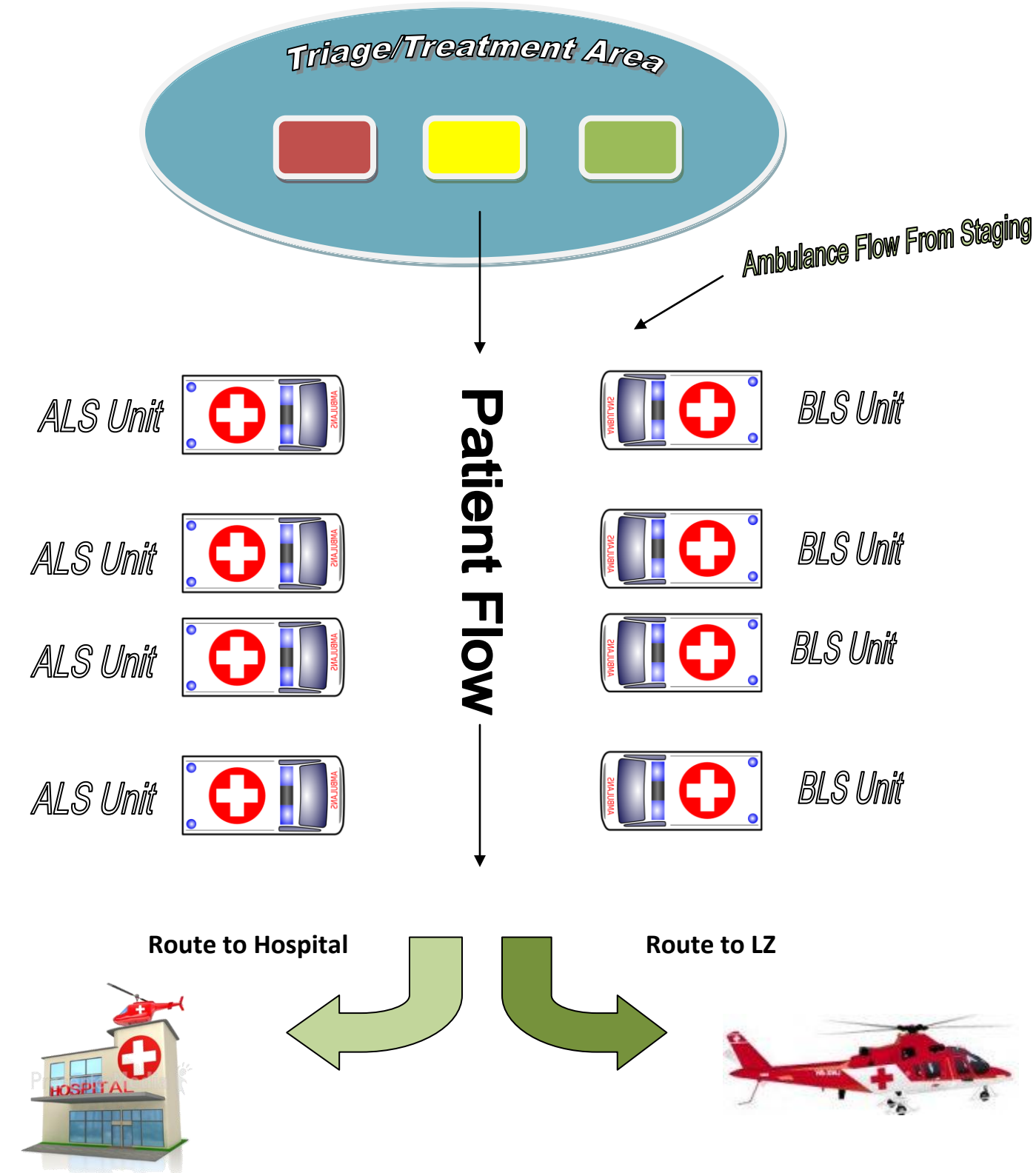

Figure VII-6 - Transport Procedures

VIII. TERMINATION OF THE INCIDENT

A. General

1. In general no incident shall be concluded until the following has been achieved.

    a) Mission and or mitigation have been accomplished.

    b) All patients have been properly treated and or transported to the appropriate facility.

    c) The Incident Commander has declared the incident “terminated”.

    d) All personnel have been accounted for and Personal Accountability Tags returned.

2. No unit or crew may return to service or “clear” without expressed authorization from the Incident Commander or his/her surrogate.

3. No unit or crew may return to service or “clear” without first collecting their Personal Accountability Tag from the Incident Commander or his/her designated surrogate.

4. After any major incident, participating personnel may be required to or be subject to one or more of the following…

    a) Debriefing

    b) Medical Screening

    c) Psychological Screening

    d) Required leave

5. Officers must host an *After Action Critique* no later than Five (5) business days after the event.

6. Any time after the event, those requesting a psychological debriefing will be granted so.

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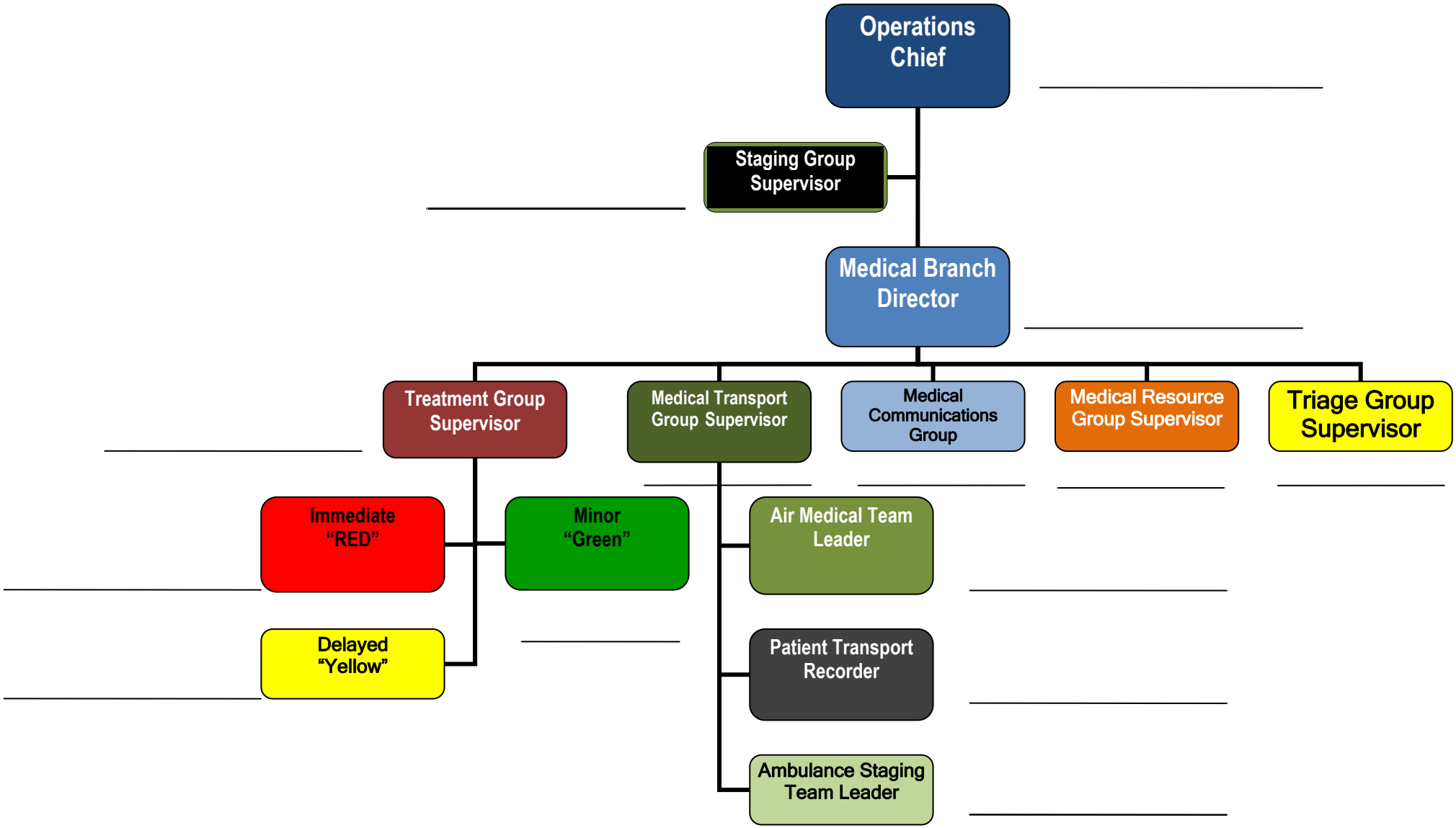
IX. APPENDIX A – Incident Command System Flow Chart

INCIDENT COMMAND SYSTEM
FLOW CHART

NOTES PAGE:

INCIDENT COMMAND SYSTEM
FLOW CHART



X. APPENDIX B – S.T.A.R.T. Triage Flow Chart

S.T.A.R.T. Triage Flow Chart

1. Separate all ambulatory from non-ambulatory patients. If this is a large incident utilize a PA (Loud Speaker) system.

2. Sort all non-ambulatory patients with the S.T.A.R.T. Flow Chart below.

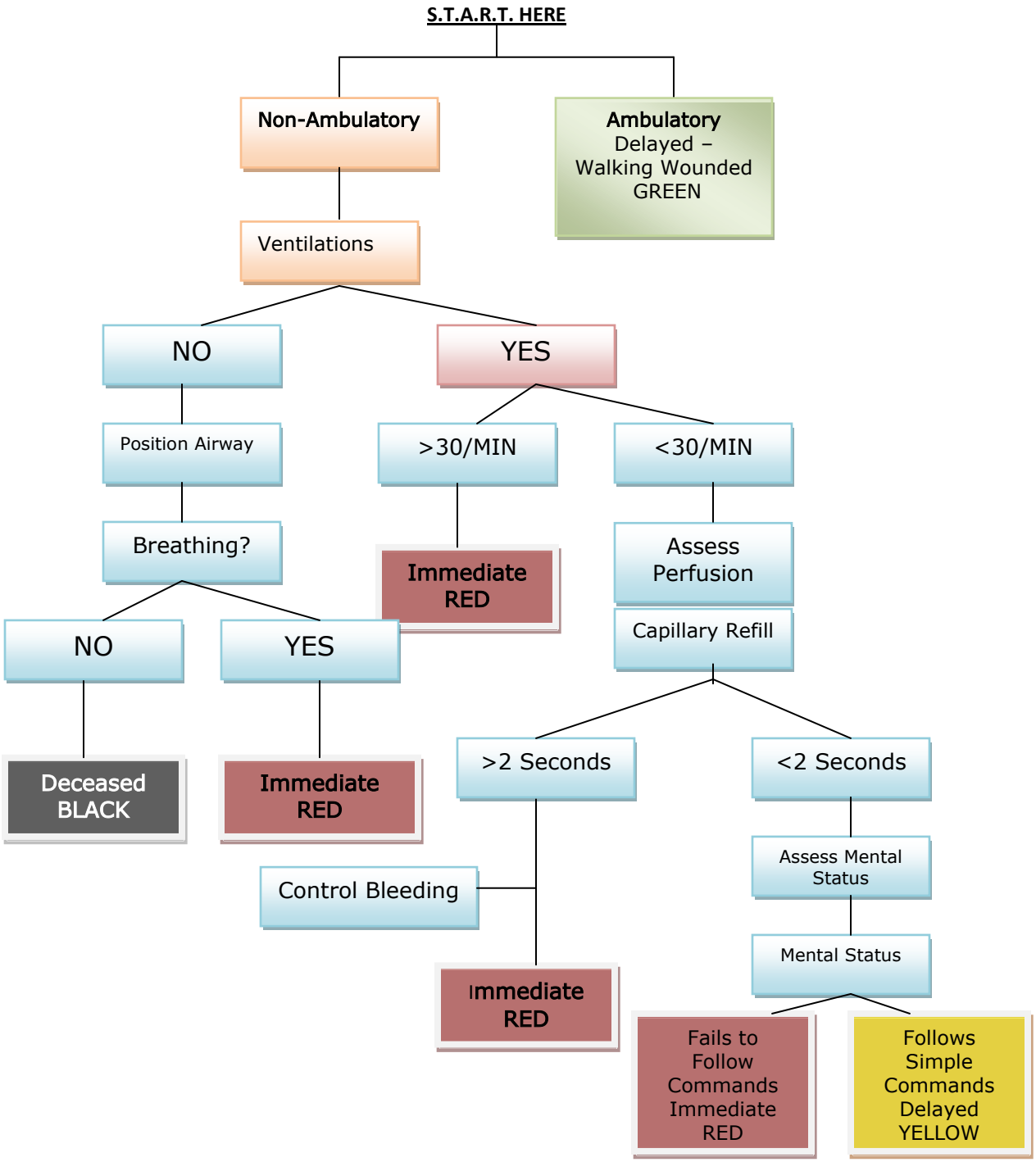


Figure X-1 - S.T.A.R.T. Flow Chart

XI. Appendix C – Side, Quadrant & Division Figures

SIDE, QUADRANT & DIVISION FIGURES

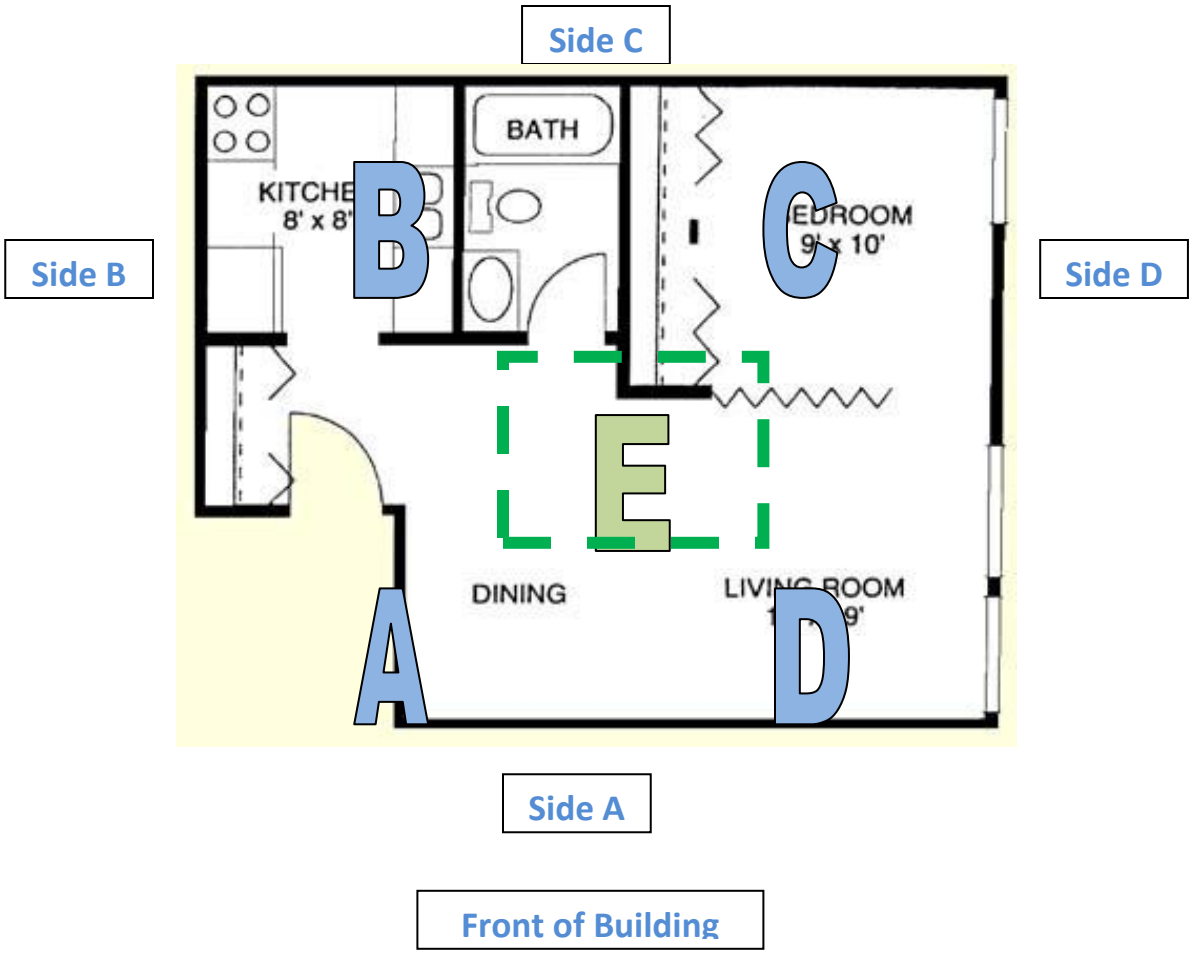


Figure XI-1 - Sides Chart

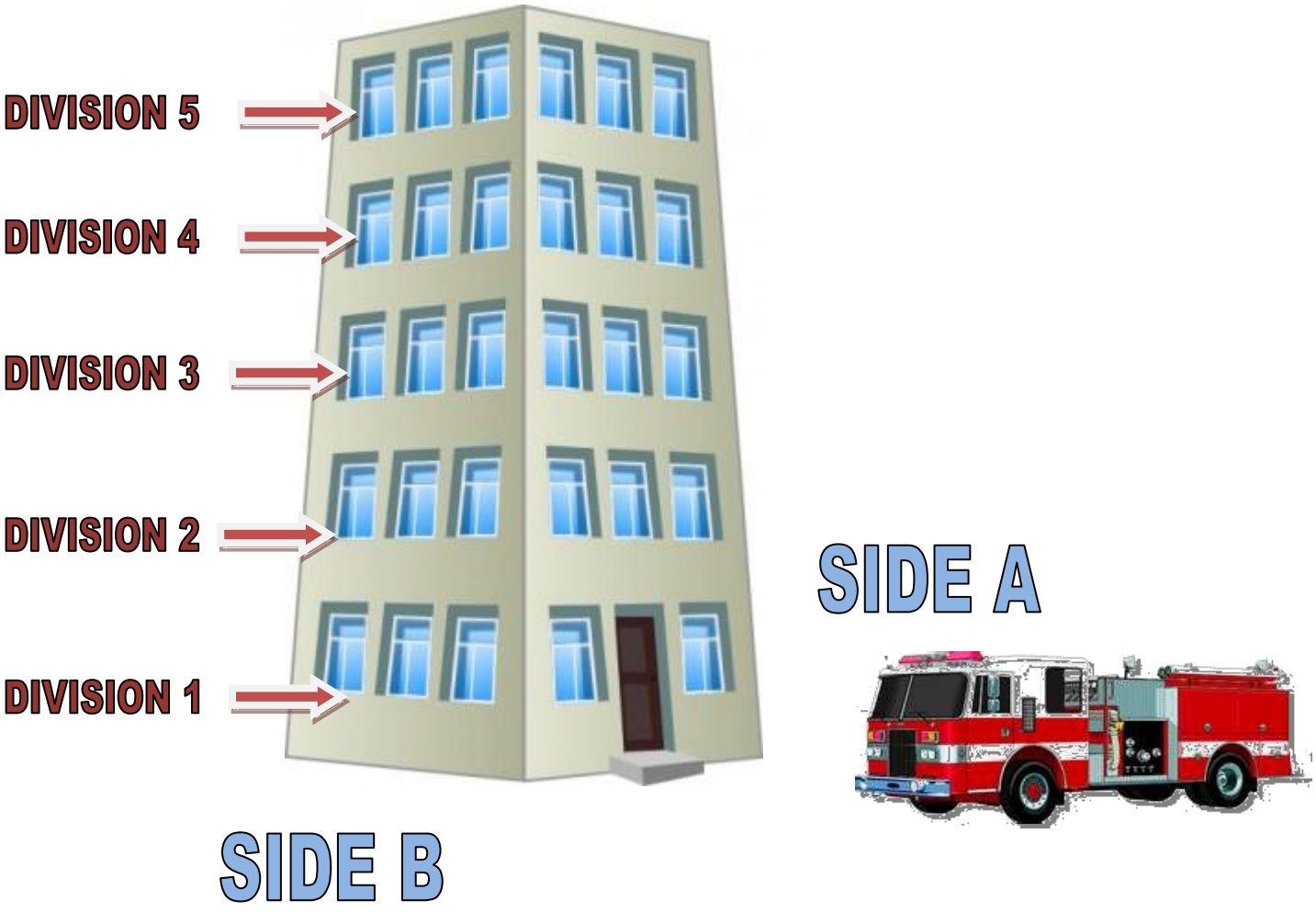


Figure XI-2 - Divisions Chart

Note: Levels below the main floor are noted as the "Basement Division".

XII. Appendix D – Helicopter Landing Zones

HELICOPTER LANDING ZONES

Helicopter Landing Zone Overview

- The preferred landing zone is 100 feet by 100 feet, with the ground relatively as flat as possible. Examples of such places would be ball fields, grass fields, empty crop fields, open highways, parking lots, etc.
- The landing zone should be centrally located; for example, if you choose a football field, center the touchdown area on the 50-yard line.
- If conditions are extremely dry then have the engine slightly wet down the field prior to landing.
- The chosen area should be free of obstructions like trees, poles, power lines, debris and people. Mark or communicate all hazards to the pilot prior to landing.
- For a detailed breakdown of Helicopter Landing Zone operations please refer to ***Charles County Emergency Services Joint SOG #12 "Helicopter Landing Zones"***

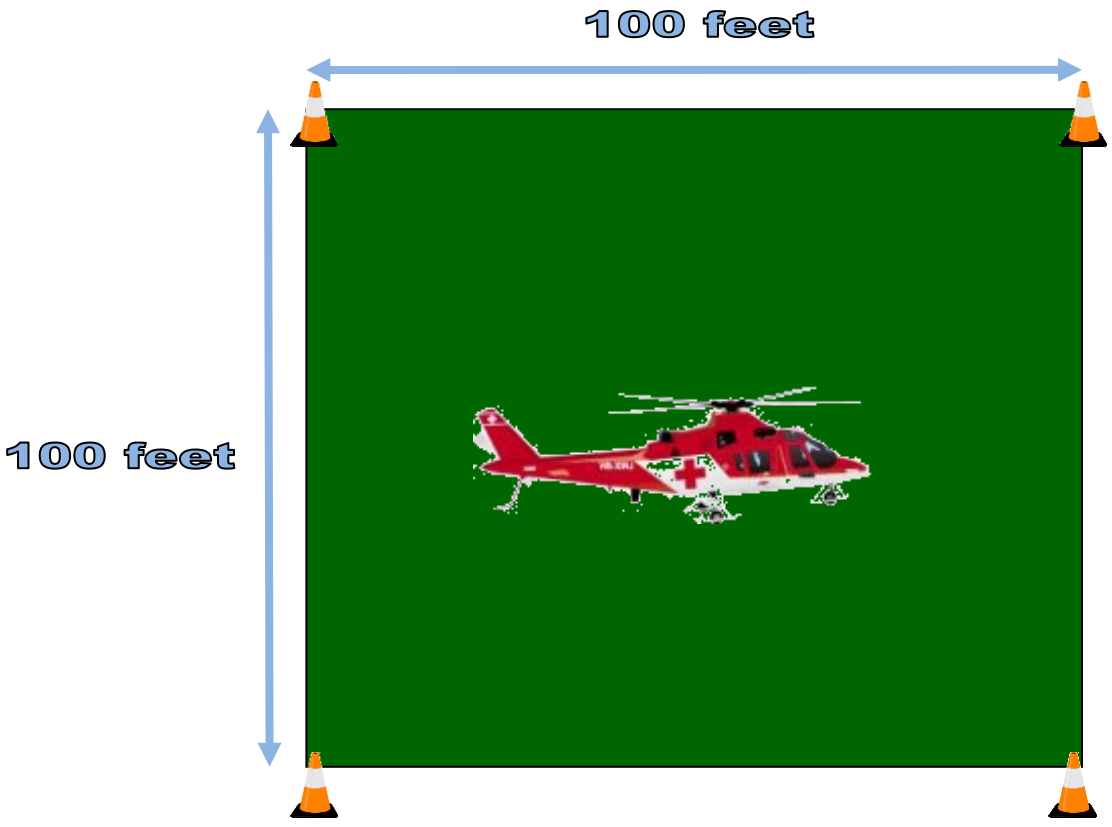


Figure XII-1 - Helicopter Landing Zones

XIII. Appendix E – Patient Placement Guide

PATIENT PLACEMENT GUIDE
(Patient Tarp Positioning)

Patient Placement Guide

- Patients should be placed side by side with ample room available for proper patient treatment.
- Patients should be placed with heads facing toward the center aisle so that they may share a mass oxygen flow system if needed.
- The center aisle should be at least two (2) feet in width so that proper medical treatment may be performed and equipment shared if necessary.

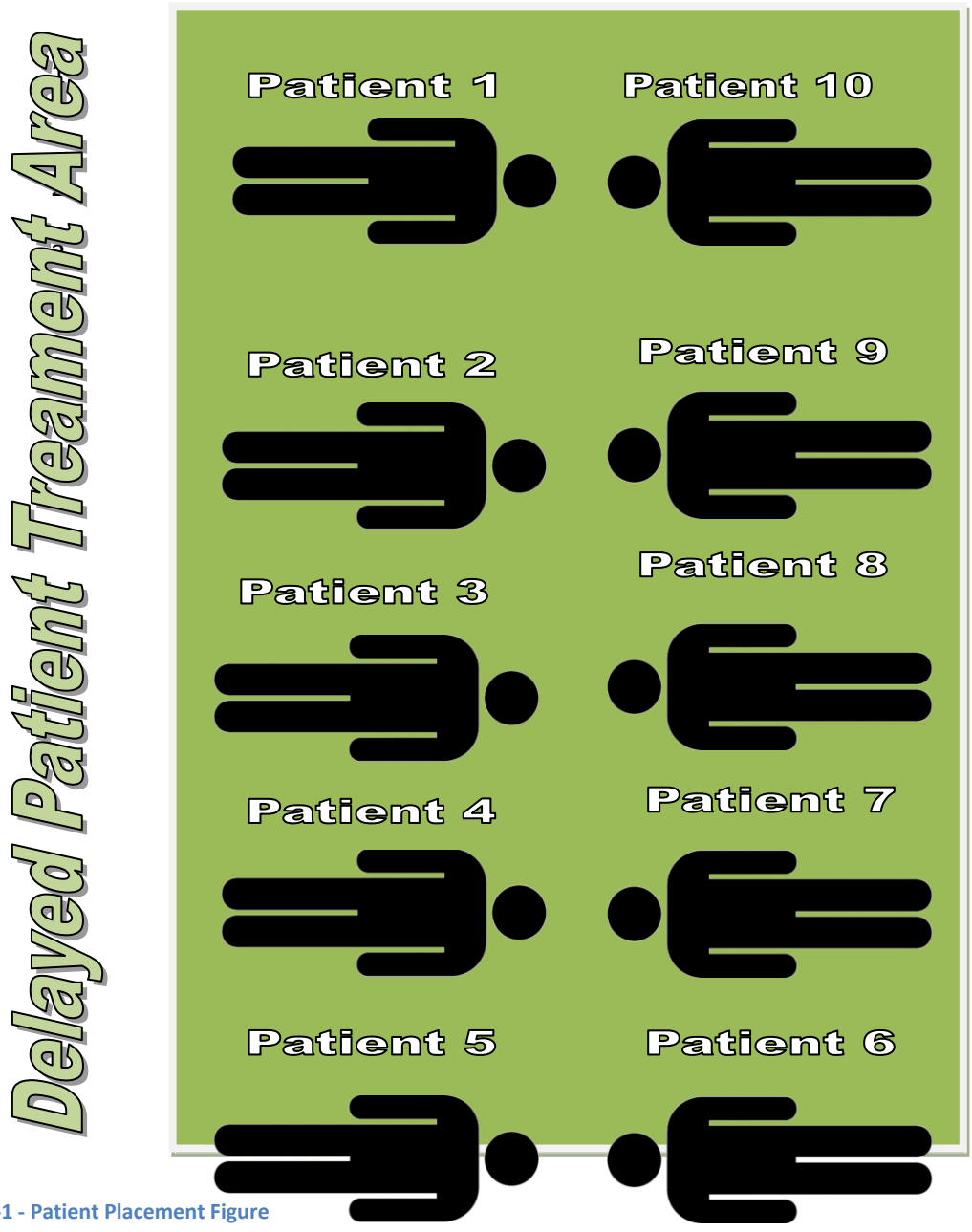


Figure XIII-1 - Patient Placement Figure

XIV. Appendix F – Hospital Resource Guide

HOSPITAL RESOURCE GUIDE

HOSPITAL RESOURCE GUIDE

HOSPITAL	PHONE #	ADDRESS	TYPE
ANNE ARUNDEL MEDICAL CENTER	(443) 481-1000	2001 Medical Parkway Annapolis, MD 21401	**LOCAL EMERGENCY ROOM**
CALVERT MEMORIAL HOSPITAL	(410) 535-8344	100 Hospital Road Prince Frederick, MD 20678	**LOCAL EMERGENCY ROOM**
CIVISTA MEDICAL CENTER	(301) 609-4000	701 East Charles Street La Plata, Maryland 20646	**LOCAL EMERGENCY ROOM/STROKE CENTER**
DOCTOR'S COMMUNITY HOSPITAL	(301) 552-8118	8118 Good Luck Road Lanham, Maryland 20706	**LOCAL EMERGENCY ROOM**
FORT WASHINGTON MEDICAL CENTER	(301) 203-3442	11711 LIVINGSTON ROAD FORT WASHINGTON, MD 20744	**LOCAL EMERGENCY ROOM**
GREATER SOUTHEAST HOSPITAL	(202) 574-6000	1310 Southern Avenue, SE Washington, DC 20002	**LOCAL EMERGENCY ROOM**
SAINT MARY'S HOSPITAL	(301) 475-8981	25500 Point Lookout Rd. PO Box 527 Leonardtown, MD 20650	**LOCAL EMERGENCY ROOM**
SOUTHERN MARYLAND HOSPITAL	(301) 868-8000	7503 Surratts Road Clinton, Maryland 20735	**LOCAL EMERGENCY ROOM / STROKE CENTER/STEMI CENTER**
GEORGE WASHINGTON UNIVERSITY HOSPITAL	(202) 715-4000	900 23rd St., NW Washington, DC 20037	**LOCAL EMERGENCY ROOM / TRAUMA CENTER**
MARY WASHINGTON HOSPITAL	(540) 741-1101	2217 Princess Anne Street, Fredericksburg, VA 22401	**LOCAL EMERGENCY ROOM / TRAUMA CENTER**
PRINCE GEORGES HOSPITAL CENTER	(301) 618-3752	3001 Hospital Drive, Hyattsville, MD 20785	**LOCAL EMERGENCY ROOM / TRAUMA CENTER**
SUBURBAN HOSPITAL CENTER	(301) 896-3100	8600 Old Georgetown Rd Bethesda, MD 20814	**LOCAL EMERGENCY ROOM / TRAUMA CENTER**
UNIVERSITY OF MARYLAND MEDICAL CENTER	(410) 328-8667	22 South Greene Street, Baltimore, MD 21201	**LOCAL EMERGENCY ROOM / TRAUMA CENTER**
WASHINGTON HOSPITAL CENTER	**(202) 877-7000**	**110 Irving St. NW** **Washington, DC 20010**	**LOCAL EMERGENCY ROOM / TRAUMA CENTER**

Figure XIV-1 - Hospital Resource Guide

NOTE: Highlighted facilities denote "local" hospitals to Charles County, Maryland

XV. Appendix G – Local Mass Casualty Resource Guide

LOCAL MASS CASUALTY RESOURCES GUIDE

NCR MASS CASUALTY RESOURCES GUIDE

MCI Resource	Location	Capabilities	Estimated Deployment Time to Incident w/in Charles County
Charles County MCSU 03	EMS Co. 03 Waldorf, MD	• Level II - 50 Patients • Cooling/Rehab Vests	15 – 20 minutes
Charles County MCSU 16	ES Bldg. La Plata, MD	• Level III - 100 Patients • Cooling Shelters • Heated Shelters • 40CBRNE Exposed Patients	15 – 20 minutes
Charles County MCSU 58	EMS Co. 58 Ironsides, MD	• Level II - 50 Patients	15 – 20 minutes
PGFD Medical Ambulance Bus 830	Station 30 Landover Hills	• Transport 26 ambulatory patients • Transport 14 non-ambulatory patients	40 – 50 minutes
PGFD MCSU 841	Station 41 Calverton	• Level II – 50 Patients	40-50 Minutes
PGFD MCSU 855	Station 55 Bunker Hill	• Level III – 100 Patients	40-50 Minutes
DCFD Medical Ambulance Bus DC	District of Columbia MAB 1 - Eng. Co. 24 MAB 2 - Eng. Co. 24 MAB 3 – Eng. Co. 33	• Transport 26 ambulatory patients • Transport 14 non-ambulatory patients	40 – 50 minutes
AACoFD Medical Ambulance Bus 21	Station 21 Harmons-Dorsey	• Transport 26 ambulatory patients • Transport 14 non-ambulatory patients	90 – 110 minutes
MCoFR Medical Ambulance Bus Montgomery County	MAB 726 – Station 26 – Bethesda MAB 722 – Station 22 – Germantown	• Transport 26 ambulatory patients • Transport 14 non-ambulatory patients	90 – 110 minutes
MCoFR MCSU 726	MCSU 726 – Station 26 – Bethesda	• Level III - 100 Patients	
MCoFR MCSU 722	MCSU 722 – Station 22 - Germantown	• Level III - 100 Patients	
Metro Wash. Airport Authority MCSU 301	MCSU 301 – Station 301 – Reagan National Airport	• Level III - 100 Patients	40-50 Minutes
Arlington County FD Medical Ambulance Bus	MAB 100 – Station 2 – Wilson Blvd	• Transport 26 ambulatory patients • Transport 14 non-ambulatory patients	40-50 Minutes
MCSU 100	MCSU 100 – Station 2 – Wilson Blvd	• Level III - 100 Patients	

Figure XV-1 - Local Mass Casualty Resource Guide

XVI. Appendix H – HC Standard Quick Start Guide

HC Standard Patient Tracking System Quick Start Guide

HC Standard County Log In

Log In: EMS0808
Password: @ccess08

KEY

DEVICE ORIENTATION
Using the Keypad

- **Scroll Up/Left:** Move up/left one item
- **Scroll Down/Right:** Move down/right one item
- **Menu:** Access the menu that appears at the bottom of the screen
- **Scan/Action:** Hold to scan a barcode; Press to take a picture
- **Backspace:** Delete one character from a text box
- **Enter:** Execute a selected item or function
- **Orange Key:** Access the orange characters and actions
  - Press once to activate temporarily
  - Press twice to lock the keypad to this mode
  - Press three times to unlock keypad
- **Backlight:** Turn the display backlight on or off
- **Tab:** Quickly Navigate to next field on screen

TIP: Turn off the backlight in bright conditions to make the screen more visible

PATIENT TRACKING SCREEN

GETTING STARTED

TURN ON

The handheld device should normally be left on. It will automatically enter hibernation mode. If touching a key or the screen does not wake the unit, push the **RED POWER BUTTON**. A warm reboot may be performed by holding the **RED POWER BUTTON** for 6 to 8 seconds. If all else fails, a cold reboot can be performed by simultaneously pressing the **1** and **9** keys and the **RED POWER BUTTON**.

CONNECTIVITY

Your handheld device will be activated on the AT&T or Verizon data network. It will automatically connect via Wifi or when a signal is available.

BOOT UP

Your handheld device may automatically load a custom Patient Tracking menu when it starts. If so, simply Select "Log into Patient Tracking" to launch the HC Standard® Patient Tracking application.

If not, follow the directions below.

From the main Windows® screen Expand the list of programs from the Windows icon on the bottom left; then Select by Clicking "Patient Tracking."

— OR —

From the main Windows® screen Open Patient Tracking by Selecting the "Patient Tracking" icon on the bottom.

LOG-IN

After you launch HC® Patient Tracking, Enter the username and password provided by your system administrator.

TIP: If you do not log in, you will not be connected to the server and can NOT submit data. The system will store the data and submit it once you log in.

SELECT INCIDENT

After log-in, Select "Menu-Change Division/Position" from the bottom right of the Patient Tracking home screen. Then Select "Incident/Position/Division/Floor/Unit Number" from the ICS screen.

TRIAGE PATIENTS

From the main Patient Tracking Screen, Scan a barcode or Tap "Triage Patients" at the bottom of the main screen to start entering patient data.

LOGIN: EMS0808
PASSWORD: Success08

PATIENT TRACKING SCREEN

ENTER PATIENT ID NUMBER/ TRIAGE SCREENS

Option 1: If you are prompted for a patient identification number, Scan a barcode by aiming the top of the device at the barcode. Press and Hold the yellow **SCAN/ACTION KEY**. If the barcode does not scan right away, vary the tag's distance from the scanner and try again.

Option 2: Alternatively, you can manually enter the patient ID number.

If the patient ID you entered has already been used, your device will download all of the current data for that patient. If not, a new record will be created.

You will always start on the Status screen, and be led through the other screens as you press the button. You can go directly to a particular screen by tapping "GoTo" in the lower left corner and making a selection.

SELECT INJURIES

Mark the location of the patient's injuries on the Injuries Screen.

- Tap the stylus on the screen to create a red "X," indicating an injury location.
- Hold and Drag the stylus from one corner to the opposite corner to draw a box for a larger area injury.

TIP: If you make a mistake, Tap "Clear" to start over.

RECORD AUDIO

From any screen, you can record audio by Tapping "Menu" and Selecting Audio. Use the "Rec," "Stop" and "Play" buttons as you would on any recording device. Tap "Done" in the lower right corner to return to the last screen you were on.

TAKE A PICTURE

To take color photos and/or capture color video on the Camera screen, Select "Color" or "Video." The camera lens is located on the back of the device.

To capture media, Press **SCAN/ACTION**, or Tap the photo button (●) on the screen (once for photos; once to start recording video and a second time to stop recording video.)

SYNCHRONIZE

Once you have saved data, the device will submit it wirelessly to the server if a signal is available and automatic synchronization is enabled. A yellow triangle (⚠) will be displayed on the Main Screen if there is any data on your device that has not been submitted. To manually synchronize, Press [ ] or Tap "Menu" in the lower right corner on the Patient Tracking screen and Select "Synchronize."

EXIT PATIENT TRACKING

Exit by Tapping "Menu" or [ ], then Select "Exit." The application will close and return to the Welcome Screen.

SAVE A PATIENT RECORD

A current patient's record will be automatically saved by scanning the new patient's barcode. This begins a new patient record regardless of current screen.

At any time, you can Tap "Menu" at the bottom right corner of the screen or Press [ ] and Select "Save."

"Save + New" saves the data for the current patient and asks you to enter a new patient ID number.

"Save + Quit" saves the data and returns to the Main Screen.

"Close Patient" will close the current record without saving any new data and will return you to the Main Screen.

Alternatively, To save a patient record on the "Save Patient" screen, Choose the option from the list that suits your needs.

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www.ger911.com

MOTOROLA
Motorola Government Solutions Provider

XVII. Appendix I – County MCI Work Sheets

COUNTY MCI WORK SHEETS

CHARLES COUNTY EMERGENCY SERVICES

"MASS CASUALTY INCIDENT WORKSHEET"

Multi Casualty Incident: Any illness or trauma-related event that kills 5 or more persons or affects or injures 3-9 persons.	**Mass Casualty Incident:** Any illness or trauma-related event that kills 10 or more persons or affects or injures 10-99 persons.	**Catastrophic Mass Casualty Incident:** Any illness or trauma-related event that involves 100 persons or greater.

Initial Actions

"Do the Greatest Good for the Greatest Number of People!! "

- ***Obtain the initial size-up information***

  Location: _____

  Type of Incident: _____

  Total # of victims: _____

  # of **RED** (immediate) _____ # of **YELLOW** (delayed) _____

  # of **GREEN** (minor) _____ # of **BLACK** (deceased) _____

- **Declare a "Mass Casualty Incident," and notify Communications to contact :**
  - **EMRC: 1-877-840-4245**
  - **SYSCOM: 1-800-648-3001**
  - **HC Standard County Log In: EMS0808 Password: @ccess08**

- **Request additional resources, as needed.** *(designate Staging Areas, see last line)*

  _____ Mass Casualty Task Force

  RS- _____ TRK- _____ ENG- _____ ENG- _____

  _____ MCSU 3 = 50 trauma patients (Level II)
  _____ MCSU 58 = 50 trauma patients (Level II)
  _____ MCSU 16 =100 trauma patients (Level III)

  If needed request Medical Ambulance Busses/Public Transportation/School Buses

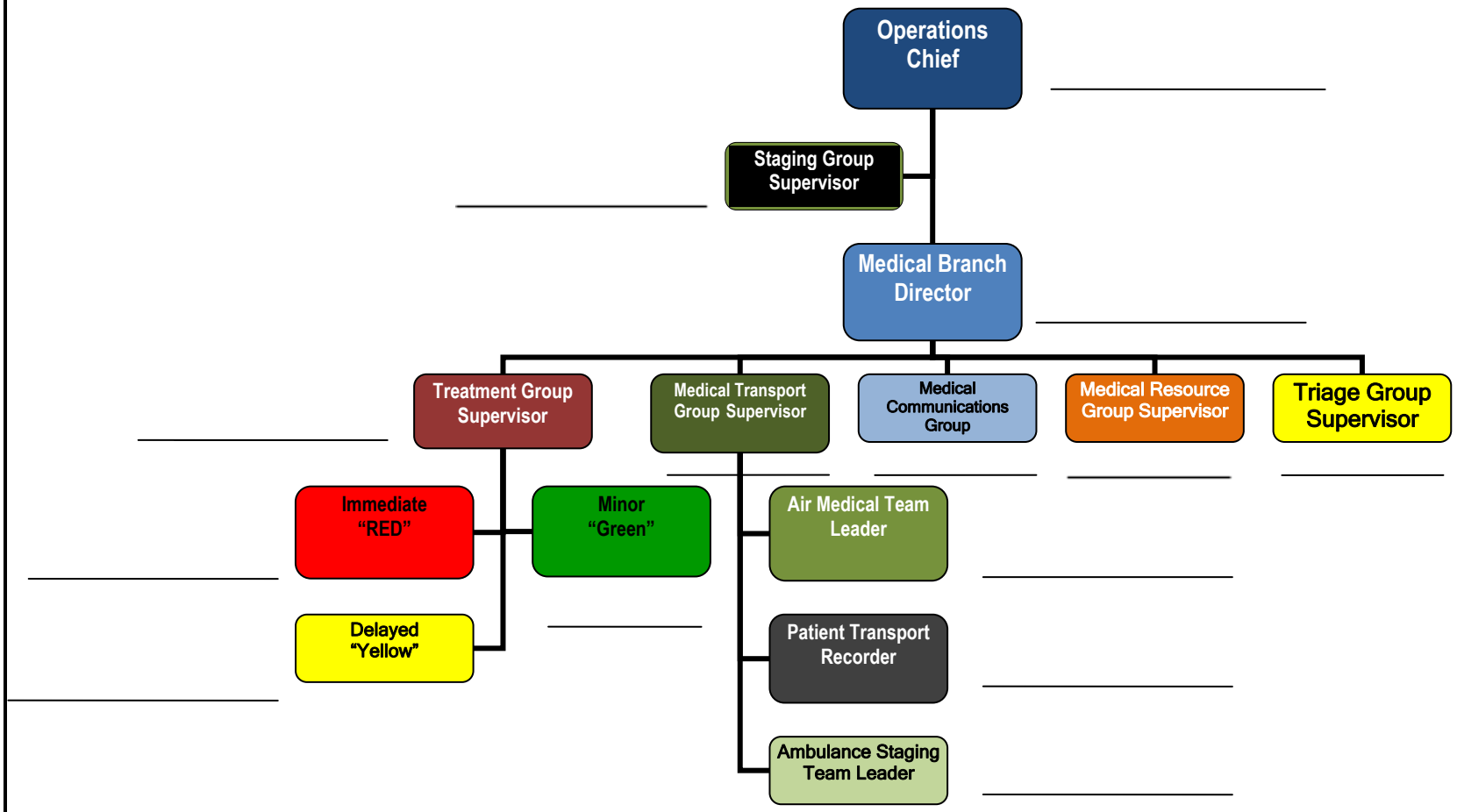
  _____ EMS Units: # of BLS ____ # of ALS ____

- **Staging Areas** : Fire: _____

  EMS: _____

CHARLES COUNTY EMERGENCY SERVICES

Mass Casualty Incident Command Structure



List the names of the officers filling the positions you have created on the appropriate line.

Initial Command Actions

- ***Established a Command Post at :*** _____

- ## *Assign NIMS Functions*

Operations Chief: _____

Medical Branch Director: _____

Triage Group Supervisor: _____

Treatment Group Supervisor: _____

Medical Comms Group Supervisor: _____

Medical Transport Group Supervisor: _____

Medical Resource Group Supervisor: _____

Staging Group Supervisor: _____

Treatment Team Immediate "RED": _____

Treatment Team Delayed "YELLOW": _____

Treatment Team Minor "GREEN": _____

Air Medical Team Leader: _____

Fire Suppression Branch Director: _____

Hazmat Branch Director: _____

Patient Transport Recorder: _____

Safety Officer: _____

Public Information Officer: _____

Liaison: _____

Morgue: _____

- ***Obtain "Hospital Call Down" information from SYSCOM***

  Advise EMRC of Incident Location, Particulars, Approximate Patient Count, and request a "Call Down" of Hospitals in each navigational direction.

- ***Establish a Morgue, if needed.***

  Location: _____

General EMS Staffing Guidelines

- 1 ***EMT-P*** for every 3 **"Red"** patients, *plus 1 EMT-B for each patient.*
- 1 ***EMT-P*** for every 5 **"Yellow"** patients, *plus 1 EMT-B for every 2 patients.*
- 1 *EMT-B* for every 5 **"Green"** patients.
- 1 *EMT-B* to maintain a **Morgue**, if established.

Ambulance Bus / Public Transportation

- 1 *EMT-B* for every 2 **"Yellow"** patients.
- 1 *EMT-B* for every 10 **"Green"** patients.

Hospital "Call Down" Information

(SYSCOM/EMRC & F.R.E.D.)

Time obtained: _____

Hospital	Availability		Received	
	Major	Minor	Major	Minor
Civista Medical Ctr.				
St. Mary's Hospital				
Calvert Memorial				
Southern Maryland				
Fort Washington				
Mary Washington				
Greater Southeast				
Anne Arundel MC				
P.G. General Hosp.				
Children's NMC				
Malcolm Grove Hosp				
Fairfax Hospital				
Providence Hospital				
George Washington				
Howard University				
Veteran's Hospital				
Walter Reed Hospital				
Wash. Adventist				
Wash. Hospital Ctr.				
Holy Cross				
Doctor' Community				
Bowie Health Center				

***Notify EMRC/SYSCOM when the Incident has been terminated.**

Triage Unit Worksheet

Triage Unit Leader: _____

- Assess patients by Respirations/Pulse/Mental Status (RPM)
- *Triage victims using the START system.* **(Red, Yellow, Green, & Black)**
- *Place appropriate color of ribbon on each victim.*
- *Move victims to the Treatment Area or Transport Area, as appropriate. Victims who are classed as **"Immediate-RED"** and are being moved directly to the Transport Area will have a triage tag placed on them before leaving the Triage Area.*
- *Update the **EMS Branch Director** of the status of the Triage Area.*
- *Notify the **EMS Branch Director** when the last patient in the Triage Area is removed.*
- *Consider Rehab and **C**ritical **I**ncident **S**tress **D**ebriefing (CISD) for responders.*

Triage Victim Tracking Table

Time	Red	Yellow	Green	Black	Total

Treatment Unit Worksheet

Treatment Unit Leader: _____

- *Select and locate appropriate area for the Treatment Area.*
  (Near incident, but not close as to impede extrication, triage, or safety.)

- *Set-up the Treatment Area.*
  ___ Area marked off
  ___ Single entrance
  ___ Single exit

- Assign crew to care each patient

- *Conduct secondary triage.*
  - *Reassess, provide gross stabilization, ABCs, Backboard, Major Fractures, Note Assessment/Treatment Interventions on TAG, Prepare patient for transport*

- *Obtain sufficient personnel based on the general guidelines below.*

Calculation Table

Color	# of Victims	EMT-P's Needed	EMT-B's Needed	AIDE's Needed
RED				
YELLOW				
GREEN				
BLACK				
Totals				

1 ***EMT-P*** for every 3 **"Red"** patients, plus 1 *EMT-B* for every patient
1 ***EMT-P*** for every 5 **"Yellow"** patients, plus 1 *EMT-B* for every 2 patients
1 *EMT-B* for every 5 **"Green"** patients
1 *EMT-B* to serve as the **Morgue** Manager, if needed

- *Notify Medical Branch of personnel and / or supply needs.*

- *Ensure all patients have a Triage Tag placed on an extremity.*

- *Coordinate the movement of patients to the Transportation Area.*

- *Notify the EMS Branch when the last patient is moved.*

Treatment Area Worksheet

RED		YELLOW		GREEN	
Supvr :		Supvr :		Supvr :	
# of Pts.	Time	# of Pts.	Time	# of Pts.	Time
Units Assigned		Units Assigned		Units Assigned	

Sketch of the Treatment Area Set-Up

Patient Transportation Worksheet

Medical Transportation Group Supervisor: _____

- Coordinate with the Medical Communications Group, Air Medical Team Leader, and Patient Transport Recorder
  - Medical Comms Group Supervisor: _____
  - Air Medical Team Leader: _____
  - Patient Transport Recorder: _____
- Responsible for patient flow
- Establish a one-way traffic flow into and out of the Transport Area
- Ensure patient barcode tags are placed on the Transport Log for the appropriate receiving medical facility

Medical Communication Worksheet

Medical Communications Group Supervisor: _____

- Contact Charles County 911 Communications Center to notify EMRC of:
  - Incident Location: _____
  - Description: _____
  - Approximate Patient Count: _____
  - Request "Call Down" of Hospitals: ☐
- Gather bed availability for hospitals in all navigational directions
- Communicate availability to the Medical **Transportation Group Supervisor**

EMRC# 1-877-840-4245

- Update EMRC every 30 minutes
  - Incident Start Time: _____ hours
  - 1st Notification to EMRC: _____ hours
  - 30 minute duration update: _____ hours
  - 30 minute duration update: _____ hours
  - 30 minute duration update: _____ hours
  - 30 minute duration update: _____ hours
  - 30 minute duration update: _____ hours
  - 30 minute duration update: _____ hours
  - 30 minute duration update: _____ hours
- Notify EMRC when the incident is terminated at _____ hours.

Treatment Log "GREEN"	CHARLES COUNTY EMERGENCY SERVICES Mass Casualty Incident Worksheet		Leader :
Incident Location :		Date :	Time :

Peel off & place "Bar Code" Tag Here	Victim's Name (if known)	Brief Description Of injuries	Time sent to Transportation

Treatment Log "YELLOW"	CHARLES COUNTY EMERGENCY SERVICES Mass Casualty Incident Worksheet		Leader :
Incident Location :		Date :	Time :
Peel off & place "Bar Code" Tag Here	Victim's Name (if known)	Brief Description Of injuries	Time sent to Transportation

Treatment Log "RED"	CHARLES COUNTY EMERGENCY SERVICES Mass Casualty Incident Worksheet		Leader :
Incident Location :		Date :	Time :

Peel off & place "Bar Code" Tag Here	Victim's Name (if known)	Brief Description Of injuries	Time sent to Transportation

Transport Log for _____Hospital	CHARLES COUNTY EMERGENCY SERVICES Mass Casualty Incident Worksheet	Patient Transport Group Supervisor

Peel off and stick the "Transport Log" tab from the bottom of the Mass Casualty Tag here.

→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.
→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.
→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.

Transport Log for _____Hospital	CHARLES COUNTY EMERGENCY SERVICES Mass Casualty Incident Worksheet	Patient Transport Group Supervisor

Peel off and stick the "Transport Log" tab from the bottom of the Mass Casualty Tag here.

→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.
→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.
→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.

Transport Log for _____Hospital	CHARLES COUNTY EMERGENCY SERVICES Mass Casualty Incident Worksheet	Patient Transport Group Supervisor

Peel off and stick the "Transport Log" tab from the bottom of the Mass Casualty Tag here.

→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.
→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.
→	Place "Transport Log" sticker here.	→	Place "Transport Log" sticker here.

Morgue Log	CHARLES COUNTY EMERGENCY SERVICES Mass Casualty Incident Worksheet		Manager :	
Incident Location :		Date :	Time :	

Peel off & place "Bar Code" Tag Here	Name, (if known)	Sex	Time In	Time Out

Patient Tracking Log

INCIDENT Location:	DATE	TIME
Treatment AREA:		

PATIENT	STATUS (CIRCLE ONE)	TIME ENTERING AREA	NOTES	TIME DEPARTED AREA
1	R Y G B			
2	R Y G B			
3	R Y G B			
4	R Y G B			
5	R Y G B			
6	R Y G B			
7	R Y G B			
8	R Y G B			
9	R Y G B			
10	R Y G B			
11	R Y G B			
12	R Y G B			
13	R Y G B			
15	R Y G B			.
16	R Y G B			.
17	R Y G B			.