IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Signature_____

EMERGENCY MEDICAL SERVICES

DISASTER RESPONSE

SOUTHWESTERN ILLINOIS EMS SYSTEM DISASTER PLAN

I. Purpose:

This policy will serve as a guideline for disaster response within the Southwestern Illinois EMS System.

II. Policy:

A. This plan shall serve as the basis for medical disaster response within the Southwestern Illinois EMS System.

1. It is MANDATORY that:

a) A full copy is kept in every unit.

b) Every provider within the Southwestern Illinois EMS System is familiar with the plan.

B. What is a disaster/mass casualty?

1. Any event that will overload the Southwestern Illinois EMS System and/or receiving facilities, whether it be gradual in nature such as a pandemic influenza or sudden such as a tornado, earthquake, etc.

2. Any event that requires an EMS agency to contact more than one additional EMS agency for mutual aid.

3. Any event that requires greater than 5 ambulances.

4. A prolonged rescue where a victim will be entrapped 60 minutes or more. (Notify EMS Medical Director directly or ask Memorial Hospital to do so. Provide location, nature of event, and contact information.)

5. A hazardous materials release (a chemical that is a direct life-threat to a population) with multiple patients or that involves 1 or more contaminated patients being transported to a hospital.

6. Any Weapons of Mass Destruction (WMD) event.

7. Any natural or man-made event with multiple patients (or the potential for multiple patients) that will have a prolonged EMS scene time of greater than 2 hours.

C. Initial Actions

1. Establish command quickly. Call BMH quickly. Call for mutual aid quickly.

2. If any of the above criteria are met, Memorial Hospital MUST be contacted. If on-scene EMS personnel anticipate that activation of the RHCC plan is not necessary (in other words, if further assistance by Memorial Hospital is not necessary), advise Memorial Hospital as such.

3. When on-scene EMS determines that they are at the scene of a MCI, it is imperative that first-responding units begin to think in an ICS thought process.

4. Call early. The benefits of early communication with Memorial Hospital cannot be underestimated, even if initial information is scarce. When in doubt, call Memorial Hospital.

5. Give the location, nature of incident, and best guess (if known) number of victims.

6. All services are encouraged to provide each of their employees with two ID badges, one to be provided at check-in and one to remain on their person.

D. Identify resources that are needed.

1. Memorial Hospital and the Incident Commander will assist with obtaining these resources. This may include, but not be limited to:

a) For prolonged incidents with numerous EMS agencies responding for mutual aid, the ITEC team may be needed to assure continuity of communications between responding agencies.

b) Disaster trailers – Memorial Hospital and the RMERT team have immediate access to several caches of medical equipment including dozens of backboards, IV fluids, trauma bags, etc.

c) The RMERT Team – Our RMERT team is maintained through St. Clair Special Emergency Services (SCSES). They are a fire department that serves as the county/region's technical rescue/HAZMAT team. The RMERT Team also has access to area disaster trailers.

d) Chem-Pack – For a WMD event with possible chemical agent release, ask Memorial Hospital for release of the antidote cache. This will take additional time as it requires direct communication with the Southwestern Illinois EMS Medical Director and Memorial Hospital pharmacy director.

e) Buses for transportation of walking wounded. These can be requested by the Incident Commander from Bi-State or from Scott AFB. The buses from Scott AFB may be staffed, if requested and available, with medical personnel. Again, requesting Scott AFB assets will require direct contact with the Southwestern Illinois EMS Medical Director and command personnel at Scott AFB.

2. All EMS personnel, including the RMERT team, shall report to the Medical Branch Director or his/her designee. This does NOT include Rescue Medics tasked with direct support of St. Clair Special Emergency Services/St. Louis USAR Task Force 4. These personnel shall report to the Chief of SCSES but will coordinate all patient care with the Medical Branch Director.

3. The Medical Branch Director or his/her designee shall make all requests for above personnel and equipment from Memorial Hospital, the RHCC.

4. At any time you are requesting these additional resources, provide the type of event, exact location of staging area, number of casualties, name and contact information for the person requesting.

E. Scene Safety

1. Scene safety at an MCI scene, as at any scene, is paramount. Each provider is responsible for his/her safety, not just command personnel or an assigned safety officer. All personnel have the responsibility of reporting unsafe situations and remaining clear of hazardous scenes.

2. When you approach the scene of a potential MCI, if you feel the situation is unsafe, do not enter the scene. Advise dispatch and all incoming units

of the potential hazard. Coordinate all actions with the Incident Commander in order to avoid entering a potentially hazardous area.

3. If you suspect Hazardous Materials are involved, stay away from the hot zone as determined by the Incident Commander. Remain uphill and upwind until command staff determine it is safe for you to proceed.

4. As with any scene, EMS calls that involve technical rescue or HAZMAT are best handled by EMS providers with the appropriate training through Illinois Office of the State Fire Marshal. When available, EMS providers with appropriate training should ideally be the providers engaged in patient care for patients at a HAZMAT release or for entrapped patients at incidents involving technical rescue.

F. Incident Command System

1. All EMS calls, regardless of the size or scope of the incident, will utilize the Incident Command System, in accordance with HSPD #5.

2. EMS will have very specific roles during a disaster. Not all may be needed; some may be combined. EMS will typically NOT be in command of the scene. Typically, fire or law enforcement personnel, depending on the nature of the incident will serve as incident command.

3. It is crucial that the initial responders NOT begin patient care. Rather, they should begin to think in an ICS thought process and establish the medical chain of command.

4. Medical care at the scene of an MCI shall be established in an orderly fashion. Medical care, unless directed otherwise by command staff, will be established as a Medical Branch beneath the Operations Section. Freelancing is strictly forbidden. All personnel must conform to the ICS process.

5. The most experienced provider on the initial responding unit shall assume the position of Medical Branch Director. He/she will answer to the Operations Section Chief and/or the Incident Commander.

   a) He/she will be responsible for implementation of the Incident Action Plan within the medical branch as set forth by command staff.

   b) The Triage, Treatment, and Transport Officers will report to the Medical Branch Director. This position and its responsibilities may be transferred to a more experienced provider on another

incoming unit when they arrive. All personnel must be made aware of the transfer of command if this occurs.

c) The main goal of the Medical Branch Director will be to step back and look at the big picture, even though it is inherently difficult for all of us to do.

(1) The Medical Branch Director should make initial contact with Memorial Hospital if the position of Transportation Officer has not yet been assigned.

d) The Medical Branch Director shall request necessary resources from the Operations Section Chief and from staging as needed.

e) The Medical Branch Director shall determine triage, treatment, and transport areas in conjunction with appropriate officers (when assigned). Assist these officers as necessary.

f) The Medical Branch Director will NOT be involved in patient care.

6. The second most experienced provider will initially assume the position of Triage Officer.

a) He/she will report to the Medical Branch Director.

b) The Triage Officer is responsible for identification and triage of all victims. He/she will establish a casualty collection point if the nature of the event dictates that casualties would be best served by being brought to one concise point for triage (whether due to relatively large geographic area or for scene safety).

c) The Triage Officer will ensure that triage tags are placed on each victim.

d) He/she will NOT be involved in patient care outside of that included in the triage process.

7. A Treatment Officer may also be assigned.

a) He/she shall report to the Medical Branch Director.

b) The Treatment Officer is responsible for establishing treatment areas if not already done. He/she may delegate an individual to supervise each treatment area (RED/YELLOW/GREEN).

c) The Treatment Officer ensures that each patient is prepared for transport and communicates with the Transport Officer to ensure that the most critical patients are transported first.

d) All treatment is to be documented on triage tags.

8. A Transport Officer may also be assigned.

a) He/she shall report to the Medical Branch Director.

b) The Transport Officer coordinates transportation/dissemination of patients of various acuities to appropriate facilities.

c) After possible initial contact by the Medical Branch Director, the Transport Officer is the only person to remain in radio contact with Memorial Hospital regarding patient destination decisions. The Transport Officer should be identified to Memorial Hospital as soon as possible, as well as a reliable means of communication. He/she will be Memorial Hospital's contact person in the field. The Medical Branch Director may continue to contact the Resource Hospital for administrative needs/concerns, to request additional EMS resources, etc.

d) The Transport Officer will NOT be involved in patient care.

9. A Patient Tracking/Accountability Officer may also be assigned.

a) The function of the Accountability Officer will be to maintain accountability of all EMS personnel operating on scene and all patients, including their ultimate destination.

b) The staging officer will account for personnel staged for transporting patients.

c) If personnel are re-assigned to on-scene operations, he/she will provide one of his/her accountability tags to the Accountability Officer. The other will remain on his/her person.

d) Patient tracking shall be undertaken in either written and/or electronic form.

e) Depending on the nature of the incident, patient tracking may be accomplished in either the triage or treatment areas but MUST be completed prior to transport of any patient.

10. Miscellaneous roles:

    a) The staging officer reports directly to the Operations Section Chief and is responsible for staging of all incoming apparatus. The Incident Commander/Operations Section Chief may request that an EMS provider assist the staging officer.

    b) Incident Rehabilitation is very important on extended incidents. The Incident Commander may request EMS to establish/assist with rehabilitation of personnel.

        (1) The Medical Branch Director will coordinate which personnel are to be assigned to the rehabilitation sector.

        (2) Personnel in the rehabilitation sector will answer directly to the Logistics Section Chief, not the Medical Branch Director or the Operations Section Chief.

        (3) Refer to the Incident Rehabilitation SOG for procedures to follow in this sector.

11. All other responding personnel:

    a) Report to the designated check-in area.

    b) It is mandatory that all responding EMS personnel have some element of a uniform in order to identify them on scene.

    c) It is highly suggested that all personnel have 2 photo IDs from his/her place of employment – one to carry with them and one to leave at the check-in area.

    d) No personnel shall self-dispatch to the scene of a reported emergency/disaster.

    e) Each agency shall have methods for internal paging/all-calls of off-duty personnel. Stricken EMS agencies may utilize their own all-call at their discretion.

    f) Memorial Hospital will contact the POC at each agency to request an all-call, if needed from another agency.

12. Volunteers

    a) Often, well-intentioned volunteers with varying capabilities will self-dispatch to the scene of a disaster. However, volunteers

unknown to responding personnel may misrepresent their capabilities and/or become a safety hazard to on-scene personnel.

b) Volunteers, if utilized, MUST conform to the Incident Command System, proceed through check-in if established, and must follow appropriate safety procedures.

c) Medical personnel NOT registered with Southwestern Illinois EMS System must show proof of licensure. If utilized, these personnel must be confined to dedicated treatment areas under the direct supervision of Southwestern Illinois EMS System personnel. They may only serve to administer basic first-aid to victims.

d) Any physician that responds to the scene of a disaster must also conform to the policies set forth in the Southwestern Illinois EMS System Policy Manual.

e) Any question or concern regarding the use of volunteers should result in the expulsion of the volunteer from the scene or communication with Memorial Hospital by the Medical Branch Director.

G. Communications

1. Notify incoming units of the staging location and check-in, if established.

2. The EMS channel for communications on scene will be EMS Common 1 (800 MHz) in St. Clair Co. The stricken ALS agency in all other counties will designate a primary EMS channel and communicate this to incoming units.

3. All services should attempt to obtain and preprogram available frequencies of other EMS agencies within the Southwestern Illinois EMS System in order to alleviate obstructions to communication as much as possible.

4. All services without the capability to communicate on the designated channel will send someone to the EMS command area to ensure a cohesive communication plan with all EMS personnel on scene.

H. Dispatch

1. EMS agencies may call for mutual aid from within their agency or from neighboring EMS agencies.

2. In order to request mutual aid from more remote agencies, the Resource Hospital shall contact these agencies and request them to respond.

3. During a disaster event, PSAPs are encouraged to utilize call-stacking via the MPDS system.

4. It is suggested that agencies defer non-emergency runs or transfers.

I. Triage

1. It is imperative that triage be performed in a rapid, coordinated, systematic fashion using the START and Jump-START algorithms. If a victim appears to be an adult or young adult, use the START algorithm. If they appear to be a child, use the Jump-START algorithm.

2. The Triage Officer (and his/her designated personnel, if any) shall move through the entire scene, rapidly assess each patient, stopping only to open an airway or stop profuse bleeding.

3. A triage tag shall be affixed to each patient. OR:

4. The Triage Officer will establish a Casualty Collection Point (depending on the nature of the incident) where other personnel (firefighters, law enforcement officers, etc.) will bring patients for triage.

5. START Adult Triage (See Appendix 1.)

   a) Mobilize all ambulatory patients to the GREEN treatment area. All ambulatory patients will initially be triaged as GREEN but may be upgraded if they are found to meet YELLOW or RED criteria.

   b) Remember to keep the GREEN triaged patients supervised by dedicated EMS personnel.

6. Assess ventilations of remaining patients:

   a) If no respiratory effort is present after opening the patient's airway, tag the patient as BLACK.

   b) If the respiratory rate is > 30, tag the patient as RED.

7. If the respiratory rate is < 30, assess the patient's perfusion.

   a) If the patient has no radial pulse present, tag the patient as RED.

8. If the patient has a radial pulse, assess the neurological status.

a) If the patient is Unresponsive or cannot follow simple commands, tag the patient as RED.

b) If the patient can follow simple commands, tag the patient as YELLOW.

9. Jump-START Pediatric Triage (See Appendix 2.)

a) Again, mobilize all ambulatory patients to the GREEN treatment area. All ambulatory patients will initially be triaged as GREEN but may be upgraded if they are found to meet YELLOW or RED criteria.

10. **Children that are not yet ambulatory due to young age may be carried to the GREEN area but MUST be the first assessed by treatment personnel in that area.

11. Assess ventilations of remaining patients (note that this differs from adult patients):

a) If the patient has no respiratory effort after opening the airway AND no pulse, triage the patient as BLACK.

b) If the patient has a pulse, open the airway and give 5 breaths. If no spontaneous respirations are triggered by these rescue breaths, triage the patient as BLACK.

c) If spontaneous respirations resume, tag the patient as RED. Provide no further respiratory assistance, and move on.

d) If the patient has a respiratory rate < 15 or > 45, tag the patient as RED.

12. If the patient has a respiratory rate between 15 and 45, assess the patient's perfusion.

a) If the patient has no distal pulses present, tag the patient as RED.

b) If the patient has distal pulses present, assess neurological status.

c) If the patient is unresponsive or cannot follow simple commands (age appropriate), tag the patient as RED.

d) All other patients shall be tagged as YELLOW.

J. Crime Scene Preservation

1. All disasters and scenes involving fatalities shall be considered crime scenes until determined otherwise by law enforcement officers or the responding coroner.

2. Movement of bodies is strictly forbidden (unless necessary to access potential survivors) until authorized by law enforcement officers or the responding coroner.

3. Refer to Section VIII for further detail.

K. Transportation

1. The Transportation Officer, in coordination with the Treatment Officer, shall determine the order in which patients shall be transported from the scene.

2. Helicopter EMS (HEMS) should be preferentially utilized for transportation of patients to trauma centers in St. Louis before transportation of lesser acuity patients.

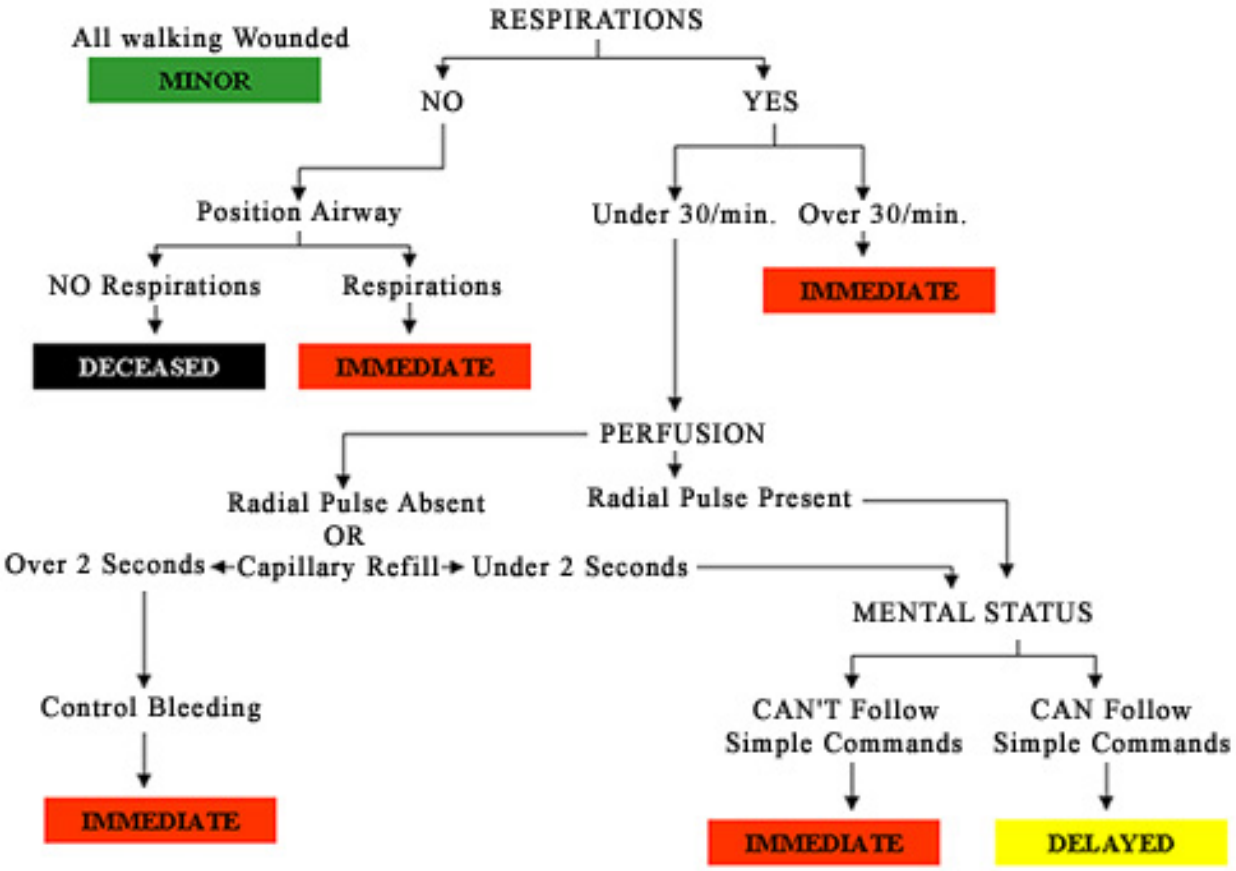
L. Documentation

1. Do not delay patient care or transportation during a disaster for documentation.

2. However, documentation is crucially important. The triage tag is considered patient documentation, as well as confidential patient information. Triage tag information should be attached to a run report for submission to Memorial Hospital.

M. For additional information concerning Regional disaster response, refer to the Region IV Disaster Manual.

Appendix 1 START Triage Algorithm



Appendix 2 Jump-START Triage Algorithm