



**Lubbock EMS**

**Disaster Operations Plan**

**And**

**Appendices**



As of June 2, 2005

## TABLE OF CONTENTS

Introduction .....	2
Levels of Disaster Activation .....	3
IMS Incident .....	3
EMS Command Incident .....	3
MCI: Initial Response and Notification .....	4
Command and Control .....	6
<b>APPENDICES</b>	
Appendix A – D-I-S-A-S-T-E-R Paradigm .....	8
Figure A1: D-I-S-A-S-T-E-R Paradigm .....	9
Figure A2: Detection .....	9
Figure A3: Scene Security and Safety .....	9
Figure A4: Assess Hazards .....	10
Figure A5: Support .....	10
Appendix B – Command and Control Positions .....	11
EMS Command .....	12
EMS Operations or EMS Branch Director .....	13
Triage Group Supervisor .....	14
Staging Area Manager .....	15
Treatment Group Supervisor .....	16
Transport Group Supervisor .....	17
Support Group Supervisor .....	18
Medical Support Unit Leader .....	19
Appendix C - Flowcharts .....	20
EMS Command Structure .....	21
Incident Management Structure .....	22
Patient and Communications Flow Chart .....	24
Appendix D – Initial Action Checklist .....	25
Appendix E - Triage .....	26
S.T.A.R.T. .....	27
Four Category Triage .....	28
M.A.S.S. .....	29
Appendix F – MCI Fatality Management .....	30
Appendix G – Hazardous Material Response .....	31
Appendix H – Weapons of Mass Destruction .....	34
Appendix I – Transport Guidelines .....	37
Appendix J – Communications Center Checklist & Phone List .....	38
Appendix K – Rehab Protocol .....	45
Appendix L - Organized Citizen Response .....	47
Appendix M - Forms .....	48



## LUBBOCK EMS MCI PLAN

Lubbock EMS, as a member of South Plains Emergency Medical Services, utilizes and supports the regional mass casualty plan. This document is a synopsis of that plan and specific procedures for Lubbock EMS. It is to be used as a guide during an actual event. All employees of Lubbock EMS should become familiar with this plan in order that on scene operations can run as needed from the onset.

The first arriving unit must establish effective command and control. Once a MCI has been declared, you are on a multi-agency scene, hazardous material incident, or weapon of mass destruction incident; the Incident Management System (IMS) **must** be utilized. Appropriate triage, patient management, and patient transport are also vital to a successful outcome.

EMS is responsible for two areas at any incident. The first is the care and transport of any sick or injured victims. Second, the medical care of the on scene responders is important as well. With these responsibilities, EMS should have a presence on scene for the duration of an incident.

Following are ten critical factors of successful MCI operations:

1. In a MCI, patients outnumber EMS providers.
2. The first arriving EMS unit **MUST** establish command and begin triage, not perform treatment.
3. The Incident Management System (IMS) establishes an EMS Branch under Operations; the key EMS areas are Triage, Treatment, and Transport.
4. Treatment is not effective without effective triage.
5. The Treatment Area must coordinate with the Triage and Transport Areas.
6. The Treatment Area is a noisy, busy place and a major resource consumer.
7. On small scale MCI events, EMS Command may be able to coordinate the entire Operation; on large incidents a separate Treatment Area is needed.
8. On large incidents the Treatment Area is divided into Red, Yellow, and Green treatment units.
9. Large-scale incidents or disasters may require separate divisions; each division is a geographic area that is an IMS structure and requires support.
10. In terrorism or hazmat incidents, the scene can be dangerous. **Total scene awareness is critical.**



## Levels of Disaster Activation

Lubbock EMS utilizes three different levels of activation for disaster response. These levels are listed below:

1. IMS Incident – (Incident Management System Incident)
2. EMS Command Incident
3. MCI – (Mass Casualty Incident)

An **IMS Incident** is activation resulting from a single incident. It is initiated due to having five (5) or more transportable patients on scene or requesting three (3) or more ambulances. Non-injured victims and those refusing transport are not counted in the number of patients to cause this activation. When one of the previous conditions is met, the following actions must be taken:

1. IMS will be instituted with one of the first medics on scene assuming role of EMS Command and sizing up the scene to determine needs and to make sure that triage has been performed.
2. All patients will be tagged with the current triage tag.
3. The on duty Chief or Assistant Chief will be dispatched to the scene to assume EMS Command.

An **EMS Command** Incident can be a single incident, but it will more likely be a combination of incidents, usually combined with poor weather conditions that overload the local EMS system. The main impact that causes activation of this level is that response times increase due to lack of available units. This level primarily effects operations within the Communications Center, except for manning backup units with off duty personnel. The following guidelines are to be used in this type of situation:

1. The on-duty EMS Shift Chief will be responsible for activating an EMS Command Incident and initiating callback of off duty personnel.
2. The Lubbock Fire Department will be used to first respond to any call that they would be closer.
3. Contact Lubbock Aid Ambulance to advise them that they may be needed to respond to emergency calls. Also, determine if they have units available to possibly post away from their normal stations. Make sure that you have determined the level of care on each ambulance that will be available and document the levels.
4. During poor road conditions, do not stage County units into the city of Lubbock unless advised by the Chief to do so. Try to leave them to cover their communities. If needed they can be called to respond to a call in the city, from their station, if they are the closest unit.
5. Anytime during an EMS Command Incident, the on-duty dispatchers can call in and off duty dispatcher to assist with Communication Center operations. This will be left up to their own discretion. This can be done without supervisor approval.

The remainder of this manual deals with the third level of disaster activation, the MCI.



## **MCI: INITIAL RESPONSE AND NOTIFICATION**

During the initial response it may or may not be known that a major incident exists. Dispatch should relay any information they might have that is suggestive of a major incident. Regardless of any information received, the initial EMS unit **MUST** make a size-up of the scene. Evaluate the nature of the incident, possible number of patients, type and severity of injuries, threats and dangers to the responders, and any specialized resources that might be needed.

After the initial size-up, a determination should be made as to whether a major EMS event or MCI exists; or whether there is neither. Dispatch should be advised as soon as possible. If a Major EMS Event is declared, notify dispatch of the number of patients and any other pertinent information. If a MCI is declared, the following information should be relayed to dispatch:

1. That an MCI has occurred;
2. Type of incident;
3. Who is in command of the EMS Branch;
4. Approximate number and severity of patients;
5. Location of Incident Command Post;
6. Location of Staging Area;
7. Number and types of transport vehicles;
8. Special hazards.

See Appendix D for the Initial Action Checklist.

Successful management of a MCI, disaster, or any scene can be accomplished by using an approach called the D-I-S-A-S-T-E-R paradigm. It is a way to organize your preparation and response to disaster management. The key is to use it routinely apply the principles on every call. It is a means to continuously assess the current status and anticipate future status needs during an event. The items in the DISASTER paradigm are not in order of occurrence or importance.

D – Detection  
I – Incident Command  
S – Scene Security and Safety  
A – Assess Hazards  
S – Support  
T – Triage and Treatment  
E – Evacuation  
R – Recovery

**Detection** is awareness and recognition of a situation that will overwhelm the resources available on the scene. The key to detection preparedness is practicing detection skills on a daily basis. Before stepping out of the vehicle, look around for anything unusual. See Figure A2 in Appendix A for goals and checklist.



**National Incident Management System (NIMS)** must be used on all MCI, disaster, Hazmat, and large incidents. It allows for the early coordination of all assets. See Page 6 for more detailed information on Incident Management.

**Scene Security and Safety** must be the immediate item addressed. This may require that law enforcement or fire services assure scene safety before EMS may access the patients. Scene safety begins before you arrive, while in route to the scene think of what hazards you might encounter. Be flexible in your approach, because the only thing that is certain is change. Don't be selfish protect yourself. Scene priorities should be as follows: Protect yourself and your fellow personnel first; then protect the public; then protect the patients; and last protect the environment.

**Assess Hazards** by being aware of everything going on around you. Continual reassessment of the scene is vital to assessing hazards. Some examples of hazards are listed in Figure A4 of Appendix A.

**Support** includes personnel, supplies, facilities, vehicles and any other resources needed to successfully manage the incident. Depending on the assessment of hazards and the number of victims expected, you must determine what support is needed, and make the request. If the complete Incident Management System is activate, these requests should be routed through Logistics.

**Triage and Treatment** will begin when you have safe access to the patients. Triage is done to sort the patients into four categories; **Immediate**, **Delayed**, **Minor**, or **Expectant/Dead**. Initial triage is done by using either the S.T.A.R.T. system or the M.A.S.S. system. S.T.A.R.T. works for most incidents, but if there are large numbers of victims, hundreds and above, consider using the M.A.S.S. system. M.A.S.S. is still based on the S.T.A.R.T. system, but is able to handle a larger number of patients faster. See Appendix E for specifics on these systems. Then the Four Category System will be used as patients are moved to Treatment and for Transport. Remember that triage is a series of assessments not just one initial pass.

**Evacuation** of people during a MCI or disaster is the short-term overall goal of the event. Being resourceful and creative in your transportation options for evacuation is key. Use the most appropriate mode of transportation available.

**Recovery** begins when the incident occurred and attention to the long-term implications, costs, and the impact to the community must be considered. Recovery is the long-term objective and goal of MCI management. CISM for the response personnel is part of this phase.



## **Command and Control**

On scene EMS operations fall under the Command, Operations, and Logistics functions of the Incident Management System (IMS). IMS is used to allow organization for all agencies operating on the scene. IMS also allows for long term planning and organization of resources. IMS allows for standardization of terminology and a uniform system for coordination across agency lines. EMS command and control functions are EMS Command, EMS Operations or EMS Branch Director, Triage Group Supervisor, Treatment Group Supervisor, Transport Group Supervisor, Staging Area Manager, Support Group Supervisor, and Medical Support Unit Leader. Appendix A contains a listing for each position stating its radio call sign, area of operation, IMS functional area, and responsibilities. Appendix B contains diagrams showing command structure of IMS, EMS position assignments, patient flow, and communication flow. Position assignments should be assigned in the following order: first in unit, EMS Command and Triage Group Supervisor; Staging Area Manager; Treatment Group Supervisor, Transport Group Supervisor, EMS Operations or EMS Branch Director, Rehab Group Supervisor, and Support Group Supervisor. Any other positions that might be needed may be added when necessary. EMS Command fills all positions until they are assigned to someone else. When appropriate supervisory personnel arrive on scene they will take command, but only after being briefed by the current EMS Command.

One benefit of IMS is that you only have to expand it out as far as needed, and then you can shrink it back down when positions are no longer needed. There are five functional areas of IMS; Command, Operations, Logistics, Planning, and Finance. The Incident Commander is responsible for all incident or event activity. Although other functions may be left unfilled, there will always be an Incident Commander. He can be a single commander or there can be Unified Command. Unified Command is a process that allows all agencies that have jurisdictional or functional responsibility for the incident to jointly develop a common set of incident objectives and strategies. This is accomplished without losing or giving up authority, responsibility, or accountability. During Unified Command, the following applies: the incident will function under a single, coordinated Incident Action Plan; one Operations Section Chief will have responsibility for implementing the Incident Action Plan; and one Incident Command Post will be established. The Operations Section is responsible for directing the tactical actions to meet incident objectives. The Logistics Section is responsible for providing adequate services and support to meet all incident or event needs. The Planning Section is responsible for the collection, evaluation, and display of incident information, maintaining status of resources, and preparing the Incident Action Plan and incident related documentation. The Finance Section is responsible for keeping track of incident related costs, personnel and equipment records, and administering purchase contracts associated with the incident or event.



Each of these functional areas can be expanded into organizational units with further delegation of authority. The individual designated as the Incident Commander (IC) has responsibility for all functions. The IC may elect to perform all or some of the functions, or delegate functions to other personnel. EMS should have a representative at each of the IMS functional areas.

Span of control is an important aspect in IMS. It relates to the number of individuals that a person is responsible for. As span of control exceeds one supervisor over three to five individuals, an adjustment to the organizational structure should be considered. The rule of thumb for IMS is one supervisor to five subordinates.



**APPENDIX A**  
**D-I-S-A-S-T-E-R PARADIGM**  
**FIGURES**



**Figure A1  
D-I-S-A-S-T-E-R  
Paradigm**

- D – Detect**
- I – Incident Command**
- S – Scene Security and Safety**
- A – Assess Hazards**
- S – Support**
- T – Triage and Treatment**
- E – Evacuation**
- R – Recovery**

The **D-I-S-A-S-T-E-R** paradigm organizes the responders preparation and response to disaster management.

**Assessment Checklist:**

- Do I **detect** something, what caused this?
- Is a **safety** or **security** issue present?
- Did we **assess the hazards** that could be here?
- Do we need to **triage**, how much **treatment**?
- Can we **evacuate/transport** the victims?
- What **recovery** issues are present?
- Do we need an **Incident Command**, where?

**Disaster or MCI present:**

- Is my need greater than my resources?

**Figure A2  
Detection**

**Goal to Assess if:**

- Disaster or MCI present
- All-Hazards cause identified
- Identified, but UNSAFE

**Checklist:**

- Are my capabilities or capacity exceeded?
- Does need exceed my resources?
- Before you step out of the vehicle, look around.
- If a threat or agent is suspected, what is it?
- What do you see, smell or hear that is different?
- What are bystanders saying or doing?
- Is everyone coughing, crying, staggering or lying still?

**Figure A3  
Scene Security and Safety**

**Don't be selfish, protect yourself!**

- Protect Yourself and Your Team Members **FIRST**
- Protect the Public
- Protect the Patients
- Protect the Environment



Figure A4 Assess Hazards Examples	
<ul style="list-style-type: none"> <li>- Power lines downed</li> <li>- Debris/trauma</li> <li>- Fire/burns</li> <li>- Blood and fluids</li> <li>- Hazardous materials</li> <li>- Flooding/drowning</li> <li>- Explosions</li> </ul>	<ul style="list-style-type: none"> <li>- Smoke or toxic inhalations</li> <li>- Natural gas lines</li> <li>- Structural collapse</li> <li>- Weather conditions</li> <li>- Snipers</li> <li>- Secondary devices</li> <li>- NBC exposures</li> </ul>

Figure A5 Support
<p><b>What do I need to get the job done?</b></p> <ul style="list-style-type: none"> <li>- How do we mitigate the disaster or MCI?</li> <li>- What <b>human resources</b> or skilled teams are needed?</li> <li>- What <b>agencies</b> are needed?</li> <li>- What <b>facilities</b> will be needed?</li> <li>- What <b>supplies</b> do I need?</li> <li>- What <b>vehicles</b> are needed?</li> </ul>



**APPENDIX B**

**COMMAND AND CONTROL POSITIONS**



## EMS COMMAND

Call Sign: **EMS Command**

ICS Functional Group: Command

Commanded By: Incident Command

Subordinates: EMS OPERATIONS OR EMS BRANCH DIRECTOR, TREATMENT GROUP SUPERVISOR, TRANSPORT GROUP SUPERVISOR, TRIAGE GROUP SUPERVISOR, STAGING AREA MANAGER, SUPPORT GROUP SUPERVISOR, and AIR OPERATIONS BRANCH DIRECTOR.

Function: Establish command, and control on-site EMS activities to insure the best possible care for the greatest number of patients.

Roles and Responsibilities:

- Responsible for all EMS operations on the scene
- Establish Command Post, usually at Incident Command
- Function within the unified command system
- Delegate subordinate positions as needed and as personnel become available
- Coordinate joint operations with all other commands and INCIDENT COMMAND



## **EMS OPERATIONS or EMS BRANCH DIRECTOR**

Call Sign: **EMS Ops**

ICS Functional Group: Operations

Commanded By: EMS COMMAND OR OPERATIONS SECTION CHIEF

Subordinates: TREATMENT GROUP SUPERVISOR, TRANSPORT GROUP SUPERVISOR, TRIAGE GROUP SUPERVISOR, STAGING AREA MANAGER, SUPPORT GROUP SUPERVISOR and AIR OPERATIONS BRANCH DIRECTOR.

Function: Field supervisor of all on-site EMS activities to insure the best possible care for the greatest number of patients.

Roles and Responsibilities:

- Supervise all field operations of EMS Branch
- Represents EMS at any Operations meetings
- Coordinates with EMS Command on resources needed
- Move between EMS functional areas as needed to oversee operations



## TRIAGE GROUP SUPERVISOR

Call Sign: **Triage**

ICS Functional Group: Operations

Commanded By: EMS COMMAND or EMS OPS/EMS BRANCH DIRECTOR

Subordinates: Triage Strike Team Leaders

Functions: Assume responsibility for coordination of EMS activities in areas actually impacted by the incident.

Roles and Responsibilities:

- Determine in cooperation with the fire department where triage is to be performed
- Coordinate with fire department to insure that patients are immediately removed from danger areas
- Evaluate resources needed for extrication of trapped patients, initial triage and primary treatment (maintaining airway and bleeding control)
- Ensure personnel have tags and are trained in START triage and correct procedure for applying tags
- Obtain adequate personnel and equipment to move patients to Treatment Area
- Coordinate with fire department on rescue of any trapped patients
- Communicate resource requirements to EMS COMMAND
- Allocate assigned personnel
- Supervise assigned personnel and resources
- Report progress to EMS COMMAND
- Advise EMS COMMAND when all patients have been delivered to Treatment Area

NOTE: Do not allow bodies of persons killed in the incident to be moved from their original locations unless absolutely necessary. If possible, take pictures and mark locations.



## STAGING AREA MANAGER

Call Sign: **EMS Staging**

ICS Functional Group: Operations

Commanded By: EMS COMMAND or EMS OPS/EMS BRANCH DIRECTOR

Subordinates: AIR OPERATIONS BRANCH MANAGER, other personnel as needed

Function: Assume responsibility for coordination of Staging activities for ground and air transport units.

Roles and Responsibilities:

- Coordinate with law enforcement agencies to block streets and secure access as required for staging operations
- Establishes Staging Area for incoming personnel and vehicles
- Enlist a Deputy to assist in tracking incoming personnel
- Insure all apparatus and vehicles are parked in an appropriate and orderly manner at Staging
- Maintain log of units available and all personnel at Staging Area, and an inventory of all specialized equipment and medical supplies that might be required at the scene
- Review with EMS COMMAND and EMS OPS/EMS BRANCH DIRECTOR what minimum resources must be maintained in the Staging Area
- Request resources as needed, after coordinating with EMS Command and EMS OPS/EMS BRANCH DIRECTOR
- Dispatch EMS vehicles and personnel to areas as requested by EMS COMMAND OR EMS OPS/EMS BRANCH DIRECTOR
- Dispatch EMS vehicles to the Transport Area as directed by the TRANSPORT GROUP SUPERVISOR
- Keep EMS COMMAND updated on status of staging operations
- Establish Air Operations Area if needed and an Air Ops Branch Manager to oversee that area

NOTE: This role can be best filled by a dispatcher. This will free field trained personnel for caring for patients. Initially, it will probably be filled by a field person.



## TREATMENT GROUP SUPERVISOR

Call Sign: **Treatment**

ICS Functional Group: Operations

Commanded By: EMS COMMAND or EMS OPS/EMS BRANCH DIRECTOR

Subordinates: Treatment Strike Team Leaders

Function: Assume responsibility for coordination patient care in the Treatment Area

Roles and Responsibilities:

- Establish Treatment Area of appropriate size at a location appropriate for weather conditions and the nature of the incident
- Oversee treatment personnel
- Ensure patients re-triaged as come into Treatment Area
- Divide the Treatment Area by triage category; Red, Yellow, and Green
- Avoid becoming directly involved in patient care unless absolutely necessary
- Request resources as needed
- Coordinate with Transport Group Supervisor to transport patients to proper facilities
- Keep EMS COMMAND and EMS OPS/EMS BRANCH DIRECTOR updated on the status of treatment operations and report when the last patient has been treated and moved to the Transport Area
- Coordinate with the Red Cross and the local or state Health Departments to establish holding areas for the Walking Wounded with OBVIOUS minor injuries
- Consider need to provide long-term treatment on the scene
- Coordinate with other areas as required
- Coordinate with EMS OPS/EMS BRANCH DIRECTOR as needed to establish temporary morgue facilities



## TRANSPORT GROUP SUPERVISOR

Call Sign: **Transport**

ICS Functional Group: Operations

Commanded By: EMS COMMAND or EMS OPS/EMS BRANCH DIRECTOR

Subordinates: Personnel, as needed

Functions: Coordination of patient transportation and maintenance of records relating to patient identification, triage category, mode of transport, and destination

Roles and Responsibilities:

- Establish a Transport Area near the Treatment Area
- Communicate with Comm Center to obtain medical facility status and treatment capability
- Coordinate with Treatment Group Supervisor on transport of patients
- Retriage patients, and determine appropriate transport vehicle and destination
- Enlist person to assist in documenting each transport, and to notify receiving facility of incoming patients
- Request vehicles from Staging Area Manager as needed
- Direct transport of patients to hospitals capable of providing appropriate treatment without exceeding hospital capabilities
- Contact receiving facilities, via radio, and advise them of triage categories for each patient they are receiving and the estimated time of arrival as patients are transported, and notify EMS COMMAND of the same information
- Maintain record of patient destinations
- Notify EMS COMMAND and EMS OPS/EMS BRANCH DIRECTOR when the last patient has been transported
- Coordinate with EMS OPS/EMS BRANCH DIRECTOR as needed to provide transport for the dead



## SUPPORT GROUP SUPERVISOR

Call Sign: **EMS Support**

ICS Functional Group: Operations, during initial phases

Commanded By: EMS COMMAND or EMS OPS/EMS BRANCH DIRECTOR

Subordinates: Personnel, as needed

Function: Acquire and distribute appropriate medical equipment medical equipment and supplies as dictated by nature of incident and number and types of patients

Roles and Responsibilities:

- Establish suitable location for Support Area operations – normally near the Treatment Area
- Determine the medical supply and equipment needs of other areas
- Coordinate procurement of medical supplies from hospitals with TRANSPORT GROUP SUPERVISOR, AIR OPS BRANCH DIRECTOR, and EMS OPS/EMS BRANCH DIRECTOR
- Works in the Resource Group of IMS
- Coordinate procurement of additional supplies not available at hospitals
- Ensures that requested resources are distributed to needed area
- Report progress to EMS COMMAND and EMS OPS/EMS BRANCH DIRECTOR
- Coordinate with other areas



## MEDICAL UNIT LEADER

Call Sign: **Medical Support**

ICS Functional Group: Logistics

Commanded By: INCIDENT COMMAND and LOGISTICS SECTION CHIEF

Subordinates: Rehab Team members

Function: Responsible for the physical and emotional health of the rescuers through all phases of the incident

Roles and Responsibilities:

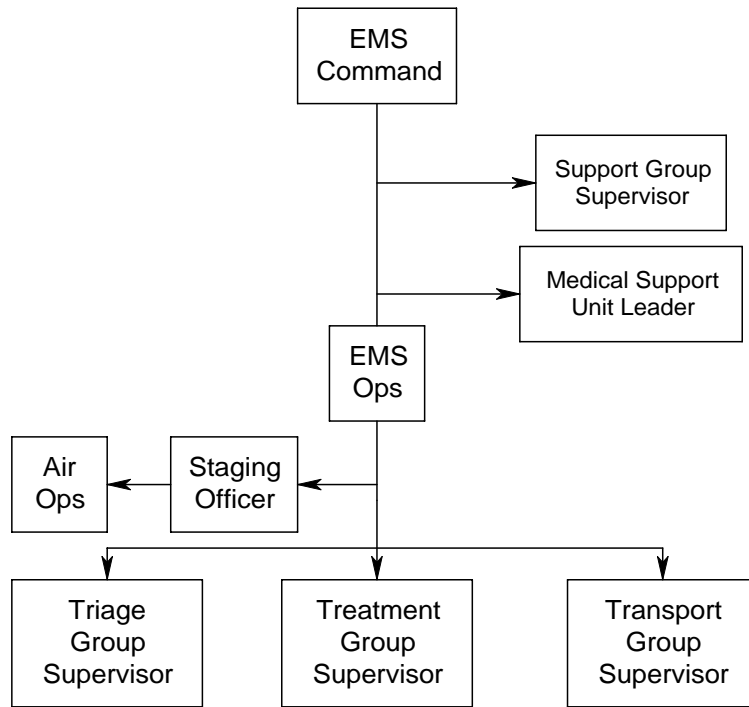
- Establish Medical Support Area in proper location, out of direct view of incident
- Enlist personnel to man the Medical Support Unit that will monitor and log the vital signs of all personnel going through the area, at least upon entering and leaving the area
- See that personnel are monitored for critical incident stress and notify SAFETY OFFICER when signs are observed
- Ensure rescuers are fit to return to duty prior to leaving Medical Support Unit
- Coordinate with the American Red Cross and the Salvation Army for fluid and dietary needs of the rescuers



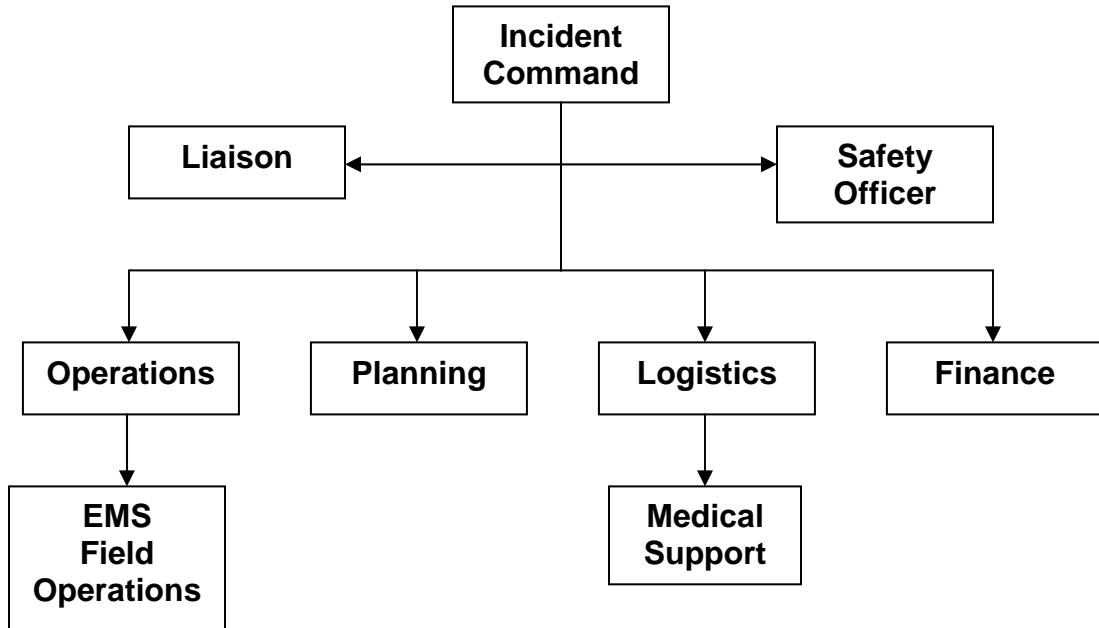
**APPENDIX C**  
**FLOWCHARTS**

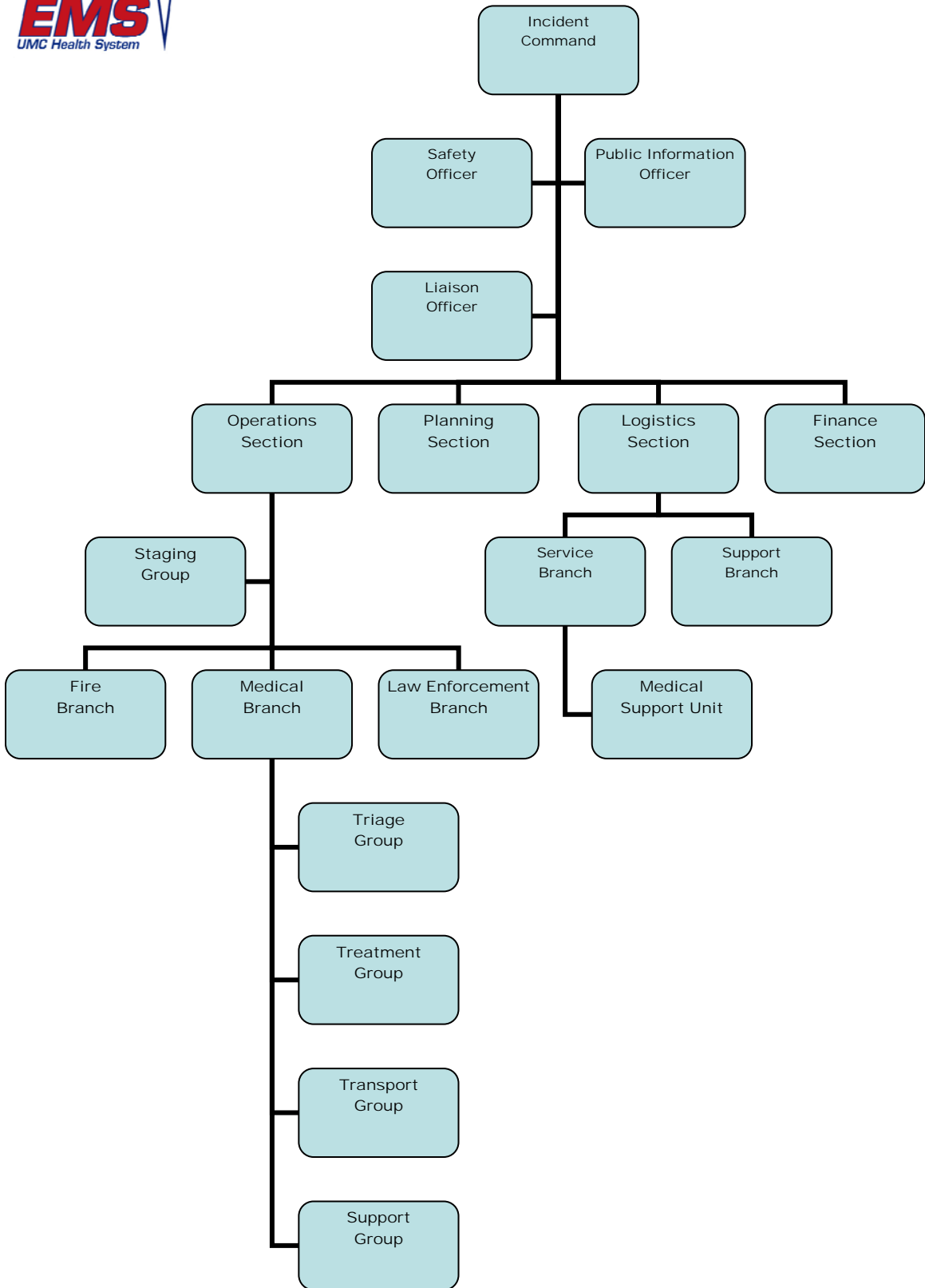


## EMS COMMAND STRUCTURE

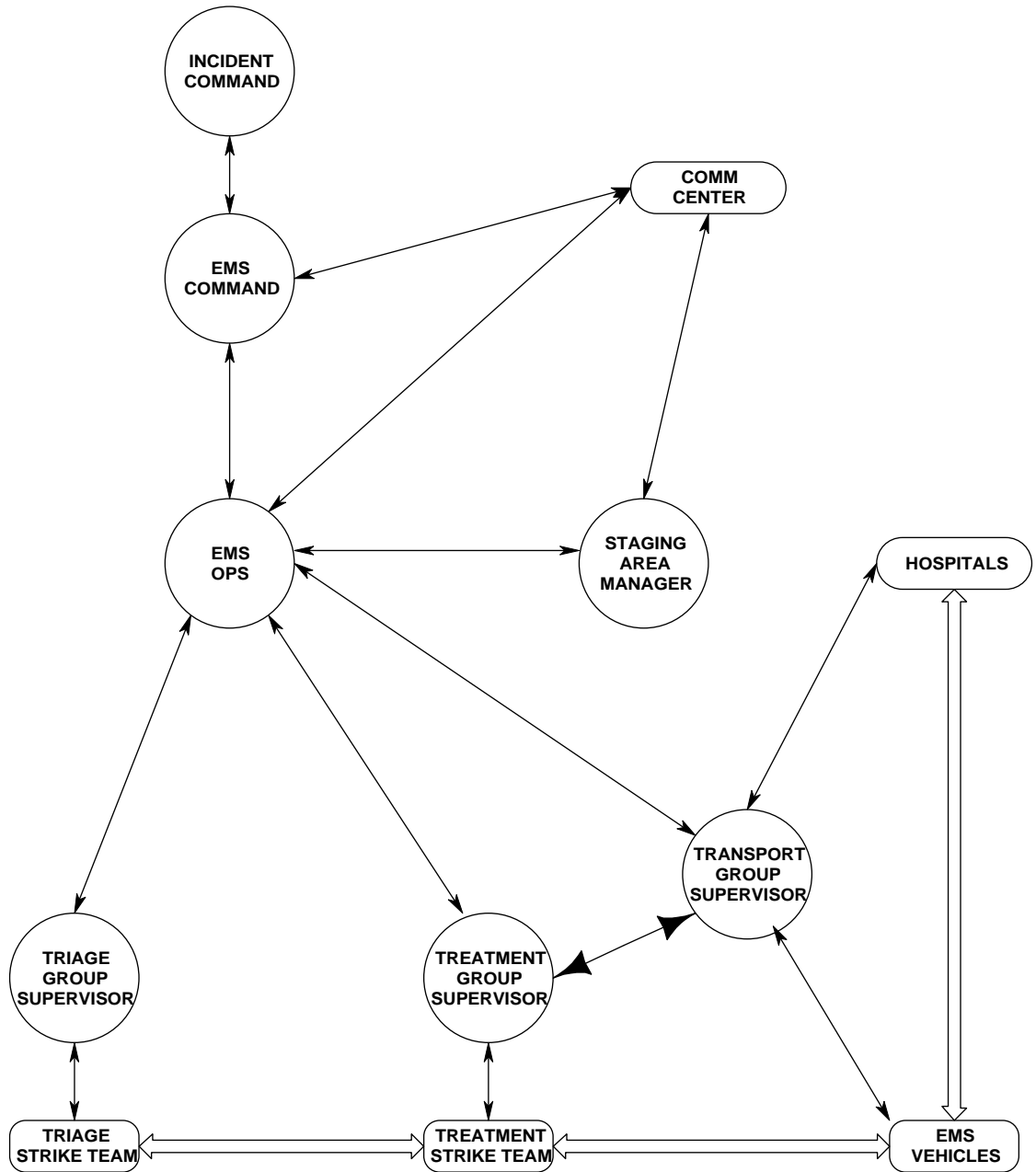


# INCIDENT MANAGEMENT SYSTEM





# PATIENT AND COMMUNICATION FLOW CHART



← COMMUNICATIONS FLOW →

⇄ PATIENT FLOW ⇄

◄ Face to Face Communications ►



## APPENDIX D

### INITIAL ACTION CHECKLIST

- Position vehicle at safe location that provides good visibility of the incident and easy access. Avoid having to relocate vehicle unless absolutely necessary.
- Quickly “size up” the situation to determine:
  - Nature of incident;
  - Possible number of patients;
  - Severity of patient injuries;
  - Danger zones and nature of hazards present; and
  - Need to establish multiple treatment areas.
- Select Staging Area for EMS vehicles at location which can be easily accessed without having to back-up vehicles to turn them around.
  - Select a helicopter landing zone, if need for air transport exists.  
**(Do not use if hazardous materials are involved.)**
- Contact 660 and provide:
  - Your unit number and channel you are operating on;
  - A statement that a MCI has occurred, that the MCI Plan should be activated, and that you are assuming EMS Command;
  - The nature of the incident;
  - The number and types of casualties;
  - The number of EMS and other transport vehicles needed;
  - The location of the Staging Area and helicopter landing zone;
  - The location of the current Command Post;
  - Any additional information needed for a safe, efficient response.
- Coordinate with the police to begin securing the perimeter, routes for EMS vehicles entering and leaving the scene, and the helicopter landing zone.
- Coordinate with the fire department to begin search and rescue, and initial triage.
- Establish locations for one or more Treatment Areas based on environmental conditions, the size of the incident, and your best estimate of the number of casualties.
- As additional personnel arrive, make functional area assignments as needed:
  - Triage Group Supervisor – Triage Strike Teams
  - Staging Area Manager and Deputy – Air Ops Branch Director
  - Treatment Group Supervisor – Treatment Strike Teams
  - Transport Group Supervisor
  - Support Group Supervisor
- EMS Command must remain at Command Post until relieved of command.



**APPENDIX E**

**TRIAGE**

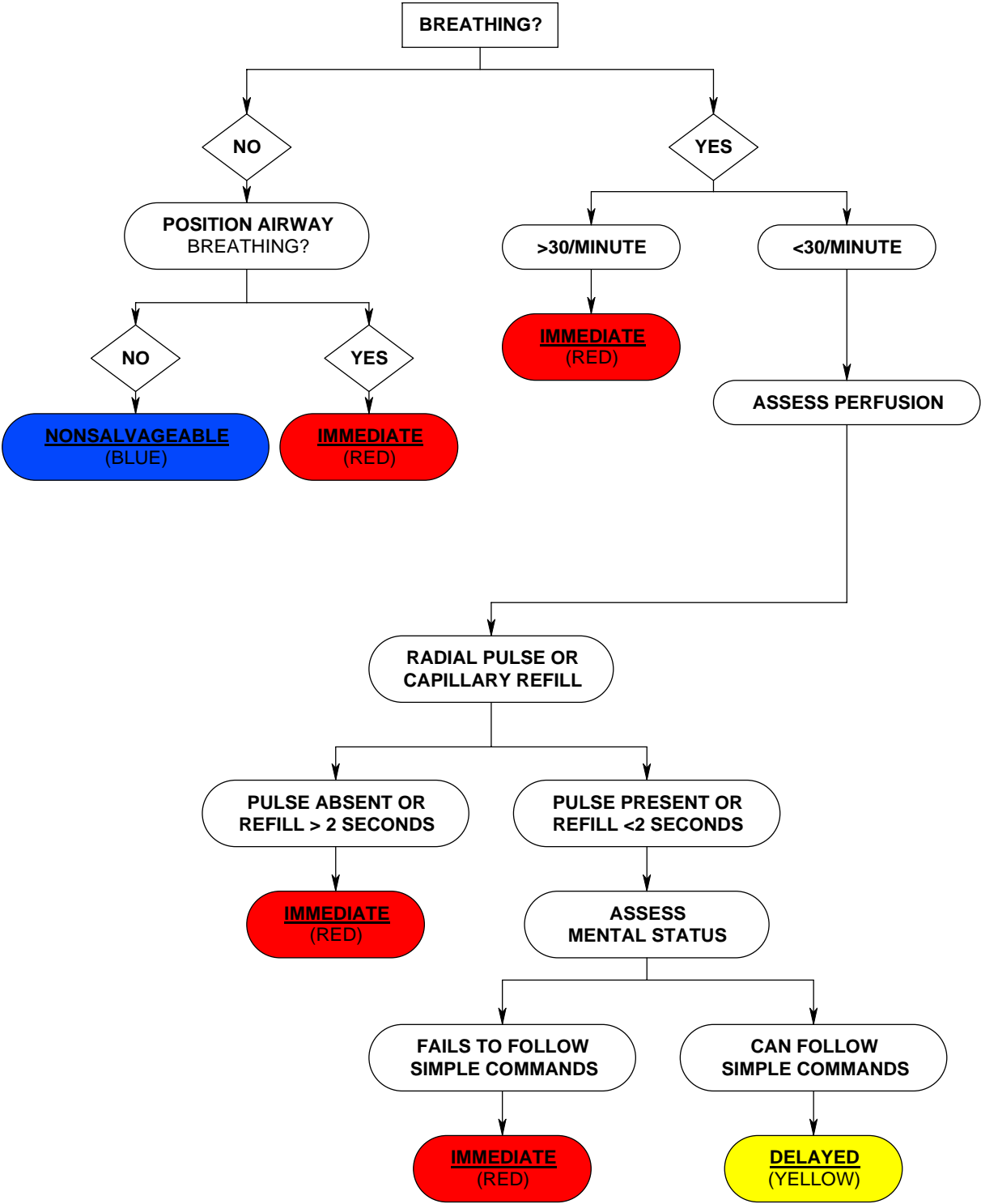
**S.T.A.R.T.**

**Four Category System**

**M.A.S.S**



# S.T.A.R.T. Simple Triage and Rapid Treatment



## **FOUR CATEGORY TRIAGE SYSTEM**

### **Priority I (IMMEDIATE: Red)**

**All** airway problems or potential airway problems

**All** penetrating chest trauma

Blunt chest trauma associated with shock, significant Dyspnea, paradoxical movement of chest wall, possible pneumo/hemothorax

**All** penetrating abdominal trauma

Blunt abdominal trauma associated with shock, altered level of consciousness, guarding, rigidity, or diffuse tenderness

Uncontrolled or suspected severe hemorrhage

**All** shock, regardless of cause

**All** altered level of consciousness regardless of cause

Major medical emergencies (non-traumatic chest pain, dysrhythmias, poisoning, status epilepticus, significant non-traumatic dyspnea, etc)

Obstetrical complications

Burns, if:

- a. Third Degree > 10% body surface area (BSA)
- b. Second Degree > 25% BSA
- c. Face or Necked Involved
- d. <11 or >50 years old
- e. Associated with additional major trauma or chronic illness
- f. Electrical

### **Priority II (DELAYED: Yellow)**

Burns, if:

- a. Third Degree 2-10% BSA
- b. Second Degree 15-25% BSA
- c. Hands, Feet, or Perineum Involved

Spinal injuries with or without spinal cord damage

Blunt chest trauma without shock or significant dyspnea

Blunt abdominal trauma without shock or signs of peritoneal irritation (guarding, rigidity, diffuse tenderness)

Major orthopedic or soft tissue injuries, including open fractures, impaired neurological function, or loss of distal pulse

### **Priority III (Minor: Green)**

Burns, if:

- a. Third Degree <2% BSA
- b. Second degree <15% BSA
- c. First Degree

Minor orthopedic and soft tissue injuries, including closed fractures with distal neurovascular function intact

### **Priority IV (Expectant – Nonsalvageable: Blue/Black/White)**

Full arrest without adequate manpower

Neurological death (traumatic coma with areflexia and fixed, dilated pupils)

Third Degree burns >80% BSA

Obvious mortal wounds (severe open skull fracture; massive crushing trauma to chest, abdomen, or pelvis, etc.)

Obvious D.O.S. (Decapitated, burned beyond recognition, dismembered)



## M.A.S.S. Triage

This method can be used when the number of casualties or number of Triage personnel make it difficult to achieve Initial Triage in a timely fashion. This method is still based off the S.T.A.R.T. system and is only for use in the Initial Triage phase. Reassessment is also a required throughout all patient contact.

**M – Move**  
**A – Assess**  
**S – Sort**  
**S – Send**

<b>MOVE Of M.A.S.S. Triage</b>		
<b>Goal:</b>	<b>Action:</b>	<b>Category:</b>
Group ambulatory patients	“Everyone who can hear me and needs medical attention, please move to the area with the green flag.” (or other identifier)	<b>Minor</b> initial group
Group awake, follow commands	Ask the remaining victims “Everyone who can hear me please raise an arm or leg so we can come help you.”	<b>Delayed</b> initial group
Identify who is left	Proceed immediately to these patients and deliver immediate life-saving interventions (open airway and bleeding control)	<b>Immediate</b> initial group  Or <b>Expectant/Dead</b> initial group

Tag all patients in the Delayed, Immediate, or Expectant/Dead categories. As you continue assessing patients their categories could change due to change in patient condition or change in available resources. As patients are moved to the Treatment area, they will be triaged by the Four Category System. The Four Category System will also be used in aiding which patients should be moved first to Treatment.



## APPENDIX F

### MCI FATALITY MANAGEMENT

1. Persons found dead at the scene of a major EMS incident will be the responsibility of the Medical Examiner or Justice of the Peace for the affected jurisdiction(s).
2. Bodies will not normally be moved unless the responsible authority or his authorized deputy gives permission.
3. Obviously dead bodies will be tagged by the TRIAGE GROUP SUPERVISOR, then covered with a sheet or blanket until removal. While first priority will be given to the living, efforts will be made to safeguard bodies.
4. Personal belongings will be left on the bodies to aid in identification.
5. Bodies may be moved prior to the arrival of the responsible authority to provide patient care, to prevent further damage, or at the direction of law enforcement. Under these circumstances the following procedures must be followed:
  - a. Do not remove any personal effects from the body;
  - b. Attach a tag to the body with the following information:
    - i. Date and time found
    - ii. Exact location where found
    - iii. Name and address of decedent, if known
    - iv. If identified, how and when
    - v. Name of person making identification or filling out tag
  - c. Place body in disaster pouch or in plastic sheeting securely tied to prevent unwrapping. Attach a second tag to sheeting or pouch.
  - d. If personal effects are found near the body and thought to belong to the body, place them in a separate container and tag. Do not assume that any loose articles belong to a specific body.
  - e. If possible take photographs or mark location of body with stake and tag.
  - f. Move the properly tagged bodies with their personal effects to one location, preferably one with refrigeration. Avoid exposure of bodies to heat or direct sunlight. If at all possible, do not locate temporary morgue facilities at or near Treatment Area(s). Do NOT use vehicles or storage area with a floor that can be permeated with body fluids, such as the wooden floor of a gymnasium. If refrigerated trucks or rail cars are used, COVER THE COMPANY NAME ON THE VEHICLE.
6. EMS COMMAND will coordinate with POLICE COMMAND, the authority responsible for the dead, and local health authorities in arranging for temporary morgue facilities and transportation of bodies.
7. EMS COMMAND will consult with local or state health authorities, if they are present, on appropriate procedures to safeguard the health of personnel assigned to move the dead. In absence of such advice, universal precautions against communicable disease will be exercised.
8. Release of information about persons killed in an incident will be the responsibility and prerogative of the Medical Examiner, Justice of the Peace, or authorized law enforcement officials.



**APPENDIX G**

**HAZARDOUS MATERIAL RESPONSE**



## **RECOGNITION**

EMS responders must always be alert for the possibility of a hazardous material exposure. The exposure can be a single person exposed by a small amount, up to a large release. Without recognition more people could be exposed, and ambulances and hospitals could be contaminated, rendering them out of service.

The following clues should help in recognition of hazardous materials:

- Occupancy/Location
- Container Shape
- Markings and Colors
- Placards and Labels
- Shipping Papers/Manifests
- Senses

Recognition is the key to responder safety and effective management of the incident. Remember to use the “Rule of Thumb” as you approach a possible hazmat scene. “Rule of Thumb” is where you stay far enough away from the scene so that your thumb will cover the entire scene.

Occupancy and location is the first and safest clue to a hazmat scene. Manufacturing plants, laboratories (commercial and academic), construction sites, and agricultural sites are examples where hazardous materials could be located.

In most cases, solids, liquids and gases are stored in distinctive containers. Corrosives are usually stored in plastic drums. Containers with rounded ends usually contain liquids and pressurized gases.

Markings on tanks and containers should be looked at for indications of poisons, flammable substances, corrosives, explosives, radioactive materials, etc. Colors of compressed gas cylinders can also give an indication of contents.

Placards and labels are a valuable source in recognition of hazardous materials. If a placard is present, there is at least 1,001 pounds of that substance on board. If it is below that weight a placard is not required. Placards and labels should be observed from a distance if at all possible.

Shipping papers and manifests should list what is carried on transport vehicles. These papers are in different locations on different types of vehicles. Ask the operator of the vehicle, if possible, for the proper papers.

Senses include visual signs such as, vapor clouds, visible liquid or solid products; dead or incapacitated people or animals, dead vegetation; or damage to a vehicle with a visible placard. If you are experiencing skin, eye, or nasal irritation move back; you have been exposed to the material. The only sense that should be used due to safety is vision. Remember that these materials can also be tasteless, odorless, and colorless. Also, radioactive materials cannot be detected by the senses.



## **TRIAGE ISSUES**

Hazmat exposure influences triage in numerous ways. Access to patients and treatment may be delayed due to scene conditions and decontamination requirements. The time needed to decontaminate patients may delay definitive patient care. Chemicals can modify the physiologic response to trauma by amplifying signs and symptoms or decreasing the efficiency of various protective mechanisms. Some chemicals may also have delayed symptoms due to differing absorption rates. Triage must be a continuous process and patient's condition charted so that an exposure history can be obtained.

## **DECONTAMINATION**

**Any potentially contaminated patients MUST be decontaminated prior to being placed in an ambulance.** Consult the *Emergency Response Guide* for proper procedure, and coordinate with the fire department to achieve decontamination. A large portion of any contaminants can be removed by simply removing the patient's clothing. All clothing should be bagged and sealed until it can be deconned. Under NO circumstances should a patient arrive at the emergency department still wearing potentially contaminated clothing.

## **MEDICAL SURVEILLANCE**

EMS may also be called upon to provide medical support for the hazmat team members. The goal of medical surveillance is to provide pre-entry vital signs, exit vital signs, monitor current medical conditions of the rescuers, and to assess and manage any problems during the response. You should also obtain a current medical history pre-entry. Baseline pre-entry vital signs are important in order to evaluate the team member's condition upon exit. These values must be documented and they become part of the incident report.

**Transport of any patient that could possibly have been exposed to hazardous materials will NOT be initiated UNTIL the appropriate decontamination can be performed.**



**APPENDIX H**  
**WEAPONS OF MASS DESTRUCTION**



## **Emergency Response Challenges**

Weapon of Mass Destruction (WMD) events can lead to four major challenges to first responders. First it will be a hazardous materials incident, and all the appropriate protection must be put into place. Second, it usually is a mass casualty incident because a terrorist wants to strike at a large number of people to reach his goal. Third, there is a higher incidence in the use of a secondary device towards the first responder. All responses should be aware and alert for these. Last, a WMD event is a crime scene and evidence must be preserved as much as possible and first responders must be alert to what they observe so that they can recount it later.

## **Recognizing Suspicious Incidents**

The first responder's index of suspicion should be increased if they are called to an incident if it meets certain criteria relating to occupancy, type of event, or timing of event. Certain types of occupancy should lead the first responder to be more suspicious. Symbolic or historic structures such as government buildings have been targets due to being the location of government or symbolic of our financial system. Public building or assembly areas are targets due to large number of persons in one contained area. Controversial businesses such as abortion clinics are targets of domestic terrorists. And, infrastructure systems, such as water systems, electrical systems, oil refineries, etc are targets. Type of event should also increase the responder's level of suspicion. Explosion, fire, or firearms go without saying. Non-traumatic MCI can be an indicator to a chemical, biological, or nuclear release. Timing of the event is also an indicator. Significant dates such as the anniversary of Waco, or other major incident. Weekend or nights are also an indicator as the goal might not be to inflict a large number of casualties so they pick a time of limited occupancy. There can also be on scene warning signs such as unexplained patterns of illnesses or deaths; unexplained signs/symptoms, skin, eye, or airway irritation; or containers in unusual locations.

## **Self Protection**

Self protection in a WMD event is best done by utilizing three concepts; time, distance, and shielding. Time is achieved by spending the shortest time possible in hazard area. This protects the crime scene and responders from exposure. Maximize your distance from the hazard by utilizing the "rule of the pinkie", being able to cover the scene with the tip of your small finger. Shielding can be achieved by utilizing vehicles, buildings, and PPE.



Below are some aids to help you protect yourself:

### **Staying SAFE**

**S** – Safety is first

**A** – Assess before acting

**F** – Focus on avoiding the hazard

**E** – Evaluate the situation and report

**Don't** rush in

**Don't** assume anything

**Don't** TEST (taste, eat, smell, or touch)

**Don't** become a victim

### **Remember RAIN**

**R** – Recognize a potential threat exists

**A** – Avoid that threat, and make sure others avoid it as well

**I** – Isolate the area and any exposed persons or materials

**N** – Notify the appropriate authorities

### **Decontamination**

All patients **MUST** be deconned before being placed in a transport vehicle by gross decon. A definitive decon should then be performed at the receiving facility.

### **Types of Harm**

- Thermal
- Radiological
- Asphyxiation
- Chemical
- Etiological
- Mechanical

### **Establish Control Zones**

- Obtain safe, secure area
  - Control Access
- Self-Protection #1 Priority
- Anticipate multiple hazard locations
- Recognize and Evaluate Dangers



## APPENDIX I

### TRANSPORT GUIDELINES

Once the patients have been triaged they must receive definitive care. This may be done at an on scene treatment center, or they must be transported to an appropriate facility. The patients will need to be evacuated in proper order to obtain treatment for the most severe down. Loads should still be mixed with Immediate and Delayed patients as appropriate. All transport decisions should be based on the Four Category Triage System. Immediate patients with injuries or illnesses, which cannot be managed initially on the scene, should be transported first. The following list of conditions can be used in making decisions for transport.

The following patients should be considered for immediate transport: multi-system trauma; penetrating trauma to chest; sustained hypotension  $<90$ mm Hg; sustained pulse  $>120$  or  $<50$ ; pulmonary insufficiency, which includes respiratory rate  $>35$  or  $<10$  per minute or respiratory compromise/obstruction or clinical symptoms of hypoxia; Glasgow Coma Scale  $\leq 8$ ; Revised Trauma Score  $\leq 10$ ; traumatic amputation of limb; life threatening burns; cardiac chest pain; other life threatening injuries.

The judgment of the Triage, Treatment, and Transport Group Supervisors should be used to determine which patients should receive care and transport first. Full cardiac arrest patients can be treated and transported **ONLY** if adequate manpower is present to care for all other patients, and all patients with life threatening injuries have been transported.

**Transport of any patient that could possibly have been exposed to hazardous materials; will not be initiated UNTIL the appropriate decontamination can be performed.**



**APPENDIX J**  
**COMMUNICATIONS CENTER CHECKLIST**  
**AND PHONE LIST**



**Lubbock EMS Regional Communications Center  
MASS CASUALTY INCIDENT CHECKLIST**

**LOCAL MCI**

A. Pre-Command Mode: When advised that a **POSSIBLE** MCI has occurred, the communications technician will notify the following personnel:

- \_\_\_\_\_ 1. On Duty Shift Chief
- \_\_\_\_\_ 2. Lubbock EMS Emergency Preparedness Coordinator  
(Tim Berry 535-6004 or 767-8504 or console pager)
- \_\_\_\_\_ 3. House Supervisor, at all city hospitals. Advise them of the type of **POSSIBLE** incident:  
UMC – 241-0286  
Covenant Medical Center – 786-9460  
CMC – Lakeside  
CMC – Pedi  
Highland Medical Center – 790-7402  
Heart Hospital – 472-5373 **CHARGE NURSE**
- \_\_\_\_\_ 4. Comm Center Chief and Extra Dispatcher, if needed  
(Bruce Mowrey 438-5632 or 721-4746 or console pager)

B. If the responding EMS unit advises that there is **NOT** a MCI situation. The Communications Center will so advise the above personnel.

C. If the responding EMS unit advises that a MCI **HAS OCCURRED** (document time confirmed \_\_\_\_\_), the Communications Center will contact and advise;

- \_\_\_\_\_ 1. Those above.
- \_\_\_\_\_ 2. All On-Duty Lubbock EMS stations and crews
- \_\_\_\_\_ 3. All applicable local public service and safety agencies available  
Via “direct” line in Communication Center’s radio console.
- \_\_\_\_\_ 4. Contact all Off-Duty Shift Chiefs, Assistant Chiefs, Training Chief, Senior Field Training Officers, Field Training Officers, and Off-Duty Personnel.
- \_\_\_\_\_ 5. All Lubbock County Volunteer EMS personnel via pagers.



- \_\_\_\_\_ 6. Aeromedical Services, place on **NO LAUNCH STANDBY**, until safe landing zone is secured  
Aerocare – 725-1100
  
- \_\_\_\_\_ 7. All local non-emergency ambulance and wheelchair services  
Lubbock Aid Ambulance – 792-2166
  
- \_\_\_\_\_ 8. EMS/SPEMS Medical Direction.  
Dr. Hagedorn –  
Dr. Addington – 766-9766
  
- \_\_\_\_\_ 9. Notify Salvation Army D.A.R.T. team.  
765-9434
  
- \_\_\_\_\_ 10. Notify Red Cross  
765-8534
  
- \_\_\_\_\_ 11. Other (specify)\_\_\_\_\_
  
- \_\_\_\_\_ 12. Other (specify)\_\_\_\_\_
  
- \_\_\_\_\_ 13. Other (specify)\_\_\_\_\_
  
- \_\_\_\_\_ 14. Other (specify)\_\_\_\_\_
  
- \_\_\_\_\_ 15. Other (specify)\_\_\_\_\_
  
- \_\_\_\_\_ 16. Other (specify)\_\_\_\_\_
  
- \_\_\_\_\_ 17. Other (specify)\_\_\_\_\_



## COMMUNICATIONS CENTER PHONE LIST

Sta B	775-8725	775-8724 Fax	
Sta 1	747-1081	747-1125 Fax	
Sta 2	796-7290	796-7297 Fax	
Sta 3	775-9919	775-9921 Fax	
Sta 4	748-1064	748-1250 Fax	
Sta 5	747-1220	747-1274 Fax	
Sta 12	794-7627	698-8553 Fax	
Chief	747-1647	241-0795 M	
Training Chief	796-7697		
Sta 6	298-2241	298-2831 Fax	Darrell Stephens
Sta 7	892-2414	892-3298 Fax	David Moore
Sta 8	828-2011	828-2012 Fax	Tyra Rodgers
Sta 9	866-4215	866-9126 Fax	Charles Addington
Sta 10	832-4521	832-0609 Fax	Jay Foerster
Sta 11	797-0412	797-0514	Tim Smith
LECD	747-6911	747-5803 Fax	
Health Dept.	775-2933	1902 Texas Ave	
Tx DSHS	744-3577	1109 Kemper Ave	
Telephones			
Plant Equipment	1-800-491-1734		
SW Bell	1-800-945-7776	1-800-280-3857	
Radios			
City Radio Shop	775-2326		
South Plains Com	795-5823		
Ty	767-6083		
Jack	777-4236		
Jim	239-7305		
Eventide	1-972-896-5796		
Parkinson's	1-800-332-7003		
LRPS	762-0811		
Vehicle			
Fleet Maintenance	723-2211	241-0257 C	791-3898 H
Pollard	797-3441		
John	535-9610		
Rescue Towing	791-2887		
Aeriform	763-8241		



Lubbock Aid Amb	792-2166 792-2167 792-9295	799-5060 Fax	David Ehler
Aerocare	725-1100 725-1112	747-1562 Fax 1-800-627-2376	
Citibus	793-5376		John Hendrickson
Sunrise	740-1420 740-1400	740-1569 Fax	
UMC			
House Supervisor	761-8874	775-8880 Office	241-0286 C
Security	775-9990		
Main	775-8200		
ER	775-9700	775-8460 Fax	
Nurse Desk	775-8490		
Business Office	775-8636		
Heart Hospital			
Main	687-7777		
ER	472-3876	472-3765 Fax	
Charge Nurse	472-5373		
Security	472-5362		
CMC			
Main	725-1011		
House Supervisor	786-9460 C		
Security	725-4054		
ER	725-4288 725-2288 725-2291	725-0021 Fax	
Pedi ER	725-0030	725-0015 Fax	
Lakeside			
Main	725-6000		
ER	725-6850	725-6270	
Security	725-4054		
Highland			
Main	788-4100		
House Supervisor	788-4196	790-7402 C	
ER	788-4000	788-4275 Fax	
Security	788-5120		



Clinics			
Abernathy	298-2524	409 8 <sup>th</sup> St	
Chatman	749-0024	2301 Cedar Ave	
Freedom	762-3597	1301 50 <sup>th</sup> St	
Idalou	892-2537	113 Walnut	
Kings Park	792-8843	7501 Quaker	
KP Urgent	788-3306	5100 82 <sup>nd</sup> St	
Parkway	767-9744	406 MLK	
Slaton	828-5822	130 N 7 <sup>th</sup> St	
Wolfforth	866-0158	502 E. Hwy 62-82	
Lubbock Fire	765-5757 E	775-3510 Fax	
	775-2635	775-3825 Fax	
Lubbock Police	763-5333 E	762-4912 Fax	
	775-2865		
Desk Sergeant	775-2817		
Sheriff's Office	767-1441 E	775-1453 Fax	
	767-0417		
	775-1480		
	775-1601		
DPS	472-2794 E	472-2795 Fax	
	472-4794		
Abernathy Police	298-2545		
New Deal Police	746-5860		
Idalou Police	892-2500		
	892-2531	892-3224 Fax	City Hall
Ransom Police	929-2600		
Buffalo Police	747-3353		
Slaton Police	828-2020 E	828-2023 Fax	
	828-2022		
Wolfforth Police	866-4605		
Shallowater Police	832-4565		
LIA Police	775-2044		
LISD Police	766-1193		
Crosby Co SO	675-7301	Caprock	
		Cone	
		Crosbyton	
		Lorenzo	
		Ralls	
Dawson Co SO	872-7560	Lamesa	
		Patricia	
Dickens Co SO	623-5533	Dickens	
		Spur	
Garza Co SO	495-3595	Justiceburg	
		Post	
		Southland	
		Verbena	



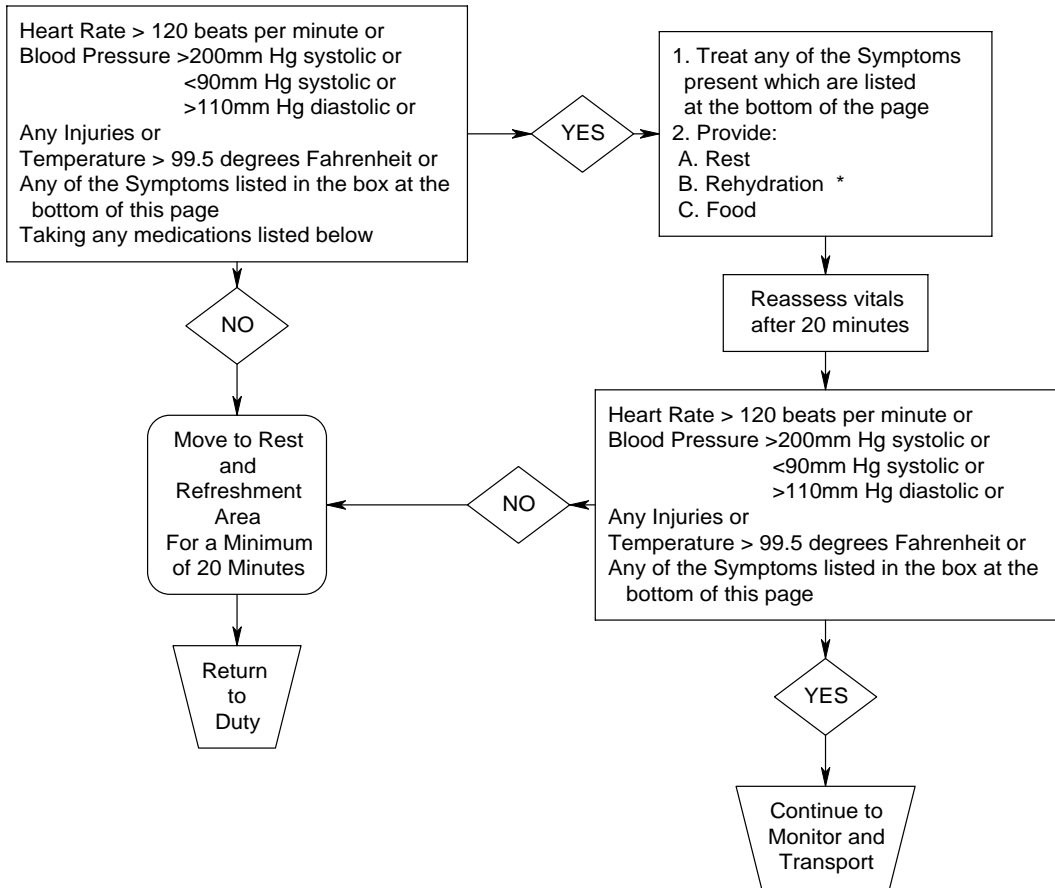
Floyd Co SO	983-4901	Floydada Lockney
Hale Co SO	296-2724 Line 1 298-2241 Line 2	Cotton Center Edmonson Hale Center Halfway Happy Union Petersburg Plainview
Hockley Co SO	894-3126	Anton Arnett Levelland Pettit Ropesville Smyer Sundown Whitharral
Lamb Co SO	385-7900	Amherst Earth Fieldton Littlefield Olton Spade Springlake Sudan
Lynn Co SO	998-4505	New Home O'Donnell Tahoka Wilson
Terry Co SO	637-2212	Brownfield Meadow Union
Swisher Co SO	995-3336	Tulia
Cochran Co SO	266-5211	Morton Whiteface



**APPENDIX K**  
**REHAB PROTOCOL**



# REHAB PROTOCOL



**Treat Immediately if present:**  
**Chest Pain**  
**Shortness of Breath**  
**Palpitations**  
**Altered Mental Status**  
**Skin that is hot and either dry or moist**  
**Irregular pulse**  
**Oral Temp >101**  
**Pulse > 150 bpm**  
**Pulse > 140 bpm after cooldown**  
**Systolic BP > 200mm Hg after cooldown**  
**Diastolic BP > 110mm Hg at any time**

**\* Rehydration**  
 If patient has a positive tilt test rehydrate with IV therapy per the Hypovolemia Protocol  
 If patient has a negative tilt rehydrate orally

**Special attention should be given medications that can lower heart rate.**

acebutol	alprenolol	Adalat	amlodipine
atenolol	Betabloc	betaxolol	bisoprolol
Blocadren	bunolol	bupranolol	Cardene
Cardizem	Calan	carteolol	Catrol
carvedilol	Coreg	Corgard	Corzide
Covera-HS	Dilacor	diltazem	Diltia XT
DynaCirc	epanolol	felodipine	Inderal
Inderide	Isoptin	isradipine	Kerlone
labetalol	Lexxel	Lopressor	Lotrel
metoprolol	Monitan	moprolol	nadolol
nicardipine	nifedipine	nisoldipine	Normodyne
Norvasc	oxprenolol	pamatolol	Plendil
practolol	Prindolol	Procardia	propranolol
Renedil	Sectral	Sular	talinolol
Tarka	Teczem	Tenoretic	Tenormin
Tiamate	Tiazac	Timolide	timolol
tiprenolol	tolamolol	toliprolol	Toprol
Trandate	verapamil	Verelan	Visken
Zebeta	Ziac		

**Responders taking any of these medications may not exhibit tachycardia**



## APPENDIX L

### ORGANIZED CITIZENS RESPONSE

History has shown that neighbors come to the aid of each other, especially Americans. The LA City Fire Department began to capitalize on this in the late 1980s and early 1990s by organizing and training citizen response teams to aid themselves and neighbors in earthquakes and wildfires. After the terror attacks of September 11, 2001, President Bush encouraged this type of system to be organized nationwide. This was the birth of the Citizens Corp. Citizens Corp is comprised of four programs; Community Emergency Response Teams (CERT), Medical Reserve Corps (MRC), Volunteers In Police Services (VIPS), and Neighborhood Watch. During a disaster, EMS responders will come into contact primarily with CERT. CERT is a group of volunteers trained in basic first aid, simple search and rescue, triage, small fire extinguishment, basic incident command, and other special training as needed. These teams are in place to help their families and neighbors until professional help arrives, but they could also be used by EMS after you arrive on scene.



## APPENDIX M

### FORMS

Recognized IMS forms will be used where appropriate.

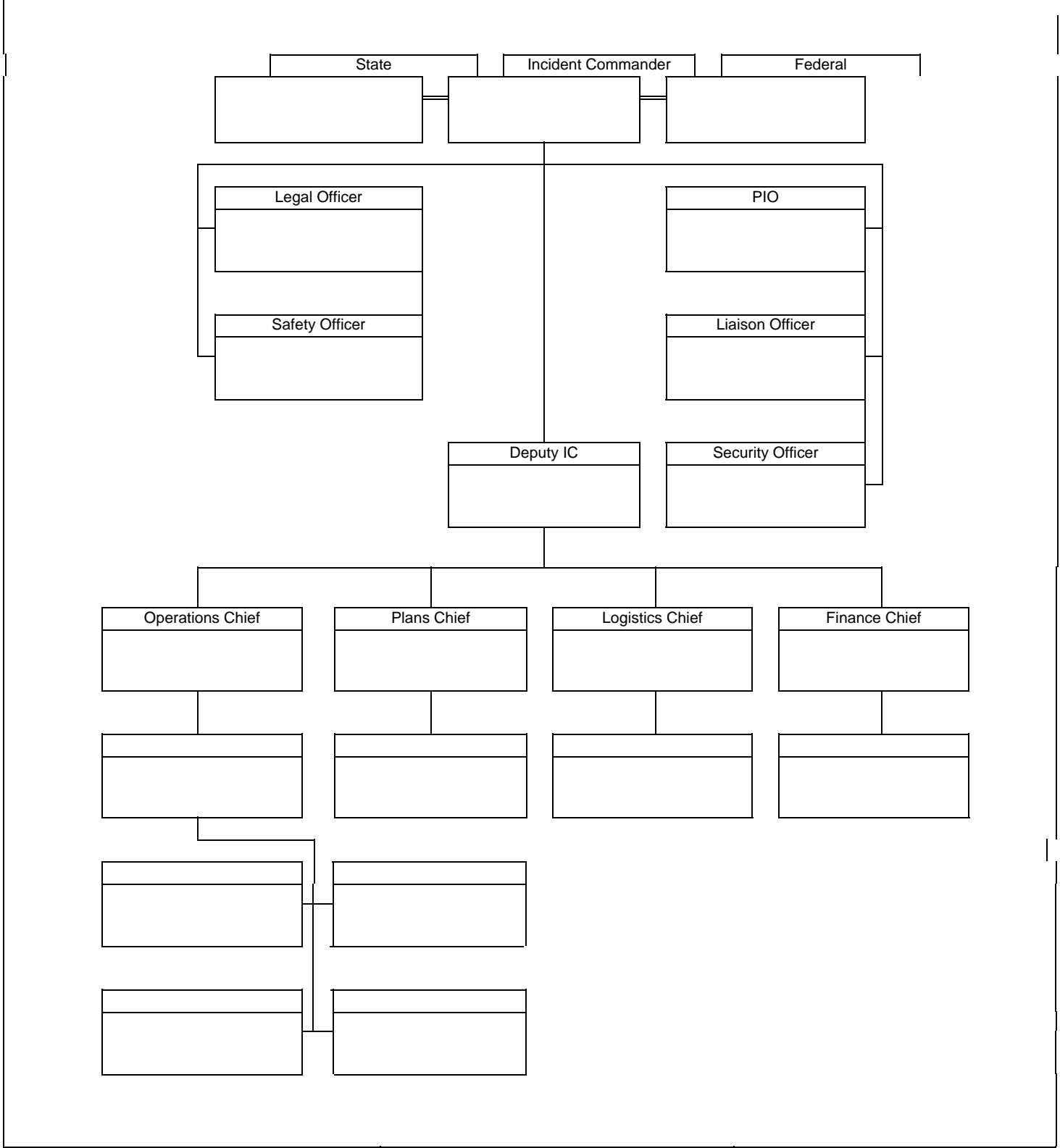
Initial Briefing: Summary of Current Actions	ICS-201-2
Initial Briefing: Initial Incident Organization	ICS-201-3
Initial Briefing: Local Resources Summary	ICS-201-4
Initial Briefing: Meteorological Data/General Info	ICS-201-6
Incident Action Plan: Incident Objectives	ICS-202
Incident Action Plan: Organizational Assignment List	ICS-203
Incident Action Plan: Division/Group Assignment List	ICS-204
Incident Action Plan: Task Force/Strike Team Personnel	ICS-204-2
Incident Action Plan: Incident Radio Communications Plan	ICS-205
Incident Action Plan: ICS Positions/Phone Numbers	ICS-205-1
Incident Action Plan: Medical Plan	ICS-206
Check In/Out Log: Personnel and Equipment	ICS-211
General Message/Resource Request	ICS-213
Unit Log	ICS-214
Unit Log Continuation	ICS-214-1
Field Resource Status & Demobilization Request	ICS-216
Incident Action Plan: Health and Safety Plan	ICS-223
Hospital Resource Inventory	SPEMS-901
Patient Transport Log	SPEMS-902





# Initial Briefing

Incident Name:	Date Prepared	Time Prepared:
Operational Period Date: From:                      To:	Operational Period Time: From:                      To:	



Prepared By:	Company Name:	ICS Position:
Approved By:	Company Name:	ICS Position:

















## Incident Action Plan

Position	Name	Phone	Fax	Current Location
Incident Commander				
Deputy IC				
Safety Officer				
Security Officer				
PIO				
Legal Officer				
Liaison Officer				
<b>Operations Section Chief</b>				
Deputy Operations Chief				
Air Operations Manager				
Staging Area Manager				
<b>Task Force No.    Leader</b>				
<b>Planning Section Chief</b>				
Situation Unit Leader				
Environment Unit Leader				
Resource Unit Leader				
Documentation Leader				
Technical Specialist				
<b>Logistics Section Chief</b>				
Communication Leader				
Supply Unit Leader				
Medical Unit Leader				
Facilities/Food Unit Leader				
Ground Support Leader				
Personnel Unit Leader				
<b>Finance Section Chief</b>				
Time/Cost Unit Leader				
Claims Unit Leader				
Contracts Unit Leader				
Prepared By:	Company Name:	ICS Position:		
Approved By:	Company Name:	ICS Position:		

# Incident Action Plan

Incident Name:	Date Prepared:	Time Prepared:
Operational Period Date: From:                      To:	Operational Period Time: From:                      To:	

## Incident Medical Aid Stations

Medical Aid Station	Telephone/Radio	Location	EMT	ETT

## Transportation (Assigned/Stanby Ambulance Services)

Name	Telephone/Radio	Address	Ground	Air	Doctor	Nurse	EMT	ETT

### Ambulance Services In Addition to Above

Name	Telephone/Radio	Location	EMT	ETT

## Hospitals

Name	Telephone/Radio	Address	Travel Time		Helipad (Y/N)	Burn Center (Y/N)
			Ground	Air		

## Medical Emergency Procedures

Prepared By:	Company Name:	ICS Position: <b>Medical Unit Leader</b>
Approved By:	Company Name:	ICS Position: <b>Safety Officer</b>



**ICS 213**  
**General Message/Resource Request**

Incident Name:		Date Prepared:	Time Prepared:
Operational Period Date:		Operational Period Time:	
From:	To:	From:	To:
To:	Company Name:	ICS Position:	
From:	Company Name:	ICS Position:	
Subject:			

**Message**

Signature:	Company Name:	Date:	Time:
------------	---------------	-------	-------

**Resources Required (To Logistics)**

Type of Resource (e.g. Personnel, Facilities, etc.)	Quantity	Location	Description of Resource (e.g. Man Camp, Beach Cleaners Hazwoper Level, Required Gear, etc.)	Date Required	Time Required

Signature:	Date:	Time:
------------	-------	-------

**Reply**

Signature:	Company Name:	Date:	Time:
------------	---------------	-------	-------





**Field Resource Status & Demobilization Request**

Incident Name:	Date Prepared:	Time Prepared:
Operational Period Date: From:                      To:	Operational Period Time: From:                      To:	

**General Information**

Branch Number:	Division Number:	Group Number:	Task Force:	Strike Team:
----------------	------------------	---------------	-------------	--------------

**Resources**

Item	Status <sup>1</sup>	Comments
A.		
B.		
C.		
D.		
E.		
F.		
G.		
H.		
I.		
J.		
K.		
L.		
M.		
N.		

**Sketch<sup>2</sup>**

Prepared By:	Company Name:	ICS Position:
Approved By:	Company Name:	ICS Position:

**Notes:** 1. Show status as Assigned, Available, De-Mob, or Out-of-Service.  
 2. On sketch show geography, North arrow, resource location, wind and current speed/direction at the time of report. Use separate page if necessary.



# HOSPITAL RESOURCE INVENTORY

HOSPITAL		IMMEDIATE	DELAYED	MINOR
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			
	<b>AVAILABLE</b>			
	<b>UTILIZED</b>			

