

**“15 ‘til 50”**

# **Mass Casualty Incident Response Plan**



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The 15 'til 50 Mass Casualty Guide was developed by Henry Mayo Newhall Memorial Hospital and Providence Little Company of Mary Medical Center Torrance.

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

### Project Sponsor

Terry Crammer, RN  
Los Angeles County Department of Health Services EMS Agency

### Project Managers

Terry Stone, RN  
Henry Mayo Newhall Hospital

Chris Riccardi, CHSP, CHEP, CHCM-SEC  
Providence Little Company of Mary Medical Center Torrance

### Consultants

Constant and Associates, Inc. served as the project consultant.

The following individuals supported content development:

Robbie Spears, MSW  
Francisco Soto, MS  
Jim Sims, MS  
Ashley Slight, MPH  
Michelle Constant  
Crystal Chambers

## ACRONYMS

Acronym	Definition
AAR	After-Action Report
C&A	Constant & Associates
CERT	Community Emergency Response Team
CDPH	California Department of Public Health
DHS	Department of Homeland Security
DPS	Department of Public Safety (Security)
DRT	Disaster Response Team
ED	Emergency Department
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ERP	Emergency Response Plans
EVS	Environmental Safety
FEMA	Federal Emergency Management Agency
FSE	Full Scale Exercise
HCC	Hospital Command Center
HICS	Hospital Incident Command System
IAP	Incident Action Plan
ICP	Incident Command Post
ICS	Incident Command System
JIC	Joint Information Center
JITT	Just-in-Time Training
LA	Los Angeles
LACDPH	Los Angeles County Department of Public Health
MCI	Mass Casualty Incident
NIMS	National Incident Management System
PHEP	Public Health Emergency Preparedness
PIO	Public Information Officer
POM	Plant Operations and Maintenance
PPE	Personal Protective Equipment
TFD	Torrance Fire Department
TPD	Torrance Police Department
TTX	Tabletop Exercise
TX	Treatment
UCP	Unified Command Post

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## INTRODUCTION

### **Overview**

Working at full capacity on a daily basis, hospitals around the country often find that there isn't a comprehensive plan in place that specifies what will happen within the first 15 minutes of a Mass Casualty Incident (MCI). Providence Little Company of Mary Medical Center Torrance (PLCMMCT) noted that their own hospital's disaster plan was ambiguous and lacked specific roles and functions for responding staff. Staff were assigned unfamiliar roles and expected to still function effectively. PLCMMCT convened a Planning Team to address this gap and as part of the research phase and developed the "15 Minutes 'til 50 Patients" MCI response program.

The "15 Minutes 'til 50 Patients" Mass Casualty Incident (MCI) response program was conceptualized by a small, multidisciplinary team within the Emergency Department at Providence Little Company of Mary Medical Center Torrance (PLCMMCT), California. The premise of this plan is the rapid deployment of staff, supplies and equipment. The goal is to prepare hospital personnel to respond to an MCI by familiarizing them with their roles and responsibilities. It is an MCI response plan that is flexible, scalable and adaptable to the needs of any hospital or healthcare facility.

### **Purpose**

The purpose of the 15 'til 50 Plan is to prepare PLCMMCT to be able to rapidly deploy staff, supplies, and equipment in the event of an MCI. The plan covers pre-incident measures such as coordination and procurement of equipment. It also covers the phases of incident management: activation, operation, and transition into either ongoing emergency operations or demobilization.

It is applicable to events that test medical surge capacity. The planning framework falls within what the CDC describes as the "Dual Wave Phenomenon" in which the larger group of less severely injured walking wounded typically arrive within 15-30 minutes of an incident, followed within an hour or two by a second wave of more severely injured who will require pre-hospital emergency transportation.

### **Scope**

This plan is designed and intended to address numerous hazards that would result in a MCI that may affect PLCMMCT. It is intended to supplement pre-existing Emergency

Operations Plans, which have been created using an all-hazards model. Therefore, this plan may be used for any type of incident, whether natural, man-made, or technological. This plan applies to all departments, personnel, and agents of PLCMMCT.

### ***Assumptions***

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

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

### ***Supplies and Equipment***

PLCMMCT has procured and prepositioned caches specifically for 15 ‘til 50 activation. These include:

- 15 ‘til 50 “Go-Kits”
- Mobile and Stationary Storage Units/Trailers
- Command Center Supplies
- Labor Pool Supplies

A detailed list of supplies and equipment for each element above can be found in the Emergency Operations Plan (EOP) under the INVENTORIES tab. The lists were created based on PLCMMCT’s capacity. Supplies are located in the Earl Street Loading Dock supply shed, Disaster Supply trailer the Disaster Food Supply room, supply shed in parking structure, the Facilities Building Incident Command Center and the Emergency Department. A map of the facility with caches marked is included under the MAPS tab within this plan. All prepositioned supplies and equipment for the 15 ‘til 50 program will not be used for day-to-day operations. The Emergency Management Officer or designee will re-evaluate supplies annually as well as after each and every exercise and/or incident.

## ACTIVATION

The notification of a mass casualty incident (MCI) may come to the hospital in any one of numerous formats; ‘walking wounded’ coming into the hospital, a staff member noticing a breaking news story on the television, or a phone call from the local fire department. It might be immediately obvious that PLCMMCT will be handling an MCI immediately, or the scope of the MCI might not be clear for some time. Regardless of how the hospital is informed of an MCI, the decision must be made to activate the 15 ‘til 50 Plan.

### **Authorization to Activate**

Regardless of time or staffing, the decision to activate the 15 ‘til 50 plan will be made by the House Supervisor and/or Administrator In Charge that ultimately determines to activate the MCI in conjunction with the Emergency Department Physician, Director, Emergency Department and/or Emergency Management Office. Information to consider when determining whether the 15 ‘til 50 Plan should be activated includes:

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

Ultimately, the final decision to activate the 15 ‘til 50 Plan lies with Administrator-In-Charge and should be activated when it is apparent that patient surge will outstrip the hospital’s ability to handle with normal operations.

### **Notification**

When the Emergency Department Charge Nurse, MD and House Supervisor have determined that an MCI has occurred and that the hospital must prepare for surge capacity, The House Supervisor will notify PBX who will announce the activation to all department heads via overhead page to initiate a Code TRIAGE External

As the 15 ‘til 50 Plan involves all hospital departments, it is important that all departments be made explicitly aware that the 15 ‘til 50 Plan is being activated. To accomplish this, the code over the intercom will explicitly state after an audible “ping” “Code TRIAGE External” three times. All staff are to report to their positions and prepare to support the influx of patients.

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

Organization/Department	Point of Contact	Contact Information (phone, email, etc.)	Position Responsible for Notifying
Torrance Fire	Dispatch	Phone/911	Liaison Officer
Hospital Admin	AOC	Phone	House Supervisor
Torrance PD	EOC	Ring Down Phone (HCC)	Liaison Officer
LACo EMS/MAC	MAC	ReddiNet	MICN
Other Hospitals	MAC	ReddiNet	MICN
Liberty Ambulance	Shift Supervisor	Phone	MICN

**Coordinate Staffing and Prepare Staff for Activation**

Upon announcing that the 15 ‘til 50 Plan is being activated, Emergency Department Charge Nurse will assign roles and distribute the go kits, which contain vests, job action sheets, treatment area set up maps stethoscopes, trauma shears and pens. Staff should also immediately begin following their specific protocols and procedures, including reporting to their assigned location/supervisor, and carrying out tasks that directly support the 15 ‘til 50 effort.

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

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

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

Using established procedures for recalling hospital staff, the individual hospital departments and/or PBX personnel will make notifications and ensure adequate



personnel are recalled to support ongoing surge capacity in the Hospital. While the initial 15 ‘til 50 response will likely be handled by staff already at the Hospital, it is important to begin making notifications and requesting additional personnel as soon as the decision is made to activate the plan. The Hospital Command Center will also keep a list of key contact information for all personnel involved in incident response.

Daily Position Title	15 ‘til 50 Position Title	Location
ED Charge Nurse	Treatment Area Lead	External Treatment Area
House Supervisor	Incident Commander	HCC
Safety Officer	Safety Officer	HCC
Media Relations	Public Information Officer	HCC
Managers/Directors	HICS Positions	HCC
Human Resources	Labor Pool	Cafeteria
ED Staff	As Assigned	External/Minor Treatment Areas
In Patient Unit Staff	ED Backfill Staff	ED
Unassigned Staff	Labor Pool	Cafeteria

### ***Deploy Supplies and Equipment***

Another key step upon activation of the Plan is for the ED staff, POM staff and Registrars to begin distributing, deploying, allocating, and tracking resources. All of the set-up team must deploy to the Earl Street loading dock and to the Minor Equipment storage room to unlock containers, release necessary materials, track which resources are being sent to the triage site, and ensure the proper flow and tracking of all resources released. Deployed staff assigned radios should also set up direct lines of communication to the Hospital Command Center, Internal Charge Nurse and the Triage Nurse(s).

### ***Hospital Command Center***

Additionally upon the announcement that the 15 ‘til 50 Plan is being activated, the Hospital Command Center (HCC) should be activated. The House Supervisor is responsible for activating the HCC following procedures set forth in the HCC Plan. Resource management will also supervise the distribution of radios, ensuring each radio is signed out and tracked before being released. Upon arriving at and activating the HCC, the Incident Commander should notify the Labor Pool and the Treatment Area Lead that the HCC is open and that resource requests and information should be sent to the HCC.

## OPERATIONS

### *Triage*

Some special challenges faced in MCI triage could include:

- Mixed chemical, biological, radiological, nuclear, or explosive (CBRNE) casualties
- Responder protection and safety
- Crime scene management and evidence preservation

Therefore, *all 15 'til 50 triage staff* should abide by the following actions during triage:

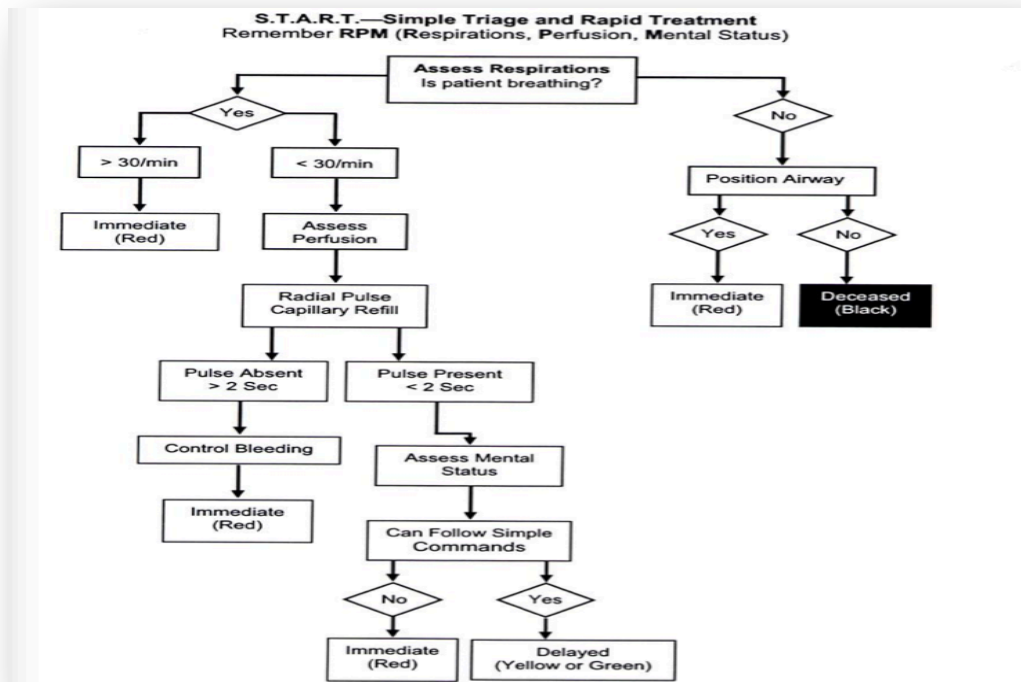
- Evaluate each patient individually before making decisions
- Determine any possible hazards associated with each patient (i.e. CBRNE hazards)
- Use appropriate Personal Protective Equipment (PPE)
- Remain in the appropriate areas (do not leave the assigned zone unless directed otherwise)
- Never make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

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

- Separate the patients into ambulatory and non-ambulatory
  - If not already included in the triage site setup, triage staff might want to demarcate a separate line for non-ambulatory patients coming in on gurneys, using traffic cones and caution tape
- Initial Patient Assessment (should take less than one minute for each patient)
  - Interview each patient (or accompany EMT or paramedic) for the main complaint and the location from which the patient is coming from
  - Tag each patient (omit personal information on the tag for now and concentrate only on the main complaint, the need for decontamination, and the type of injury) according to the following:
    - Confirmed deceased – Tag Black
    - Unresponsive – Tag Red
    - Severe bleeding or severe injury – Tag Red
    - Minor injuries – Tag Yellow or Green
    - Walking Wounded – Tag Green
    - Possibility of CBRNE-related injury – Note for Primary or Secondary Decontamination
- Secondary (Advanced) Patient Assessment
  - Depending on the surge of patients, the 15 til 50 triage staff may have the resources and time to perform a full assessment for better triaging during their initial assessment. However, if there is a large surge of patients, triage

staff should separate into two groups: those who conduct initial triage and tagging, and those who make the rounds of the tentative treatment areas to measure the following:

- Respiratory Status
  - No respiration – check for obstruction
  - Still no respiration – Tag Black
  - R > 30 – Tag Red
  - R < 30 – Check perfusion
- Perfusion
  - No pulse – Tag Black
  - P > 2 seconds – Tag Red
  - P < 2 seconds – Check mental status
- Mental Status
  - Those who cannot follow simple commands – Tag Red
  - Those who can follow simple commands – Tag Yellow or Green
  - Be sensitive to those who:
    - Do not speak English
    - Have hearing deficiencies
    - Have Mental Impairment



- Re-tag patients as necessary and direct them to the appropriate treatment area

## **Treatment**

Once patients have moved past the Triage area and have been directed to either Immediate, Delayed, Minor, or the Morgue, treatment should follow the S.T.A.R.T. process.

All External Treatment Area staff should complete the following priority items before moving on to administrative items:

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

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

- Ask the patient for their name, age, and personal information
- Fill out the labels attached to the Documentation Packet and assign a patient ID #
- Bag all personal items in a Patient Belongings bag and label with the patient's ID # and include the tear-off Personal Property Receipt from the Triage Tag (if available)
- Fill out any necessary x-ray or test request forms and drop into the appropriate box located on the Loading Dock or in the Minor Treatment Area
  - Radiology or X-ray staff should have a box or boxes in the treatment areas designated for quick test requests. These staff should periodically check the boxes and assign staff to transport those patients to the appropriate areas
- Provide patient privacy if possible and/or appropriate. Staff can use tents, sheets, portable showers, or whatever is on hand to provide privacy
- Refer separated family members to the Family Information Center or established hotline number to obtain information

The Treatment Unit Leader should be regularly reporting the status of treatment area capacity, recommended patient transports, treatment area resource requests, staffing capacity, and security issues.

### **Security (Department of Public Safety)**

As soon as the 15 'til 50 Plan has been activated, hospital Department of Public Safety (DPS) staff should immediately begin the process of locking down the facility, setting up traffic control, internal security, and law enforcement coordination, before assisting with setup of the mobile triage/treatment site.

One of the most important aspects of MCI response is the management of ingress and egress routes to the mobile triage/treatment area. Hospital security will first coordinate with the Hospital Command Center to confirm the location of the mobile triage/treatment area, and which ingress and egress routes should be used. The egress route used to evacuate patients from existing departments should always be separate from the ingress routes used to process incoming patients once 15 'til 50 has been activated. Initial actions for hospital security staff are categorized and outlined in more detail below:

#### Traffic Control

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

#### Internal Security

- Post security staff according to the established ingress and egress routes, taking into consideration the safety of the facility (i.e. if the hazard was an earthquake that affected the integrity of hospital facilities) and estimates of incoming surge amounts. Coordinate with the Hospital Command Center and Facilities or Engineering staff
- Ensure that all security staff are equipped with radios
- Ensure that security personnel are posted in the Family Information Center, the Treatment Area, and the Triage Area

- Establish a secure perimeter around the hospital
- Advise all hospital staff to be on the alert for suspicious behavior
- Deputize Valets, Volunteers and any available staff to assist with monitoring paths of ingress and egress

#### Law Enforcement Coordination

- Activate any existing MOU agreement with local law enforcement to call in additional security personnel, especially if the hospital may be considered a secondary target of terrorist attacks
  - Contact the Shift Commander at the Torrance Police Department (310) 618-5670 to activate the MOU and request an additional Sargent and five officers to assist with traffic control, crowd control and treatment area security
  - Ensure incoming law enforcement personnel have parking and identification
  - The Manager of Public Safety or designee will be in charge of briefing incoming law enforcement personnel on internal processes, flow maps, radio protocols, and role assignments
- Coordinate with the Hospital Command Center's Liaison Officer and the local law enforcement agency to establish protocols for providing evidence, interviewing patients, and collecting forensic information or data. These protocols should be briefed to ALL triage and treatment area staff once established
- Coordinate with the Hospital Command Center's Liaison Officer and Public Information Officer about the need for any joint media coverage, messaging, or press conferences with local law enforcement

#### **Patient Processing**

Patient processing involves the ongoing efforts of intake and case management staff to facilitate rapid admission, patient tracking, and discharge throughout triage.

Intake and case management staff in the Treatment Areas should complete the following priority items for each patient:

- Ensure that the Patient Charts are labeled and have been filled out completely and accurately for each patient
- Place ID sticker for each patient on color coded treatment area tracking sheets
- Ensure color coded sheets are delivered to the HCC when: 1) sheet is completely filled, or 2) every 15 minutes (whichever comes first!)
- Fill out PsySTART triage tags for each individual to evaluate possible mental health crises or emergencies
- Ensure that personal property is tagged and stored in an appropriate location. When possible, utilize the color coded bin for the appropriate treatment area.
- Facilitate the discharge process for minor or delayed treatment patients

- Monitor the treatment areas for possible HIPAA violations (i.e. forms lying out where other patients can easily read or view them)
- Monitor for low quantities of admit forms or triage tags
- Follow-up with patients regularly and check for patients who can be moved to a lower treatment area or discharged
- Report intake or discharge information to the Treatment Unit Leader

### **Communications**

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

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

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

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

The Public Information Officer will take charge of all communications with the public and the media, in coordination with the Family Information Center. All other staff should refrain from speaking with the media or posting incident details to social media. Requests regarding patient information or missing family members should be directed to the Family Information Center's hotline. As soon as 15 'til 50 has been activated, the Public Information Officer should coordinate with the Liaison Officer and other PIOs at other

agencies to draft media messaging, notify internal staff of policies for speaking to the media, and begin rumor control.

### ***At Risk Populations***

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

All Triage and Treatment staff should be looking out for potential at-risk populations represented in the patients coming in, and in addressing them accordingly or referring them to the appropriate staff.

*Children or unaccompanied minors* should be referred to treatment specialists as well as the Family Information Center for family reunification. If a child is with a parent, do not separate them unless the child is interfering with treatment. The Family Information Center should be supplied with toys, books, and coloring books to keep children occupied while waiting for family members. The Family Information Center will fill out an Unaccompanied Minors form when applicable and assist with family reunification.

For those with *access and functional needs*, staff should make every effort to accommodate their needs. Improvisation is the key: for example, if the portable decontamination trailer only has stairs, staff can create a wheelchair accessible decontamination area with a portable shower, privacy screen, and caution tape to demarcate decontamination zones. The triage and treatment area should be fully accessible, but depending on the incident, it may not always be feasible. The Treatment Unit Leader and Triage Unit Leader are responsible for evaluating the site for accessibility issues during site set-up, and providing solutions or recommendations. If extra equipment is necessary, requests should be communicated to the Command Center through the Unit Leaders.

Portable translator equipment and/or volunteer staff translators should be included in the 15 'til 50 setup for *those for whom English is a second language*. If a patient coming into triage does not speak English, use sign and body language as much as possible, and request translation (through equipment or personnel) through the Unit Leaders.

*Those who are chemically dependent or those with existing mental impairments* will also need to be accommodated. Case management staff should be called in to consult with patients with these pre-existing conditions, and to check on them regularly.



### ***Mental and Behavioral Health***

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

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

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

### ***Staff Support Services***

MCI incidents will create a significant amount of stress on responders and staff. Case management staff should monitor the triage and treatment area staff for the following and report cases to the appropriate Unit Leaders (utilize Critical Incident Stress Management protocol as needed):

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

## TRANSITION

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

### ***Authority to Transition***

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

- Patient inflow has reached within 5%-10% of the day-to-day average
- Hospital no longer needs to transfer patients to other hospitals and can fully handle patient inflow internally
- Incident has stabilized and no additional incident-related patients are arriving at the hospital
- All remaining incident-related patients have been diverted to another facility

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

### ***Notify Stakeholders***

Notification of internal hospital personnel will follow much the same procedures as activating the 15 ‘til 50 Plan. Upon the decision to begin Transition, the Incident

Commander or AOC will verbally, either in person or over the radio, tell all unit leaders that the operation is moving into transition at the designated time. If Transition is staggered at different times for different units, a written schedule should be developed and distributed to all unit leaders in a timely manner. Regardless of whether Transition times are staggered or not, all unit leaders should be reminded that they must officially notify the Incident Commander when their unit has ‘closed’ and fully transitioned to normal operations. As such, the Incident Commander will be the last position to demobilize.

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

Lastly, off-duty hospital personnel should also be informed of the changing status of hospital operations. Staff not at the facility should be notified via the phone tree or mass notification system that hospital operations are transitioning at the designated time, and that at that time normal schedules and responsibilities will be back in place. PBX or department Unit Secretaries (or assigned personnel) may be tasked with activating the phone tree and ensuring that all personnel are notified of the changing status of operations.

### ***Transition Operations***

Demobilization procedures should follow the HICS form 221 Demobilization Check List. All units and personnel should follow demobilization procedures, including tracking and returning resources, demobilizing personnel back to their regular positions and responsibilities, and collecting all paperwork. All resources must be received and tracked by Resources Unit Leader or the Planning Section Chief. The Planning Section Chief or designee should collect all paperwork.

### ***Prepare Messaging***

Upon the decision to begin Transition and notification of stakeholders, the Public Information Officer should be briefed on hospital operations and response to the MCI. The Operations Section Chief, Planning Section Chief and Incident Commander should

work with the PIO to prepare a message detailing overall patient intake, ongoing family information and next-of-kin notification efforts and the successes of the response. The public message during or immediately following Transition should specify that Hospital operations are returning to normal, and that regular appointments and intake procedures will be followed henceforth. During and immediately following Transition, the PIO should receive a full briefing on all elements of hospital response, in order to ensure that they are fully able to answer questions in the future.

### ***Debrief***

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