# CHATHAM COUNTY EMERGENCY OPERATIONS PLAN

## ESF ANNEX 8
## APPENDIX 8-6

# SECONDARY TRIAGE, TREATMENT, AND TRANSPORTATION

MARCH 2013

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## RECORD OF CHANGES

- March 2013 – separated from 8-1 (Special Needs Evac).

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# ACRONYMS

| | |
|---|---|
| ALS | Advanced Life Support |
| ARC | American Red Cross |
| BLS | Basic Life Support |
| BSA | Body Surface Area |
| CHOC | County Health Operations Center |
| CISD | Critical Incident Stress Debriefing |
| CNS | Central Nervous System |
| CPG | Command Policy Group |
| DCH | Department of Community Health |
| EAA | Evacuation Assembly Area |
| ESF(s) | Emergency Support Function(s) |
| EMS | Emergency Medical Services |
| EMT | Emergency Medical Technician |
| EOC | Emergency Operations Center |
| EOP | Emergency Operations Plan |
| GEMA | Georgia Emergency Management Agency |
| GHA | Georgia Hospital Association |
| HAZMAT | Hazardous Materials |
| ICU | Intensive Care Unit |
| MOU | Memorandum of Understanding |
| NBC | Nuclear, Biological, Chemical |
| PD | Police Department |
| PH | Public Health |
| PIO | Public Information Office(r) |
| POC | Point of Contact |
| PPE | Personal Protective Equipment |
| START | Simple Triage and Rapid Treatment |
| ST3C | Secondary Triage, Treatment, Transportation Center |

WMD Weapons of Mass Destruction

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# I. Introduction

A. The mission of the ST3C is to supplement the existing health care infrastructure by providing staging, triage, basic decontamination, treatment, clergy support, mental health counseling and if necessary transportation to a higher level of care, for victims in time of emergency or disaster. Concept of operation addresses the following Health Care functional areas:

1. Coordination and Delivery of Emergent Out of Hospital Care

2. Coordination and Delivery of Patient Care.

3. Pharmacy and Immunization Requirements

4. Maintaining Routine Health.

5. Coordination of Mental Health Support for Victims, Responders, and Special Needs Shelters

B. The threat of chemical or biological terrorist attacks against U.S. citizens is of national concern. The Tokyo subway attack in March 1995 illustrated the likelihood of a chemical weapons attack against a civilian population and the overwhelming impact 5,500 patients had on the existing health care system. This occurrence, together with other more recent national and international terrorist incidents, heightens concerns about the United States' ability to effectively manage incidents involving chemical agents.

C. It is the intent of terrorists to cause damage and confusion in an attempt to throw society into a state of chaos. They are more tempted than ever to use weapons of mass destruction (WMD) for an attack because of their effectiveness in creating mass casualties and hysteria. It is impossible to predict exactly which agents will be used, how they will be disseminated, where they will be employed, and which population will be targeted. The best way to effectively mitigate the effects of an incident is through comprehensive planning, training, and preparation. The Tokyo Sarin attack exemplified how even an educated civilized society responds to an act of terrorism. The ratio of those who thought they were injured to actual casualties was 5:1. Twelve people died as a result of the incident, less than 200 patients were treated as hospital inpatients and approximately 1,000 others needed to be evaluated and treated in the emergency department; yet more than 4,500 additional people sought medical care.

D. The overwhelming number of casualties from the incident will put a tremendous strain on a community's health care system. Victims might leave the scene and attempt to seek medical care on their own. They may

arrive at their private physicians' offices, managed care organizations, and local emergency departments without the benefits of triage. If the incident involves the use of chemical/biological agents they could contaminate their own homes, their loved ones, and anywhere they may go from the incident site. The ST3C supplements the existing health care system in managing the overwhelming number of casualties, both actual and psycho-physiologic, following a mass casualty incident.

E. Most hospitals will have difficulty coping with the sudden onslaught of patients and the need to triage and provide basic care for patient arriving from the scene. In order to cope with these large numbers of patients, we must be prepared to activate pre-planned and tested mass casualty plans.

F. In an attempt to manage a large number of casualties, the ST3C concept has been developed. The ST3C is a Secondary Triage, Treatment, and Transportation Center that are capable of handling between 80-125 non-critical patients per hour, or 400-750 victims during a six-hour period. The ST3C can be replicated to meet the need to handle a larger patient population. The duration of the ST3C is short-lived due to staff constraints and, as most casualties will not require extended patient observation or in-hospital care.

## II. Purpose

A. The intention of this document is to provide a basic understanding of the Secondary Triage, Treatment, Transportation Center (ST3C) so that support agencies can customize the concept to fit their specific needs and incorporate the Center into the larger response effort.

B. The ST3C site is sensitive information and should be release on a need to know basis.

## III. Scope

A. General care provided at the ST3C Center will be performed at the basic life support (BLS) level. The facility is not intended to be a definitive care site nor is it intended to operate at the level of a traditional emergency department. Staff should conservatively assess a patient's chief complaint, vital signs, and pre-disposing medical history when determining if a patient should be sent to a higher level of care facility.

B. Scope of practice may be broadened to include administering antidotes. Antidotes should be placed where patients are initially triaged to help stabilize those who start to deteriorate.

C. Depending on the magnitude of such an event, the level of care that our society is accustomed to will temporarily change to effectively care for the greatest number of victims. Medical decisions will have to be made swiftly and will be based on limited information and can only be enacted based on limited resources.

D. Public Health protocols will need to be developed and approved prior to use. The Department of Public Health will develop guidelines addressing the expectations regarding level of care, patient confidentiality, and patient privacy. Although the community would not directly dispute that the enormity of the disaster will likely affect the availability of resources, they will grow concerned when there is a change from the medical norm and possible litigation could result. The scope of practice and standard of medical care will not exceed the educational preparation and authorized level of proficiency of the provider.

## IV. Authorities

A. This Tab is developed under the authority of the Chairman of the Board of the County Commission, Chatham County, Ga; and the Director of the Chatham County Emergency Management Agency, Chatham County, Ga. This Tab supersedes all similar and previous versions to date.

B. Assignments and Responsibilities:

1. CEMA has the responsibility for compliance with the provisions of the Chatham County EOP; therefore will have primary responsibility for ensuring execution of activities outlined in the supporting documents.

2. ESF 8 has the primary responsibility for the maintenance and update of the Special Needs Register and for the Operation of the ST3C site. It will also coordinate with CEMA regarding the EMS system in support of this TAB.

3. ESF 6 has the responsibility to assist in the registration and manifest of Special Needs Residents at the ST3C and to provide other necessary support to ensure residents' needs are met.

C. Municipalities are responsible for providing support to this Tab that are necessary for carrying out the tasks described in this Tab.

## V. Assumptions

A. A hurricane is projected to make landfall in or near enough to Chatham County to cause significant infrastructure damage and pose a threat to

anyone remaining in the county. The threat requires the evacuation of the special needs population as well as the general populace.

B. As identified below, a special needs evacuation decision shall be made prior to the evacuation of the general population. The evacuation decision making process should allow for sufficient time to provide for a:

1. Six hour period prior to the onset of tropical storm force winds.

2. Twenty hour period of mandatory evacuation clearance time.

3. Six hour daylight period for a voluntary evacuation.

4. Twelve hour period of special needs evacuation prior to the initiation of the voluntary evacuation.

C. Supplemental transportation resources will be coordinated and made available by GEMA. It will take at least 12 hours for State procured transportation to be in place.

D. Due to the gravity of the threat, an evacuation order will be given by local elected officials. GEMA will have been advised of this order.

E. Local transportation resources have been deemed inadequate to accomplish this special needs evacuation.

F. Local hospitals will remain at least partially operational in conditions up to a Category 4 hurricane for patients that are too critical to evacuate. All remaining patients will be evacuated via the GHA Live Process Regional Coordination designate.

G. State operated special needs shelters will be activated upon demand for Level 3, 4 and 5 care.

H. Unaccompanied minors will be supervised by Red Cross Disaster Services personnel until they can be delivered into DFCS care.

I. Persons exhibiting uncontrollable and disruptive behavior will be referred to law enforcement.

## VI. Implementation

A. Implementation of this Tab in a major event will be coordinated through the EOC based on a decision by the CPG and EOC manager.

B. Once the decision is made to implement this Tab, ESF will assume the lead.

# VII. Concept of Operations

A. Aspects Influencing Operational Methodology

1. Hospitals will not be able to handle the patient surge:

a. Traditionally in any type of incident, hospitals provide the bulk of treatment for victims. In a large disaster or WMD incident however, it is questionable if hospitals will be able to handle the patient surge. Most hospitals are not prepared to care for a large number of patients. Such an influx of patients may threaten the integrity of the hospitals and the safety of their personnel. If a few hospitals shut down in a particular health care system, due to a large number of minimal care patients, then the system may no longer be in a position to care for the remaining casualties. Maintaining the current or routine patient load is an important consideration during a mass casualty incident. For example, there will still be people who will suffer from heart attacks (possibly even more than normal, which occurred in the 1996 Centennial Park bombing in Atlanta, (Nordberg, 1996)), medical emergencies, motor vehicle collisions, traumatic incidents, etc. The health care system must continue to accommodate the so-called “unaffected community.” In addition to the patients transported from the incident scene, the health care system will be inundated with the following populations:

1) Large numbers of psycho-physiologic patients.

2) Victims who have left the scene and seek treatment on their own.

3) Friends and family members seeking information regarding casualties.

b. In order to accommodate the patient surge, hospitals should look to initiate their own disaster plans. Those disaster plans may include discharging patients that can be moved to outlying facilities or to their respective homes. Other options may include relocating some of the in-patient populations, who are stable enough, to a ward unit or unused portion of the hospital. Further options may include transferring patients to an alternate location outside the hospital to make room for patients arriving from the incident. Hospitals will not be able to accommodate the patient surge from a mass

casualty incident involving weapons of mass destruction or a large-scale disaster.

2. Re-Distributing Resources during a Disaster

a. Hospitals should continue to provide care for those patients who need a level of treatment that only a hospital is most suited to provide. Hospital resources even under disaster conditions cannot be easily replicated, supplied, or staffed. The traditional mission of a hospital may shift during a disaster from rendering care for the community at large to rendering care for acute patients.

b. A more generally accepted premise in disaster management is to provide treatment for triaged Minimal patients outside traditional emergency departments. Minimal casualties require considerably less resources thereby making it easier to provide appropriate care in non-traditional settings. Minimal casualties generally do not require in-patient services, or extensive medical tests, nor do they demand acute care treatment. Well before hospitals are taxed beyond their capability the Public Health Director in collaboration with the Public Health representative located at the County Emergency Operation Center (EOC) along with hospital administrators will establish a means to treat casualties outside the boundaries of the traditional hospital realm. Several factors influence when a community should set-up a ST3C or when treating casualties outside the normal hospital setting is beneficial. Such factors include but are not limited to:

1) The size/magnitude of the incident.

2) The geographic distance from the incident site to a planned alternative health care facility site.

3) The need to care for patients within a reasonable period of time.

4) The expected surge of patients will likely occur within the first six hours of the incident.

5) The length of time needed to stand-up a ST3C

6) The optimal number of patients that can be treated per hour in proportion to the number of staff available to operate each ST3C.

3. Planning for Unexpected Patient In-Flow

   a. At times we may receive patients that are not covered under Public Health responsibility or authority and these may include patients from nursing homes and assisted living facilities.

   b. These patients are under the care of for-profit organizations and are regulated by the Georgia State Office of Regulatory Services. The Office of Regulatory Services has mandated that these for-profit agencies develop and practice a disaster plan. Sometimes this group of patients may be inserted into special needs populations or other medical priority groups needing evacuation. At some point we may end up having to provide ST3C services to this group as well. In this instance the Special Needs Populations template may be used.

B. Facility Requirements:

1. The ST3C may be either a fixed or temporarily established facility. The ST3C may utilize our 50 bed portable Acute Care Center or services may be applied from our portable ST3C trailers. Whatever forms the ST3C take, the following resources should be provided. The facility can be established however, with considerably fewer resources and adapted to fit within our assets and disaster plans.

   a. Separate male and female locker rooms and showers.

   b. Large open areas to support helicopter delivery of state and federal resources.

   c. Spacious parking facilities.

   d. Good internal access roads allowing for emergency vehicle ingress and egress

   e. Electricity, preferably with generator backup.

   f. Internal and external water supply (e.g., fire hydrant).

   g. Access to sanitary sewer system.

   h. Easily identifiable to the public.

   i. Large enough facility to co-locate multiple services within one campus, (e.g., patient decontamination /treatment, crisis

intervention, law enforcement investigation, animal decontamination).

j. Gymnasium or large room.

k. Bathrooms (standard male and female).

l. Heating/Air Conditioning/Ventilating System that can be sectored off to avoid cross contamination.

m. Securable internal and external rooms.

n. Chairs.

o. Tables.

p. Areas to post information (e.g., chalk and bulletin boards).

q. Public announcement systems.

r. Cafeteria/food service facility.

s. Auditorium.

t. Copy machine.

u. Fax machine.

v. Hard-wired phone lines.

2. Examples of buildings that may have much of the recommended items or buildings that can be modified to facilitate a ST3C include fitness centers, medical buildings, hotels, college dormitories and campus facilities, motels, high schools, middle schools and recreation or community buildings. Even warehouses and tents can be converted into a ST3C. Of the aforementioned facilities, high schools and middle schools contain much of the needed equipment and may be an optimal choice for many communities. For any building to be readily available as a ST3C there should be a specific Memorandum Of Understanding (MOU) in place between Public Health, and the superintendent of the facility. The MOU should address how the point of contact for each building will be notified, how the building will be evacuated if necessary, and if any specific personnel from the building are needed to staff the center such as the building maintenance engineer.

3. The potential exists that the facility may become contaminated during its use. Wooden floors for example, are specifically subject to irreversible contamination, as they are porous. Priority should be to use older buildings first so that new facilities are not razed or closed down if the building cannot be fully decontaminated.

4. Facilities that have the following items are optimal: male shower/locker room, female shower/locker room, large parking areas, good access roads, easily identifiable by the public, large gymnasium or similar area, electricity, heating, securable internal and external rooms for storage, and internal and external water supply. Located close to the population it would serve although outside of the affected or contaminated area. It should be close to public transportation for those individuals who self-refer.

C. Organization and Staffing: Public Health is the lead agency for the ST3C. These key positions are necessary to accomplish each function.

1. Command: Management Personnel: During Activations of this Plan, the Incident Command System will be utilized.

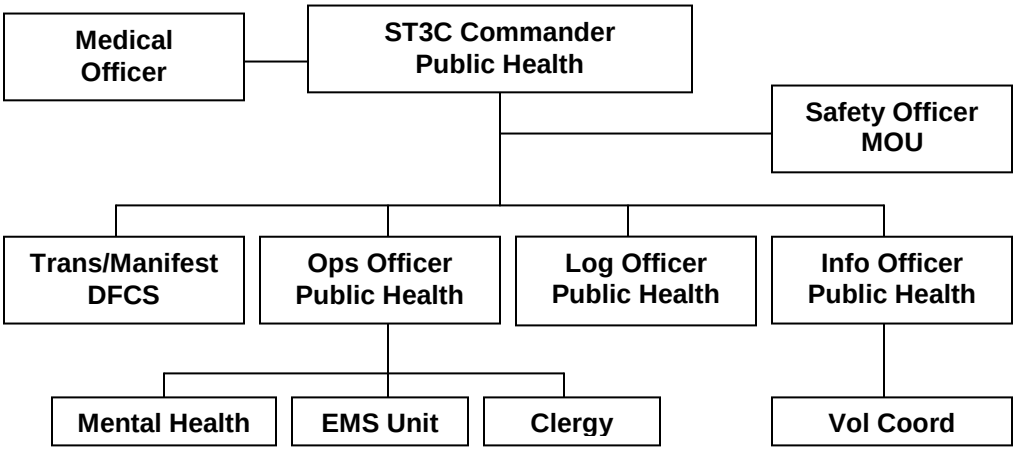



Figure 1.0

a. ST3C Commander (Public Health Nurse): The Commander will be responsible for overall command and control of the facility, report staffing and resource needs to the County Health Operations Center (CHOC) and assign officers to serve other command functions in the organizational chart (See Figure 1.0)

b. Safety Officer (Public Health/Environmental): The ST3C requires the use of a Safety Officer. The critical function of the Safety Officer is to monitor safe practice and mitigate any safety issue before undo harm is posed to personnel or patients. Safety officer should also ensure that all patients are decontaminated before entering the center in a WMD event. Safety Officer will ensure air, water, food and sanitation needs meet established guidelines.

c. Public Information Officer (Public Health/PIO): The critical functions of the Public Information Officer are to release information to patients and the media in accordance with established protocols. The PIO will be responsible for both internal briefings for patients and external briefings for the public. All information must be linked with the District Health Director so that all information regarding the incident is consistent, accurate, and released to the public in a controlled manner. The PIO generally disperses information regarding the incident, hotline/help-line numbers, and information regarding location of those transferred from the ST3C.

d. Operations Officer (Public Health): Critical functions under the Operations Officer include triage, and treatment. The Operations Officer will oversee the critical functions of the ST3C such as patient flow, triage, treatment and general assistance.

e. Transportation/Manifest Officer (DFCS): The Transportation / Manifest Officer must develop a means to track, register patients through the facility. This information is necessary to planning the overall needs of the ST3C. All patients will be in-processed/out-processed by assigned staff under the direction of the Transportation/Manifest Officer. The Transportation/Manifest Officer will also recruit, train and assign spontaneous volunteers.

f. Logistics Officer (Public Health): Critical functions within logistics include transportation, facility maintenance, communications, supply/equipment and contracts for all goods and services required. Transportation must be coordinated as patients will arrive from the scene by bus or will self-refer. They may arrive by private vehicle, bicycle, commercial transportation, or foot. Transportation also includes coordinating patients requiring transfer to outlying

hospitals. Transferring patients to area hospitals requires coordination with EMS and availability of hospitals to receive patients.

g. Security Officer (MOU): The Security Officer will maintain control in the ST3C. Patients will become unruly and disruptive if they have to wait in long lines, or are unable to locate other family members. It is also possible that those that perpetrated the incident may present as patients seeking care or it is possible that others responsible for criminal acts will be among the patient population. If patients become particularly disruptive, local police will be notified to remove them from the facility.

h. Medical Officer (Public Health): The Medical Officer is a Board Certified Physician and has the responsibility for overseeing all medical aspects associated with patient care at the ST3C. The Medical Officer will be located specifically in the treatment area, assisting other providers with patient treatment, and should have direct contact with EMS, if need for patient transport should arise. The Medical Officer reports directly to the Operations Officer but can provide the ST3C Commander input and should be considered part of the staff.

2. General Staffing: There are many critical factors that must be considered when composing a compliment of staff to work at the ST3C. Each county in the district will have different resources from which to draw, therefore the specifics for staffing the ST3C should be planned by the county. Under disaster circumstances you will need to initiate MOUs with specific institutions (i.e. hospitals, clinics and emergency response sections of local businesses), to allocate a certain number or percentage of staff to disaster relief functions.

a. All ST3C staff should receive training and become familiar with the ST3C Concept of Operations. In extreme situations, when a community cannot staff the center with people who have received this training, the general staff should be assigned positions that are closely related to their regular job function.

b. Sources that may be able to allocate medical providers include volunteer fire and EMS services, private ambulance companies, allied health agencies, and health professional education institutes (e.g., physician/medical school, nursing, nursing practitioner, physician assistant, and paramedic

schooling programs). Veteran's Administration hospitals, home health agencies, temporary nursing agencies, professional associations, volunteer agencies such as Red Cross, etc. may also be able to medically support the efforts of the ST3C.

3. Volunteer Staffing:

   a. Volunteer organizations can be a great source for additional staff. Due to limited DCH staffing resources, each County Facilities Administrator should appoint a Volunteer

   b. Coordinator: The Coordinator will to establish a disaster volunteer compliment of personnel. The more prepared this pool of personnel are, the easier it will be to assign them to a ST3C or any disaster relief function. Volunteers that are selected to assist in the facility must be free from other obligations/conflicts that would prevent them from assisting during an emergency (e.g. ARC volunteers, military reservists, assigned to other support agency emergency plans). All training will be coordinated through the Biological Terrorism Training Coordinator for Public Health.

   c. When resources are limited and volunteers comprise a large contingent of the work force, it is recommended that key personnel be assigned to leadership positions and place volunteers in support roles.

   d. Should citizens arrive at the center attempting to volunteer their services, the Commander or Operations Officer should direct them to an area where they can best be utilized based on their experience and specialty. Keep in mind, you must verify medical credentials/license, training and suitability before assigning persons to medical positions.

4. Control & Communications:

   a. The ST3C must have a communication system. The form of communication, e.g., 2-way radios, HAM radio operators, cell phones, runners, or networked computers will depend on the availability of resources. Like any disaster, communications is vital to the overall operation at the center. Public Health is responsible for providing resource and training needed to support this function.

b. A backup communication should be prepared if the primary system fails. If runners are used as a backup system for communication, the logistics officer must educate staff how to effectively use them

D. Notification, Activation, and Deployment of Personnel

1. Notification

a. The Local Public Health Department is the lead agency to manage and coordinate the ST3C efforts. Public health will establish a notification process to activate those other agencies that will be needed to support the facility. The notification process should follow pre-established protocols and call-down lists. Automated emergency phone calls, reverse 911 systems and/or automated fax notifications are methods to notify supporting agencies of activation.

b. Part of the notification process includes informing hospitals where the incident occurred, the impact of the incident and information regarding the ST3C. Regarding the ST3C, the notifications should specify the following:

1) The location of the ST3C

2) The purpose of the ST3C

3) The anticipated duration of operation.

4) The type of patients should be directed or re-directed to the facility.( Level 1&2 care residents will be evacuated through the EAA to congregate shelters. Level 3&4 residents will be evacuated through the ST3C. Level 5 residents will be evacuated through the Hospital System).

c. The public must also be informed of the ST3C. The media should be briefed and their help enlisted in disseminating accurate information to the public. The Public Information Officer at the Emergency Operations Center (EOC) should announce the ST3C purpose, location, and duration of operation. Involving the media early will help inform the community that they can obtain care quickly and it will instill the public's confidence that they can be helped.

2. Activation

a. The Amount of time needed to establish the ST3C can greatly influence its effectiveness in mitigating a mass casualty incident. The ST3C should be operational within a short period of time. Activation procedures will entail deploying specific pre-packaged resources/equipment that can be automatically delivered to or stored at an site, or requiring supporting agencies to deploy pre-packaged disaster items.

b. Each supporting agency should mobilize their own required staff and resources and be responsible to check their personnel's credentials/identification and deployment readiness. Each agency will maintain their own personnel rosters and staff assignments and will provide the local health department with a copy. Once agencies are mobilized they should report directly to the ST3C Commander.

3. Deployment of Personnel: Assigned personnel will report directly to the ST3C Commander. The Commander will remind the agencies of their primary mission, hand out written checklists, request that they assign personnel to specific jobs, and obtain a staff roster from every agency.

E. Patient Population

1. General:

a. The intent of the ST3C is to care for the following types of patient populations:

1) Triaged minimal patients transported by EMS.

2) The worried well population upon hearing a public announcement.

3) The psycho-physiological patient.

4) The non-critical patients that arrive at area hospitals but would be more appropriately cared for at the ST3C.

b. For the purposes of this concept, Minimal will be defined as a known casualty that was at the incident site and falls within the triage parameters of Minimal versus Immediate or Delayed. In general, patients who fall within the Minimal category can breathe spontaneously, are oriented to their

surroundings and have adequate circulatory/tissue perfusion.

c. Psycho-physiological patient is defined as persons who present at health care facilities with the intent of receiving a medical evaluation and treatment. Often these patients may not have been part of the initial incident nor have they sustained a physical injury.

d. The psycho- physiological patient generally does not have any physical ailments but do believe that they may have some physical injury and are concerned that they have been harmed. These patients need medical evaluation and emotional support.

e. Non-critical patients fit the same description as minimal, however, hospital personnel do not always triage patients in the same manner as EMS providers. Patients generally fall into other sub-categories such as acute/critical, monitored, and non-critical/fast track. Non-critical patients will leave the scene and arrive at area hospitals seeking care, those patients that hospital personnel deem non-critical may be more appropriately cared for at the ST3C. This is especially true when an excessive number of patients are waiting for care at a hospital.

f. Patients transported from the incident to the ST3C may have received at best an initial triage evaluation but no treatment. Self-referring patients will not have been evaluated at all. It is possible that even though the ST3C is not intended to receive critical patients, Immediate or Delayed self-referring patients may arrive.

g. If patients have been exposed to WMD or certain chemical hazards patients may not have been decontaminated. Some patients, especially the elderly, may have refused to remove their clothes or to be wet down at the incident scene. Parents with young children may not have wanted them exposed to environmental elements especially in inclement weather. Therefore, you may not know if patients are contaminated. Remember, ALL PATIENTS MUST BE CLEAN BEFORE ENTERING THE CENTER. If the center becomes contaminated it will be of no use to the operation.

2. Unaccompanied Children (Mental Health/DFACS):

a. It is likely that the facility, as well as all health care facilities, will receive unaccompanied children during the disaster. Children may have been separated from their families at the scene and arrive at the facility without them; or families who arrive at the ST3C may be separated from their children when directed to the decontamination area; or critical patients requiring immediate transfer to a higher level of care may result in unaccompanied children.

b. Unaccompanied children will be assigned to mental health providers for management and necessary counseling. In situations when children may become separated from their parents after they arrive at the center, or parent is evacuated to a higher level of medical care, extended family members will be contacted so care for the child can be provided.

3. Special Needs Population (Volunteers): Elderly and handicapped patients may also arrive at the Center seeking care. These patients can fall into the Minimal or non-critical triage category but have difficulty ambulating at the facility, (e.g., the blind). Staff must take into consideration that the facility demands a lot of walking and navigating through the building. Options may include the following in processing these patients:

   a. Staffing the Center with additional patient assistant volunteers.

   b. Re-directing all physically challenged persons to traditional emergency departments.

   c. Setting up Center in handicapped accessible buildings.

   d. Making existing buildings more accessible to the handicapped with portable wheelchair ramps.

4. Special Needs Evacuation (Triage and Transportation)

   a. A Special Needs Staging/Triage Center will be established, within the County, to receive, screen, Triage, and prepare the Special Needs Population for transportation to a Special Needs Population Shelter.

   b. The Center will be established when the EMA determines that it is time to evacuate the Special Needs Population. The Special Needs Triage team will be notified and told the location of the site. The site location will not be publicized.

If the Center is to be of a fixed facility nature, the EMA will have responsibility to provide.

c. Transportation to the Triage center will be performed to the best ability of the Shelter population. Persons not having transportation will be provided transportation by ESF-1. Transportation of Special Needs Populations from the Staging/Triage Center to a Special Needs Population Shelter will be the responsibility of the Georgia Emergency Management Agency (GEMA).

d. Re-entry of Special Needs Populations into the County will be the reverse of the evacuation sequence. GEMA will transport and deliver Special Needs Populations to the ST3C Triage Center for in-processing back into the County.

e. Team Make-up will include a Physician, Nurse Manager, Clerical staff, Logistics Officer and Transportation/Manifest Officer

1) Physician Lead - This function is staffed by a Chatham County Health Department Physician. This person will have the functional responsibility of determining the Application of the 5 Levels of Care as outlined by the Care of Special Needs Populations document dated 2005.

2) Nursing Lead: This position is staffed by the Chatham County Nurse Manager or her/his designee. The functional responsibility of this position is to triage Special Needs Registrants based on the 5 levels of Care. Standard State of Georgia Nursing Protocols will be used as a template for decision making. Registrants will be triaged for assignment to a Special Needs Population Shelter.

3) Clerical Lead: This position is staffed by the Chatham County Administrative lead or his/her designee. Functional responsibilities of this position include providing / maintaining the Special Needs Registry at the Triage Center. Staff will provide the Registry, Special needs Registry Application form and disseminate the information to responding or supporting agencies as needed. DFCS will be responsible to manage the Triage Center and track

the Special Needs Population to their assigned Shelters.

4) Logistics Lead: This position is staffed by the Chatham County Facilities Manager or/his/her designee. The functional responsibility of this position is to provide equipment and supplies as needed by the Nursing Function of the Triage shelter.

F. Tracking

1. Patient Tracking: (PH, DFCS/Volunteer Coordinator) DFCS is the lead agency that will provide administrative support needed to support this area. If the ST3C Commander sees additional staff is needed to support the incident, the DFACS representative will be contacted at the EOC.

a. Volunteers from the community can also be used to support these requirements and would be placed under the supervision of the DFACS supervisor.

b. The Special Needs Registry will be the standard document of use in tracking Special Needs Populations through the Staging / Triage Center.

c. The numbers of Special Needs Populations will be communicated through the District Operations Center (DOC) to the receiving District and State Operations Center. The receiving District will determine shelter locations and numbers to be housed in each facility.

d. Patients that are processed at the ST3C must be tracked and their medical status/evaluation documented. Patients will report to the facility and undergo a triage. The Safety Officer will ensure that the patients have been properly decontaminated if they have been exposed to agents. If patients report to the facility with personal belongings that look suspicious the Safety Officer will notify police officials to have their items checked before they are allowed to enter the facility. Personal belongings will remain with the patient as they are processed through the ST3C. Once the patient has been triaged the patient will in-process into the facility. At a minimum, Administration must capture the name and triage tag number/identifier, at the beginning of the process. If patients leave the ST3C before they have completed the process, then a more accurate list of who arrived at the

facility is available. Patients that are discharged from the facility will out-process. During out-processing the triage tag will be removed by staff and become part of the patient's treatment record.

2. Patient Charting (PH Nurse): Health care providers at the ST3C must document the patient's medical status and collect patient demographic data. Patients can start to fill out the demographic portion of their chart should they need to wait for an available provider. If the patient is transported to a higher level of care the treatment record will accompany the patient. Patients information will be recorded in the out-process log as having been evacuated. The chart will be completed at the out-processing station. Any information that patients or staffs were unable to obtain, personnel at this area can fill in while patients review their discharge papers.

G. Critical Functions within the ST3C: The ST3C Commander, Operations Officer and representatives from the supporting agencies will determine patient flow. Certain challenges, such as narrow corridors, or doorways, and stairs that do not allow stretchers or wheelchairs to pass easily must be considered in the patient flow planning. The following section delineates and describes the critical aspects of the ST3C. Each area must be considered when establishing the facility.

1. Perimeter Security

a. Due to the nature of the incident the ST3C may require a full compliment of security officers. Terrorists may want to target large groups of citizens and emergency workers. Those with knowledge of a community's response plan may see the ST3C as an ideal secondary target. Perimeter security is needed to maintain order, deter criminal acts, and provide for the safety of the public. Local PD will provide security for the facility and surrounding areas. Security officers will need to ensure that only authorized and properly credentialed staff enters the grounds. All entrances should be locked from the inside while still maintaining an exit capability or have security staff in place to control entry into the building. Security will establish separate entrances for victims and staff. Signs will be posted directing them to their respective entrance. To aid law enforcement in identification of staff workers, orange colored armbands will be worn on the right arm of all staff members.

b. Perimeter security will also be called upon to check personal belongings of patients as needed. If dangerous items are

suspected/seen in patient's belongings (i.e. weapons), security will immediately confiscate the articles and notify the local law enforcement authorities.

c. Perimeter security efforts also include directing traffic and controlling traffic patterns. Though most of the patients will arrive by bus or ambulance from the scene, many citizens may arrive in their private vehicles, taxis, public buses, or foot. Officers must determine ambulance and bus drop off points, and private citizen vehicle parking. Persons who arrive in their own vehicles may unknowingly be contaminated. If vehicles have been identified as being contaminated they will be quarantined. Security will have to direct these citizens to a place to park and get them decontaminated before they are allowed to enter the facility.

d. Once patients are discharged from the ST3C they will not be allowed to re-enter. Patients will be directed away from the facility.

e. The number of security officers needed at the facility will depend on the size of the ST3C and the number of functions that are to be assigned. Local law enforcement will provide perimeter security but other agencies and volunteers will also be used to support this effort. School crossing guards, private security agencies, traffic controllers for stadium/concert events, and the Department of Public Works will be able to provide barricades, cones, directional signs, and personnel to supplement traffic control efforts.

2. Triage/Registration

a. The START Triage System will be the method for triaging patients at the scene of the incident. Staff at the ST3C should be familiar with the system. The tracking of patients will be as follows. Upon entry into the facility DFACS will complete an in-processing checklist. There may be an EMT/Paramedic at the reception point who will direct the patient flow. Although the center is designed to treat only Minimal triaged patients, it is possible that some patients may deteriorate medically during their in-processing into the center. Self-referring patients may also show up in a critical state. The EMT/Paramedic at the initial in-processing point will be able to direct transport of these patients to the Immediate/Delayed care areas for stabilization and further evacuation.

b. Patients that have trouble ambulating will receive assistance from volunteers in the labor pool. It is possible that these patients have been triaged Minimal but due to some disability need physical assistance. Wheelchairs or litters will be at each station within the patient area to assist with the transport of these patients and others whose medical condition may deteriorate. If litters are used litter bearers from the labor pool will perform this function.

c. An antidote cache will be needed at the ST3C. By placing the antidote at the facility both patients and staff will benefit. Protocols for the administration of the drugs will have to be developed before Public Health nurses will be allowed to administer. Communities will have to conduct drug inventories and develop MOUs with other agencies (Veterans Administration, local hospitals and retail pharmacies) to plan for this resource.

3. Decontamination

a. Avoiding contamination is important. If Weapons of Mass Destruction (WMD) have been used not all patients that arrive at the center will have undergone a gross decontamination. If contaminated patients are allowed to enter the building, operations will have to be terminated. An improvised decontamination site outside the building must be established to prevent contamination from entering the facility. A more detailed decontamination may take place inside the building if the resources are available (showers).

b. Since public health is not prepared to accomplish this task it is suggested that each community develop MOUs with an agency that is not typically used at the actual incident site to perform decontamination for the Center.

c. Planning considerations for determining how elaborate the decontamination site will be is based entirely on resources. Standard guidelines for decontamination will be followed. If the resources are not in place to perform this task at the ST3C, patients will be routed to an established decontamination site using vehicle exchange procedures.

4. Internal Security

a. The Security Officer will maintain control in the center.

b. Patients will become unruly and disruptive if they have to wait in long lines, or are unable to locate other family members.

c. It is also possible that those that perpetrated the incident may present themselves as patients seeking care or it is possible that others responsible for criminal acts will be among the patient population. If patients become particularly disruptive (mental health counselors are unable to contain the situation) then the local police will be notified to remove them from the facility. Suggest that this task be contracted out to private security firms. All Security Officers should be trained and equipped with firearms.

5. Treatment

a. The ST3C will evaluate and treat patients who arrive at the facility. Staff will transfer patients that have more critical conditions than the center can provide, to traditional hospital emergency departments. An EMS ambulance crew will transport these patients. A fully equipped ambulance crew will be on standby at all times at the ST3C to support this requirement.

b. Treatment at the ST3C will be based on what can be provided by local hospital staff, public health staff and EMS. At a minimum, basic life support (BLS) must be provided. The treatment area will be arranged based on the triage categories .

c. Comprehensive patient documentation begins when patients arrive in the treatment area. Staff must complete the medical portion of the chart for all patients and the demographic portion of the chart if patients are transferred from the facility.

d. An Immediate treatment area will be established. This area is meant to stabilize patients only and arrange for their transport to a higher level of care. EMS personnel and the Medical Officer will staff this area. The Medical Officer will provide oversight and emergency care as needed. Staff will collect patient demographic information, which is normally captured at out-processing. Critical patients must have beds/stretchers on which to lie. Personnel with a minimum of Advanced Cardiac life Support (ACLS) certification ability

will staff this area. Staff will stock each bed with ACLS equipment and medications

e. Delayed patients will need a more in depth, subjective cardiac and respiratory evaluation. A Delayed area should also have beds/stretchers and be able to handle more patients than the Immediate area but not as many as the Minimal area. Ideally it should have EKG monitors, respiratory flow meters, oxygen, and access to a minimal supply of medication. Staff in this area should know how to perform Advanced Life Support (ALS).

f. A Minimal area should use tables and chairs and be capable of processing 12 or more patients at one time. Staff will include a public health nurse, and emergency medical technician or paramedic and an administrative assistant. It may also include medical students and other pre-hospital care providers. EMTs/Paramedics are particularly good at performing quick and in-depth subjective patient assessments without relying on a patient chart as a prompt.

g. Patient treatment will be based on the following findings:

1) Symptomatology

2) Vital Signs

3) Pertinent medical conditions that may be exacerbated by WMD exposure

4) Medications and medical allergies

5) If WMD suspected method of agent exposure

h. The Division of Public health must provide nursing staff guidelines that contain the following information for each type of WMD exposure:

1) A fact sheet on the agent including antidote.

2) Pertinent medical conditions that are complicated by the agent exposure.

3) Actual treatment modalities to include basic life support and advanced life support procedures and hospital provider treatment.

i. All patients that do not need to be transferred to an outlying hospital will continue through the ST3C process until either transported to higher level of care or discharged from the facility.

j. Patient treatment will include more than just physically evaluating casualties. Patients may suffer from severe mental distress after having been a victim of the incident. The incident may exacerbate any underlying mental illness. If the Medical Officer or the mental health support personnel determine that a patient needs to be medically sedated or restrained this patient will be transported to facilities capable of evaluating their condition IAW established mental health protocols, legal requirements and privileges of credentialed provider.

6. Out-Processing:

a. Once patients have received treatment, they are ready to be discharged. DFCS staff will obtain patient demographic/tracking data, and then officially discharge patients from the center. This information should include as a minimum:

1) Patient identification number/medical chart number/triage tag number.

2) Name.

3) Date of birth.

4) Address.

5) Phone number.

6) Emergency point of contact.

7) Social security number.

b. The discharge process should include as a minimum:

1) Nursing staff informs the patient of signs and symptoms that warrant them re-entering the medical system.

2) Nursing staff informs the patient how to re-access care if they become symptomatic at a later time.

3) If patient was exposed to a particular agent nursing staff notifies the patient of particular agent.

4) Nursing staff provides the patient written self-care instructions.

5) Nursing staff obtains patient's signature, which specifies that the patient is being discharged from the center and then the date and time of discharge is entered into the record.

c. Patients may make inquires regarding transportation home, how to find other family members, how to best obtain medication re-fills to replace damaged medication bottles, etc. DFCS staff out-processing patients should direct patients, with these types of inquiries, to the general assistance area.

7. General Assistance:

a. After the patients have been officially discharged from the center, they may still need some basic assistance before they are ready to leave. The general assistance area should be located in the general vicinity of the ST3C but away from patient care. Memorandum of Understanding (MOU) should be developed with ARC to provide support for this function. The following aspects should be considered:

1) A collection point where patients can gather before they are transferred home or to a Reunification Center.

2) A location where family members can reunite.

3) A rest point where patients can sit and for the first time rest.

4) A family assistance desk where patients can talk to someone regarding individual concerns and gather information.

5) A place where patients can make a phone call.

6) The ability to obtain mental health support.

7) A location where patients can get more appropriate clothing.

b. All patients will need transportation home. Patients, who drove themselves while they may have been contaminated, cannot re-enter the same vehicle until it is declared free from contamination. Other patients who arrived via bus left their vehicles at the incident site. All citizens will be transported home or to a Reunification Center. Public transportation assets may be used to perform this function. Services will be provided using either the county school buses or vehicles used to support public transportation system.

c. ARC will need to establish arrangements with the local phone company to set up a mobile phone bank (out-going calls only) at the location. Patients will want to inform relatives that they are okay and where they can be picked up.

8. Reunification Center

a. The ARC is accustomed to providing lodging, food, clothing vouchers and emotional support and is the best agency to initiate a Reunification Center. When an incident is so large that it requires the use of a Secondary Triage Center, considerations should be made to stand up a Reunification Center. This facility should be located at a different location.

b. Family members need a location where they can meet up with their loved ones or obtain information regarding their location and status. The Reunification Center can become an information hub that collates the status and location of all casualties, and creates a list of missing persons.

9. Transportation:

a. The ST3C is not designed to provide care equal to that of an emergency department, consequently patients requiring a higher level of care should be immediately transferred to a traditional hospital.

b. EMS provides dedicated ambulances for the community. Units will be fully engaged responding to or supporting mutual aid efforts surrounding the incident site. MOUs will need to be established with private transportation agencies, or public mass transit to support this effort.

10. Temporary Morgue

    a. It is possible that patients will die at the ST3C. County coroner will establish procedures for the removal, storage and humane treatment of deceased persons which may include: using a refrigerated truck as a temporary morgue, arranging local law enforcement to secure the temporary morgue, maintaining a chain of custody, and filling out specific paperwork. Other procedures should include a physician signing the death certificate, staff documenting the time of death, and staff reporting the death to the public health.

    b. Any death that occurs during the same period as a terrorist incident may be case evidence. The medical examiner or coroner will handle remains as to preserve evidence.

11. Pet Management

    a. Many people will bring their pets to the ST3C expecting personnel to help them. Pets are not allowed in the ST3C unless they are working animals assisting disabled persons (these animals must remain with the owner at all times).

    b. Animal Control will provide the staff and equipment to temporarily care for animals that are brought to the center. Animal Control should keep in mind the following when incorporating pet management into their plan:

        1) Animal drop-off point.

        2) How to identify animals with their owner.

        3) Animal decontamination efforts.

        4) Medical evaluation/treatment regimens.

        5) Holding animals when an owner has been transferred to a hospital.

        6) Animal retrieval procedures that prevent re-contamination for WMD exposure.

        7) Handling Seeing Eye Dogs and other specialty dogs to include: if these animals need a more extensive

evaluation, they should be separated from their owner.

8) Food and water (depending on the length of time animals are held in kennels).

9) Location of kennels with regards to inclement or extreme weather, i.e., placing kennels in shade when temperatures are hot.

10) MOUs with pet product distributors/stores for supplies not normally supplied by the local animal control department.

H. Site Shutdown:

1. Once all patients have been absorbed into the health care system the ST3C Commander must coordinate with the Emergency Operation Center (EOC) to “stand down” the facility.

2. Once decision reached to “stand down” the following actions must occur:

a. Remove all hazardous waste.

b. Arrange to have all durable items that citizens relinquished, to include their vehicles, decontaminated if needed.

c. Return all personal items.

d. Arrange for the facility to be inspected and turned over to owner.

e. Inventory, clean and repack all equipment.

f. Maintain all records in accordance with approved guidelines established by the Department of Public Health.

g. Conduct After Action Review.

I. Conclusion:

1. The ST3C is one tool that may be used when mitigating the effects of a disaster or emergency. It is designed to be flexible, temporary, stand-alone facility that can be replicated when any one-hospital facility exceeds its capacity.

2. The primary medical mission is to provide casualty triage, decontamination if needed, treatment, and transportation to definitive health care facilities, without intentionally overwhelming the health care system. Once victims have been absorbed into health care system, the ST3C can be deactivated.

## VIII. Responsibilities

A. CEMA Director: Responsible as the primary advisor to the County Commission and County Manager regarding the Special Needs evacuation plan and the ST3C site operations. His role is to ensure the plan is properly executed and that a system is in place to track the residents and the costs involved in the evacuation and return of special needs residents.

B. CEMA Deputy Director: Primary Operations Officer and assumes the responsibilities of the Director in his absence. The CEMA Assistant Director ensures that all support ESF's are activated to meet the needs of executing this Tab.

C. ESF 8 Representative: Ensures that the provisions of this TAB are implemented and that the Special Needs residents are moved as smoothly and as safely as possible to the ST3C. He/She also maintains contact with GEMA thru the CEMA Assistant Director regarding the necessary resources outside the County that are being sent to Chatham County to support the Special Needs Evacuation.

## IX. Tab Management and Maintenance

A. Chatham Emergency Management Agency (CEMA) is the executive agent for Tab management and maintenance. The Tab and supporting documents will be updated periodically as required to incorporate new directives and changes based on lessons learned from exercises and actual events. This section establishes procedures for interim changes and full updates of the Exhibit.

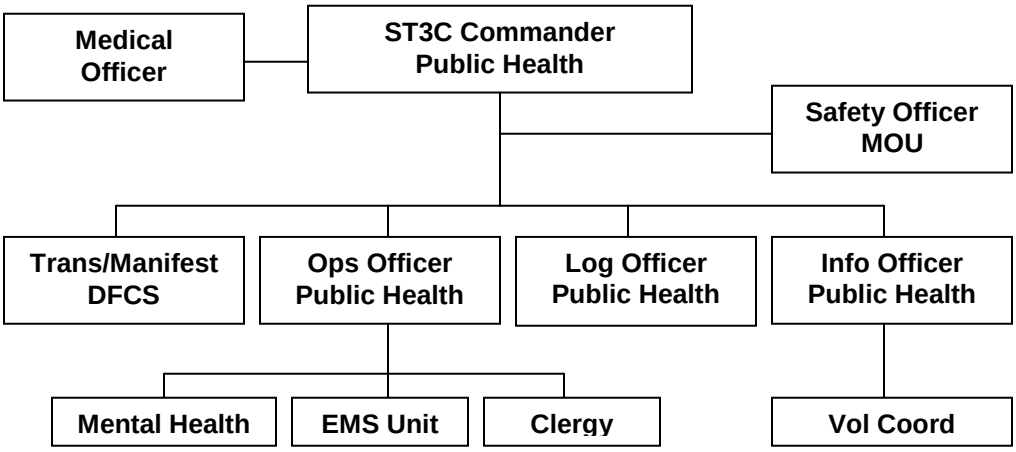
B. Types and Changes: Changes include additions of new or supplementary material and deletions. No proposed change should contradict or override authorities or other plans contained in statute, order, or regulation.

C. Coordination and Approval: Any department or agency with assigned responsibilities within the Tab may propose a change to the plan. CEMA is responsible for coordinating all proposed modifications to the Tab with primary agencies, support agencies and other stakeholders. CEMA will coordinate review and approval for proposed modifications as required.

D. Notice of Change: After coordination has been accomplished, including receipt of the necessary signed approval supporting the final change language, CEMA will issue an official Notice of Change. The notice will specify the date, number, subject, purpose, background, and action required, and provide the change language on one or more numbered and dated insert pages that will replace the modified pages in the Emergency Operations Plan (EOP), Annex, or supporting documents. Once published, the modifications will be considered part of the EOP for operational purposes pending a formal revision and re-issuance of the entire document. Interim changes can be further modified or updated using the above process.

E. Distribution: CEMA will distribute the Notice of Change to all participating agencies. Notice of Change to other organizations will be provided upon request. Re-issuance of the individual annexes or the entire EOP will take place as required. Working toward continuous improvement, CEMA is responsible for an annual review and update of the EOP to include related annexes, and a complete revision every four years (or more frequently if the County Commission or Georgia Emergency Management Agency deem necessary). The review and update will consider lessons learned and best practices identified during exercises and responses to actual events, and incorporate new information technologies. CEMA will distribute revised EOC Annex documents for the purpose of interagency review and concurrence

## TAB A – ST3C ORGANIZATIONAL CHART



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## TAB B – CRITICAL FUNCTIONS AND REQUIRED SKILL SETS

### Secondary Triage Commander

- Perform overall command and control (C2) for the ST3C
- Ensure highest level of efficiency possible given staff and resources.
- Report all activities and needs to Public Health Representative in LEOC.
- Ensure that staff certifications and licenses have been verified.
- Plan for continual needs for the center.
- Mitigate operational concerns to ensure mission.
- Provide safe work environment.
- Report all activities and needs.
- Assign personnel to Operations, Logistics, Safety and Information.
- Establish a command post and communicate with officers regularly.

### Safety Officer

- Survey the site/Center to ensure that people have a safe environment to work in and intercede where necessary.
- Survey the site/center to ensure that personnel are working in a manner that promotes safety and intercede where necessary.
- Evaluate operations based on OSHA Safety Directives and Regulations pertaining to workspace, Hazardous materials, PPE and medical operations.

### Information Officer

- Brief the Incident Commander about the ST3C status.
- Direct news media to the LEOC or PH District PIO to obtain information.
- Provide patients information.

### Operations Officer

- Oversee the operations of triage, treatment and general assistance.
- Assign each area in the treatment of patients a list of critical tasks that they must accomplish.
- Ensure that the mission to triage/treat 80-125 patients per hour is successfully planned.
- Predict future needs of the Center.
- Assist in maintaining the patient tracking system.

### Logistics Officer

- Provide all necessary supplies to include, pharmaceuticals, food, drink, facility maintenance and transportation
- Ensure internal/external communications needs are met.

### Security Officer

- Provide internal security and enforce order.
- Provide input to the Commander as needed.

**Medical Officer**

- Oversee medical aspects of the ST3C.
- Specifically provide medical direction for triage personnel, and treatment personnel.
- Position should be directly inside facility and should have direct communications contact with medical providers,
- Provide input to the ST3C Commander.
- Directly report to the Operations Officer.

**Perimeter Security**

- Establish and maintain control of the external perimeter of the center.
- Coordinate activities to include sweeps for possible secondary devices.
- Coordinate security requirements of temporary morgue with local law enforcement agencies and medical examiner.
- Control ingress/egress.
- Direct traffic in and around the center.
- Maintain control points of entry for reporting staff and patients.
- Establish landing zone, staff parking, ambulance staging, and supply delivery area.
- Verify staff identifications.
- Monitor quarantined of private citizen equipment.

Note: Critical Skill Set

- Sworn law enforcement officer.
- Perform duties wearing PPE.

**Triage**

- Triage all patients who arrive at the Center into categories that correspond with designated treatment areas.
- Direct all patients to the treatment area.
- Obtain assistance for non-ambulatory patients.

Note: Critical Skill Set

- Triage multiple patients.
- Utilize the established triage method.

Administer antidote treatment to critical patients if medical direction allocates responsibility to providers.

**Decontamination**

- Perform gross/detailed decontamination for victims.
- Decontaminate according to established triage categories.
- Provide assistance for non-ambulatory patients.
- Establish a means for patients to disrobe, bag, tag their belongings and redress.

Note: Critical Skill Set

- Perform decontamination on multiple patients following HazMat Operations Guidelines.
- Mitigate cross contamination.

**Internal Security**

- Assist Building evacuation utilizing the building's disaster plan.
- Sweep building and grounds for explosive devices before staff arrives.
- Secure building keys to provide access to necessary areas.
- Coordinate efforts with law enforcement agency.
- Patrol interior of facility to promote order and patient flow.
- Establish a detention/holding area.
- Secure exit points so that as patients leave they are not allowed to re-enter.
- Establish division of labor-staff entry point, exit point, roving, detention area, any location that becomes a holding area

**Treatment Area: Immediate**

- Stabilize and prepare all Immediate patients that arrive in the treatment area for evacuation to higher level of care via ambulance.
- Gather patient demographic data on patients who are transferred from the center to out-processing prior to transport.
- Establish direct medical oversight
- Administer antidote treatment if applicable.

Note: Critical Skill Set

- Medical Officer should be board certified in Emergency Medicine.
- Support staff should treat patients according to ACLS protocols.
- Support staff should administer antidote treatment if applicable.

**Treatment Area: Delayed Sector**

- Treat all Delayed patients that arrive in the Delayed treatment area.
- Transfer all critical Delayed patients to appropriate hospitals via ambulance.
- Stabilize patients.
- Gather any information needed by patient out-processing prior to transport.
- Direct other patients to patient out-processing.
- Assist all patients who require physical assistance.
- Provide basic medical intervention for those patients who are unstable.

Note: Critical Skill Set

- Assess patients as critical or non-critical and determine if they need a higher level of care.
- Treat basic airway concerns to include nebulizer treatments, and oxygen administration.

- Assess basic vital signs.

**Treatment Area: Minimal Sector**

- Treat all Minimal patients that arrive in the Minimal treatment area.
- Transfer critical patients to holding areas for appropriate transport via ambulance to hospitals.
- Direct other patients to patient out-processing.
- Assist all patients who require physical assistance.
- Go over patient self-care instructions.

Note: Critical Skill Set

- Assess patients as critical or non-critical and determine if they need a higher level of care.
- Assess basic vital signs.

**Out-Processing**

- Collect patient demographic information and complete patient medical record.
- Discharge patient from the center.
- Direct all patients to a general assistance area.
- Assist patients requiring physical assistance.

Note: Critical Skill Set

- Gather data utilizing approved forms/devices.

**Law Enforcement Investigation**

- Conduct initial interviews of patients.
- Prioritize citizens for interview.
- Direct patients to an established area in the general assistance area.
- Share pertinent information with appropriate players to include the lead investigating agency, their own department and the ST3C Commander.

Note: Critical Skill Set

- Detective or other sworn law enforcement officer.

**General Assistance**

- Arrange for the special needs of patients who enter the ST3C.
- Organize patient transportation to home or a Reunification Center.
- Observe patients for signs of stress or medical deterioration.
- Provide a phone bank for outgoing calls only.
- Provide area where family members can reunite.
- Provide a means for patients to obtain information regarding the incident and a means for them to ask questions.
- Assist patients with special needs.
- Assist patients requiring physical assistance.

- Provide an official Critical Incident Stress Debriefing (CISD), for patients.

Note: Critical Skill Set

- Staff providing medical care should be capable of rendering BLS for those patients who may medically deteriorate.
- Staff providing mental health intervention should be social workers to help those patients who are not able to care for themselves due to significant stress.
- Staff providing CISD should be trained professionals in CISD.

**Temporary Morgue**

- Provide an area to temporarily store human remains if needed.
- Establish means of securing human remains and notifying appropriate agencies.

Note: Critical Skill Set

- Ability and authority to maintain a chain of custody.

**Supplies/Resources**

- Obtain supplies for the ST3C.
- Deliver supplies to areas within the treatment areas.
- Restock medications, antidote treatments.
- Obtain equipment that makes the center friendly for those requiring physical assistance (e.g., wheelchairs, stretchers, stair ramps, etc.)
- Establish a means for maintaining the building.
- Establish a means for backfilling needed supplies.
- Establish a communications system.

Note: Critical Skill Set

- Assign key personnel who can accomplish each duty as previously determined-communications, pharmaceuticals, and supplies.
- Contact local suppliers who can back fill resource needs, to include transportation needs, and pharmaceutical needs.

**Transportation**

- Responsible for coordinating all transports to hospital facilities.
- Record all bus arrivals from the scene.
- Coordinate hospital availability with PH representative at the LEOC.
- Oversee ambulances.

Note: Critical Skill Set

- Utilize multiple ambulance and transportation options.
- Determine capability of area hospitals.
- Interact with all agencies supplying transportation assets.

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## TAB C – ST3C EQUIPMENT AND SUPPLIES LIST

### EQUIPMENT

| ITEM | UNIT OF ISSUE | QUANTITY |
|---|---|---|
| Tables 3'X9' | Each | 8 |
| Chairs, Folding | Each | 25 |
| Lamps, Examine, Floor | Each | 6 (0) |
| Cots, Folding | Each | 20(5) |
| Wheelchair | Each | 2(0) |
| TV/VCR Combination | Each | 2(0) |
| Radios (Handheld) | Each | 10 |
| Laptop Computer | Each | 1 |
| Printer | Each | 1 |
| Fax Machine | Each | 1 |
| Trash Receptacles (50GL) | Each | 10(0) |
| Vests (Identification) | Each | 20 |
| Clipboards | Each | 25 |
| Hand-Washing Machine | Each | 3(0) |
| Water cooler (5 GL) | Each | 3 |
| 7500 Watt Generator | Each | 1 |
| 100' 10/3 Extension Cords | Each | 2 |
| 50' Extension Cords | Each | 2 |
| Quartz Halogen Lights | Each | 2 |
| 4 Cubic' Ref/Freezer | Each | 1(0) |
| Golf Cart | Each | 1(0) |

**REFRESHMENT SUPPLIES**

| ITEM | UNIT OF ISSUE | QUANTITY |
|---|---|---|
| Coffee Urn (100 cup QTY) | 1 | Each |
| Paper Towel | 6 | Rolls |
| Napkins | 6 | Pkgs |
| Sponges | 4 | Each |
| Trash Bags | 2 | Pkgs |
| Canister of Creamer | 2 | Each |
| Canister of Sweetener | 2 | Each |
| Tea Bags | 1 | Pkg |
| Gatorade Mix | 2 | Cans |
| Can Opener | 1 | Each |
| Hefty Zip-Lock Bags (1GL) | 1 | Box |
| Utensils (Spoons, Forks,etc,) | 1 | Box |

**CLEANING SUPPLIES AND TOILETRIES**

| ITEM | UNIT OF ISSUE | QUANTITY |
|---|---|---|
| Facial Tissue | 5 | Boxes |
| Toilet Tissue | 10 | Rolls |
| Latex Gloves | 6 | Boxes |
| Mops | 4 | Each |
| Brooms | 4 | Each |
| Dustpans | 4 | Each |
| Disinfectant | 2 | Bottles |
| Mop Buckets | 4 | Each |
| Cleaning Cloths | 2 | pkgs |

**MEDICAL SUPPLIES**

| ITEM | UNIT OF ISSUE | QUANTITY |
|---|---|---|
| Antacid Tablets | 1 | Bottle |
| Acetaminophen 500mg | 1 | Bottle |
| Acetaminophen Elixir | 1 | Bottle |
| Aspirin 325mg (Adult) | 1 | Bottle |
| Sore Throat Lozenges | 1 | Package |
| Ibuprofen 200 mg | 1 | Bottle |
| Calamine Lotion | 1 | Bottle |
| Hydrocortisone Cream | 1 | Tube |
| Diphenhydramine 25mg | 1 | Bottle |
| Anti-Diarrheal | 1 | Bottle |
| Saline solution | 1 | Bottle |
| Cough Syrup | 1 | Bottle |
| Antibiotic Ointment | 1 | Tube |
| A&D Ointment or Desitin | 1 | Tube |
| Cough Drops | 1 | Bag |
| Decongestant | 1 | Bottle |
| Afrin Nasal Spray | 2 | Bottles |
| Ipecac Syrup | 1 | Bottle |
| Band Aids, Assorted | 100 | Each |
| Sterile Gauze Pads (2X2, 4X4) | 100 | Each |
| Elastic Bandages (2,3,4,6”) | 6 | Each |
| Hypo-allergenic Tape 1” | 1 | Roll |
| Cotton Balls | 1 | Pkg |
| Cotton Tip Applicators | 100 | Each |
| Alcohol Wipes | 100 | Each |
| Tongue Depressors | 100 | Each |
| Exam Gloves, (S,M,L) | 1 | Box Each |
| Blue, Chux | 5 | Pkgs |
| Diapers (Assorted Sizes) | 1 | Pkgs of Each |
| Face Masks(Disposable) | 1 | Box |
| Emesis Basins | 1 | Pkg |
| Cold/Hot Packs | 12 | Each |

| ITEM | UNIT OF ISSUE | QUANTITY |
|---|---|---|
| Stethoscopes | 20 | Each |
| Blood Pressure Cuffs | 20 | Each |
| Blankets | 25 | Each |
| Petroleum Jelly | 1 | Tube |
| Medical Chest (Dispensing) | 4 | Each |
| Chest, Packing | 10 | Each |
| Medicine Cups | 25 | Each |
| Baby Wipes | 2 | Boxes |
| Safety Pins | 1 | Pkg |
| Thermometers, Disposable | 1 | Box |

**OFFICE SUPPLIES**

| ITEM | UNIT OF ISSUE | QUANTITY |
|---|---|---|
| Pencil | 24 | Each |
| Pencil Sharpener | 2 | Each |
| Stapler w/ Staples | 6 | Each |
| Staple Remover | 6 | Each |
| Highlighter | 1 | Box |
| Ballpoint Pens (Red & Black) | 2 | Boxes |
| Folders, File | 1 | Box |
| Spiral Notebooks | 12 | Each |
| Duct Tape | 6 | Rolls |
| Tape w/ Dispenser | 6 | Each |
| Rubber Bands | 6 | Pkgs |
| Scissors | 6 | Each |

## TAB D – ST3C PERSONNEL SIGN IN SHEET

| NAME | SIGNATURE | TIME IN | TIME OUT | ASSIGNMENT |
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## TAB E – ST3C UNIT LOG

| 1. Incident Name: | 2. Operational Period (Date/Time)<br>From: To: | Unit Log<br>ICS-214 |
|---|---|---|
| 3. Unit Name: | 4. Unit Leader | |

5. Personnel Assigned

| NAME | ICS POSITION | HOME BASE |
|---|---|---|
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6.Activity Log

| TIME | MAJOR EVENTS |
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| 7. Prepared by: | Date/Time: |
|---|---|

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## TAB F – ST3C COMMUNICATIONS LOG

| COMMUNICATIONS LOG | | | | | |
|---|---|---|---|---|---|
| **Name/Organization of Communicator** | **Message** | **Person Receiving Communications** | **Action Taken** | **Lead Person** | **Closure of Issue** |
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## TAB G – ST3C OBSERVATIONS/COMMENTS/LESSONS LEARNED

| NAME: | ACTIVATION TITLE |
|---|---|
| ROLE DURING ACTIVATION | OFFICE/ORGANIZATION |
| TELEPHONE | DATE |

| OBSERVATION/COMMENT/LESSON LEARNED<br>**(Be as specific as possible, give example)** |
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| DISCUSSION<br>**(Discuss your observations and the potential implications of the observed activity. If appropriate, identify related references.)** |
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| RECOMMENDATION<br>**(Describe what you think should be done to improve the activity or response in this area. If appropriate, identify the organization or entity to implement this recommendation or the plan IOP that needs to be revised.)** |
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## TAB H – ST3C SITUATION REPORT

**Chatham County Health Department**
**Emergency Operations Center Status**

| 1.Threat Conditions | Red "Severe" | Orange "High" | Yellow "Elevated" | Blue " Guarded" | Green "Low" |
|---|---|---|---|---|---|

2.Emergency Operations Center Status

| Alert | X Partial Activation | Full Activation | Stand-Down | Deactivation |
|---|---|---|---|---|

3. Operations Status Summary

**Operational Period 0800-2000** **Time of Report : 0700** **Date- 06/05/2004**

### 4. ST3C

**Summary:**

**Issue: none**

**Disposition:**

**Action, Follow-up:**

### 5. EMS

### 6. EPI

**7. ENVIRONMENTAL HEALTH**

**8. NURSING**

**9. OTHER**

| **10. PHAST** |
| --- |
| |
| **11. COMMENTS:** |
| |

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## TAB I – MEMORANDUM OF UNDERSTANDING

**Between Department of Public Health**
**(Chatham County Health Department)**
**and**

_____

PURPOSE:
The purpose of this document is to state the terms of a mutual agreement between the Department of Human Resources, Division of Public Health, Chatham County Health Department, and _____ where, in case of a local disaster the Public Health Department may use the property located at: _____to coordinate and/or deliver essential medical, environmental health, rehabilitation and mental health services to the citizens of Georgia. All parties agree to the terms expressed in this agreement.

RESPONSIBILITIES:
Department of Public Health, Chatham County Health District

1. In support of the Local Emergency Operations Plan (LEOP) the agrees to assist in the prevention of emergency situations, reduce vulnerability, establish capabilities to protect residents from affects of public health crisis, respond effectively and efficiently to emergencies and provide for rapid recovery from an emergency or disaster.
2. The Chatham County Health Department will identify, train and provide technical assistance to professional staff and volunteers of emergency medical, environmental health, mental health and rehabilitation services in support of the public health mission.

_____

1.
2.
3.

DURATION OF THE AGREEMENT:
This agreement shall remain in place until otherwise agreed to by the parties. The agreement may be terminated at any time, given 120 days advance written notice from either party.

AMENDMENTS:
This agreement, or any of its specific provisions, may be amended by signature approval of both of the parties signatory hereto, or their respective designee.

POINTS OF CONTACT
For Public Health:_____ Facility Manager:_____
Telephone Number:_____ Telephone Number:_____

**CAPACITY TO ENTER INTO AGREEMENT**
The persons executing this Memorandum of Understanding on behalf of their respective entities hereby represent and warrant that they have the right, power, legal capacity, and appropriate authority to enter into this Memorandum of Understanding on behalf of the entity for which they sign.

Signed:_____ Signed:_____ Signed:_____
(District Health Director) (Facility Manager) (Other Agency)

Date:_____

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## TAB J – START TRIAGE SYSTEM

Many jurisdictions across the U.S. are using the Simple Triage and Rapid Treatment (START) system for triage. Individuals with very little medical training can effectively use the system. START merely requires an understanding of basic first aid. Under START, all victims who are able to walk on their own ("walking wounded") are directed by the first emergency personnel on the scene to a designated area upwind of the hazard area and are labeled as Minimal (green tag). This reduces the number of victims to be evaluated. These victims will require supervision and might be detained to obtain further assessment and possible decontamination. The remaining victims will be evaluated using the START triage system. This should take no longer than 1 minute per patient and will focus on three primary areas:

1. Respiratory Status - As the responder moves through each level of assessment, any condition that is deemed Immediate (red tag) stops the evaluation process. Life-threatening injuries will be addressed, if necessary, during primary triage. The patient is tagged, and the responder moves on to the next patient. If the patient is adequately ventilating (breathing), the triage officer moves on to the next step. If however, ventilation is inadequate, the triage officer must attempt to clear the airway by either repositioning the victim or clearing debris from the patient's mouth. If these attempts are unsuccessful, the victim is classified as follows:

    - No respiratory effort – Expectant (black tag)- this is the only START category that defines a patient as Expectant.
    - Respirations greater than 30 or the patient needs help maintaining an airway – Immediate.
    - Normal respirations – Go to next step.

2. Perfusion - Perfusion is initially evaluated by measuring the radial pulse. If the casualty has a radial pulse, the blood pressure is assumed to be adequate (80 mm Hg), and the triage officer proceeds to the next step. If a radial pulse is absent or the patient appears cyanotic, then the patient is classified as Immediate.

3. Neurological Status - The third and final level of assessment is the patient's neurological status. Depending on the level of Consciousness, the following classification is made:

    - Unconscious – Immediate.
    - Altered level of consciousness – Immediate.
    - Change in mental status – Immediate.
    - Normal mental responses – Delayed, then move to next victim.

Triaging Patients Exposed to Chemical Agents

1. Nerve Agents - Unconscious or convulsing casualties, or those with major disorders of two or more body systems, are triaged Immediate. Immediate treatment should include antidote administration and positive pressure ventilation to preserve the airway. Rapid intervention will result in an improved outcome. Nerve agent casualties are categorized as Delayed, if their initial symptoms are improving. Antidote treatment of these patients is dependent on the amount of antidote available. If supplies are limited, then Immediate patients will be treated first. The Delayed category is also used for patients recovering from exposure after treatment who are conscious and have an improved respiratory status. These patients may require additional treatment and definitely need to be observed for several hours. The Minimal nerve agent casualty is walking and talking and indicates intact breathing and circulation. These patients may be able to assist other patients and/or decontamination efforts. The patient who has been apneic for more than 5 minutes and has no pulse or blood pressure is categorized as Expectant.

2. Mustard - Most mustard casualties are triaged as Delayed. However, patients with moderate to severe pulmonary signs and symptoms are classified as Immediate. Casualties with burns covering 5 to 50 percent of body surface area (BSA) or with eye involvement are Delayed and those with burns on less than 5 percent BSA are Minimal. The Expectant casualty is the victim with liquid mustard burns on greater than 50 percent BSA or no respirations or pulse.

3. Cyanide - Few signs and symptoms are visible except at very high doses. Severe cyanide exposures require rapid intervention and are categorized as Immediate. Immediate signs and symptoms include convulsions, cessation of respirations, and death within 6 to 10 minutes. Casualties with lower dose exposures have headaches, nausea and vomiting, hyperventilation, and dizziness. These patients will deteriorate further if exposure continues.

4. “Choking” Agents - Patients who require Immediate attention are those who develop non-cardiogenic pulmonary edema within 6 hours after exposure to a “choking” agent such as phosgene. These patients should be transported to a hospital intensive care unit (ICU) if support is readily available. When there are no ICU resources available then casualties are Expectant. Delayed casualties include those who develop cough and dyspnea 6 hours after exposure. These casualties should be transported to the hospital and admitted for observation, as they may develop pulmonary edema.

5. Psychological Casualties - Disasters have a tremendous emotional and psychological impact on victims and rescuers. A terrorist incident involving NBC agents has the potential to produce large numbers of psychogenic casualties who may quickly overwhelm existing hospital resources. The presenting signs

and symptoms of these psychogenic casualties may confuse the clinical picture, making triage decisions more difficult. By following START, the subjective nature of the triage process is reduced, allowing personnel to make more appropriate triage decisions. Psychological casualties will normally be placed in the Minimal category. They should be collected in an observation area and monitored by a medical provider familiar with the signs and symptoms exhibited by patients with actual medical effects from the incident. Once clinical injury has been ruled out, a crisis team of psychiatric assessment specialists should continue the evaluation in a more controlled setting.

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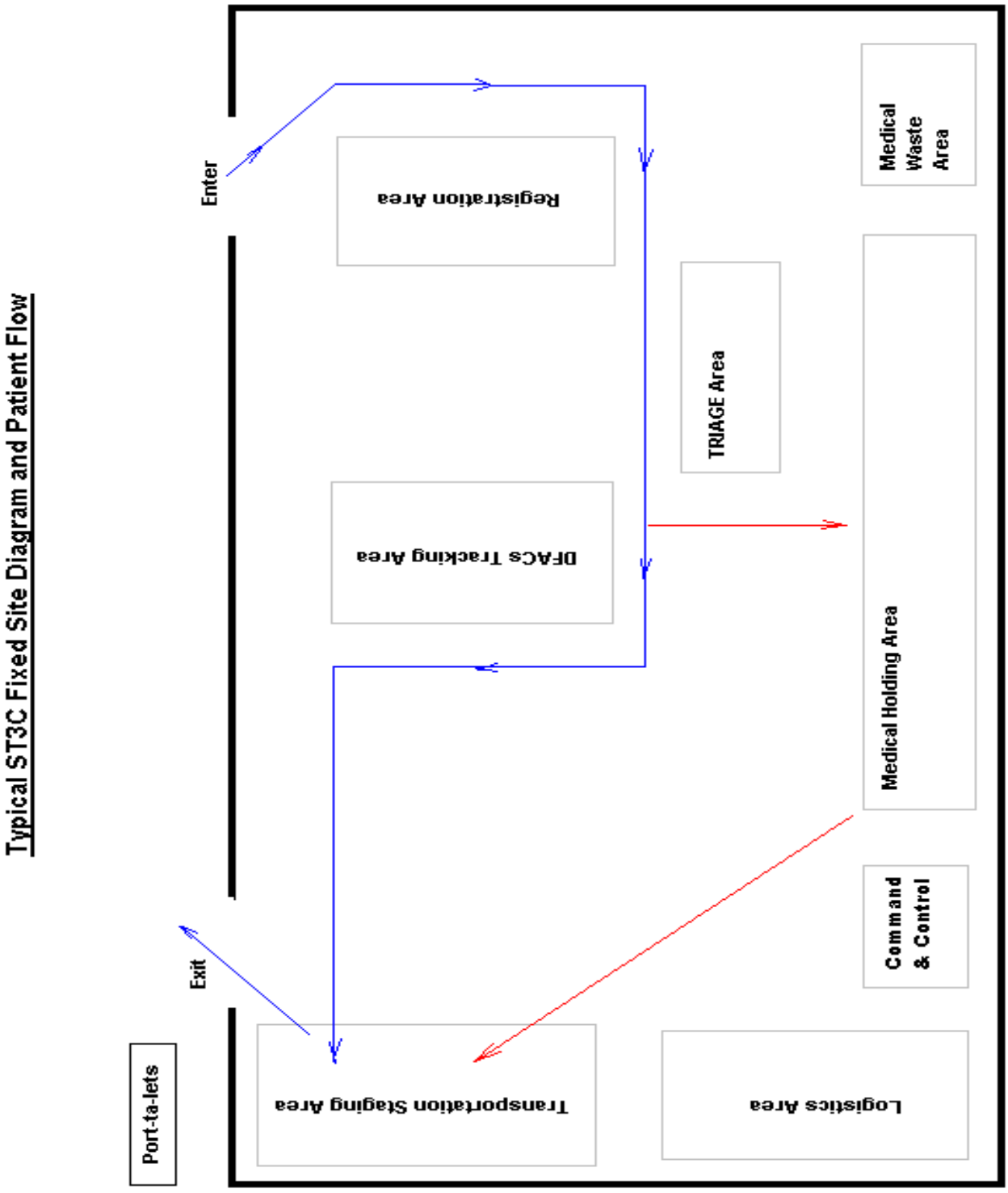
## TAB K – TYPICAL ST3C SITE DIAGRAM AND PATIENT FLOW



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