

ANNEX H

ESF 8: PUBLIC HEALTH AND MEDICAL SERVICES

PROMULGATION STATEMENT

Transmitted herewith is the ESF –8: Public Health and Medical Services Annex to the Caddo Parish Emergency Operations Plan (EOP). This annex supersedes any previous Annex promulgated for this purpose. It provides a framework in which Caddo Parish and its political subdivisions can plan and perform their respective functions during an emergency when EOC activation is necessary.

This annex is in accordance with existing federal, state, and local statutes and understandings of the various departments/agencies involved. It has been concurred by the Caddo Parish Sheriff’s Office of Homeland Security and Emergency Preparedness (OHSEP), Louisiana Governor’s Office of Homeland Security and Emergency Preparedness and the Federal Emergency Management Agency. All recipients of this annex are requested to advise Caddo Parish OHSEP as to changes that might result in its improvement or increase its usefulness.

This annex will be annually reviewed by the Caddo Parish OHSEP Deputy Director.

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ESF-8: Public Health and Medical Services

I. PURPOSE AND SCOPE

This annex deals with providing public health services for Caddo Parish during emergency situations. It takes into consideration many factors including disease control, sanitation, and mental health.

II. SITUATIONS AND ASSUMPTIONS

A. Situation

In many instances emergency and disaster situations will involve a wide range of health and medical problems. To respond adequately to a major incident in Caddo Parish, a well planned health and medical support network should address procedures for responding to incidents involving mass casualty accidents, diseases, sanitation problems, contamination of food and water, and community mental health problems.

B. Assumptions

In Caddo Parish there is an adequate health and medical response capability in place to meet the demands of most major accidents and disaster situations. However, should additional support resources be needed, Caddo Parish will request such assistance from neighboring parishes. State and federal agencies will also be contacted should health and medical service support be unavailable locally.

III. CONCEPT OF OPERATIONS

A. General

Emergency Operations for public health services will be an extension of normal duties. One of the primary concerns of public health personnel is disease control. This involves the detection, and control of disease causing agents, as well as purification of water. Sanitation is a very significant aspect of public health. One of the primary considerations is the continuation of water disposal under disaster conditions. Medical facilities and food establishments need sanitary inspections. Personnel health and hygiene education is very important before, during, and after an emergency. Personal food and water supplies must be kept free of contamination.

The health and medical services planning team must provide a basic understanding of the extent of its responsibilities for developing an EMS capability. During a disaster, EMS will simply be an extension of the normal duties of EMS provider agencies. This section of the annex describes several general responsibilities and then lists specific operational activities that are typical of health and medical services planning concerns. Close cooperation

between health and medical service personnel and support agencies requires an understanding of several medical issues to include the following:

1. **Triage**

Sorting of patients is necessary in a disaster because resources, especially personnel, are limited. As a result, an attempt is made to actively conserve the equipment and time of EMS personnel. A victim whose injuries are too serious must occasionally be bypassed so that patients who can benefit from medical assistance can receive it in a timely manner.

Triage includes assessing and classifying patients to provide efficient and effective treatment and transportation. Assessing patients is a medical art. Assessing patients during a disaster is a much more rudimentary skill. Patients are classified in four very broad categories—minor injuries, urgent (but stable) injuries, life threatening (but correctable injuries), and victims who are dead and dying. After patients are classified, transportation is arranged for the living. The dead are usually relocated to a temporary morgue for definitive identification and disposition of remains at a later time.

2. **Medical Control**

Medical control is the provision of adequate medical supervision to ensure quality care. Decisions made about medical care will be scrutinized after and even during the disaster.

3. **Advanced Life Support**

During a disaster, bringing the skills of a hospital to the scene is vital. Advanced life support (ALS) does just that. Under the voice direction of a physician, paramedics provide sophisticated skills to victims, such as starting intravenous therapy and giving medications. Medical control is a key element of ALS, as is the ability to integrate ALS-trained personnel with other public safety personnel into efficient, on-site work teams.

4. **Transportation**

The number and types of vehicles available to transport victims to medical facilities must also be considered in planning. Ambulances are the usual vehicles; however, large numbers of patients with minor injuries can be transported in school buses. Using helicopters for both rescue and transportation has become commonplace. Other transport means, such as off-road vehicles or boats, should also be considered.

5. **Communication and Command**

Methods of communicating with and among EMS personnel, other emergency response forces, and the EOC should be coordinated. Local EMS agencies have two-way radio capabilities and a separate mutual-aid

channel. Field response forces and the EOC have equipment capable of operating on EMS frequencies.

Command, as an issue, revolves around the understanding that only physicians have authority over medical matters. Beyond that, the usual command and control issues that deal with such things as the management of resources and providing additional transportation are outlined in departmental standard operating guidelines (SOGs). The establishment of field command posts will streamline the process of on-site command during a disaster.

B. Phases of Emergency Management

1. Mitigation (Prevention)

- a. Conduct a community assessment of hazard/vulnerability analysis to identify likely disaster scenarios.
- b. Specialized training in disaster operations for EMS personnel, first responders and local hospital staffs.
- c. First aid training for members of the public.

2. Preparedness

- a. Coordinate storage of medical supplies and equipment.
- b. Maintain medications and other critical medical supplies.
- c. Develop and maintain emergency plans for mutual aid response of emergency medical service agencies outside the jurisdiction.
- d. Develop and maintain emergency plans and procedures for hospitals, nursing homes, and pre-hospital emergency medical service treatment of patients.
- e. Develop emergency procedures for provision of temporary morgues.
- f. Develop procedures for contacting local ministerial associations.

3. Response

- a. Initiate first-aid activities in the hazard area.
- b. Initiate triage, treatment and transportation activities; make provisions for a field command post.
- c. Establish staging areas for mutual aid forces.
- d. Initiate in-hospital triage and treatment activities.
- e. Notify appropriate state and federal agencies.
- f. Conduct crowd and traffic control at disaster perimeter.
- g. Provide resources to support emergency medical service operations.
- h. Initiate activities dealing with handling the deceased and transporting uninjured or slightly injured people.
- i. Initiate temporary morgues and prepare for identification, storage, autopsy (if needed) and of release of body to funeral home.

- j. Process data (incident report sheets, etc.), including identification of casualties. Keep track of casualties at each stage of treatment.
- k. Activate ministerial support.

4. Recovery

- a. Continue response and treatment activities, as necessary.
- b. Compile reports for state and federal agencies; compilation of reports for critique and review.
- c. Re-supply health and medical services and response agencies.
- d. Inspect disaster areas to insure sanitary conditions are safe for re-entry of population.

C. Execution

Coordination between Health/Medical providers is necessary to ensure emergency operational readiness. All hospitals and nursing homes will maintain individual emergency operating plans for emergency procedures that will be used in conjunction with this plan. Jointly, these emergency plans include the provision of care for key emergency workers and injured persons remaining in hazard areas and for the relocated population in reception areas.

IV. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

This section of the annex takes the operational considerations detailed above and recasts them as specific duties and responsibilities for designated local agencies. The task assignments listed below are extensive but certainly not exhaustive.

A. General Organization

Caddo Parish OHSEP Health and Medical Officer is responsible for coordinating emergency health/medical service operations.

B. Assignment of Responsibilities

1. Caddo Office of Homeland Security and Emergency Preparedness

Local government is responsible for the development of a health and medical annex within the framework of the comprehensive emergency management plan. The plan delegates authority for its execution to the Caddo Parish OHSEP Health and Medical Officer.

2. Caddo OHSEP Health and Medical Officer

- a. Assemble a team of representatives from EMS providers and planning agencies (and other emergency services) to develop the annex.
- b. Coordinate implementing the plan when necessary.
- c. Coordinate the management, distribution, and use of EMS and health and medical service resources-personnel, equipment, and facilities.
- d. Provide public information, including pertinent first-aid

- information.
- e. Coordinate mutual-aid response, as necessary.
- f. Determine on-scene medical coordinator.
- g. Determine on-scene operations and support coordinator.
- h. Determine staging and triage areas.
- i. Coordinate list of physicians who can assist with site triage.
- j. Determine location of temporary morgue.
- k. Coordinate an annual training program that provides health and medical services personnel with practice in mass casualty handling (i.e., annual Caddo Community Disaster Drill).

3. EMS Pre-Hospital Care Providers

- a. Develop and update specific operations procedures for disaster situations.
- b. Conduct specialized training and drills in disaster operations.
- c. Develop mutual-aid agreements with other local providers.
- d. Maintain sufficient medical supplies, medications, and equipment.
- e. Educate the public in health practices through public information programs.
- f. Provide emergency medical care for essential workers in hazardous areas that have been provided by the general population.

4. Caddo Parish Health Unit

- a. Conduct or coordinate environmental health activities in regard to waste disposal, refuse, food, water control, and vector/vermin control.
- b. Prevent and control communicable diseases by intelligence, evaluation, prevention, detection and inoculation.
- c. Conduct laboratory activities, including diagnostic tests, to determine the presence or absence of food and water contamination.
- d. Monitor vector/vermin conditions in preparedness phase and take appropriate action.
- e. Monitor stray animal conditions and take appropriate measures.
- f. Insure that people in reception and shelter facilities are surveyed and provided medical and health care, including medicines and inoculations as appropriate.
- g. Provide inoculations to first responders.

5. Caddo Animal and Pest Control

- a. Monitor vector/vermin conditions on preparedness phase and take appropriate measures.
- b. Monitor stray animal conditions and take appropriate measures.
- c. Monitor and take appropriate action to minimize animal and pest control problems in the response and recovery phases.

6. Hospitals and Medical Centers

- a. Conduct specialized training and drills in disaster operations.
- b. Educate the general public in health matters through public information programs.
- c. Maintain sufficient medical supplies, medications and equipment.
- d. Develop and update emergency operating and evacuation plans for pre-hospital, in-hospital, transfer of patients.
- e. Conduct in-house triage and emergency treatment in field operations and emergency transportation.
- f. Provision for resource management and acquisition of needed equipment and supplies.
- g. Provide crisis counseling for emergency workers and victims of the disaster.

7. Louisiana Blood Center

- a. Conduct drawing of blood supplies.
- b. Make provision for distribution of blood supplies to hospitals.
- c. Advise hospitals on volume and type of blood available.
- d. Develop and update internal standard operating guidelines (SOGs).

8. Nursing Homes and Retirement Centers

- a. Conduct specialized training and drills in disaster operations.
- b. Maintain sufficient medical supplies, medications, and equipment.
- c. Develop and update emergency evacuation plan for nursing home residents including transportation, support equipment and supplies, and support personnel.

9. Caddo Community Action Agencies

- a. Assist with public warning of the non-institutionalized disabled and elderly. Compile lists of transportation, medicine and other resources needed by such people in time of emergency.
- b. Assist with emergency evacuation of the disabled and elderly.

10. Caddo Council on Aging

- a. Assist with public warning of the non-institutionalized disabled and elderly.
- b. Assist with emergency evacuation of the disabled and elderly.

11. Caddo Coroners Office

- a. Recover, identify, register, and dispose of the dead.
- b. Formulate plans for temporary morgues and for the expedient disposal of corpses as necessitated by the situation.
- c. Notify next of kin.
- d. Maintain records of deaths.

- e. Set up emergency morgues when numbers of casualties necessitate.

12. Law Enforcement Agencies

- a. Provide security and law enforcement at the disaster scene.
- b. Provide traffic control at the disaster scene.
- c. Assist with body identification, transfer and storage.
- d. Conduct such activities as blood runs, physician transports, and communication backup, as required.
- e. Provide public information activities.

13. Fire Services

- a. Maintain fire suppression and prevention activities.
- b. Provide first responder-trained personnel and/or basic life support-trained personnel, as necessary.
- c. Conduct rescue operations, as necessary.

14. Military Support

- a. Inform EOC of the availability of rescue/medical support from Barksdale Air Force Base, National Guard and reserve units.
- b. Coordinate use of military hospitals and medical personnel.
- c. Provide logistics support of critical supplies and equipment.

15. Caddo School System

- a. Provide buses for medical evacuation of uninjured and slightly injured victims.
- b. Provide school facilities (especially gymnasiums) for use as secondary or tertiary triage areas or temporary hospital.
- c. Provide medically trained personnel (school nurses), as needed.

16. SPORTRAN

Provide buses and drivers for medical evacuation of slightly injured or uninjured people as necessary.

17. Public Works

- a. Support health and medical operations.
- b. Assist with recovery operations.

18. Codes Enforcement

- a. During recovery operations, inspect structural soundness of buildings in disaster area, as appropriate.
- b. Determine if disaster was related to code violations.
- c. Recommend improvements in building codes, as appropriate.

19. Caddo OHSEP Communications Director

- a. Determine health and medical service field command post

- telephone and radio needs and arrange for support as necessary.
- b. Maintain records of radio frequencies and call signs of EMS agencies and mobile units.
- c. Ensure that EOC radios and select local government mobile units can communicate with EMS forces.

20. American Red Cross/Salvation Army/Community Service Groups

- a. Assist in health and medical service operations, as appropriate.
- b. Provide support services for victims and their families, and for emergency response personnel.

21. Caddo Department of Social Services (DSS)

- a. Provide assistance for disaster victims and families.
- b. Coordinate private and nonprofit social services.

22. Local Ministerial Associates

- a. Provide chaplain services at disaster site.
- b. Organize use of church facilities for triage sites.

23. All Local Government Agencies

- a. Develop a roster of essential employees and designate other employees needing emergency preparedness training, as appropriate.
- b. Support health and medical services operations, as necessary.

24. Louisiana State Department of Public Health will provide assistance in all areas of public health services.

25. The Federal Government will provide assistance as needed.

26. Shreveport Regional Metropolitan Medical Response System (MMRS) Plan, under separate cover, located at Caddo Emergency Operations Center.

- a. Shreveport MMRS enhances local ability to respond to, and recover from, a terrorist employment of a weapon of mass destruction and is specifically tailored to address nuclear, radiological, biological, chemical and/or explosive terrorist incidents.
- b. MMRS identifies hospitals, nursing homes and other facilities that could be expanded into emergency treatment centers for disaster victims.

V. DIRECTION AND CONTROL

The Caddo OHSEP Health and Medical Officer or his designee is responsible for coordinating all emergency health and medical activities from the EOC. The Health and Medical Officer is appointed by the Caddo OHSEP Director and is a member

of the EOC emergency staff. Routine operations will be handled using the standard operating guidelines of departments or agencies concerned. State and federal support will be requested as needed.

VI. CONTINUITY OF GOVERNMENT

In the event that an official or agency charged with participating in the disaster operation is unable to perform, lines of succession are established to ensure that direction and control and health and medical services operations are provided, as needed (see Basic Plan and departmental Standard Operating Guidelines).

A determination will be made as to the medical operating records that are indispensable during the disaster (i.e., triage tags, incident report sheets, and emergency room charts)

VII. PLAN DEVELOPMENT AND MAINTENANCE

The Caddo OHSEP Director along with the Health and Medical Officer will be responsible for the development and updating of this annex. Periodic testing and review of capabilities will also be conducted annually with associated health and medical providers as part of the annual disaster drill.

VIII. ADMINISTRATION AND LOGISTICS

Departmental Standard Operating Guidelines (SOGs) should address criteria regarding personnel, procedures, equipment, training, and general support requirements. Specific areas that must be addressed include:

A. Lack of Consent

Legal authority to perform medical procedures on patients who refuse to consent to care. Note: Unconscious persons are generally presumed to have given implied consent.

B. Medical Control

Legal authorities to allow mutual aid health and medical service personnel to perform ALS procedures outside of their medical control operational area.

C. Abandonment

Legal authority to permit health and medical services personnel to perform triage without fear of civil suit for abandonment.

D. Reports and Records

Casualty tags and reports, notification of next of kin procedures, and casualty lists and reports for public release must be specified.

E. Supplies and Equipment

Authorizations for emergency purchases and requisitions, as well as procedures for re-supplying EMS response forces.

IX. AUTHORITIES AND REFERENCES

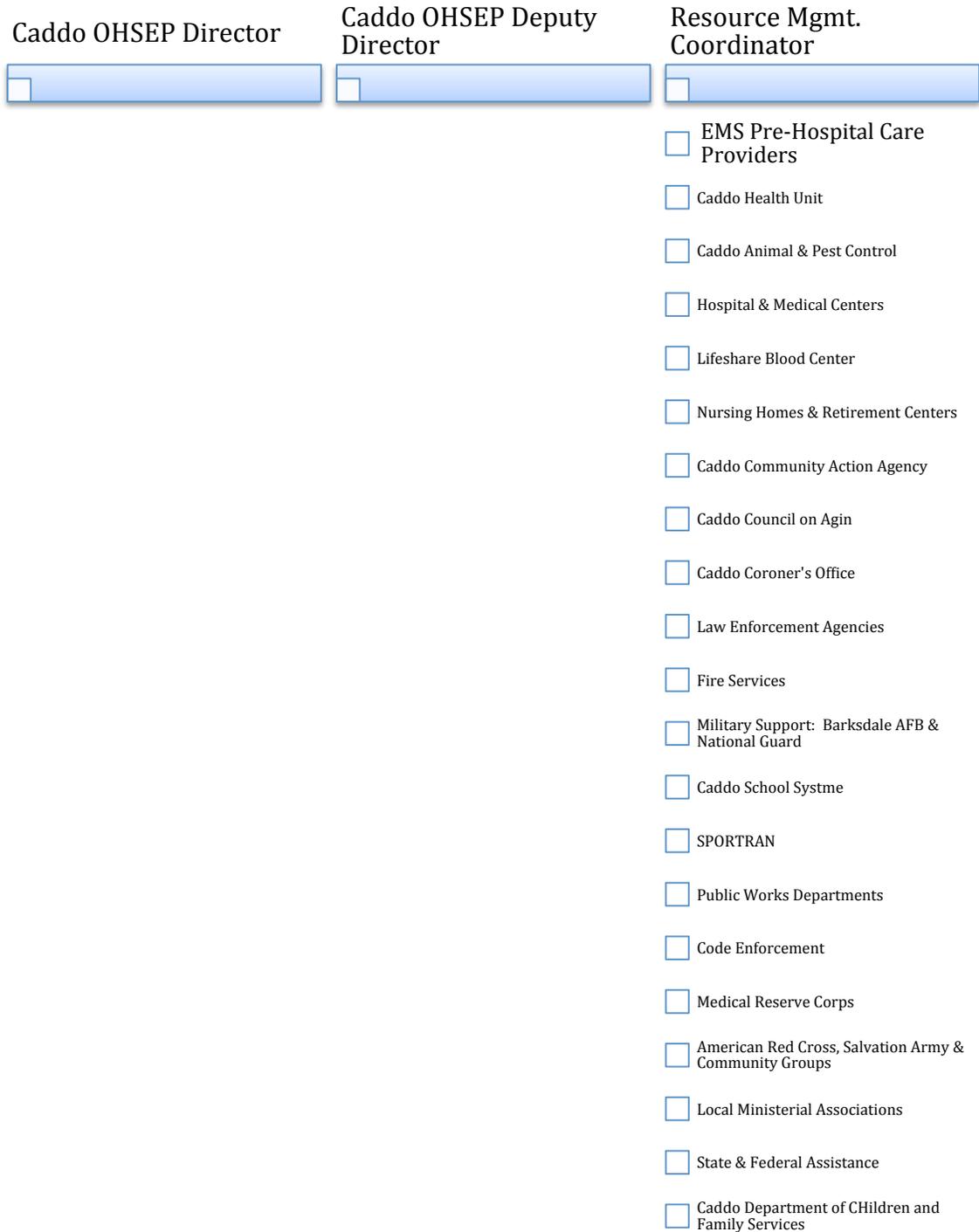
See Basic Plan

1. If hazard-specific authorities exist, they should be listed.
2. Hazard-specific references are often different than the basic plan. A list of the technical manuals, technical studies, software, and procedures used to develop or execute the annex should be included.

X. APPENDICES TO ANNEX H

1. Organizational Chart
2. Emergency Medical Guidelines
3. Ambulance and Transportation Guidelines
4. Triage Guidelines
5. METTAG Use
6. Mass Casualty Incident (MCI) Guidelines
7. MCI Mutual-Aid Agreement
8. Health and Medical Facility Directory
9. Health Emergency Guidelines
10. Animal Control Guidelines
11. Radiation Emergency Medical Guidelines
12. Anthrax Contingency Plan
13. Medical Reserve Corps

Appendix 1 – Organizational Chart



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Appendix 2 – Emergency Medical Guidelines

I. INTRODUCTION

Caddo Parish has seven major medical facilities within its jurisdiction. The reasonable assumption that an incident could generate casualties exceeding treatment capabilities of any one or more hospitals necessitates the formulation of this health and medical annex to ensure an orderly approach to coordinating various medical services and support units. This plan was developed to provide a general framework of operations that will be flexible enough to meet any mass casualty situation that may affect the parish.

II. BASIC PLAN

The operational concept upon which this annex is based is applicable to any incident that causes an extraordinary number of casualties in excess of emergency treatment capability of any one or more of the medical facilities in Caddo Parish.

III. PURPOSE

The purpose of this annex is to outline responsibilities and procedures to develop a system of coordinated responses between hospitals/medical centers and local government during emergency/disaster operations.

IV. DEFINITIONS

A. Ambulance Service

Those agencies responsible for transporting the sick and injured.

B. Central Morgue

A facility designated by the coroner's office to receive and process mass fatalities.

C. Chief of Medical Staff

The physician designated by his/her peers to head the medical staff of his/her hospital or medical institution.

D. Communications

Those communications systems that include, but are not limited to, established telephone, cellular phone, radio, computer and message.

E. Emergency Medical Disaster

Any incident that generates an emergency patient load that exceeds the expanded emergency patient treatment capability of any one or a number of the community's hospitals.

F. Emergency Operations Center (EOC)

The facility especially designed and staffed to coordinate support activities

including, but not limited to, communications, public information personnel, and resources beyond that normally needed.

G. EOC Public Information Officer

The official at the EOC who is responsible for collecting statistics from the medical treatment facilities regarding injured and deceased and for preparing releases to the media regarding casualty and situation summaries.

H. Fire Service

Those agencies responsible for preventing, suppressing, or controlling fire, leading search and rescuing of entrapped persons; and assisting in evacuation of affected areas.

I. Forward Command Post

That area established by the initial responding fire department senior officer situated at a location of his/her discretion, taking into account the hazard involved, the accessibility and space requirement to marshal and manage the personnel and material to combat the hazard. The forward command post serves as the onsite communications and intelligence link to the EOC.

J. Hospital Administrator

The administrator or chief executive of hospital or his/her designee.

K. Hospital Disaster Coordinator

The individual designated by the Caddo OHSEP to report to the EOC and serve as medical community coordinator for disaster/emergency operations.

L. Hospital Information Officer

The official at the hospital who is responsible for the rapid collection of statistics concerning disaster victims, the notification of next of kin, and the timely dissemination of information to the EOC.

M. Emergency Medical Treatment Facilities

1. Christus Schumpert Highland Hospital
2. University Health Shreveport
3. North Caddo Medical Center (Vivian)
4. Overton Brooks V A Medical Center
5. Willis-Knighton Medical Center
6. Willis-Knighton Pierremont Health Center
7. Willis-Knighton South Medical Center

N. Law Enforcement

Those agencies responsible for maintaining law and order through traffic and crowd control and for providing security for vital facilities and supplies, controlling access to operating scenes and vacated areas, initial notification of emergency agencies and evaluating danger areas, if appropriate.

O. Triage Team

A team of qualified emergency medical service personnel who sort, prioritize and route casualties for distribution to medical treatment facilities.

P. Triage Coordinator

The person designated by each respective EMS agency to act as the liaison between the Triage Officer and the On-Scene Commander.

V. ORGANIZATIONAL RESPONSIBILITY

1. The Caddo Parish Office of Homeland Security and Emergency Preparedness (OHSEP) Director will select a Health and Medical Officer to serve as hospital disaster coordinator liaison. This person is responsible for serving the medical community from the EOC as medical service coordinator during disaster and emergencies. The coordinator's primary duty is to ensure the orderly coordination of medically oriented logistics.
2. In addition, the hospital disaster coordinator shall call on the individual disaster coordinator or the chief executive officer of each hospital to provide support in accordance with the provisions of this annex.
3. The ambulance services are responsible for transporting casualties as directed by the triage team and shall act as the on-scene triage team.
4. Caddo OHSEP is responsible for the activation/operation of the EOC, and as such, shall coordinate personnel, material, supplies, transportation, hazard mitigation, security, communications, public information and other resources and support as necessary.
5. Fire services are responsible for the containment or removal of a fire or hazardous agent, establishment of the forward command post, and the initial extraction of trapped victims.
6. Law enforcement is responsible for dispatching a communications unit to support the forward command post, control access to the disaster area, crowd control, and assisting in removal of victims (if properly trained) from hazard areas. In addition, law enforcement is responsible for assisting with evacuations.
7. The triage team is responsible for the classification of victims, setting priority for transportation and treatment, and directing the distribution to medical facilities.
8. The triage coordinator is responsible to act as liaison between the on-scene medical personnel and the on-scene commander.

VI. CONCEPT OF OPERATIONS

1. The Caddo Parish Office of Homeland Security and Emergency Preparedness (OHSEP), through the Emergency Operations Center, will coordinate the support effort.
2. The triage officer shall be responsible for the formal declaration of a medical disaster, the classification of victims, setting priority for transportation/treatment and directing the distribution of casualties to medical facilities.
3. The on-site senior fire officer shall be responsible for control of the forward

- command post.
4. Fire services, through Biotel Communications, shall be responsible for notification of hospitals. Fire service shall also be responsible for notification of support agencies and determination if an evacuation is necessary. Law enforcement will assist with the evacuation efforts.

VII. PROCEDURES

The following procedures will be implemented for an emergency medical disaster:

A. Preliminary Survey and Notification

The first responding unit shall make a preliminary survey and immediately report the type of incident, location and approximate number of casualties involved to the radio dispatcher.

B. Increased Readiness and Response

Upon notification of an emergency medical disaster, the triage team establishes on-site sorting, prioritizing and routing of casualties. In the interim, hospitals will begin increased readiness measures as outlined in their respecting standard operating guidelines (SOGs). EMS will commence preliminary triage, emergency treatment and transport.

C. Emergency Medical Declaration

Upon declaration of an emergency medical disaster, fire services and/or Biotel communications will notify the hospitals and support agencies. Caddo OHSEP will activate the Emergency Operations Center (EOC).

D. Implementation

Implementation shall take place as set forth in the following appendices.

VIII. READINESS

All agencies assigned responsibilities in this plan are responsible for developing or updating internal action plans that will ensure a continuing acceptable degree of operational readiness to carry out their responsibilities. Essential to any internal plan is a current listing of responsible individuals and alternates who may be contacted at any time in any emergency. This information is detailed in appropriated annexes.

IX. TESTS AND EXERCISES

In order to keep this annex practical, there will a formal full-scale disaster drill held annually, organized by Caddo OHSEP and using a sufficient number of mock casualties to ensure calling a full emergency medical disaster.

Appendix 3 – Ambulance and Transportation Guidelines

I. PRE-EMERGENCY

1. All ambulances and emergency rescue vehicles in Caddo Parish, both public and private, will be equipped with METTAGS (International Field Triage Tags) furnished by their respective departments and/or Caddo Parish OHSEP.
2. All ambulances serving in Caddo Parish shall contain at all times those essential items as specified by the state board of health.
3. Private ambulance companies shall designate and train individuals to serve as Triage Officer.

II. EMERGENCY

1. Upon notification of an emergency situation, the appropriate ambulance shall respond with the necessary units to the scene. Mutual-aid ambulance services will also be notified and placed on standby status to respond to the scene if the situation warrants.
2. The senior EMT or paramedic who first arrives on the scene shall:
 - a. Survey the disaster scene.
 - b. Report to the senior fire officer and establish a proper triage area.
 - c. Institute a preliminary screening of casualties and begin transport of those most critically injured as put in priority in the triage guidelines. He/she will record the number of casualties transported and their destinations.
3. If the disaster warrants, the EMT will request, through the Incident Commander, that other ambulance services and mutual-aid units begin responding to the site.
4. Upon establishment of the Triage Officer, all ambulance service personnel will place themselves at the disposal of the Triage Officer and will follow the directions of the Triage Officer in regard to casualty movement.
5. The senior EMT will report to the Triage Officer and inform the Triage Officer as to what procedures were begun, locations of the triage area, number of casualties, and number transported.

Appendix 4 – Triage Guidelines

I. PRE-EMERGENCY

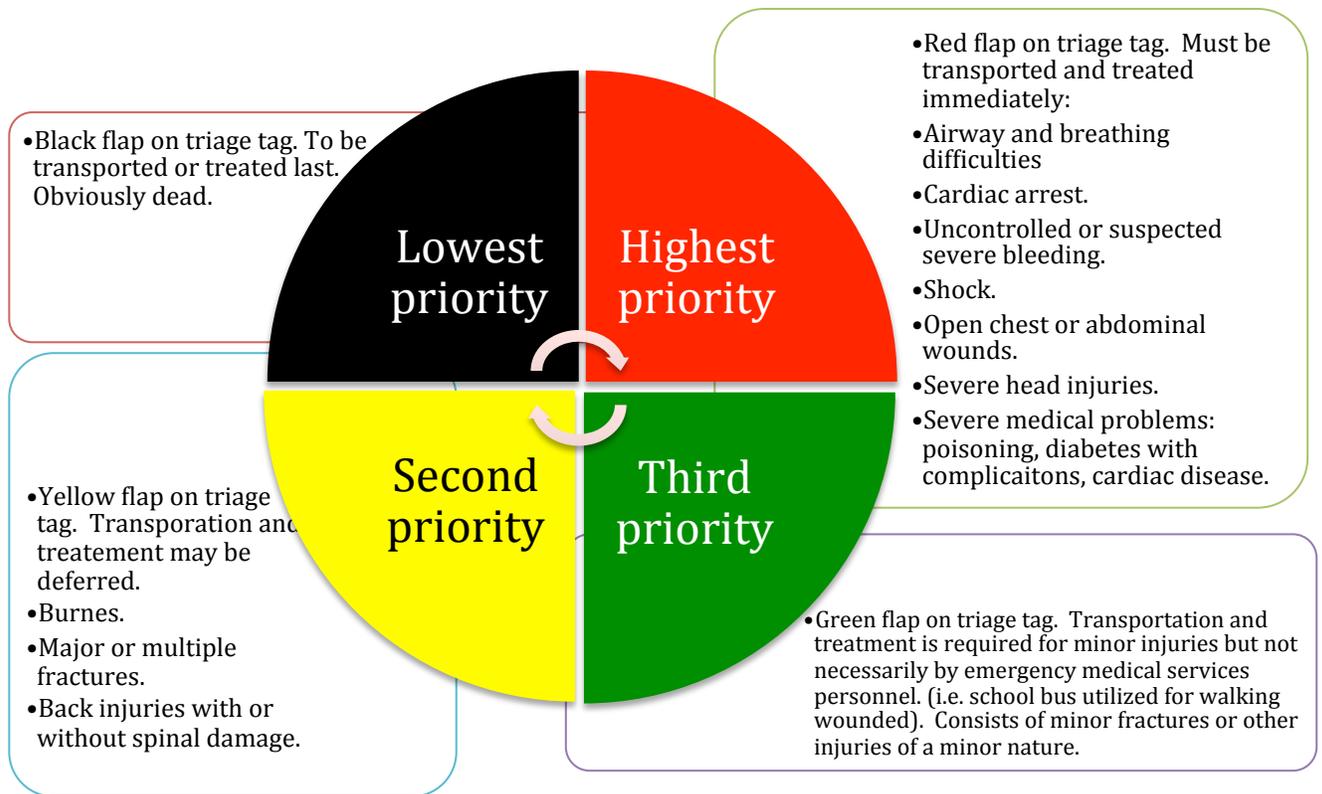
1. All ambulances and emergency vehicles in Caddo Parish will be equipped with a supply of METTAGS (International Field Triage Tags). These tags are to be furnished by the respective departments and/or Caddo OHSEP.
2. All ambulances serving in Caddo Parish shall contain at all times those essential items as specified by the state board of health.
3. Medical supplies for providing advanced life support to trauma victims will be stored in ambulances and rescue vehicles and mobilized to the scene of a mass casualty disaster. Each respective department will furnish these supplies.
4. All ambulance personnel in Caddo Parish will receive periodic training in triage techniques relating to mass casualty incidents.

II. EMERGENCY

1. It is the responsibility of the EMTs who first arrive on the scene of a mass casualty incident (MCI) to assess the situation, institute a triage system and implement action necessitated by the situation.
2. The appropriate hospitals should be notified by Biotel or fire serve dispatcher as to the type of MCI, preliminary number of casualties and anticipated injuries so they can make the necessary preparations.
3. The Triage Officer will be in charge of the overall triage activities. The Triage Officer will be the first senior EMT Paramedic arriving at the scene and shall be responsible for formal declaration of a medical disaster.
4. The Extrication Officer is responsible for the initial triage and tagging of victims as well as the removal of victims to the treatment area.
5. Mutual-aid ambulance services capable of providing advanced life support in the field will respond immediately to the disaster site if requested by Biotel or fire service dispatch. Mutual-aid forces will work with the Triage Officer and apply their skills to disaster victims.
6. Responding mutual-aid ambulance providers will monitor the designated EMS mutual-aid channel.

A. Triage Priorities

1. Patients with certain conditions or injuries have priority of being transported and treatment over others. These priorities are detailed in the chart below:



2. Attach tag securely to clothing or body (arm, leg, around neck, etc.) so that it is clearly visible and the appropriate flag removed to indicate the priority by the last remaining flap.
3. Any medications administered before the patient's arrival at the hospital should be indicated on the triage tag. Should the receiving hospital decided to institute its own disaster tag upon patients' arrival, the original triage tag should be retained with the hospital tag.

III. RADIATION CONTAMINATION

A separate category of triage should also be noted, as it supersedes all others. Patients who have undergone radiation contamination and are themselves carrying radiation particles must be decontaminated as an initial step. They should not be allowed to contaminate other patients, ambulances, or the hospitals.

In the event of a radiation accident with resulting casualties, trained personnel from Barksdale Air Force Base can assist with decontamination of these

victims. Mutual-aid assistance from Barksdale may be obtained through existing agreements with the base fire department or by contacting Caddo Parish OHSEP at 675-2255.

See Appendix 12 - Radiation Emergency Medical Guidelines.

Appendix 5 – METTAG Use

The Universal Field Triage Tag — Suggestions For Use

I. DISPENSE CONTROLLED NUMBER OF TAGS TO TRIAGE PERSONNEL.

II. STABILIZE MOST SERIOUSLY INJURED PATIENTS FIRST, IF POSSIBLE.

1. Enter time of triage (+ date if advisable) on tag.
 2. * Enter name if patient is conscious and coherent.
 3. * Enter home street address if practical.
 4. *Enter home city and state if practical.
 5. Enter other pertinent information on blank lines.
 6. Enter name of person doing triage on bottom line.
 7. On reverse side indicate injuries on body diagrams.
 8. Enter as appropriate: time, blood pressure, pulse, and respiration (breaths per minute) in vital signs chart.
 9. Enter intravenous (IV), intramuscular (IM), with time.
 10. Tear off all colored tabs BELOW determined priority and retain. These tear-offs may be used at local option - for example, identification of personal effects, for ambulance driver records, etc.
 11. Attach tag securely to clothing or body (arm, leg, around neck, etc.) so that it is clearly visible.
- These steps may be delayed or accomplished by others while awaiting transport or during transport.

III. TRANSPORT VICTIMS TO BEST AVAILABLE HOSPITALS STRICTLY BY PRIORITY:

- A. **(I) RED (Critical, in need of immediate care)**
- B. **(II) YELLOW (Serious, but hospitalization can be delayed to after priority I)**
- C. **(III) GREEN (Emergency transportation not considered necessary)**
- D. **(0) BLACK (Dead, move to morgue)**

IV. COLLECT UNUSED TAGS AND ESTIMATE TOTAL CASUALTY COUNT.

V. KEY HOSPITAL ADMISSION AND MEDICAL RECORDS TO PATIENT'S TAG SERIAL NUMBER.

NOTE: Briefing before use is recommended. A policy of METTAG use in day-to-day emergencies will automatically establish familiarity and provide faster and more effective disaster triage.

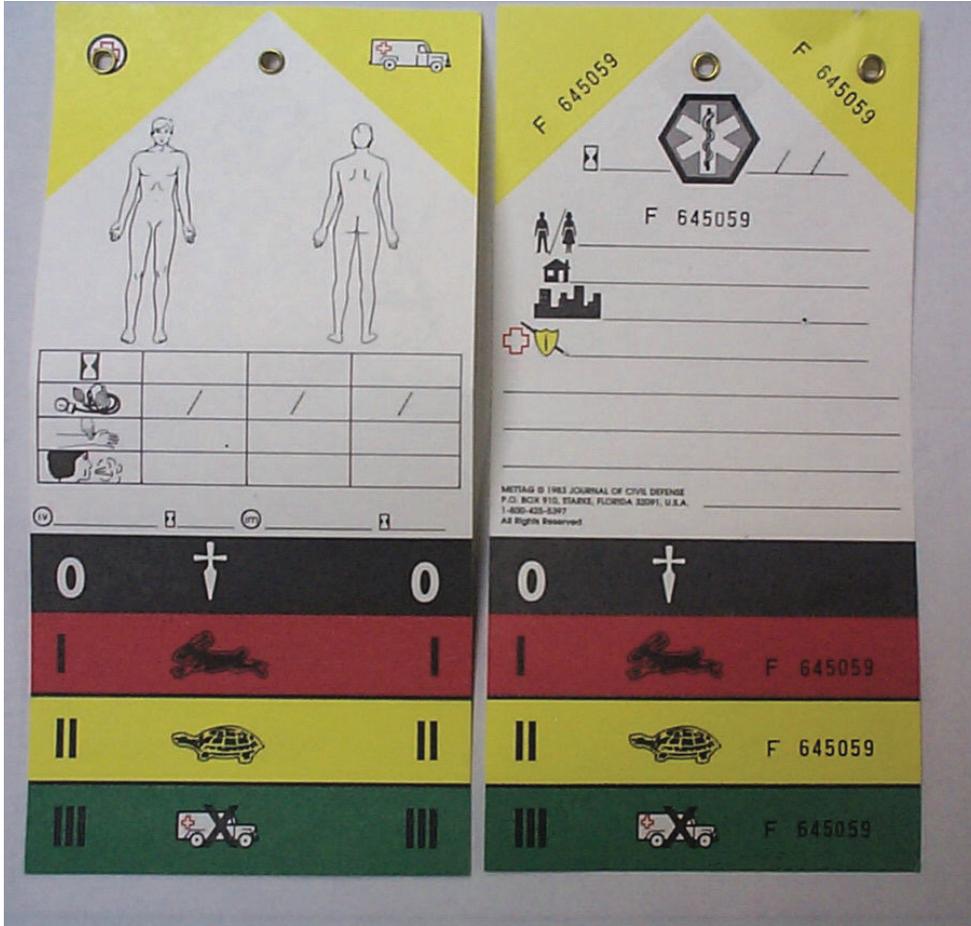


Figure 1: METTAG – The Universal Triage Tag (Front Shown at Left)

Appendix 6 – Mass Casualty Incident (MCI) Guidelines

I. GENERAL

A large number of injured people is an overwhelming site, especially when it is realized that there is no way to take care of everyone at once...or as fast as emergency responders would like to. The key to the management of a mass casualty incident is organization. The better organized the emergency response forces are, the better the incident will be managed. Key elements of organization for handling a mass casualty incident are:

A. Close coordination with hospitals

B. Separation of the tasks of:

1. Site management
2. Triage
3. Treatment
4. Transportation

C. Centralized control

D. Logistical support

E. An adequate supply of triage tags

Each of these elements will be discussed in this section, followed by a suggested series of procedural steps to implement when notified of an incident involving large numbers of injured people.

II. CLOSE COORDINATION WITH HOSPITALS

The local hospitals and medical centers can handle quite a few casualties within their own facilities. In many cases, however, hospital officials will have to implement their disaster plan to strengthen personnel and equipment capabilities. This means that there should be close coordination with hospitals ahead of time.

Hospital coordination procedures include alerting the hospital(s) immediately upon receipt of notification of a mass casualty incident either by Biotel (ambulance routing system) radio or by telephone. In the event of a major disaster involving mass casualties, local ambulance notification and routing procedures will be supplemented by the use of pre-assigned amateur radio operators at each of the area hospitals, the disaster site and the Emergency Operations Center (EOC).

In preparation for a mass casualty incident, all local hospitals in Caddo Parish will participate in the annual community disaster drill sponsored by Caddo OHSEP. Each year OHSEP coordinates a different full-scale disaster drill which includes an MCI aspect with moulaged students acting as victims. These student casualties will

be “treated” and transported to area hospitals by ambulance, helicopter and bus.

III. SEPARATION OF TASKS

The management of mass casualty incidents will run smoother at the scene if all concerned recognize the importance of the separation of tasks. As much as possible, each team should restrict its activities to fulfilling its specific mission—not crossing over to assume someone else’s responsibilities.

IV. INCIDENT COMMANDER

The first task, site management, is a management function, not a medical function. The Incident Commander will usually be a ranking fire officer. The Incident Commander must be able to give orders and understand the “big picture” of scene management. He can give directions himself on the radio or relay them through radio operator(s) reporting to him.

Site Management is concerned with:

1. Establishing and maintaining ambulance staging areas.
2. Establishing and maintaining patient staging areas.
3. Establishing and maintaining traffic patterns for emergency medical functions on-site (may require police support).
4. Direct departing ambulances to specific hospitals.
5. Designating an emergency morgue area in coordination with the Coroner’s Office.
6. Coordinating mutual-aid assistance and resource management.
7. Coordinating with fire and other specialized response personnel to most effectively manage the entire incident with minimal conflict and risk to all concerned.

V. TRIAGE

The triage function involves the actual medical sorting of victims, based on the critical nature of injuries—including the need for treatment and the survival expectancy. Triage is the first step of a three-step process: triage, treatment and transportation. The triage team evaluates each victim, and based on that evaluation determines priority for treatment and transportation. The results of the triage evaluation are recorded on a special triage tag (METTAG) which is then attached to the victim. All fire/EMS personnel who might serve as members of a triage team should be very familiar with their specific role and with the proper use of the triage tag system.

VI. TREATMENT

After the triage evaluation has been done, paramedics and/or emergency medical technicians provide indicated first aid treatment to stabilize the condition of victim. They move the victim, usually by stretcher to the patient staging area. This is the place where the ambulances will pause to pick-up the victims and transport them to the hospital(s). In some cases, treatment will continue in the ambulance enroute to the hospital.

In a mass casualty incident, the person providing the treatment may or may not be associated with the ambulance that provides the transportation of the victim.

VII. TRANSPORTATION

Ambulances and other types of vehicles will perform transportation of victims to receiving hospital(s). Ambulatory patients with less severe injuries may be moved by bus. Helicopters may be used to move more critical patients. Regardless of the mode of transportation, each patient will be taken to a hospital designated by the Transportation Officer. This person, positioned near the ambulance exit or another vantage point, will advise each driver in person or by radio where to go. This coordination will reduce the possibility of overloading hospitals instead of spreading the load among all appropriate receiving hospitals. Careful record keeping, using the numbered tags on the triage tags, will facilitate full accountability throughout the system. It is critical, in evaluation of incident response, to know the sequence and pattern of triage, treatment and transportation (including destination). Use of triage tags will build this knowledge base.

Transportation vehicles should move their patients to the designated hospital, then return directly and immediately to the scene if more patients are awaiting transportation. This is contrary to normal operation for many ambulance crews, used to waiting at the hospital emergency room to retrieve stretchers, backboards, blankets, etc. Equipment can be redistributed to the proper ambulance operators after the emergency is over. Expediency is the principal concern while the emergency is in progress.

VIII. CENTRALIZED CONTROL

Centralized control is imperative in the management of a mass casualty incident. A command post should be established at the scene as a top priority. All coordination and management of the comprehensive incident will be controlled from this location. Included in the command post operation should be:

1. The Incident Commander (IC),
2. Ranking law enforcement officer to assure full support in matters of traffic control, perimeter management, and personnel assistance as needed and available,
3. Fire department officers to assure close coordination between victim handling (including rescue) and any fire suppression or hazard reduction efforts,
4. Sufficient support personnel to operate radios and telephones and to provide needed clerical support.

IX. LOGISTICAL SUPPORT

There are many important logistical support considerations that need to be addressed prior to a mass casualty incident or any other type of disaster. The primary area of importance are addressed next:

1. Communications will be essential. Radio communications capabilities will need to address interaction:

- a. Between the scene and the hospital(s).
- b. Between ambulances and the transportation officer.
- c. Between ambulances and the hospital(s).
- d. Between on-site and mutual-aid agencies.
- e. Between the Emergency Operations Center and the on-site command post.

Amateur radio operators can be utilized as a supplemental communications resource. These dedicated volunteers can provide efficient, relatively secure communication—independent of normal frequencies (which may be heavily loaded with other traffic concerning the emergency).

2. Mass casualty incidents attract curiosity seekers. Perimeters will need to be established quickly. Law enforcement agencies will need rope, caution tape, barricades and signs from public works departments. Public works employees must make a rapid response with these items. Their help will be needed right away—not several hours later. Public works personnel may need to help man the barricades to keep streets or other areas closed. Manpower needs may be large, depending on the circumstances at the time of the incident.
3. Traffic control will be very important. If private vehicles jam the streets around the scene, it will be very difficult for ambulances to move in and out of the area quickly. Extra traffic officers will be needed. If there isn't sufficient manpower available with the local law enforcement agency, mutual-aid assistance will need to be requested from surrounding jurisdictions. National guard assistance can also be requested by contacting Caddo OHSEP at 675-2255. However, it may take some time to mobilize a national guard unit. Requests for National Guard assistance should allow for as much lead-time as possible.
4. Supportive medical supplies may be needed. An extra assortment of bandages, tape, tags, drugs, and other first aid supplies should be stockpiled at a secure location until needed. Supportive medical supplies such as additional blankets, stretchers and body bags should be kept on hand or at least listed in a resource directory along with 24-hour contact numbers.
5. The mobile command/communications bus will need a sufficient supply of pencils, pens, paper, staplers, paper clips and clipboards on hand for personnel helping to manage the mass casualty incident. These supplies should be readily available and stored in an appropriate place. There should also be an adequate supply of pre-printed forms to record events and keep track of where various response units are deployed.

X. ADEQUATE SUPPLY OF TRIAGE TAGS

The most widely used triage tag is known as METTAG (Medical Emergency Triage Tag). It is a full-color perforated tag that uses symbols instead of words for quick international efficiency. METTAGs come in sealed packages, with instructions (see appendix 5 to this annex entitled "METTAG Use).

XI. DRILLS AND EXERCISES

As with any other specialized response procedures, readiness and strength will be improved significantly through exercises. A mass casualty incident is valuable as a disaster drill because it tests a number of different functions of local government, the hospitals and private support groups. Caddo OHSEP will develop and coordinate a disaster drill to test response procedures to a mass casualty incident on an annual basis.

XII. GENERAL PROCEDURAL STEPS

1. Dispatch law enforcement unit to confirm and assess overall situation.
2. Dispatch emergency medical service unit to assess medical situation.
3. Dispatch fire department to suppress fire, reduce hazards and provide supportive manpower.
4. Advise personnel who will serve as the in-charge official (Incident Commander) at the scene.
5. Alert additional ambulance units.
6. Alert hospitals and medical centers on the number and types of injuries associated with the incident so they can enact their in-house emergency plans.
7. Activate Emergency Operations Center (EOC).
8. Dispatch available ambulance and rescue units to fill the reported need.
9. Responsible personnel establish perimeters and command post at scene, initiate communications with hospitals and identify staging areas.
10. Notify coroner if fatalities are involved.
11. Arrange for logistical support as needed.

In Caddo Parish, the triage responsibility rests with the paramedics and emergency medical technicians from the fire departments that operate rescue squad/ambulance service. Standard operating guidelines (SOGs) call for the first arriving medical team to act as the initial triage team. Their first action should be to request additional ambulances to treat and transport victims. Then they should establish their vehicle as a command post and immediately begin triage. Next arriving medical units should be directed to the victims most needing treatment. The first team should not begin treatment until the full situation assessment has been completed, and even then they may have their hands full directing incoming rescue/ambulance units. This means that whoever may be part of the first arriving medical unit should be trained and prepared in functions of triage and on-scene management.

Appendix 7 – MCI Mutual-Aid Agreement

MUTUAL-AID AGREEMENT FOR EMERGENCY SERVICES WITHIN CADDO PARISH IN THE EVENT OF A MASS CASUALTY INCIDENT

I. PURPOSE

To provide a standardized approach in the management of a mass casualty incident within Caddo Parish and in order to efficiently manage area emergency response resources, this mutual aid agreement will utilize common terms and standard operating procedures during an incident that requires multiple agency responses.

A. Mass Casualty Incident (MCI)

The term Mass Casualty Incident (MCI) is used to describe any emergency medical situation that would overwhelm an agency's ability to manage and would necessitate utilization of other resources outside its jurisdiction. An MCI will be classified according to its severity by a three-tier system:

1. LEVEL I

An MCI that can probably be handled by the resources available within the host agency's jurisdiction.

2. LEVEL II

An MCI that requires all available emergency response host agency resources to manage and could require outside agency response. This level MCI will require the host agency to alert other resources for their potential dispatch to the MCI or to provide back-up emergency response to other incidents within their boundaries.

3. LEVEL III

An MCI that will require mutual aid from outside agencies to manage.

B. Level III Standard Operating Procedures

In the event of a MCI Level III, as declared by the host agency, the following standard operating procedures will be followed by all participants:

1. The MCI will have one Incident Commander who will have authority over the MCI until otherwise relieved by a higher-ranking officer who will then become the Incident Commander. His radio designation "Command" will be used along with the geographical location of the incident (i.e., "Parkway Command"). This designation will not change throughout the duration of the MCI, regardless of who assumes command.
2. As soon as possible, the Incident Commander will establish a Primary Command Post that will be visibly identified by a flashing green light. All

other Command Post type apparatus that may arrive on the scene will establish a position near the Primary Command Post but in a location that does not interfere with the operations of the Primary Command Post. Only the Primary Command Post will be identified with a green light in order to avoid confusion.

3. Radio communications must be established between the Command Post and other responding agencies as well as Biotel. Amateur radio operators, available through Caddo OHSEP, may be dispatched to the Command Post, EOC and area medical centers to serve as back-up to the 800 Mhz. radio system.
4. In order to avoid confusion, clear text language will be used during radio transmission between other agencies.
5. The Incident Commander will establish a staging area (or areas) for incoming personnel and equipment that will report there for assignment (unless otherwise directed by the Incident Commander). As more personnel become available, the Incident Commander will establish a safe "treatment" area for casualties as well as an assembly area for accountability of non-injured casualties (see Attachment 1 and 2).
6. The Incident Commander will designate qualified command individuals for the following sections (Areas of Responsibility):

- a. STAGING DIRECTOR – Radio designation "Staging"

The Staging Director will control incoming units in the staging area and facilitate the dispatch of vehicle, equipment, or personnel to other sectors as directed by the Incident Commander.

- b. EXTRICATION OFFICER - Radio designation "Extrication"

The extrication sector personnel will be at the actual MCI site under the control of the Extrication Officer. They are responsible for initial triage and tagging of victims as well as the removal of patients to the treatment area. Casualties will be marked using the color-coded universal field medical tag - Mettag (see Attachment 2 & 3). No attempt will be made by extrication sector personnel to revive clinically dead victims. No advanced life support will be given in the extrication sector.

- c. TRIAGE OFFICER - Radio designation "Triage"

The Triage Officer will be located at the entrance of the designated treatment area to ensure incoming casualties have triage tags and that

priorities are correct; and to direct them to a designated place within the treatment area according to their priority.

d. TREATMENT OFFICER - Radio designation "Treatment"

The Treatment Officer commands treatment sector personnel who will provide life saving care to stabilize patients before transportation to a hospital. This sector will provide advanced life support utilizing the approved standing orders of their assigned agency.

e. TRANSPORTATION OFFICER - Radio designation "Transportation"

The Transportation Officer is responsible for the transportation area, which will be located near the Priority I classified patients of the treatment area. This will be the ambulance-loading zone. The Transportation Officer will also designate helicopter landing areas, maintain knowledge of hospitals capacity status, advise Biotel or other regional hospitals of the number and priority of patients enroute to their facility and insures medical re-supply needs are communicated to medical command (see below).

f. MEDICAL COMMAND OFFICER - Radio designation "Medical"

The Medical Command Officer has overall command of extrication, treatment, triage, and transportation sectors, which will communicate their needs and status reports to him. He in turn will communicate directly to the Incident Commander on EMS activities. The Medical Command Officer will insure each of his sector officers is clearly identified with labeled vests and each sector is clearly marked. He will reassign resources as needed between sectors.

C. This mutual-aid agreement does not affect the day to day routine operations within any jurisdiction but will be utilized in any MCI involving outside agencies. It does not intend to address fire, rescue, or hazardous environment threats, but will be useful in any MCI where these factors exist.

D. All emergency agencies can expand the roles of each sector but are to ensure the training of their personnel follow this basic format. Cross training between agencies is encouraged.

E. It shall be understood that any agency requesting assistance in an MCI is not responsible for reimbursement costs incurred by responding agencies.

Appendix 8 – Emergency Health & Medical Facility Directory

I. GENERAL

1. For planning purposes hospital patients can be divided into three categories:
 - a. Dischargeable
 - b. Non-relocatable
 - c. Relocatable
2. Dischargeable patients are those people in hospitals for elective procedures such as treatment of non-life threatening conditions or illness. These individuals can be discharged immediately or within three days.
3. Non-relocatable patients include those patients that cannot be relocated for one or more of the following reasons:
 - a. Because of their serious conditions, a move of more than a few miles would probably result in their death.
 - b. Because transportation, equipped with sophisticated life support systems is not available.
 - c. Because an inordinate demand on already short supply of host-area resources would be committed to caring for a few patients that may have poor prognoses.
 - d. Because the necessary hospital and personnel is not available elsewhere.
4. Relocatable patients are those patients who require hospitalization but do not present the limiting factors described above for non-relocatables. Thus they can be relocated.
5. The approximate percentages of general hospital patients that are dischargeable, non-relocatable, or relocatable are as follows:
 - a. Dischargeable 75%
 - b. Non-Relocatable 15%
 - c. Relocatable 15%

II. HEALTH AND MEDICAL FACILITIES

Christus Schumpert – Highland
1453 E. Bert Kouns Industrial Loop
Shreveport, LA 71115
Bed Capacity: 156
ER Capacity: 13
Phone: 798-4300
ER: 798-4343

University Health Shreveport
1541 Kings Highway
Shreveport, LA 71130
Bed Capacity: 452
ER Capacity: 23 & 8 Pediatric
Phone: 675-5000
ER: 675-6883

North Caddo Medical Center
1000 S. Spruce Street
Vivian, LA 71082
Bed Capacity: 26
ER Capacity: 4
Phone: 375-3235
ER: 375-3235 ext. 200

Overton Brooks VA Medical Center
510 E. Stoner Avenue
Shreveport, LA 71101
Bed Capacity: 112
ER Capacity: 7
Phone: 221-8411
ER: 424-6115

Willis-Knighton Medical Center
2600 Greenwood Road
Shreveport, LA 71103
Bed Capacity: 310
ER Capacity: 18
Phone: 212-4000
ER: 212-4500

Willis-Knighton Pierremont
8001 Youree Drive
Shreveport, LA 71115
Bed Capacity: 170
ER Capacity: 12
Phone: 212-3000
ER: 212-3500

Willis-Knighton – South
2510 Bert Kouns Industrial Drive
Bed Capacity: 140
ER Capacity: 12
Phone: 212-5000
ER: 212-5500

Appendix 9 – Health Emergency Guidelines

I. **GENERAL**

There are a number of different kinds of health emergencies that have the potential to affect Caddo Parish. Some may threaten in the aftermath of another disaster (example: flooding may increase mosquito population, increasing potential for diseases to be transmitted by the biting insects). Others will have no relationship at all to any other factors.

II. **POTENTIAL PROBLEMS**

Potential health related disasters include the following:

- A. **Major food poisoning.**
- B. **Disease epidemic.**
- C. **Chemical poisoning (could relate to hazardous materials incident).**
- D. **Serious air pollution.**
- E. **Extreme heat or cold.**

III. **RESPONSE PROCEDURES**

Response to health emergencies is often specialized, requiring the services of the professionals employed by the Caddo Health Unit. If they need help, they have the knowledge of how to contact surrounding health departments, the state agency, and national resources such as the Center for Disease Control (CDC) in Atlanta, Georgia.

Response procedures should be concerned with:

- A. **Notifying the health department.**
- B. **Providing support to the health department.**
- C. **Maintaining calm in the community.**
Coordination with the local health units has helped to ensure that supporting efforts are considered. Special emphasis has been placed on the need to avoid panic in the community. News media and clergy will be utilized as needed.

IV. **RESOURCE MATERIAL**

Caddo OHSEP has the following public information materials available for the public during a disaster. The material can be reproduced and placed at mass gathering sites, feeding, water distribution sites, law enforcement departments, or

anywhere people are likely to go during a disaster. The Caddo Health Unit has additional public information material available as needed for distribution.

1. “How to Get Safe Drinking Water During an Emergency”
2. “Sanitation in an Emergency”
 - a. Temporary means for handling human wastes
 - b. How to handle garbage
3. “What to do with Food Items Subjected to Flood Waters”
 - a. Milk
 - b. Canned goods
 - c. Frozen foods
4. “How to Disinfect Your Water Supply”
5. “Home Safety Precautions”
 - a. Final clean-up instructions and precautions
 - b. Test plumbing drains before using them

V. EMERGENCY CONTACTS

A. Caddo Parish Health Unit

Sanitarian Parish Manager
1035 Creswell
Shreveport, LA 71101
676-5222

B. LA Department of Health and Hospitals (DHH)

Regional Administrator
1525 Fairfield Avenue, Room 569
Shreveport, LA 71101-4388
676-7489

C. Office of Public Health

Regional Epidemiologist
676-7499

Appendix 10 – Animal Control Guidelines

I. GENERAL

Response needs for a dangerous animal call will vary with the type of community and geographic location. A dangerous animal could be as “simple” as a rapid dog in a suburban area to rats in an urban area. The same call in another environment could refer to a wolf, wildcat, poisonous snake or a skunk. The variety of problems that may confront the local area is included in the Caddo hazard analysis.

CAUTION: Be particularly careful of live or dead animals that may have been exposed to a hazardous materials incident and may be contaminated. HAZ/MAT response personnel wearing proper protective clothing should assist with these animals. If possible, animal control personnel should receive hazardous materials training to the Awareness Level.

II. RESPONSE PROCEDURES

A. First Response

First response procedures in the local area include dispatching a law enforcement officer or animal control officer to assess the situation. The first responder might be able to take the necessary actions to neutralize the threat, by capturing, chasing away or killing the creature. In other cases, the first responder may be more concerned with protecting human lives until more specialized responders arrive to assume control of the situation.

B. Dead Animals

The pickup of dead animals may be handled by the same agency, and/or arrangements may be made with other service firms or organizations for larger animals. Calls for clean-up of dead animals could range from a domestic pet that has been hit by a car to wildlife that has suffered the same fate. Another concern may be the disposal of carcasses of diseased animals. An example would be some sort of (accidental) poisoning of part of a herd of cattle. Another concern will be the clean-up and disposal of livestock and household pets killed as a result of a natural or technological disaster. Flash floods, tornadoes, toxic chemical accidents and other disaster agents can claim a number of animals. Unless the carcasses are removed quickly, they could cause a serious threat to public health.

C. Insect Control

Insect control should not be overlooked. Mosquitoes can spread a number of diseases, and these insects can cause serious difficulties after flooding. This effort should be coordinated with the Caddo Health Unit. Another hazard is the stinging insects—bees, wasps, and hornets. Occasionally these insects are confronted and pose serious obstacles during emergency conditions.

III. EMERGENCY CONTACTS

Caddo Parish Animal & Mosquito Control

1500 Monty Street

Shreveport, LA

Animal Control: 226-6624

Mosquito Control: 226-6627

After Hour Emergencies: 800-357-7948

NOTE: See also Annex E (Shelter), Appendix 6 – Animals and Emergency Shelter.

Appendix 11 – Radiation Emergency Medical Guidelines

The U.S. Department of Energy (DOE) has compiled the following information for “Emergency Handling of Radiation Cases - Ambulance/Rescue Squads.”

I. GENERAL

Emergency handling of radiation exposures or radioactive contamination cases should not be feared. Handling these cases involves common sense, cleanliness, and good housekeeping.

Radiation can be detected and measured by a simple instrument - a survey meter. Radiation accident problems have parallels in other conditions handled frequently by emergency rooms and rescue squads without concern and by following simple rules.

II. PATIENT CATEGORIES

There are four types of radiation accident patients:

1. The individual who has received whole or partial body external radiation may have received a lethal dose of radiation, but he/she is no hazard to attendants, to other patients, or to the environment. This individual is no different from the radiation therapy or diagnostic x-ray patient.
2. The second type is the individual who has received internal contamination by inhalation or ingestion. He/she also is no hazard to attendants, other patients or the environment. Following cleansing of minor amounts of contaminated material deposited on the body surface during airborne exposure, he/she is similar to the chemical poisoning case. His/her body wastes should be collected and saved for measurements of the amount of nuclides to assist in determination of appropriate therapy.
3. External contamination of body surface and/or clothing by liquids or by dirt particles presents a third type, with problems similar to vermin infestation. Surgical isolation techniques to protect attendants and cleansing to protect other patients and the hospital environment must take place to confine and remove a potential hazard.
4. The fourth type of radiation accident case involves external contamination that is complicated by a wound. Care must be taken not to cross-contaminate surrounding surfaces and the wounds. The wound and surrounding surfaces are cleansed separately and sealed when clean. When crushed dirty tissue is involved, early preliminary wet debridement following wound irrigation may be indicated. Further debridement and more definitive therapy can await sophisticated measurement and consultant guidance.

III. AMBULANCE/RESCUE SQUAD PROCEDURES

Ambulance/rescue squad personnel usually see the case of radiation exposure or radioactive contamination before anyone else. Their first acts will vary in degree whether they treat a university or medical group regularly working with nuclear material or from a road transportation accident. Trained, knowledgeable coworkers, supervisors, or health physicists are usually on hand at the facility, but not at the road site.

When the accident has occurred at a medical or university facility, the health physicist, supervisor, coworkers and the patient(s) should be able to inform the rescue squad of the nature of the accident, number of patients and type of radiation exposure or radioactive contamination involved, and possible body areas that may be affected. A gross measurement of the amount of radiation involved may be available. Such information is most helpful.

It is the responsibility of the rescue squad to:

A. For the Patient

1. Give lifesaving emergency assistance, if needed.
2. Secure pertinent information, including rough radiation measurement from those in attendance.
3. Determine if physical injury or open wound is involved. Cover wound with clean dressing; use elastic bandage to hold wound-cover in place; do not use adhesive.
4. Cover stretcher, including pillow, with open blanket; wrap victim in blanket to limit spread of contamination.
5. Notify hospital of available information by radio or telephone.

B. For Ambulance/Rescue Squad Personnel

1. Perform survey of clothing, ambulance, etc., on arrival at hospital before undertaking further activity.
2. If contaminated, discard clothing in container marked "Radioactive - Do not Discard." Cleanse self by washing and/or showering, as appropriate.
3. If in contaminated area, ambulance/rescue squad personnel must be surveyed by radiation-survey meter and measurements must be recorded. Cleansing must continue until contamination is removed.

IV. EMERGENCY ROOMS

1. It is the responsibility of the senior hospital emergency room person on duty, on receipt of notification of the momentary arrival of a case involving radiation exposure or contamination, to:
 - a. Notify responsible staff physician or nurse and aides (trained health physicists or trained technicians from x-ray or nuclear medicine departments), if available.
 - b. Get appropriate survey meter, if one is available in the hospital. If

- hospital has no meter, notify hospital administrator or responsible hospital official so he/she may obtain survey meter and other pertinent equipment by calling the fire department or Caddo OHSEP.
- c. Notify the hospital administrator so he/she may seek expert professional consultation for technical management of the case.
 - d. If contamination is suspected, prepare separate space, using either isolation room or cubicle, if available. If such is not available, cover floor area immediately adjacent to emergency room entranceway with absorbent paper—the area to be adequate for stretcher-cart, disposal hampers, and working space for professional attendants. Mark and close off this area. Be prepared to shut off air circulation system.
2. On ambulance arrival, the physician and/or nurse in the emergency room should:
- a. Check patient on stretcher for contamination (as stretcher is removed from ambulance) with survey meter.
 - b. If seriously injured, give emergency lifesaving assistance immediately.
 - c. Handle contaminated patient and wound as one would a surgical procedure; i.e. gown, gloves, cap, mask, etc.
 - d. If possible external contamination if involved, save all clothing, bedding from ambulance, blood, urine, stool, vomitus, and all metal objects; i.e., jewelry, belt, buckles, dental plates, etc. Label with name, body location, time and date. Save each in appropriately covered containers. Mark containers clearly “Radioactive—Do Not Discard.”
 - e. If medical status permits, decontamination should start with cleansing and scrubbing the area of highest contamination first. If extremity alone is involved, clothing may serve as an effective barrier and the affected limb alone may be scrubbed and cleansed. If whole body is involved or clothing generally permeated by contamination material, showering and scrubbing will be necessary. Pay special attention to hairy parts, body orifices, and body-fold areas. Re-measure and record measurement after each washing or showering. If a wound is involved, prepare and cover the wound with self-adhering disposal surgical drapes. Remove wound covering and irrigate wound, catching fluid in a basin or can to be marked and handled as described in Rule 4 above. Each step in the decontamination should be preceded and followed by monitoring and recording of the location and extent of contamination.
 - f. Save attendant’s clothing as described for patients. Attendants must follow the same monitoring and decontamination routine as recommended for the patients.
3. The senior administrator on duty should inform the emergency room disaster administrator and other public officials, such as parish and/or state health departments as appropriate, police and fire departments, as indicated.

4. The physician in attendance in the emergency room, if confronted with a grossly contaminated wound with dirt particles and crushed tissue, should be prepared to do a preliminary simple wet debridement. Further measurements may necessitate sophisticated wound counting detection instruments supplied by the consultant who will advise if further definitive debridement is necessary.

Appendix 12 – Anthrax Contingency Plan

I. GENERAL

Anthrax is an acute infectious disease caused by the spore-forming bacterium *Bacillus anthracis*. Anthrax most commonly occurs in wild and domestic lower vertebrates (cattle, sheep, goats, camels, antelopes and other herbivores), but it can also occur in humans when they are exposed to infected animals or tissue from infected animals.

Because anthrax is considered to be a potential agent for use in biological warfare, the Department of Defense (DoD) has begun mandatory vaccination of all active duty military personnel who might be involved in conflict.

Anthrax is most common in agricultural regions where it occurs in animals. These include South and Central America, southern and Eastern Europe, Asia, Africa, the Caribbean, and the Middle East. When anthrax affects humans, it is usually due to an occupational exposure to infected animals or other products. Workers who are exposed to dead animals and animal products from other countries where anthrax is more common may become infected with *B. anthracis* (industrial anthrax). Anthrax in wild livestock has occurred in the United States.

II. TRANSMISSION

Anthrax infection can occur in three forms: cutaneous (skin), inhalation and gastrointestinal. *B. anthracis* spores can live in the soil for many years, and humans can become infected with anthrax by handling products from infected animals or by inhaling anthrax spores from contaminated products. Eating undercooked meat from infected animals can also spread anthrax. It is rare to find infected animals in the United States.

III. SYMPTOMS

Symptoms of the disease vary depending on how the disease was contracted, but symptoms usually occur within 7 days.

A. Cutaneous

Most (about 95%) anthrax infections occur when the bacterium enters a cut or abrasion on the skin, such as when handling contaminated wool, hides, leather or hair products (especially goat hair) of infected animals. Skin infection begins as a raised itchy bump that resembles an insect bite but within 1-2 days develops into a vesicle and then a painless ulcer, usually 1-3 cm in diameter, with a characteristic black necrotic (dying) area in the center. Lymph glands in the adjacent area may swell. About 20% of untreated cases of cutaneous anthrax will result in death. Deaths are rare with appropriate anti-microbial therapy.

B. Inhalation

Initial symptoms may resemble a common cold. After several days, the symptoms may progress to severe breathing problems and shock. Inhalation anthrax is usually fatal.

NOTE: For Anthrax to be effective as a covert agent, it must be aerosolized into very small particles. This is difficult to do, and requires a great deal of technical skill and special equipment. If these small particles are inhaled, life threatening lung infection can occur, but prompt recognition and treatment are effective.

C. Intestinal

The intestinal disease form of anthrax may follow the consumption of contaminated meat and is characterized by an acute inflammation of the intestinal tract. Initial signs of nausea, loss of appetite, vomiting, and fever are followed by abdominal pain, vomiting of blood, and severe diarrhea. Intestinal anthrax results in death in 25% to 60% of cases.

NOTE: Disease can be prevented after exposure to the anthrax spores by early treatment with the appropriate antibiotics. ANTHRAX IS NOT SPREAD FROM PERSON TO ANOTHER PERSON.

IV. LOCATION

Anthrax can be found globally. It is more common in developing countries or countries without veterinary public health programs. Certain regions of the world (South and Central America, Southern and Eastern Europe, Asia, Africa, the Caribbean, and the Middle East) report more anthrax in animals than others.

V. PERSON-TO-PERSON CONTACT

Direct person-to-person spread of anthrax is unlikely to occur. Communicability is not a concern in managing or visiting with patients with inhalation anthrax.

VI. INFECTION CONTROL

In countries where anthrax is common and vaccination levels of animal herds are low, humans should avoid contact with livestock and animal products and avoid eating meat that has not been properly slaughtered and cooked. Also, an anthrax vaccine has been licensed for use in humans. The vaccine is reported to be 93% effective in protecting against anthrax.

VII. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

A. General

The Caddo Office of Homeland Security and Emergency Preparedness should be notified by local emergency services of all anthrax related calls and cases. OHSEP will log calls, track and plot locations of suspected anthrax cases in Caddo Parish.

OHSEP will disseminate educational materials to local news media outlets concerning anthrax. Departmental PIOs will assist with this effort. The stated policy on suspected contamination is to test suspected substances whenever possible, not individuals.

B. Emergency Dispatch

If an individual calls claiming that he or she has been contaminated advise the individual to:

1. Isolate the substance to prevent any further spread.
2. Wash hands immediately, using soap and water.
3. Close off the area, and advise others to avoid the area.
4. Dispatch HAZMA T response team.
5. Delay seeking medical attention until the situation is assessed.

C. HAZMAT Response Teams

If an individual reports receiving a suspicious package:

1. Treat every case as suspect.
2. Respond and investigate.
3. Collect and secure suspected material in a sterile container, if possible (use a Q-tip or tape to obtain smaller samples).
4. Deliver specimen to the LA Dept. of Health & Hospitals (LDHH) – Office of Public Health (OPH) Shreveport regional public health lab for screening.
5. Sign public health lab receipt (be sure to include phone and fax numbers).
6. Notify EOC/OEP of actions.
7. Provide individual with anthrax guidelines booklet.
8. Advise individual to wait until results of local screening return before seeking medical help (15-24 hours).
9. Secure perimeter as needed.
10. Notify individual of results of local screening.

If the location of suspicious material is a building or office, advise the building official to hire a HazMat contractor to decontaminate as needed.

D. LDHH OPH (Shreveport Regional Lab)

The public health lab will perform the following procedures:

1. Provide 24-hour screening until further notice (regular lab hours are 8 a.m. to 4:30 p.m.; on pager for after-hours screening). Turnaround time is 18- 38 hours for each sample.
2. Notify Caddo OHSEP of all screening results.
3. Forward results to LDHH OPH Central Office in New Orleans. The Infection Disease, Epidemiology and Bioterrorism Center in New Orleans is the releasing authority for all anthrax screening information in Louisiana. Results will be made available within 48 hours and can be

obtained by phone (1-800-256-2748). Efforts are under way to set up a web page that will post test results in a discreet, secure manner.

4. Samples that test positive in the Shreveport lab are forwarded to the central office in New Orleans for confirmation (turnaround time is 3-5 days).
5. There is the possibility of local hospital labs serving as augmentees in the event the public health lab becomes overwhelmed.

POC: Jim Gilbert, LA DHH-OPH
533 Vine Street
Shreveport, LA
Lab: 221-0859
Pager: 1-800-999-6710, pin #999-9782

E. Hospitals/Medical Centers

If an individual visits the hospital and believes he or she has been contaminated:

1. Have the patient disrobe.
2. Double-bag the patient's clothing (public safety will mark and store bags at hospital's request).
3. Direct the patient to decon. or shower, using soap and water (bleach and water solution is no longer advised).
4. If the patient is a-symptomatic, medical interventions should end. If the patient has symptoms consistent with anthrax, consider performing blood cultures and/or chest X-rays, and then only under the direction of state health officials.

Should any area of a hospital become contaminated, the fire department will investigate and contain the spread of the contaminant. Depending on the amount of contamination, the hospital may be advised to contact an environmental clean-up contractor for decontamination.

VIII. EMERGENCY CONTACTS

National FBI Hotline: 1-800-424-8802, local FBI office: 221-8439

CDC Anthrax Hotline: 404-639-2807

CDC Biological Threat Hotline: 404-639-7100

CDC Requests for Serology: 404-639-2468

Appendix 13 – Mass Fatalities

I. ORIGINS

In response to the outpouring of volunteer support in the days following September 11, 2001, President George W. Bush created the USA Freedom Corps. That national initiative is made up of several components, among them AmeriCorps, the Peace Corps, and Citizen Corps. The Medical Reserve Corps (MRC) is a specialized component of Citizen Corps.

II. OBJECTIVES

The MRC plays an integral part in our preparedness and response strategy. It provides an organized way for medical and public health volunteers to offer their skills and expertise during local crises and throughout the year. Locally-based MRC volunteers can assist during large-scale emergencies. MRC volunteers also work to strengthen the overall health and wellbeing of their neighborhoods and communities.

Major emergencies can overwhelm the capabilities of our first responders, especially during the first 12 to 72 hours. Medical and other health volunteers can provide an important “surge” capacity during that critical period. They can also augment medical staff shortages at local medical and emergency facilities. MRC volunteers can also provide assistance in Special Needs Shelters as needed.

III. TRAINING

Volunteers who are eligible to train as MRC volunteers already know how to perform the medical and health functions within their field of expertise. Therefore, training as an MRC volunteer will focus primarily on learning local emergency systems and health procedures, trauma response techniques, use of specialized equipment, and other methods to enhance effectiveness as a volunteer. Trained volunteers will be familiar with the Caddo response plan, will know what materials are available for use, will know its response partners, and will know where its skills can be put to best use and in a coordinated manner.

Appendix 13: Attachment 1 – Mass Fatalities Annex

PROMULGATION STATEMENT

Transmitted herewith is the new Mass Fatalities Annex for the cities of Shreveport, Bossier City and Caddo and Bossier Parishes. This annex supersedes any previous Mass Fatalities Annex promulgated for this purpose. It provides a framework in which Caddo and Bossier Parishes and its political subdivisions can plan and perform their respective functions during an incident involving mass fatalities.

This annex is in accordance with existing federal, state and local statutes and understandings of the various departments/agencies involved. It has been concurred by the Caddo-Bossier Office of Homeland Security and Emergency Preparedness (OHSEP) Executive Council, Louisiana Office of Homeland Security and Emergency Preparedness and the Federal Emergency Management Agency. All recipients of this annex are requested to advise Caddo-Bossier OHSEP as to any changes that might result in its improvement or increase its usefulness.

This annex will be annually reviewed and maintained by Caddo-Bossier OHSEP, with input solicited from the corresponding agencies involved.

Date: July 2004

I. PURPOSE

The purpose of this annex is to describe and define roles and procedures in mitigation, preparedness, response and recovery resulting from mass fatality incidents. This annex provides for the proper coordination of mass fatality incident response activities and establishes the means and methods for the sensitive, respectful, orderly care and handling of human remains in multi-death disaster situations.

The responsibility for bodies—their collection, identification, and disposition—lies with the Office of the Coroner. As soon as it is realized that even one fatality is involved, the Coroner's Office must be immediately notified. In many instances, the Coroner's Office will take control of the scene...at least the aspect dealing with dead bodies. To establish cause of death, the coroner may want to take photographs, videotapes, and/or measurements at the scene.

Caddo Parish Coroner

Dr. George McCormick
1704 Market Street
Shreveport, LA 71101
(318) 226-6881

II. SITUATION AND ASSUMPTIONS

A. Situation

Caddo Parish is vulnerable to numerous natural and technological disasters such as tornadoes, floods, hazardous materials incidents, transportation accidents, ice storms and acts of terrorism. Any of these occurrences could result in multiple death response requirements that would overwhelm local capabilities.

Should local capabilities be exceeded, support will be available from neighboring parishes, state agencies and federal agencies.

B. Assumption

The Louisiana Mass Fatalities Task Force at 1-800-256-7036 will be available to aid the parish coroner in the necessary acts of recovery, evacuation, identification, sanitation, preservation or embalming (as authorized), notification of next of kin, counseling and facilitating the release of identified human remains to next of kin or their representative.

III. CONCEPT OF OPERATIONS

A. General

1. Mass fatalities incident response is separate from and secondary to search and rescue operations. Mass fatality response activities should occur only after all survivors of the incident are moved to safety.

2. The primary concerns of mass fatality incident response are recovery, identification of human remains and assistance to affected families.
3. Mass fatality incidents involve many tasks and can become very complex. Teamwork and an appreciation of the roles of other agencies are crucial during planning and during the incident itself.
4. Responsibility for collection, identification, storage and dispatch of deceased victims lies with the parish coroner as set forth by law in the State of Louisiana.
5. The Louisiana Mass Fatalities Task Force will assist at the request of the Coroner, and as coordinated through the Caddo Emergency Preparedness.

B. Phases of Emergency Management

1. Mitigation

- a. Pre-designation of temporary morgue sites.
- b. Development of mutual-aid agreements.
- c. Specialized training and education.

2. Preparedness

- a. Planning, training and exercising.
- b. Updating and revising plans.

3. Response

- a. Identification of staging areas.
- b. Coordination for transportation of equipment and personnel.
- c. Provisions for family reception area.
- d. Public information activities.
- e. Search and body recovery.
- f. Body Identification.
- g. Logistics support.

4. Recovery

- a. Continuation of response activities as needed.
- b. Compilation of reports and records.

IV. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

A. General

The mass fatality function is the responsibility of the Caddo Coroner's Office that has overall authority. Caddo Office of Homeland Security and Emergency Preparedness will provide coordination for activities and resources.

1. Considerations in a mass fatality incident include:
2. General guidance.
3. Disaster worker and death.
4. Dealing with the media.

5. Communicating with the immediate survivors.
6. Developing an on-site temporary morgue site.
7. Radiation and other hazardous materials/contaminated fatalities.
8. Legal and financial costs.
9. Coordinating post-death activities.
10. Human behavior in disasters.

B. Assignment of Responsibilities

1. Caddo OEP

- a. Coordinate response and recovery activities through the Caddo Emergency Operations Centers (EOCs) to include mass feeding, public information activities, family counseling, transportation support and other related activities.
- b. Coordinate training and exercises in mass fatalities incident response. NOTE: Mass fatality incident training courses are available through the Federal Emergency Management Agency and conducted at various locations throughout Louisiana. The annual Caddo Community Disaster Drill routinely includes mass fatality components.

2. Caddo Coroner's Office

- a. Recovery and evacuation of remains.
- b. Body identification.
- c. Disposition of human remains.
- d. Preserving or embalming.
- e. Notification of next of kin.
- f. Grief Counseling.
- g. Family assistance.
- h. Documentation of each victim.
- i. Prepare and file death certificates.
- j. Resource listing.
- k. Safeguarding of personal effects.
- l. Identification of temporary morgue site.
- m. Establishment of staging areas.

3. Other City/Parish Departments

Provide support as requested.

V. DIRECTION AND CONTROL

The Caddo Parish Coroner are responsible by law for the collection, identification, storage and dispatch of the deceased. The Caddo Parish Coroner can request assistance from other parish agencies through the Caddo Office of Homeland Security and Emergency Preparedness. The Louisiana Mass Fatalities Task Force is available to assist the parish coroner in a coordinated effort of recovery and identification.

The direction and control of procedures in relation to the care of deceased victims shall follow the chain of events below.

A. Collection

1. The corresponding Caddo Coroner's Office will be notified immediately in the event of an emergency situation involving fatalities. The coroner's office will dispatch the appropriate staff to the scene.
2. Collection of deceased victims on scene, from hospitals, and other designated collection points shall be accomplished through the use of enclosed vehicles; e.g., funeral home coaches.
3. Victims will be taken to a designated identification point as established by the coroner's office.

B. Identification

1. Identification of victims shall be made by use of accepted forensic methods by the Caddo Coroner's Office as supplemented by (if necessary):
 - a. Louisiana Mass Fatalities Task Force.
 - b. Law enforcement fingerprint identification teams.
 - c. Funeral home personnel.
2. If circumstances warrant, the Caddo or Bossier Coroner's Offices may also be assisted in the identification of victims by:
 - a. Special agents of the Federal Bureau of Investigation (FBI).
 - b. Barksdale AFB mortuary affairs personnel.

C. Temporary Storage

1. Caddo Coroner's morgue.
2. Area funeral homes.
3. Area hospital/medical center morgues.
4. Refrigerated trucks.
5. Refrigerated rail cars.

D. Internment

1. Upon positive identification of victims, bodies will be released to funeral homes specified by the deceased's family.
2. If no preference is noted, bodies will be released to local funeral homes on a rotation basis.