
Emergency Management Plan

Section 7

7-7 Mass Casualty Response Plan

June 2006



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WACCAMAW HRSA HOSPITAL REGION
MASS CASUALTY RESPONSE PLAN



The mass casualty response plan is funded through the Health Resources & Services Administration's (HRSA) National Bioterrorism Hospital Preparedness Program whose purpose is "To ready hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies."
Six area hospitals, healthcare providers, county emergency management authorities and first responders in cooperation with the department of health work through the Waccamaw HRSA Region Task Force to produce this document.

Waccamaw HRSA Region Task Force
2830 Oak Street
Conway, SC 29526
(843) 365-3126

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Waccamaw Region Mass Casualty Response Plan

I. INTRODUCTION

A. General

Unlike natural disasters, weapon of mass destruction (WMD) events or disease epidemics may occur without warning and strike at any time. The unpredictable nature of such events will cause great public health and societal impacts. The mass casualty response plan addresses disasters that cause mass casualties.

The purpose of this plan is “To ready hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies.”

National Bioterrorism Hospital Preparedness Program⁴

The operational goal of the response plan is to manage 1,000 casualties, accomplished by maximum use of existing resources, asset and resource scalability, and sustained operations for 24-72 hours. The effectiveness of the response is based on mutual sharing of resources among hospital facilities and healthcare providers outlined in a memorandum of agreement. In addition, cooperation among community organizations and use of public assets provides the flexibility of scale described in the plan.

B. Specific

This Region Mass Casualty Response Plan describes activation and notification of appropriate personnel and response operations should a WMD attack, disease epidemic or natural disaster occur.

State and local assistance under this function consists of *health and medical service resources* (including transportation) temporarily realigned from established programs having coordination or direct service capability for medical care, public health and sanitation, crisis counseling, and deceased identification and mortuary services.

1. MEDICAL CARE refers to emergency (including field operations) and resident medical and dental care, doctors, nurses, technicians, pharmaceuticals, supplies, equipment, ambulance service, hospitals, clinics and first aid units, planning, operation of facilities and services.
2. PUBLIC HEALTH AND SANITATION refers to the services, equipment, and staffing essential to protect the public from communicable diseases and contamination of food and water

supplies; development and monitoring of health information; inspection and control of sanitation measures; inspection of individual water supplies; disease vector and epidemic control; immunization; laboratory testing.

3. CRISIS COUNSELING refers to the professional personnel, services and facilities to relieve mental health problems caused or aggravated by a disaster or its aftermath.
4. DECEASED IDENTIFICATION AND MORTUARY SERVICES refers to the identification and disposition of human remains.

C. Authorities and References

See Attachment 1 for authorities and references.

D. Organization

The Waccamaw Region consists of Georgetown, Horry and Williamsburg counties, supports six hospitals with a bed capacity of 830 beds. In addition, two ambulatory surgery centers operate full-time emergency rooms, which bring the regions total response capability to eight full-time emergency rooms throughout the three-county region. Horry County is the largest county jurisdiction east of the Mississippi while it is the second fastest growing county in South Carolina, serves as the lead county in the Northern conglomerate for emergency preparedness and hosts an advanced COBRA team. The region generates 33 percent of the state's tourism revenue and attracts annually an average 14 million visitors with Spring, Summer and Fall the primary tourism seasons.

1. The designation of a "lead" hospital establishes itself naturally in a developed SMSA (Standard Metropolitan Statistical Area) in contrast to a developing SMSA characteristic of the Grand Strand area. As a result, alternative leadership structures must be considered that will best manage the medical component for a mass casualty event. Considerations include the following:
 - a. SC DHEC and the "Emergency Health Power" laws become the authority when a state of emergency is declared and the agency seeks the collective resources of hospitals in the region.
 - b. The convening jurisdiction for emergency management issues becomes the county emergency management department and health and medical report through emergency support function 8 (ESF 8) of the county emergency operation center.
 - c. A Unified Medical Command (UMC) structure that reports to county ESF 8 while simultaneously collectively managing the medical and public health aspects of a mass casualty incident.
2. Specific hospital command center points of contact from each hospitality facility and the Waccamaw Public Health District's

- Incident Command Team are identified in an SOP Attachment, UMC List of Contacts.
3. Hospitals talk to each other via several methods but primarily those referenced below and to include satellite teleconference systems where available, teleconference calls, telephones, fax, cell phone, email and/or radios as necessary. Regional assets and hospital assets are coordinated through these methods of communication.
 - a. Their representative at the county ESF 8.
 - b. Telephones as the primary telecommunications system.
 - c. An 800 MHz radio system as the emergency backup system.
 5. Hospitals will talk to the SC DHEC public health district using several methods to include:
 - a. Their representative at the county EOC ESF 8.
 - b. Telephones as the primary telecommunications system.
 - c. An 800 MHz radio system as the emergency backup system.
 6. Hospitals will talk to the County Emergency Management EOC using several methods to include:
 - a. Their representative at the county EOC ESF 8.
 - b. Telephones as the primary telecommunications system.
 - c. An 800 MHz radio system as the emergency backup system.
 7. Hospitals will talk to the local Law Enforcement using several methods to include:
 - a. Their representative at the county EOC ESF 8.
 - b. Telephones as the primary telecommunications system.
 - c. An 800 MHz radio system as the emergency backup system.
 7. To be developed: How other healthcare providers, ambulatory surgery centers, federal health facilities, community health centers communicate within the mass casualty response structure.
 8. An organizational chart listing point of contact and HEICS position is referenced in the standard operating procedures while Attachment 9 lists participating hospitals.

II. MISSION

To establish region-wide preparedness for a mass casualty event by a regional response plan developed, maintained and exercised through committed community partners dedicated to a trained network of professionals.

III. SITUATION AND ASSUMPTIONS

A. Situation

Any one of three incidents may trigger the mass casualty response plan. These incidents will overwhelm existing medical resources and result from a WMD event, natural disaster or disease outbreak.

1. An act of terrorism produces a crime scene and results in mass casualties. This act may or may not have a biological component.
2. A disease epidemic or covert WMD event delayed due to delayed onset of symptoms or whose characteristics mimic typical illnesses. Discovery will require medical professionals to detect similar patterns of symptoms.
 - a. The most likely diseases from bioterrorism are Anthrax, Botulism, Plague, and Smallpox.
 - b. The incident response plan may be activated prior to lab confirmation of a suspicious agent by DHEC.
3. Natural occurring disaster or significant accident may cause the immediate activation of the incident response plan by the county emergency management authority.

B. Assumptions

1. Citizens and property in the Waccamaw Region could be at risk for the potential of terrorist threats resulting from a WMD, disease epidemics, natural disasters or widespread accidents.
2. County Emergency Operations Plan and the Mass Casualty Response Plan activates at OPGON 1 in response to a known WMD attack, natural disaster or disease epidemic.
3. Healthcare facilities activate MOAs and the region activates the Waccamaw HRSA Hospital Region MOU.
4. The health care system response capabilities are overwhelmed. Hospital emergency rooms reach surge capacity in a short period of time. Isolation and quarantine capabilities are strained. Issues such as patient tracking, security, communications, diagnosis and treatment of infectious diseases, as well as disposal of infectious medical waste pose a tremendous hardship on the health care system.
5. The Waccamaw Region Unified Medical Command in concert with the DHEC Waccamaw Public Health District requests a State of Emergency, when local capabilities are exceeded.
 - a. The county may declare a state of emergency
 - b. The governor may declare a state of emergency
6. Significant aid from state and federal governments to the Waccamaw Region will not be available for 72 hours.
7. Tourist populations, seasonal events and business conventions and/or conferences may be present.

8. Normal communications channels will be disrupted.
9. Routine medical emergencies, emergency surgeries and medical care events will be significantly compromised and may be impossible to sustain.
10. Standard of Care: Once the Governor declares a "State of Emergency, the existing standard of care may be adjusted to provide a level of care appropriate for the circumstances given the resources available. These modifications may include but are not limited to the following:
 - a. Adopt "battlefield triage" to include an additional "expectant" category for victims not likely to survive without extensive immediate care.
 - b. Establish alternative acute care centers away from traditional inpatient facilities to manage large numbers of victims that would otherwise overwhelm existing treatment facilities.
 - i. Temporary acute care facilities may group patients with same conditions such as infectious disease or biological contamination.
 - ii. Acute care facilities are staffed by hospital personnel.
 - c. Establish neighborhood help centers located in densely populated areas of the community and provide triage, minor outpatient treatment, medications, counseling, family support services and referral to other care facilities.
 - i. Neighborhood help centers may be established as an SNS dispensing center for mass prophylaxis and/or vaccinations.
 - ii. Neighborhood help centers may serve in a dual capacity as a shelter facility.
 - iii. Help centers are staffed by public health personnel in cooperation with area volunteer organizations.
 - d. Activate alternative transportation systems to move non-critical victims within the regional health care system or to referral treatment facilities in other jurisdictions. This system component permits EMS to provide transport and emergency treatment to critically ill patients.
 - e. Establish community outreach to provide critical public information to high-risk populations as well as assess community public service and/or public health needs.

IV. CONCEPT OF OPERATIONS

The Waccamaw Hospital Region supports response and recovery efforts in the event of bioterrorism, disease epidemics or other disasters involving mass casualties. The concept of operation integrates several responses using a variety of facilities and resources, both medical and non-medical, to support Emergency Support Function 8. Other response plans are referenced when appropriate to do so.

- A. The Regional response unfolds as a single incident overwhelms the capacity of a single hospital and the incident escalates consuming the capacities of area hospitals. The response may be immediate or may be delayed depending on the nature of the event and the point at which the event is detected.
1. Immediate activation occurs when a single event overwhelms the capability of a single hospital and consumes the capacities of area hospitals.
 2. Delayed activation occurs when medical personnel detect a pattern of symptoms presented by a number of patients occurring across the region among hospital emergency rooms or physician offices. Once suspicion of a public health threat is determined, the plan is activated and hospitals activate their all hazards plan.
 3. Member hospitals of each county's EOC Unified Medical Command maintain an all hazards plan that incorporates responses to WMD event and disasters. Hospitals have established command centers and activate under HEICS (Hospital Emergency Incident Command System).
- B. Command and Control: Agencies use the incident command system when operating under emergency conditions. Hospitals provide representation to the county EOC under ESF 8 and serve as a Unified Medical Command to support emergency management operations when a medical emergency exists.
- C. Division of federal, state, and local responsibilities. This section summarizes what takes place at three jurisdictional levels and how they are integrate:
1. Federal: Federal assets may be dispatched to the region once the Governor has requested assistance and/or the President has declared an emergency. Assets to support a mass casualty event may include, DMAT, DMORT, DVET from the National Medical Response System as well as the Strategic National Stockpile's medications, supplies and medical equipment. The South Carolina Funeral Directors Association serves as an entry point for federal DMORT assets.

2. State: Coordination for resource requests may come from either emergency management authority or through the SC DHEC public health district depending on the nature of the event and how it evolves.
 - a. Emergency management: the local authority has access to state agencies through the SC EOC in a declared emergency.
 - b. Public Health: DHEC officials have access to medical supplies, services and expertise in an emergency.
 - c. Governor: the Governor must declare a state of emergency to request federal assets including the SNS.
 - i. The Governor may declare a state of emergency when local resources have been depleted; and
 - ii. When state resources have been depleted.
 3. Local: In an emergency that overwhelms hospital capacity, hospitals coordinate information through the county ESF 8 and the Unified Medical Command to the respective county EOC. Hospitals collect disaster related information and pass through either ESF 8 (if activated) or through public health. The District Public Health Director serves as the Unified Medical Commander for all public health emergencies.
- D. Regional Plan Activation: In general, the plan is activated once existing casualty capacity (75 casualties) is exceeded as outlined in Attachment 5: Surge Capacity. The plan may be activated by a hospital facility, county emergency operation center or by the Waccamaw Public Health District.
- E. Critical Elements of Information: Attachment 4: Hospital Capability Inventory summarizes the capability by hospital. In addition on a regular basis, hospitals share information that provides regional authorities with the region's capacity to respond to any given event such as Attachment 4. This information includes:
- Region wide surge capacity (Attachment 5)
 - Surge bed capacity (Attachment 5)
 - Pharmaceutical surge availability
 - Staffing
 - Transportation/EMS
 - Significant and critical events.
- Attachment 5: Table 1 Mass Casualty Surge Capacity models casualty increments by existing resource and by surge resource. The worksheet conveys the types of surge resources that will be brought online as casualties mount.
- F. Requests:

- How are requests made? Requests are made through either county ESF 8 or the county emergency management coordinator.
 - What are the procedures for processing? Requests are processed through IRIS or SC EMD's Internet Routed Information System.
 - How are they monitored? Requests are monitored through IRIS.
- G. Communications: Telephone, land line and cell are the primary communications methods. During a planned response (hurricane) HAM operators deploy to facilities and serve as a backup alternative. An 800 MHz radio system is used but depends on coordination among the various towers and the jurisdictions they serve. Horry and Georgetown counties each have their tower, some municipalities have a local system and state agencies use the Palmetto 800 System. Hospitals are currently limited in this capability to tap these systems but plans are developing to address these limitations. Attachment 10 conveys an 800 MHz operations concept.
- H. Crime scene preservation of evidence: Special teams and crime scene investigators have been trained on preservation for most WMD events including biological.

Preservation of biological event evidence begins immediately once a first responder is suspicious. Law enforcement is immediately informed and chain of custody procedures implemented for all evidence. Biological samples require six hours for confirmation once received by the Bureau of Labs in Columbia.

- I. Public Information: The jurisdiction in which the event has occurred will assume lead duties with support from other PIOs whose jurisdiction, facility or department has been affected. Each hospital has a Public Information Officer on staff. In addition, PIOs are established in the Myrtle Beach PD and FD. The City of Myrtle Beach and Horry County have PIOs. Georgetown County and Williamsburg do not have full-time PIOs.

An Area Recovery Council has been established for the region's tourism industry staffed by area marketing organizations and the private sector. It coordinates tourism related messages on behalf of the industry in the event of disasters or other events that affects the economy.

- J. Patient Tracking: During the first phase of an emergency response, each hospital uses its internal emergency operations system to perform the following tasks.
1. Receive patients.
 2. Identify patients.
 3. Triage patients.
 4. Stabilize patients.
 5. Admit patients.

6. Transfer patients.
7. Transport patients.
8. Treat patients.
9. Isolate patients.
10. Quarantine patients.
11. Patient diversion.

Each county EMS unit uses a triage system for managing 500+ acutely ill patients in regards to triage, treatment and disposition during a bioterrorism, natural disaster or epidemic. In the event of 500+ acutely ill patients, the surge model calls for the staging of additional resources to include facilities, equipment and personnel to manage the patient surge, guided by Attachment 5: Surge Capacity Worksheet with facilities outlined in SOP "List of Neighborhood Help Centers & Acute Care Centers."

- K. Bed Expansion: The Region increases bed capacity, inpatient, outpatient and ambulatory using a number of methods in the event of a disaster. (See SOP "List of Neighborhood Help Centers & Acute Care Centers.")
1. Expand inpatient capacity: Each hospital initiates an evaluation of possible discharges from transfers to its facility to expand bed capacity. Hospital SOPs indicate the procedure for expanding inpatient capacity and includes adding cot capacity.
 2. Add inpatient capacity: Predetermined Acute Care Centers are setup as an inpatient facility to accept casualties.
 - a. Off-site fixed facilities
 - i. Wellness centers or related facilities
 - ii. Ambulatory surgery centers for outpatient care
 - b. Temporary facilities (Tents such as Expeditionary Medical Support or EMEDS)
 3. Neighborhood Help Centers: Alternate large capacity areas for outpatient locations.
- L. Regional laboratory capabilities: While hospital laboratories are limited in their capabilities to detect WMD agents, each works routinely with the DHEC Bureau of Labs and has established contact information. Hospital labs have some capability to rule out agents but are unable to isolate an agent. Hospital labs have no capability to detect chemical agents.
- M. Authorized Personnel Credentialing: Each hospital maintains an active list of personnel credentialed for their facility and a method for identifying and allowing access to the facility. Methods include employee files, picture identification and lists of authorized professional personnel and staff.

A plan will be developed that addresses protective procedures such as vaccinations, antibiotic prophylaxis, personal protective equipment (PPE)

and training/education regarding staff, and prevention and management of clinical personnel who fail to report to work during a disaster.

- N. Surge Capacity Credentialing: Hospitals maintain mutual aid agreements with out-of-state facilities and clinicians as required by JCAHO. Corporate based facilities such as the HCA Grand Strand Regional, can request assistance from facilities within the HCA structure.

A plan will be developed that addresses protective procedures such as vaccinations, antibiotic prophylaxis, personal protective equipment (PPE) and training/education regarding staff.

- O. Hospitals use a medical staff coordinator who identifies retired and volunteer medical personnel. Each hospital plan addresses identifying, credentialing, supervision, and rapid deployment of retired or volunteer (both solicited and unsolicited) health care professionals.

A plan will be developed that addresses protective procedures such as vaccinations, antibiotic prophylaxis, personal protective equipment (PPE) and training/education regarding staff.

1. Develop mutual aid agreements for out-of-state clinicians.
2. Establish plans to implement a database of credentialed health care staff.

- P. Security: Each hospital maintains security at its facility to meet its day-to-day security needs. A request for additional security is made through the unified medical command ESF 8 to the EOC's ESF 13 Law Enforcement Services Representative.

- Q. Surge Capacity & Staffing: The region will augment medical staff and personnel in three distinctive methods determined by casualty count, event type and longevity of the event.

1. Regional sharing of medical resources from area healthcare facility partners, ambulatory care facilities, community healthcare centers and healthcare providers.
2. Medical assets are requested by the county EOC activating the Regional Emergency Management Compact (S.C. code Ann. 25-9-420, Article V).
3. Once the Governor declares a state of emergency, DMAT (Disaster Medical Assistant Team) medical resources are requested from the National Defense Medical System.

- R. Surge Capacity & Regional Staffing: The regions capability to immediately deploy 50 or more extra personnel (EMS, etc.) from the area is outlined in the Waccamaw HRSA Hospital Region MOA.

- S. Mass decontamination is delegated to fire/rescue teams. Each hospital has written decontamination protocols and established limited decontamination capabilities to include decontamination of victims and clinicians, as well as the facility. These capabilities vary by facility but generally include both an enclosed decontamination capability and a portable capability. See Attachment 2: Decontamination Facilities

Due to geographic distance and resource limitations hospitals within the Region are limited in their ability to share decontamination equipment and would look to HAZMAT and COBRA teams to set up mass decontamination stations at the point of WMD agent release. See Attachment Hospital Decontamination Capabilities & Procedures.

- T. Mental Health: Describe how the Region will address issues concerning short and long-term mental health needs of patients and staff.
1. Does each hospital address Special Medical Needs?
 2. How are Cultural Needs met?
 - a. Language barriers.
 - b. Hard-of-hearing and deaf populations.
 3. Crisis-counseling teams are established at each hospital.

Plans are underway to identify and train regional based crisis counseling teams building on hospital-based teams. These teams are made up from professionals who serve with the Department of Mental Health, Department of Social Services, DHEC and related psychosocial professionals in both public and private service.

The local chapters of the American Red Cross work closely and support crisis-counseling teams with family support services.

- U. Resource lists and shortfalls: What resources does the Region have access to in order to accomplish the mission? Where are the resources (pharmaceuticals, cots, beds, etc.) and how do you get them? Known resource shortfalls are identified.

Region Resource Units

- Each hospital maintains a list of resources.
 - Hospitals maintain an inventory of beds
 - Hospitals use “Just in Time” pharmaceutical inventory
 - Hospitals use “Just in Time” medical supply inventory
- Cots: Horry County Red Cross has 250 cots(non-IV capability)
- Two counties have begun to train residents for the Citizens Emergency Response Teams (Horry and Georgetown).
- Horry County Fire/Rescue mass casualty trailer (50 patients)
- Horry County Decontamination trailer
- Horry County mass casualty support units
- Myrtle Beach Fire/Rescue mass casualty trailer (50 patients)

- Mobile Command Units

State Resource Units

- The Prepositioned Equipment Program (PEP) available by request through the SC Department of Homeland Security.

Region Resource Shortfalls

- The region does not have a cache of pharmaceuticals.
- The region does not have an adequate inventory of emergency transport vehicles.
- The region does not have a cache of cots to accommodate an event which creates surge capacity of 500 casualties.
- Inadequate number of medical providers to staff the operation of offsite facilities and neighborhood help centers.
- Inadequate number of public health workers to manage and staff multiple mass dispensing sites to vaccinate the region's 300,000 population within 10 days as recommended by CDC.
- Inadequate number of health care workers to manage an event that draws upon multi-use community assets (shelter and vaccination).
- Inadequate number of isolation beds to contain and treat a large infectious disease outbreak (smallpox, pandemic flu or plague).
- Inadequate hospital equipment and supplies to establish temporary inpatient facilities.
- Inadequate training for health care workers as well as other first responders to manage a mass casualty event.
- Inadequate public knowledge for community members experiencing a mass casualty event.
- Triage management systems are county based versus region-wide comprehensive system.
- Patient tracking is hospital by hospital versus a region-wide comprehensive, integrated system.

- V. Training: To prepare regional teams for a mass casualty event, information is communicated through the regional task force meetings.
1. Regional & State Agencies: Regional and in-state training information is shared among regional task force members.
 - a. Regional Hospital Training
 - b. SC Emergency Management Division
 - c. South Carolina Hospital Association
 - d. South Carolina Department of Health & Environ Control
 - e. USC School of Pubic Health, Center for Public Health Preparedness
 2. Federal Agencies: Advanced training opportunities include:
 - a. Department of Justice
 - b. Department of Homeland Security

- c. Office of Domestic Preparedness
 - d. Federal Emergency Management Agency
 - e. Center for Disease Control & Prevention
 - 3. First responder agencies, partner to this plan, have identified the following training needs for their particular personnel. Participation by partners in regional tabletop and functional exercises is equally essential to reinforce didactic information gained through training.
 - a. Incident Command and Unified Medical Command
 - b. Hospital Emergency Incident Command
 - c. Mass Casualty Response & Surge Capacity
 - d. Decontamination Principles & Techniques
 - e. "Battlefield" Triage in Mass Casualty Events
 - f. Medical management of biological, chemical & radiological events
 - g. Forensic Epidemiology
 - h. 800 MHz Radio Operations
 - i. Strategic National Stockpile Training
 - j. Tabletop and functional exercises
 - A. Multi-disciplinary
 - B. Multi-jurisdictional
 - C. Across county jurisdictions
 - D. Across state jurisdictions
- W. Plan Maintenance: Regional plans are reviewed and updated annually by participating task force members. The annual revision cycle is listed below.
 - Oct 01 – Hospitals conduct internal review.
 - Nov 01 – Updates to plan sent to DHEC.
 - Dec 01 – DHEC updates plan changes.
 - Jan 01 – Task force reviews revised plan.
 - Jan 15 – Changes finalized.
- X. Continuous operations: Each hospital operates under its internal operating procedures and shares in the regional unified medical command in a mass casualty event. Problems that relate to the ability to provide continued care, treatment, staff shortages, inadequate medical supplies or pharmaceuticals are addressed by the unified medical command ESF 8 in cooperation with the respective county EOC.
- Z. Regional Plan Deactivation: To be developed.

V. HRSA REGION ACTIONS

Waccamaw HRSA Hospital Region supports ESF 8 with four specific emergency operations to include Preparedness, Response, Recovery and Mitigation.

A. Preparedness

1. General.
 - a. Develop mutual support relationships with county emergency preparedness divisions, volunteer organizations, healthcare providers and other private services and professional associations that may assist during an emergency or disaster.
 - b. Participate in state and local exercises. Conduct annually, a mass casualty exercise to validate annex and support SOPs.
2. Medical Care.
 - a. Coordinate the provision of emergency and resident medical care.
 - b. Identify and coordinate the deployment of doctors, nurses, technicians and other medical personnel to disaster areas.
 - c. Maintain inventory lists of medical supplies, equipment, ambulance services, hospitals, clinics and first aid units.
 - d. Plan for establishment of staging areas for medical personnel, equipment, and supplies.
 - e. When emergency facilities are not available, plan for alternative emergency medical care centers to include acute care and ambulatory care.
 - f. Establish and maintain an infrastructure that can accommodate Disaster Medical Assistance Teams (DMAT).
 - g. Assist in the organization of a regional disaster medical capability, which can be deployed to a disaster area on short notice and provide emergency medical care in either a fixed facility or field environment.
 - h. Know protocols for requesting federal medical assistance teams and coordinate their support through DHEC EOC.

- i. Assure health care facilities (i.e. hospitals, nursing homes, youth and adult medical care facilities) develop patient reduction, evacuation, and relocation procedures.
 - j. Identify agencies, organizations, and individuals capable of providing support services or assistance including area Red Cross chapters, Salvation Army and ESF 6 organizations.
 - k. Develop plans to implement Strategic National Stockpile operations in the Waccamaw HRSA region.
3. Public Health and Sanitation
- a. Develop procedures to protect the public from communicable diseases and contamination of food, water, and drug supplies.
 - b. Develop procedures to monitor public health information.
 - c. Develop sanitation inspection procedures and protocols to control unsanitary conditions.
 - d. Develop procedures for inspection of individual water supplies.
 - e. Develop procedures for identification of disease, vector, and epidemic control.
 - f. Develop emergency immunization procedures.
 - g. Identify laboratory testing facilities.
4. Crisis-Counseling.
- a. Develop procedures for rapidly providing crisis counseling and mental health assistance to individuals and families, to include organizing and training crisis-counseling teams.
 - b. Develop support relationships with government agencies, professional associations, private services, and volunteer organizations to provide mental health assistance during disasters.
5. Deceased Identification and Mortuary Services.
- a. Develop plans for location, identification, removal and disposition of the deceased.
 - b. Establish a system for collecting and disseminating information regarding victims and have the operational capability to deliver

the information in a field environment in coordination with the SEOC Public Information Group.

- c. Establish and maintain an infrastructure that can accommodate Disaster Mortuary Operational Readiness Teams (DMORT).
- d. Identify agencies, organizations, and individuals capable of providing support services for deceased identification including South Carolina Funeral Directors Disaster Committee and South Carolina Coroners Association. See Attachment 7.
- e. Maintain a description of capabilities and procedures for alert, assembly and deployment of state mortuary assistance assets.

B. Response

Members of the HRSA Hospital Region are alerted once the plan has been activated. Information on the extent, location and severity of the pending emergency or disaster damage is collected and members advised.

1. General

- a. Activate emergency operations plans
 1. Waccamaw HRSA Region Mass Casualty Response Plan
 2. Facility Emergency Operation Plans (or equivalent)
 3. Shelter Plans (if required)
 4. Special Medical Needs Shelter Plan (if required)
- b. Coordinate response efforts with county and state agencies as required.
- c. Maintain records of expenditures and resources used for possible post-event reimbursement.

2. Medical Care

- a. Coordinate staffing for off-site facilities that may include acute care centers, neighborhood help centers, vaccination clinics or shelters. Arrange for DMAT.
- b. Monitor, and assist where necessary, the coordination of patient evacuation and relocation.
- c. Arrange for the provision of medical personnel, equipment, pharmaceuticals and supplies.
- d. Implement Strategic National Stockpile operations.

- e. Coordinate and communicate ongoing operations with county emergency management, hospital facility command centers and DHEC EOC and, if necessary, the Waccamaw EQC Office.
3. Public Health and Sanitation
 - a. Manage public health and sanitation services outlined in Section V, A 3 above.
 - b. Identify need for disease surveillance throughout the Region.
 - c. Respond to reportable conditions, outbreaks, and urgent communicable disease conditions.
 - d. Respond to reports of animal bites, wastewater, food service, and general sanitation concerns.
 - e. Perform food service inspections, as needed, in disaster-impacted areas.
 - f. Provide technical assistance on the decontamination of individual water supplies.
 4. Crisis Counseling
 - a. Provide emergency counseling and assistance to patients, staff, and other community members as appropriate.
 - b. Coordinate for the provision of mental health and recovery services for individuals, families and communities.
 5. Deceased Identification and Mortuary Services.
 - a. Coordinate DMORT Services.
 - b. Coordinate next-of-kin notification.
 - c. Initiate the notification of deceased identification teams.
 - d. Retain victim identification records.

C. Recovery

1. General

- a. Anticipate and coordinate with federal officials (such as FEMA) establishment of a disaster field office.
- b. Maintain appropriate records of activities and costs incurred.
- c. Provide public health support in the event “tent cities” are erected after a disaster to provide shelter, food, water, basic medical care, and sanitation facilities.
- d. Prepare a District level After Action Disaster Report to be forwarded through the District Health Director to DHEC's Director of Emergency Management for appropriate distribution.

2. Medical Care

- a. Coordinate staffing of facilities to include shift changes and personnel changes.
- b. Assist, where necessary, with the re-introduction of patients to the area.
- c. Work to re-establish health department facilities and services as quickly as possible.
- d. Determine the status and provide assistance to home health patients.
- e. Determine types of health services assistance needed and coordinate local needs by requesting assistance from SC DHEC EOC. Each request includes:
 1. Type and scope of action completed;
 2. Manpower, resources, and expenditures committed;
 3. Number of casualties;
 4. Extent of damage to public health related facilities; and
 5. Additional assistance required during recovery.

3. Public Health and Sanitation

- a. Continue disease and environmental surveillance efforts.
- b. Respond to reports of disease.
- c. Respond to reports of animal bites, wastewater, food service, and general sanitation concerns.

- d. Assist EQC by reporting status of food service facilities in regards to public water and sewer capabilities. Issue official notices, closure notices, or other orders, as appropriate, to ensure protection of the public health.

4. Crisis Counseling

- a. Conduct critical incident-stress debriefings for responders.
- b. Participate in shelter discharge planning and reunification.
- c. Assist residents in the location of basic needs (shelter, food, clothing).

5. Deceased Identification and Mortuary Services.

- a. Continue operations necessary for identification and disposition of deceased and personal effects.
- b. Provide a final fatality report.
- c. Request reimbursement for expenditures.
- d. Receive required death reports.

D. Mitigation

1. Support, plan, and implement mitigation measures.
2. Support requests and directives resulting from the Governor and/or FEMA or SC DHEC concerning mitigation and/or re-development activities.
3. Document matters that may be needed for inclusion in agency or state/federal or local briefings, situation reports and action plans.

VI. RESPONSIBILITIES

A. Waccamaw Public Health District

Mission: Provide regional coordination and public health support services for the medical/public health response in a mass casualty event to include prophylaxis, vaccines, emergency health powers, environmental control, surveillance, detection and epidemiological investigation.

1. Notify all Waccamaw HRSA Region member agencies and supporting organizations upon activation.
2. Use District Public Health Staff to staff
 - a. SNS warehouse distribution and dispensing sites,
 - b. Neighborhood help centers,
 - c. special medical needs shelters and
 - d. community outreach or health assessment teams, as staffing permits.
3. Communicate with member agencies and support organizations to compile and exchange information concerning the extent of the disaster and the status of response operations. Provide such information through the Unified Medical Command to county and state EOCs as well as SC DHEC EOC.
4. Provide a county ESF-8 coordinator to the county emergency operations center upon request.
5. Through the Unified Medical Command, coordinate to ensure operational coordination in mass casualty disaster response support to local government.
6. Keep the public informed of available mass casualty assistance programs, in coordination with mass casualty support agencies and organizations by augmenting the county and state public information services.
7. Collect, compile, and maintain all essential information, generate reports and records concerning mass casualty disaster response.
8. Coordinate specific resource requests with the SC DHEC EOC.
 - a. Coordinate the request, receipt and distribution of the Strategic National Stockpile.
 - b. Coordinate the identification and assignment of out-of-state medical personnel.
 - c. Manage the increased tempo of disease surveillance and epidemiology team response.
 - d. Activate the SC Emergency Health Powers Acts.
9. Support county relief efforts through county ESF 8.

Crisis Management Phase:

10. Coordinate with National Disaster Medical System

11. Consult and advise on safety for re-entry into contaminated areas
12. Assure implementation of crisis counseling
13. Support mass care and sheltering.

B. HRSA Region Hospitals

Mission: Provide emergency and definitive medical care, isolate patients, dispense medications, and vaccinate patients, provide acute care in a mass casualty event.

1. Notify HRSA Region member agencies and support organizations upon activation.
2. Provide limited hospital staff to support mass casualty operations i.e. temporary acute care centers until federal and other staffing assets are available.
3. Communicate with the Unified Medical Command and support organizations to compile and exchange information concerning the extent of the disaster and the status of response operations. Provide such information through the Unified Medical Command to county EOC.
4. Through the Unified Medical Command, coordinate to ensure operational coordination in mass casualty disaster response support to local entities.
5. Keep the public informed of available mass casualty assistance programs, in coordination with mass casualty support agencies and organizations by augmenting the county and state public information services.
6. Collect, compile, and maintain all essential information, generate reports and records concerning mass casualty disaster response.
7. Maintain a current all-hazards plan to include evacuation, out-of-state clinician credentialing, decontamination of both staff and patients, use of proper PPE, prophylaxis, patient tracking & triage system. Plans also address continued basic services if possible.
8. Maintain procedures for safe and appropriate disposal of medical waste in a mass casualty event.
9. Hospitals will participate in region and state surveys to assess training, equipment and other mass casualty resource needs.

C. Ambulatory Surgery Centers/Community Health Centers

Mission: Deliver outpatient care and treatment including minor surgery to victims in a mass casualty event.

1. Provide triage to victims of a mass casualty event.
2. Serve as an SNS dispensing clinic.
3. Treat ambulatory victims with non-critical care.

D. Emergency Management Authority

Mission: In a mass casualty incident, the county emergency management department hosts the county EOC and has overall responsibility for coordination of the county response logistics, deployment of assets during both crisis and consequence management phases.

1. Crisis Management

- k. Identify requirements of the incident.
- l. Activate the EOC to gather information about the incident, serve as a point of contact for affected departments and agencies, establish communications links, support deployment of appropriate state resources, and serve as the initial coordination point for state and federal activity until a joint information center is established onsite.
- m. Mobilize, deploy, and coordinate resources to the impacted area to assist in lifesaving and life protection efforts and coordinate additional support resources.
- n. If requested by law enforcement, notify the public of the threat as appropriate and advise the population at risk of the necessary protective actions to take.

2. Consequence Management

- a. The county EMD is the lead agency for consequence management.
- b. EMD has the responsibility for developing and maintaining communications links and issuing appropriate warnings to the public.
- c. The Emergency Alert System (EAS) will be activated upon the direction of the EMD Director.
- d. The EMD will alert appropriate local, state, and federal agencies involved in consequence management.
- e. EMD shall coordinate secured shelter activities if required.
- f. EMD will coordinate the recovery activities for county and state departments and agencies.
- g. EMD coordinates essential goods and services such as food, water, electricity, pharmaceuticals and shelter once surge capacity has extinguished available local resources. These resources may be for either patients and/or hospitals.

E. Fire/Rescue

Mission: Provide coordination for fire suppression services, hazardous materials management including on-site management and decontamination and search and rescue operations.

1. County Fire/Rescue designates an incident commander
2. In the event of a chemical, biological, radiological, nuclear, or hazardous materials incident, trained personnel take initial readings to determine the degree of the hazard and establish a hot zone.
3. Fire/Rescue provides medical attention within the outer perimeter.
4. Should a nuclear, biological or chemical (NBC) incident take place, trained personnel establish decontamination control in response to actual conditions.
 - a. Decontamination of individuals will be conducted prior to being removed from the affected area.
 - b. However, when this procedure is not possible, the person or persons will be taken to the decontamination area for decontamination.
5. Fire service responders at the scene of a potential or verified terrorist event should bear in mind they are involved in a crime scene. Further, they should be aware and prepared for the potential of secondary devices.

F. Emergency Medical Services

- Mission: EMS in cooperation with Fire Services is first on the scene and delivers initial triage, transports patients and augments hospital services.
- a. Responsibilities of County Fire/Rescue will include providing medical treatment to the injured, stabilizing the seriously injured, triage, and transporting victims to hospitals on a priority basis:
 - 1) Mobilization of NBC/Terrorism trained emergency medical squads, paramedic units, and medical personnel if available.
 - 2) Deploy and supplement specialized services, equipment, and supplies as necessary.
 - 3) Transport possibly infectious or contaminated patients to treatment areas as needed.
 - 4) Provide technical advice on patient care.
 - 5) Maintain procedures for safe and appropriate disposal of medical waste in a mass casualty event.
 - b. Emergency medical personnel will be dispatched at the request of the incident commander, but will remain in the outer perimeter until the area has been secured by law enforcement personnel.
 - c. In the event of a mass casualty incident, emergency medical personnel will set up a triage area in a suitable site close to the terrorist threat, but in a secure area that considers decontamination operations and the nature of the agent used.
 - d. Emergency medical personnel must determine whether casualties can be safely extracted or must be left (quarantined) pending arrival of appropriate assistance. If extracted, protocol will be followed for ensuring cross contamination of the medical facility does not occur.
 - e. Ambulances and/or any emergency vehicle that is contaminated during emergency operations will be removed from service and decontaminated/disinfected prior to reuse.
 - f. Emergency medical responders at the scene of a potential or verified terrorist event should bear in mind they are involved in a crime scene. Further, they should be aware and prepared for the potential of secondary devices and terrorists as patients.

G. Law Enforcement

Mission: Law enforcement ensures public safety and facilitates response and recovery activities, security and access control measures in and around the disaster site and provides threat assessment, criminal investigation, forensics and evidence processing.

a. The area will be quickly evaluated in terms of public health and safety to identify the need to implement protective actions, as well as use of protective equipment by response personnel entering the area to conduct life saving activities. Once it is suspected or determined that the incident may have been a result of terror, local law enforcement personnel begin operations to ensure the crime scene is preserved and safe for emergency responder operations.

1) The chief law enforcement officer will be responsible for the development of crisis management operations plans.

2) The chief law enforcement officer will be responsible for the security of sensitive consequence management operations plans (capabilities, sites, threats, staging areas, etc.).

b. Crisis Management

1) The chief law enforcement official for the jurisdiction will become the lead law enforcement official and incident commander.

2) The initial responsibility will be to secure the area by providing outer and inner perimeters.

3) Outer perimeter security

a) The incident commander will determine the size of the outer perimeter security team to match the needs of the situation to limit passage through the area.

b) The outer-perimeter team may be used to:

- Establish and maintain the area outside the perimeter of the incident scene
- Evacuate and seal off the incident scene
- Control access to the incident scene

- Guard critical and restricted areas outside the incident area
 - Augment on-site personnel.
- 4) Inner-perimeter security
 - a) The incident commander will determine the size of the inner perimeter team given the available resources and degree of control required by the situation for controlling the physical environment.
 - b) The inner perimeter team has the responsibility to:
 - Minimize the potential for loss of life
 - Maintain self-defense and self-protection
 - Gather and report intelligence.
 - 5) Once a terrorist or hostage situation is defined, law enforcement will respond in a timely manner to counter the incident with responding units being aware of the potential for terrorist use of “secondary devices.”
 - 6) Law enforcement will implement the necessary traffic control measures to facilitate evacuation and enhance site security measures following the event.
 - 7) The county EOC will be kept informed of the severity of the situation through establishment of communications, secure if available.
 - 8) Law enforcement shall implement measures required for evidence protection and to maintain scene integrity.

H. Department of Mental Health

Mission: Coordinates the delivery of crisis counseling services.

1. Provide mental health staff to support mass casualty operations i.e. crisis counseling response teams, mental health assessment and referral services for mass casualty victims and worried well.
2. Communicate with the member agencies and other supporting organizations to compile and exchange information concerning the extent of the disaster and the status of response operations.

3. Through the county ESF 6 Liaison, coordinate to ensure operational coordination in mass casualty disaster response support of mental health services to local entities.
4. Keep the public informed of available mental health mass casualty assistance programs, in coordination with mass casualty support agencies and organizations.
5. Collect, compile, and maintain all essential information, generate reports and records concerning mass casualty disaster response.

I. Volunteer Services: American Red Cross

Mission: Provide support for mass care operations that result from a disaster, epidemic or act of terrorism. Services may include sheltering, feeding, blood supplies, emergency welfare support or family assistance.

1. Support county relief efforts through ESF 6 (mass care) or ESF 14 (volunteer services) following a mass casualty incident.
2. Support the local response by opening emergency shelters, providing food, first aid, blood and blood products as necessitated by the event.
3. Collect, receive, and report information about the status of victims and assist with family reunification.
4. Responsible for the notification of the next-of-kin of the injured and deceased.
5. Provide first aid and other related medical support within capabilities at temporary treatment centers.
5. Provide food for emergency medical workers, volunteers, and patients, if requested.
6. Agencies assisting under ESF 6 or 14 may be required to provide after action reports, situational reports or other support documentation.

J. Volunteer Services: Salvation Army

Mission: Provide support for mass care operations that result from a disaster, epidemic or act of terrorism. Services may include warehouse support, feeding, or emergency welfare support

1. Support county relief efforts through ESF 6 (mass care) or ESF 14 (volunteer services) following a mass casualty incident.

2. Support local government warehouse operations, providing food and first aid, in their responsible areas.
3. Provide food for emergency medical workers, volunteers, and patients, if requested.
4. Agencies assisting under ESF 6 or 14 may be required to provide after action reports, situational reports or other support documentation.

K. Public Information

Mission: The mission of public information in a mass casualty event is to communicate with the public a calm, measured, and reasoned reaction by media and government. In the event mass casualties are caused by a terrorist act, public information limits the media exposure terrorists seek.

1. Media relations must be designed to identify terrorist activities as criminal acts, not justify public support and ensure that released information will not compromise counter-terrorism plans or operations. When so directed by the Incident Commander at the Incident Command Post, public notification will be released from the EOC.
2. News releases are compiled with information from other agencies and released to the media following final approval from the Director of Emergency Management or designee. To ensure rumor control, each County department or agency formulates its own news release and approved by the department/agency's senior official. Copies of news releases are provided to the lead Public Information Officer located in the county EOC. The following information is included in news releases:
 - a. Focus on specific event-related information.
 - b. When possible, report positive information concerning emergency response efforts.
 - c. Practice rumor control.
 - d. Highlight ongoing public information and education programs to increase awareness of hazards and proper response.
 - e. Depend on the cooperation of the commercial media for information and educational programs.
3. Agencies involved in the response will notify their respective media offices.

- a. The SC DHEC mobile communications center is requested to support media management operations.
- b. Local PIO's (hospital and jurisdictional) establish points of contact.

VII. ADMINISTRATION AND LOGISTICS

- A. General reporting requirements and statistics for each task force member agency will be maintained per individual agency policies and procedures. The data and information from member agencies will be compiled into a regional mass casualty SITREP for the region's Unified Medical Command. A shift journal is maintained by each shift leader to brief incoming shift leaders on important actions or pending matters for the next shift.
- B. Provisions for meals are arranged for HEICS staff by the individual responding agencies. Staff supporting any temporary acute care centers or neighborhood emergency help centers will obtain meals coordinated through the Waccamaw Unified Medical Command. Normally, meals consist of breakfast, lunch, dinner and an after-midnight meal.
- C. Transportation to and from any mass casualty response locals will be a personal responsibility.
- D. Shifts will normally be from 0800 to 2000 hours and 2000 to 0800 hours. These shift schedules may be modified by the unified medical command as necessary.
- E. All mass casualty response personnel will carry an official identification badge with photo ID for authority to access restricted areas.
- F. Policies on resource management and financial record keeping are maintained by each UMC member agency.

Supporting Attachments

ATTACHMENT 1: Authorities & References

Authorities

1. State of South Carolina Department of Health and Environmental Control Emergency Order Dated August 13, 1996. Amended September 19, 1996.
2. South Carolina Emergency Operations Plan.
3. Legal authorities (SC Code of Laws and Regulations, Executive Orders).
4. Emergency Health Powers Act.

References

1. Waccamaw District Emergency Operations Plan, January 2004
2. Guide to Emergency Management Planning and Health Care. Joint Commission Resources, Inc. (www.jcrinc.com)
3. HEICS – The Hospital Emergency Incident Command System. San Mateo County Department of Health Services Emergency Medical Services Agency. June 1998. (www.emsa.cahwnet.gov/dms2/heics3.htm)
4. Bioterrorism Hospital Preparedness Program Cooperative Agreement. Health Resources and Services Administration (HRSA). U.S. Department of Health and Human Services.
5. Mass Casualty Disaster Plan Checklist: A Template for Healthcare Facilities. Assn for Professionals in Infection Control and Epidemiology (APIC) (www.apic.org/bioterror/checklist.doc)
6. Hospital Preparedness for Mass Casualties Final Report August 2000 – Summary of an Invitational Forum Convened on March 8-9, 2000. American Hospital Association.
7. Preparing for Terrorism – Tools for Evaluating the Metropolitan Medical Response System Program. Institute of Medicine.
8. Hospital Bioterrorism Preparedness Program – Regional Hospital Plan. Washington State Department of Health Public Health and Hospital Preparedness and Emergency Management Plan Standards.
9. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Emergency Management Plan Standards.
10. Chemical and Bioterrorism Preparedness Checklist. American Hospital Association.
11. State of South Carolina Department of Health and Environmental Control Emergency Order Dated August 13, 1996. Amended September 19, 1996.
12. South Carolina Emergency Operations Plan, March 2004.
13. Conway Medical Center: Emergency Preparedness Management, Sep, 2002
14. Grand Strand Regional Medical Center: All Hazards Procedures, Sep 1999
15. Georgetown Hospital System: Bioterrorism Response Plan, February 2002
16. Loris Healthcare System: Bioterrorism Response Plan, June 2004
17. Williamsburg Regional Hospital: Bioterrorism Response Plan, TBP
18. Horry County Terrorism Incident Response Plan published by the emergency management department, April 2004
19. *A Mass Casualty Care Strategy for Biological Terrorism Incidents: Acute Care Center*, prepared in response to the Nunn-Lugar-Domenici Domestic preparedness Program by the Department of Defense, December 1, 2001.
20. *Concept of Operations for the Acute Care Center*, prepared in response to the Nunn-Lugar-Domenici Domestic preparedness Program by the Department of Defense, December 1, 2001
21. *A Mass Casualty Care Strategy for Biological Terrorism Incidents: Neighborhood Emergency Help Center*, prepared in response to the Nunn-Lugar-Domenici Domestic Preparedness Program by the Department of Defense, May 1, 2001.
22. *Expanding Local Healthcare Structure in a Mass Casualty Terrorism Incident: Modular Emergency Medical System*, prepared in response to the Nunn-Lugar-Domenici Domestic preparedness Program by the Department of Defense, January 1, 2002.
23. *A Mass Casualty Care Strategy for Biological Terrorism Incidents: Community Outreach & Mass Prophylaxis*, prepared in response to the Nunn-Lugar-Domenici Domestic preparedness Program by the Department of Defense, June 1, 2002.
24. *Guide on the special needs of people with disabilities for emergency managers, planners and responders* published by the National Organization on Disability, 2002.

ATTACHMENT 2: Decontamination Facilities

Attachment 2 references the decontamination facilities and capabilities of each hospital in the region. Annex 4: Attachment 2 of the Horry County EOP references the equipment capabilities for county fire/rescue squads.

Conway Medical Center (CMC)

The plan for CMC is a two-stage system to include a portable pool unit and its dedicated fixed shower facility located off the emergency room entrance on the east side of the hospital.

Fixed: CMC has a dedicated fixed-base decontamination room equipped with an over-head shower and eyewash capability with an external entrance. The room has a drain that leads to a 1,000 gallon storage tank and ventilates directly to the outside. Medical air is piped into the room and permits emergency workers to wear supplied air respirators (Level B) while decontaminating patients.

Portable: Portable decontamination units are in place.

PPE: CMC has a dedicated storage trailer filled with Level B PPE, clothing for patients, 20 portable cots, chemical and biological detection devices.

Georgetown Memorial Hospital

GMH is equipped with a two-stage system to include a portable pool unit and fixed shower facility located off the emergency room entrance on the south side of the hospital.

Fixed: GMH has a decontaminated shower facility with dedicated entrance from the outside

Portable: A portable decontamination pool with decontamination equipment is staged in the area of the fixed shower facility and requires a fixed source of water for operation.

PPE: Decontamination facilities are equipped with multiple sizes of Level C PPE for staff members.

Loris Healthcare System

LHS is supported by Loris Community Hospital in Loris and by Seacoast Medical Care in North Myrtle Beach.

Fixed: LHS has a decontaminated shower facility with dedicated entrance from the outside

Portable: Portable decontamination units are in place.

PPE: Decontamination facilities are equipped with multiple sizes of Level A and Level B PPE for staff members.

Grand Strand Regional Medical Center

Fixed: GSRMC is equipped with one "fixed" decontamination room, built into the side of the Emergency Department, with its own water holding tank.

Portable: GSRMC has an exterior decontamination site outside the entrance to the Physical Therapy Corridor. The Y-shaped awning has PVC pipe running along it, with hooks installed to serve as tarp hangers. The Y-shape allows for the separation of genders, as they can enter, undress, shower and don disposable clothing before entering the enclosure that leads to the PT Corridor.

The Hospital has a portable water heater to warm the outside tap water, which will be used for the showers. Complete patient kits, tarps, showerheads, and bathing supplies are maintained nearby in plastic barrels. There is no water drain-off catching capability in this design, which would be utilized if more than 5 or 6 people needed to be decontaminated.

PPE: Decontamination areas are supplied with multiple sized, Level C Personal Protective Equipment for staff members.

South Strand Ambulatory Care Center

Fixed: SSACC has one "fixed" decontamination room, built into the side of the Emergency Department, with a water holding tank.

PORTABLE:

PPE:

ATTACHMENT 3: Regional Activation Checklist**Date/Time****Completed Action**

- _____ 1. Activate and notify Waccamaw Regional Mass Casualty Response Personnel.
- _____ 2. Activate emergency plans to include this Waccamaw Regional Mass Casualty Response Plan.
- _____ 3. Activate Memorandums of Understanding (MOU), Memorandums of Agreements (MOA), and vendor contracts.
- _____ 4. Notify support staff in Region.
- _____ 5. Report to designated places at designated times.
- _____ 6. Report arrival of support staff to Lead Hospital Liaison.
- _____ 7. Report activation of hospital command center to county EOC. Establish radio frequencies availability to communicate.
- _____ 8. Maintain personnel/staff work hours for reporting and later reimbursement purposes.
- _____ 9. Ensure adequate staffing for 24-hour coverage. Confirm names and hours of liaison staff.
- _____ 10. Establish and maintain contact with each hospital through county ESF 8. Establish radio frequencies availability to communicate.
- _____ 11. Establish radio frequencies availability to communicate.
- _____ 12. Establish and maintain contact with local warning point/911.
- _____ 13. Establish and maintain contact with local healthcare providers.
- _____ 14. Establish and maintain contact with EMS. Establish radio frequencies availability to communicate.
- _____ 15. Establish and maintain contact with DHEC through county ESF 8 or through the Epi 24/7 beeper.

REGIONAL ACTIVATION CHECKLIST**Date/Time****Completed Action**

- _____ 16. Healthcare facilities notify County Emergency Management of requests for the following special teams and resources:
- Transportation Services (School Buses)
 - Local Decontamination Units (Fire)
 - Local Law Enforcement (Security and Traffic Management)
 - Local EMS
 - Local Rescue Squads
 - Other services, supplies and equipment as needed
- _____ 17. Inventory hospital resources and determine needs. Prepare requests for resources where shortfalls are identified.
- _____ 18. Inventory pharmaceuticals and medical supplies. Consider need for the Strategic National Stockpile (SNS). Prepare request accordingly.
- _____ 19. Activate crisis counseling teams for both first responders, victims and victim families.

REGIONAL ACTIVATION CHECKLIST**Date/Time****Completed Action**

- _____ 21. If needed, activate hospital decontamination procedures and set up equipment.
- _____ 22. Activate contracts for infectious medical waste disposal. Prepare for infectious medical waste disposal that exceeds the capability of the contractors by contacting CDC for disposal guidelines, procedures, and/or support.
- _____ 23. Prepare for and activate procedures for possible decontamination of service animals.
- _____ 24. Prepare for animal support services. Possible need for animal medical care, feeding, sheltering and/or transportation to sheltering may occur. Prepare requests accordingly.
- _____ 25. Prepare for and activate procedures for possible need of refrigerated trucks that would serve as temporary morgues.
- _____ 26. Prepare for and activate procedures for possible hospital lock-down to monitor all entering and exiting of the hospital facility by security.
- _____ 27. Coordinate with and provide information to county coroners and other officials involved with handling of mass fatalities.
- _____ 28. Establish filing system (may include, but not limited to, status reports, situation reports, briefing papers, assignments/mission tasking, telephone rosters, daily reports, etc).
- _____ 29. Implement tracking system to track patients in the event hospitals near or exceed capacity.
- _____ 30. Activate Chain of Custody system for preservation of evidence.
- _____ 31. Begin gathering information and provide an initial report to County EOC and/or SC EOC ESF 8.

ATTACHMENT 4: Hospital Capability Inventory
 (A Summary of the HRSA Region Hospital emergency capabilities)

		Hospital Facility						Ambulatory	
		GMH	WCH	CMC	LHS	GSRMC	WRH	South Strand	Seacoast
General Information									
Decontamination Facility	Fixed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Portable	Yes			Yes	Yes	Yes		No
Total Beds (include ER)	841	142	83	160	105	249	78	14	10
Personal Protection Equipment by Level	Level A			0	2				
	B-Airfed				6				
	B-Canister			4 to 6	10				2
	Level C	20	16	20 to 30	6-PAPR	4		2	2-PAPR
Isolation Rooms	84	14	10	29	8	17	4	1	1
HAZMAT Team		No	No	No	Yes	Developing	Developing	Developing	Yes
CAT Scan		Night Call	Night Call	Yes	Yes	Yes	Yes	Yes	Yes
MRI		Night Call	Night Call	Night Call	Yes	Night Call	No	Daytime	
Cardiac Cath Lab		Night Call	No	Night Call		Night Call		No	
Emergency Room Information									
ER Bed Capacity	119	20	12	20	9	28	6	14	10
Stretcher Capability	117	20	12	20	12	30	4	4	15
Ambulatory Capability	94	30	2	10	9	20	3	10	10
Major Trauma	22	5	2	2		8	3	2	
Ventilators	49	11	4	14	6	12	1		1
Isolation Room (Psych only)		No	No	2	0	1	0	1	0
Emergency Room Staffing (per shift)									
Nurses		4(5 11a-11p)	3(5 11a-11p)	6	4	7	3	3	4
Doctors		1(1 noon-8 p)	2	2	1	3	1	1	1
Surge Capacity (activation of All Hazards Plan)									
Bed Capacity				20	?	50	100	None	
Equipment Capacity				3-5 days	3-5 days		3 days		3-5 days
Pharmaceuticals				3-5 days	3-5 days		3 days		3-5 days

Abbreviations:

- CMC: Conway Medical Center
- GMH: Georgetown Memorial Hospital
- GSRMC: Grand Strand Regional Medical Center
- LHS: Loris Healthcare System
- WCH: Waccamaw Community Hospital
- WRH: Williamsburg Regional Hospital
- Seacoast: Seacoast Ambulatory Surgery Center
- SouthStrand: South Strand Ambulatory Care Surgery Center

ATTACHMENT 5: Surge Capacity

Tables 1-4 reference the region’s surge capabilities to include facility types, bed capacity, negative pressure units and personal protective capabilities. Tables 2-3 summarize data from the 2005 HRSA Hospital Regional Sentinel Report.

Table 1 contrasts existing capacity to meet surge fulfillment requirements with the types of facilities required to meet an estimated casualty increment.

Table 1

Mass Casualty		Surge Capacity							Comment
Phase Tempo	Casualty "Trigger" Increment	Existing Capacity		Surge Fulfillment					
		Hospital Network	Transportation	Help Center Level I	Help Center Level II	Medical Personal	CTS	Acute Care Centers	
	75	X	X						Maximum casualty capacity
	150			X					Region wide response
	225				X	X	X	X	State/Federal Reponse
	300				X	X	X	X	
	500				X	X	X	X	
	1000				X	X	X	X	

Selected Data Sets from the HRSA Sentinel Report
Waccamaw HRSA Hospital Region
March 01, 2005

Table 2: Bed Surge Capacity

Surge Bed Type	Total	Surge Bed Capacity					
		CMC	GSRMC	GMH	LHS	WCH	WRH
Stretcher	108	30	30	20	12	12	4
Off-site Facility ¹	50	0	0	0	50	0	0
Other ²	43		18		25		
Total	201	30	48	20	87	12	4

¹ Off-site includes Wellness Center, converted extended care center or portable tents

² Other includes ambulatory care centers (Seacoast & South Strand)

Table 3: Negative Pressure Units¹

Location	Total Fixed	Total Port	Fixed						Portable/Temporary					
			CMC	GSRMC	GMH	LHS	WCH	WRH	CMC	GSRMC	GMH	LHS	WCH	WRH
ED	12	0	2	1	4	1	3	1			0		0	
Other	64	8	18	15	11	6	11	3	3	4	0		0	1
Total	76	8	20	16	15	7	14	4	3	4	0	0	0	1

¹ Fixed defined as self-contained room with HVAC and portable unit is equipment that converts room to negative pressure room.

Table 4: Personal Protective capabilities

PPE Type ¹	Total	PPE					
		CMC	GSRMC	GMH	LHS	WCH	WRH
Level A	2				2		
Level B - Airfed	37	29			8		
Level B - Canister	14		0	0	14	0	0
Level C - HAZMAT	86		0	34	32	20	0
Level C - Supplies	1150	250	400				500
Total Trained	105	29	0	34	21	21	0

¹ Level C is differentiated by *Level C - HAZMAT* versus *Level C - Supplies*. The latter indicates supplies on hand by the hospital. Level - HAZMAT incorporates trained personnel who can be fitted and ready to perform Level C HAZMAT duty.

ATTACHMENT 6: Unified Medical Command

Unified medical command is a procedure during incidents which allows medical facilities with functional responsibility to establish a common set of incident objectives and strategies, and a single Incident Action Plan.

The use of Unified Medical Command is a valuable tool to help ensure a coordinated multi-agency response. Unified Medical Command procedures assure facilities they do not lose their individual responsibility, authority and accountability.

Features of a Unified Medical Command Structure

- A single integrated incident organization
- A single planning process and Incident Action Plan
- Shared planning, logistical and finance/administration operations
- A coordinated process for resource requests.

Advantages of Unified Medical Command

- One set of objectives developed for the entire incident.
- A collective approach to developing strategies that achieve goals
- Information flow and coordination is improved between all jurisdictions and agencies involved in the incident.
- All agencies with responsibility for the incident have an understanding of one another's priorities and restrictions.
- No agency's authority or legal requirements will be compromised or neglected.
- Each agency is fully aware of the plans, actions and constraints of all others.
- The combined effort of all agencies is optimized as they perform their respective assignments under a single Incident Action Plan.
- Duplicative efforts are reduced or eliminated, thus reducing cost and chances for frustration and conflict.

ATTACHMENT 7: Deceased Identification Support Services

ATTACHMENT 8: Standard Operating Procedures

SOP: Hospital Facility Emergency Contacts

SOP: List of Neighborhood Help Centers & Acute Care Centers

SOP: Regional Point of Contact Roster

Hospital Point of Contact Roster

SOP: Mutual Aid Agreements

SOP: Memorandum of Agreements

ATTACHMENT 9: Regional Organization Structure

Participating healthcare facilities include:

Hospital	County
Conway Medical Center	Horry
Georgetown Memorial Hospital	Georgetown
Grand Strand Regional Medical Center	Horry
Loris Healthcare System	Horry
Waccamaw Community Hospital	Georgetown
Williamsburg Regional Medical Center	Williamsburg

Ambulatory Centers with Emergency Room Capabilities

South Strand Ambulatory Care Center	Horry
Seacoast medical Center	Horry

ATTACHMENT 10: 800 MHz Concept of Operations

800 MHz Systems by Hospital Application

Hospital System	800 MHz System Access Requirements (Zones)									
	TAC Channels		Statewide		Horry County		Georgetown		North Myrtle	Myrtle Beach
	International	South Carolina	Pal 800	SC DHEC	EMS	EMD	EMS	EMD		
Conway					X					
Grand Strand					X				X	X
G'town							X			
Loris	X	X	X	X	X				X	
Waccamaw					X		X			
Kingstree										

1. The X indicates that this hospital requires access to this jurisdiction's 800 MHz system.

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