

**Western Australia**

**Disaster  
Medical Response Teams  
Subplan**

April 2006

## Authorisation

The Western Australia External Disaster Site Subplan for Medical Response Teams has been developed as a supporting operational document to the individual hospital disaster plans and to Westplan-Health. These protocols detail procedures to manage a major incident involving multiple casualties and a response by hospitals to send a team of healthcare staff to assist emergency services at the incident site.

This document has been endorsed formally as the Standard Operating Procedure to be followed in the event of such an incident.

Separate documents to be read in conjunction with this document are:

- ◆ Individual hospital disaster plans
- ◆ Westplan Health - Emergency Management & Support Plan
- ◆ Metropolitan Areawide Business Continuity and Disaster Plan

Approved

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Dr Robyn Lawrence  
Chair  
External Disaster Site Sub Committee of the  
State Health Disaster Management Committee

Dated

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Dr Andrew Robertson  
Divisional Director  
Health Protection Group  
Department of Health

Dated

## **Foreword**

This WA Disaster Medical Response Team Subplan has been written following the review and updating of Westplan Health - Emergency Management and Support Plan. The Subplan outlines the Local, District (including Regional and Metropolitan) and State response required to ensure that the health emergency response is coordinated and local resources can be supplemented where necessary.

Activation of this Subplan will occur at a local level in response to any major incident beyond the *normal* capability of the individual health service to be able to manage the incident, and a response team from the local health care facility is required to attend the incident site. The Subplan is supplemented by local, district, regional and metropolitan level health disaster response plans. These plans all form part of a coordinated health disaster management response under the direction of the State Health Coordinator.

The Subplan highlights the responsibilities and obligations of local and district health services to provide for initial health response to victims of a major incident within their area. They include the overall arrangements to the health response in a major incident.

It is important for all health facilities to have plans in place to meet these challenges in recognition of the emergency management principles of prevention, preparedness, response and recovery.

**Dr Andrew Robertson**  
**Divisional Director**  
**Health Protection Group.**

**April 2006**



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<b>Department of Health</b>	
Director General	1
Divisional Director, Health Protection Group	1
State Health Emergency Operations Centre	1
Metropolitan Areawide Medical Coordinator	1
Metropolitan Business Continuity Coordinator	1
Metropolitan Emergency Coordination Centre	1
All Public Hospital Emergency Coordination Centres (however titled)	1
All Private Hospital Emergency Coordination Centres (however titled)	1
<b>Royal Flying Doctor Service</b>	
Chief Senior Policy Officer	1
Medical Director	1
<b>St John Ambulance Australia, WA Ambulance Service Inc</b>	
Ambulance Operations Centre	1

## Glossary of Terms

**Areawide Medical Coordinator** - Means that person designated by the State Health Coordinator, or their delegate, to be the Metropolitan Areawide Medical Coordinator for the purposes of coordinating the metropolitan health response in an emergency.

**Disaster** - An event, actual or imminent, which endangers or threatens to endanger life, property or the environment, and which is beyond the resources of a single organisation to manage or which requires the coordination of a number of significant emergency management activities.

**NOTE:** The terms "emergency" and "disaster" are used nationally and internationally to describe events which require special arrangements to manage the situation. "Emergencies" or "disasters" are characterised by the need to deal with the hazard and its impact on the community.

The term "emergency" is used on the understanding that it also includes any meaning of the word "disaster".

**Disaster Plans** - For the purposes of this document, disaster plans refer to plans developed by the nominated person responsible for maintaining up to date plans, which include actions to be taken in the event of a disaster. Every hospital and health service should have such a plan.

**District Health Coordinator** - Means that person designated by the State Health Coordinator, or their delegate, to be the District Health Coordinator of a designated regional health service in accordance with the operational circular distributed in April 2004, for the purposes of coordinating the regional health response in a burn emergency.

**Hospital** - In this Subplan, a Hospital is any health care facility within WA that provides health care services to the public.

**Hospital Health Coordinator** – Means that person designated by the Hospital Executive to be the Hospital Health Coordinator for the purposes of coordinating the hospital response in an emergency.

**Metropolitan Areawide Business Continuity and Disaster Plan** - Provides the operational framework, to manage and maintain critical business functions in the event of system failure(s) or a mass influx of patients due to an external incident or disaster.

**Medical Response Team** – In this Disaster Subplan, the Medical Response Team is the team that is dispatched from a hospital to the site of the disaster. This Medical Response Team is responsible for providing initial triage and resuscitation measures.

**State Health Coordinator** - The State Health Coordinator has the authority to command the coordinated use of all health resources within WA, for response to and recovery from, the impacts and effects of a major emergency or disaster situation. The State Health Coordinator is also responsible for obtaining Commonwealth assistance should it be required.

**State Health Disaster Management Committee** - A committee that may be convened by the State Health Coordinator, to assist in the provision of a coordinated health response to, and recovery from, the burn emergency. It is the operational arm of the Department of Health's disaster response and includes representation from the different health care providers whom would need to be involved in the response and recovery for the burn emergency.

**Support Organisation** - An organisation whose response in an emergency is either to restore essential services (e.g. Western Power, Water Corporation of WA, Main Roads WA etc) or to provide such support functions as welfare, transport, communications, engineering, etc.

## **PART ONE**

### **1.0 Introduction**

#### **1.1 Background**

Western Australia (WA) covers a large geographical area, some 3000km by 1800km, and has a population of approximately two million people, of which 1.4 million live in the metropolitan area. There is considerable on-shore mining, an extensive off-shore oil and gas industry, as well as extensive forests and farming areas throughout WA, all of which provide significant risk of injury. This provides unique challenges for the WA Department of Health because of the tyranny of distance.

This External Disaster Subplan details the hierarchy of command, control and coordination, and the steps that should be considered when major incidents or a disaster occurs. It is acknowledged that not all situations can have plans developed and that the management of any incident will be situation specific at the time it occurs. In the metropolitan area, a motor vehicle accident resulting in 4 patients with major trauma injuries would not be considered unmanageable. However, some rural or regional health facilities may experience difficulties in managing such an incident. This plan concentrates on the roles and responsibilities for any hospital staff who attend the site of an incident.

#### **1.2 Aim**

To provide a basis for managing hospital staff and casualties at the scene of a major incident prior to admission at an appropriate hospital.

#### **1.3 Scope**

This Subplan identifies the roles and responsibilities of the individual Hospital Health Coordinators, District Coordinators, Metropolitan Areawide Medical Coordinator and State Health Coordinator in the event of a major incident or disaster.

As a component of this Subplan, standard operating procedures should be established to provide an individual hospital response.

The individual Medical Response Team procedures will be utilised for any major incident or disaster, when a coordinated response is required by Medical Response Teams to attend the site to manage the casualties.

#### **1.4 Objectives**

The objectives of this External Disaster Site Subplan are to:-

- ◆ Describe the Department of Health's management structure when coordinating a major incident / disaster response.
- ◆ Provide the basis for the provision and coordination of a health emergency management response during a major incident / disaster.
- ◆ Provide guidelines for the operating of the protocols following its activation.

### **1.5 Basic Assumptions**

The following basic assumptions have been made in the development of this plan:

- ◆ All individual hospitals have external disaster plans.
- ◆ All individual hospitals are responsible for ensuring that their staff are familiar with these plans.
- ◆ In the event of a major incident the principles of the Westplan-Health, to ensure the greatest good for the greatest number and management graduates from local or district to state level as required, will apply.

### **1.6 Title**

The plan shall be titled the Western Australian Disaster Medical Response Team Subplan and shall be known as “Medical Response Team Subplan” or “The Subplan”.

### **1.7 Related Plans**

Related health plans, which may be activated to support this Subplan are:

- ◆ Westplan Health - Emergency Management & Support Plan
- ◆ Metropolitan Areawide Business Continuity and Disaster Plan.
- ◆ Regional / District Health Disaster Plans (however titled).
- ◆ Individual Hospital Disaster Plans.
- ◆ Overseas Mass Casualty Plan (OSMASCASPLAN).
- ◆ WA Burns Disaster Subplan
- ◆ WA Trauma Disaster Subplan.

### **1.8 Authority and Planning Responsibility**

The development, implementation and revision of these protocols are the responsibility of the External Disaster Site Sub Committee, in consultation with the State Health Disaster Management Committee. The implementation of this Subplan is the responsibility of the Disaster Preparedness and Management Unit, Department of Health.

## PART TWO

### 2.0 Operational Management

#### 2.1 Introduction

Emergency management requires a structure to coordinate all actions needed to deal with incidents or disasters. This section outlines the roles and responsibilities of those persons implementing the External Disaster Site Protocols.

A Medical Response Team will attend the site of a major incident / disaster, usually at the request of the WA Ambulance Service when they have:

- assessed the situation and require extra support to be able to manage the incident, or
- been notified of a declared emergency for example; an aircraft crash at the local airport.

Requests may also be made by:

- Pre arranged agreements with emergency service agencies,
- West Australian Police Service,
- Incident Manager during a declared Emergency,
- Metropolitan Areawide Medical Coordinator (normal process for metropolitan incidents),
- State Health Coordinator.

All incidents or disasters will, in the first instance, be managed by Medical Response Teams from:

- two individual hospitals on a roster system (see appendix 11) as directed by the Metropolitan Areawide Medical Coordinator, or
- in rural or remote areas, by a hospital nominated by the District Health Coordinator.

This is in accordance with the principle of gradual escalation from local to district to state level as required at the time.

Escalation of the response to the external site disaster may be required from other hospitals:

- ◆ where the number of casualties is deemed to be beyond the normal capabilities and responsibilities of the attending ambulance personnel and Medical Response Teams;
- ◆ in the development of a worsening situation;
- ◆ when it is necessary to coordinate resources across hospitals; or
- ◆ when Westplan-Health has been activated.

#### 2.2 Roles, Responsibilities and Authorities

##### 2.2.1 State Health Coordinator

The State Health Coordinator is the Director General, Department of Health. This responsibility has been formally delegated to the Divisional Director,

Health Protection Unit, who will take the role of the State Health Coordinator in a major event or disaster. He/she has the authority to command the coordinated use of all health resources within WA for response to, and recovery from, the impact and effects of a major emergency.

The responsibilities of the State Health Coordinator are to:

- ◆ Monitor the responses to a major emergency
- ◆ Chair and facilitate the activities of the State Health Disaster Management Committee.
- ◆ Represent the Department of Health at the State Emergency Management Committee (SEMC) and advise SEMC on health related issues.
- ◆ Act as a conduit for information between other agencies, departments and Department of Health staff and services.
- ◆ Direct the operations of the State health emergency operations centre during times of activation.

### 2.2.2 Metropolitan Areawide Medical Coordinator

The Metropolitan Areawide Medical Coordinator (AWMC) has an operational role and is responsible to the State Health Coordinator (SHC) and for the activation and management of the Metropolitan Areawide Business Continuity and Disaster Plan (MAWBCDP) as appropriate.

The responsibilities of the Metropolitan Areawide Medical Coordinator are:-

- ◆ Planning and coordinating the operational control of all resources required to resolve resource and equipment failures detailed in the MAWBCDP.
- ◆ Notifying the SHC of any activation of the MAWBCDP.
- ◆ Activating the MAWBCDP, if required.
- ◆ Deployment of Medical Response Teams from hospitals.
- ◆ Activating the Expert Advisers as appropriate.
- ◆ In consultation with the SHC determining when normal operations may be resumed and managing the recovery phase.
- ◆ Maintenance of operational coordination with backup supplied from the State level.
- ◆ Maintenance of the MAWBCDP.
- ◆ Assessment and collation of information provided by the Field Medical Commander and determine appropriate hospital destinations for particular categories of injured persons and mode of transport.
- ◆ Liaison with other hospitals to determine receipt and treatment capacity.
- ◆ Providing the Medical Commander (senior health representative at the disaster site) with current information on the various hospitals' capacity to receive and treat the transported injured.
- ◆ Direct the hospital receipt and treatment response.
- ◆ Providing regular update reports to the SHC.
- ◆ In the event of a major disaster, where Westplan Health is activated, the AWMC will act as the SHC's main medical adviser.

- ◆ Providing the medical overview at debriefing events.
- ◆ Liaison with the SHC and Expert Advisers.

### 2.2.3 District Health Coordinator (however titled)

The District Health Coordinator is an operational role and is responsible to the SHC.

The District Health Coordinator's responsibilities are to:-

- ◆ Notify the State Health Coordinator of any incident or disaster which is beyond the normal capabilities of the hospital and transfer services.
- ◆ Plan and coordinate the operational management of all resources required within the health region to provide an initial response to the disaster.
- ◆ Activate and manage the District Health Disaster Plans as appropriate, including the dispatch of a Medical Response Team to the site if required.
- ◆ Represent the health region on District Emergency Management Committee (DEMC).
- ◆ Ensure regular review and testing of District Emergency Management Plans.
- ◆ Liaise with the Local Hospital Health Coordinator.
- ◆ Notify the SHC of Emergency Management and/or Business Continuity Plan activation.
- ◆ Notify the Chief Executive Officer (CEO) of the Western Australian Country Health Services (WACHS).
- ◆ Monitor the need for external agency involvement/assistance.
- ◆ Provide regular updates to the SHC and the CEO of WACHS.
- ◆ Coordinate regional recovery needs as required.
- ◆ Arrange regional debriefing following stand-down.
- ◆ Ensure a suitably qualified, resourced and supported proxy for this role is in place during periods of absence.

### 2.2.4 Hospital Health Coordinator

The Hospital Health Coordinator is responsible to the District or Metropolitan Areawide Medical Coordinator for:

- ◆ Notifying the District or Metropolitan Areawide Medical Coordinator of any incident or disaster involving multiple patients beyond the normal capabilities of the hospital and transfer services.
- ◆ Activating the Hospital Disaster Plan as necessary, including the dispatch of a Medical Response Team to the site if necessary and resources available.
- ◆ Assuming overall command and control of the Hospitals' general resources and management of its responses.
- ◆ Determining when it is appropriate to return to normal operations within the hospital and managing the recovery phase.

- ◆ Representing the Hospital at Local Disaster Management meetings.
- ◆ The maintenance of the Hospital Disaster Plan.
- ◆ Other duties as directed.

## 2.3 Management Structure

### 2.3.1 Command, Control, Coordination and Communication

The Department of Health is the single agency responsible for coordination of the Statewide health emergency management response. These protocols will be activated by the State Health Coordinator who has overall responsibility for the control and coordination of the health emergency management response. The organisational structure is outlined at **APPENDIX 1 and 2**.

The State Health Coordinator is supported within the Department of Health by Duty Officers who provide a 24hr on-call service and are the first point of contact for queries in relation to emergencies and requests to activate this plan.

The State Health Coordinator is supported in the Metropolitan Area by the Areawide Medical Coordinator of the Metropolitan Areawide Business Continuity and Disaster Plan. The Areawide Medical Coordinator is responsible for the activation and coordination of the Metropolitan Areawide Business Continuity and Disaster Plan, which may involve deploying Medical Response Teams to the scene of a disaster and will involve coordination of the hospital beds for the receipt of casualties. Coordination of the beds will involve decanting current hospital inpatients in order to create surge capacity for the receipt of mass casualties in the Metropolitan area.

The State Health Coordinator is supported in the rural areas by the District Health Coordinators. The District Health Coordinators are responsible for activation and coordination of the Regional Health Services' Disaster Plans, which may involve deployment of medical teams to the scene of the disaster, receipt of casualties at the local hospital and providing information to the State Health Coordinator regarding patient transfer requirements. All contact details are in **APPENDIX 3**.

All hospitals and health services are responsible for maintaining their individual disaster plans and ensuring that they are congruent with the District or Metropolitan Plan, whichever is appropriate to their facility. Hospitals are also responsible for ensuring there is a contact person ie a Hospital Health Coordinator, available 24hrs per day should the State Health Coordinator, Metropolitan Areawide Medical Coordinator or a District Health Coordinator require their assistance.

### 2.3.2 State Health Emergency Operations Centre

The State Health Emergency Operations Centre is the focal point of decision making and communications for the Metropolitan Areawide Medical Coordinator and District Health Coordinators, between the State Health Coordinator, the Minister for Health and senior health officials, between the State Health Coordinator and external agencies, and between the State Health Coordinator and any interstate or international agencies or departments involved in the emergency.

The primary and alternate State Health Emergency Operations Centre are located as follows:-

Primary:- 3<sup>rd</sup> Floor C Block  
189 Royal Street,  
East Perth, WA. 6004

Secondary:- Grace Vaughan House  
Stubbs Terrace  
Shenton Park, WA. 6008.

### 2.3.3 State Health Disaster Management Committee

#### *Purpose*

The purpose of the committee is to assist the Department of Health in developing and managing its disaster preparedness and management function. The committee will also provide the State Health Executive Forum (SHEF) with high level advice on service and strategic planning issues and operational matters relating to human epidemic emergency management, disaster preparedness and disaster management.

#### *Accountability*

The Committee is accountable to the Executive Director Health System Support through the Divisional Director, Health Protection Group.

#### *Responsibilities*

The SHDMC shall;-

- ◆ Maintain, develop and test the State Health Emergency Management Support Plan (WESTPLAN HEALTH) and other related plans, as required.
- ◆ Oversee the maintenance, development and testing of the State Human Epidemic Plan (WESTPLAN – HUMAN EPIDEMIC) by the State Human Epidemic Subcommittee (HES).
- ◆ Provides advice to the Department on all aspects of human epidemic and disaster preparedness and management.

- ◆ The Committee liaises with Commonwealth health authorities as required (eg regarding quarantine issues).
- ◆ Provide stimulus and focus for resolution of health disaster and emergency management issues.
- ◆ Identify health service resources within the State available for use in the management of major emergencies and disasters.
- ◆ Develop and maintain a database of the health service resources available within the State.
- ◆ Make appropriate recommendations to the Manager, Disaster Preparedness and Management (MDPM) to improve the State's health disaster and emergency management preparedness.
- ◆ Provide advice and support to the Manager, Disaster Preparedness and Management (MDPM) on all aspects of health disaster management services with regard to major emergencies and disasters.
- ◆ Provide the Operational Disaster Management Committee of the Department of Health during significant emergencies and disasters.
- ◆ Review post operations/exercise reports of emergencies involving health emergency management services with a view to amending current arrangements and plans.
- ◆ Conduct an annual audit of the health services disaster preparedness.
- ◆ Provide a reference point for Interstate or International negotiations and liaison.

#### *Membership*

The Committee, as detailed in **APPENDIX 4** will consist of members appointed by the Chief Medical Officer on recommendation from the Director Disaster Preparedness and Management.

## **2.4 Activation Procedures**

The usual activation process for activation of medical response teams, will involve a request by the WA Ambulance Service for medical assistance to attend a major incident site. In the metropolitan area this request will go through the Metropolitan Areawide Medical Coordinator. In Rural and remote areas the request will be made to the local hospital. A Medical Response Team will attend the site of a major incident / disaster at the request of usually the Ambulance Service when they have:

Requests may also be made by:

- Pre arranged agreements with emergency service agencies
- West Australian Police Service
- Incident Manager during a declared Emergency
- Metropolitan Areawide Medical Coordinator or District Coordinator
- State Health Coordinator

The first notification of a major incident may be from the self presentation of patients or bystanders from the incident site to the nearest hospital. Notification must be made to the Metropolitan Areawide Medical Coordinator or District Health Coordinator in rural and remote areas. Medical response teams should not be sent to the incident site until approval has been obtained from the Metropolitan Areawide Medical Coordinator or District Health Coordinator in rural and remote areas.

All incidents or disasters will, in the first instance, be managed by a Response Team from one individual hospital as per the hospital disaster plans (however titled) or two teams from rostered hospitals in the metropolitan area.. This is in accordance with the principle of gradual escalation from local to district to state level as required at the time.

Escalation of response to the external site disaster may be required from other hospitals where:

- ◆ the number of casualties is deemed to be beyond the normal capabilities and responsibilities of the attending ambulance personnel and Medical Response Team.
- ◆ multiple incident sites are involved,
- ◆ In the development of a worsening situation,
- ◆ Replacement / relief of Response Teams at incident sites,
- ◆ When it is necessary to coordinate resources across hospitals, or
- ◆ When the State Westplan-Health is activated.

#### 2.4.1 Stages of Activation.

This subplan will normally be activated in stages. In an impact event, these stages may be condensed with stages being activated concurrently.

International Standards describe four colour codes to identify the various stages. These are:

Stage 1	Alert	Code White
Stage 2	Standby	Code Yellow
Stage 3	Response	Code Red
Stage 4	Stand down	Code Green

**It is important not to confuse these colour codes with the Australian Standards 4083-1997 which also identifies various hospital emergencies with colour codes, the international standards will not therefore be detailed in this Subplan.**

- a. Stage 1 – Alert . The alert stage, is activated when advice of an impending emergency is received or when, following the occurrence of an event, it is unclear as to whether a Medical Response Team is needed. During this stage, the situation is monitored to determine the likelihood and nature of the disaster response. The following actions are undertaken:

- ◆ Where the call has been made from a source other than Health, the Hospital Health Coordinator must be notified by the recipient of the notification call or their supervisor, who must then notify the Metropolitan Areawide Medical Coordinator or District Health Coordinator.
  - ◆ Where Health has formally been notified, the Hospital Health Coordinator will be contacted by the Metropolitan Areawide Medical Coordinator or District Health Coordinator
  - ◆ The Hospital Health Coordinator notifies appropriate staff within the facility.
- b. Stage 2 – Standby The standby stage, is activated when information received is sufficient to warrant preparatory activities in readiness for a response. Depending on the situation, the following actions may be undertaken:
- ◆ Meeting of the State Health Disaster Management Committee to consider the situation and determine strategy.
  - ◆ Additional information allowing participating organisations time to undertake response preparations is provided to the appropriate District and, or Metropolitan Areawide Medical Coordinator. Such preparations may include checking:
    - a) Medical team members availability,
    - b) Medical kits.
    - c) Transportation requirements.
    - d) Hospital bed availability, including consideration of patients who may be discharged.
    - e) Availability of additional staff for call up.
  - ◆ State Health Emergency Operations Centre is prepared for staffing.
  - ◆ Liaison officers from participating organisations are identified and assigned.
- c. Stage 3 – Response The response stage is activated when a health emergency management response is required and resources are deployed accordingly. Depending on the situation, the following actions may be undertaken:
- ◆ State Health Emergency Operations Centre is activated and staffed.
  - ◆ The appropriate District and Metropolitan Areawide Medical Coordinator(s) and support organisations are advised of the need to initiate a health response, which may involve the deployment of a Medical Response Team(s).
  - ◆ Metropolitan Emergency Coordination Centre is activated and staffed.

- ◆ Hospital inpatients are decanted to other healthcare facilities or discharged to continue care in the community in order to create beds for the casualties.
  - ◆ Resource requirements for management of the casualties are identified and obtained.
  - ◆ Medical response team/s are sent to the incident site.
- e. Stage 4 – Stand Down The stand down stage, is activated when an organisation’s response is no longer required and may include the following actions:
- ◆ Participating organisations are informed of “stand down” by the State Health Coordinator, Metropolitan Areawide Medical Coordinator or District Health Coordinator.
  - ◆ Facilities are stood down in accordance with relevant procedures for each organisation (Emergency Site personnel are withdrawn, additional staff called in are released from duty, etc).
  - ◆ Medical response teams return to their facility from the incident site.
  - ◆ Organisations are to advise the State Health Coordinator when stand down has been completed.
  - ◆ Arrangements for debriefings are advised.

#### 2.4.2 Debriefing

The State Health Coordinator will ensure the debriefing of all participating agencies within a reasonable time following stand down and will participate in any general debrief conducted by the Hazard Management Agency, if separate from Department of Health.

#### 2.4.3 Reports

The State Health Coordinator will arrange for the provision of a report relating to the disaster response to the State Health Disaster Management Committee, the Hazard Management Agency and the SEMC.

The report is to identify any problems or shortfalls relating to the provision of health emergency management support and any amendment that may be required to this External Disaster Site Subplan.

#### 2.4.4 Contact Details

A listing of key participants and their contact details are given at **APPENDIX 3**.

#### 2.4.5 State Coordination Procedures

The overall coordination of the WA Health emergency response to a major disaster will be through the activation of Westplan Health, which will be managed from the State Health Emergency Operations Centre. The Operations Centre will liaise with the hospitals via the Emergency Coordination Centre in the Perth Metropolitan Area and the District/Regional Health Coordinators in the rural and remote areas.

#### 2.4.6 Perth Metropolitan Area

The overall operational management, preparation and assessment of victims in a major emergency will be managed under the Metropolitan Areawide Business Continuity and Disaster Plan.

The overall medical response is coordinated from the Metropolitan Emergency Coordination Centre (MetroECC) situated in Royal Perth Hospital. The MetroECC is in immediate contact with the State Health Emergency Operations Centre and the external emergency site. The MetroECC will obtain details of numbers and types of casualties, and respond to any request for assistance from the site. The MetroECC coordinates all metropolitan hospitals and, depending on the types and numbers of casualties, will instruct the emergency site which hospitals specific casualties should be transported to.

In addition, the Metropolitan Areawide Business Continuity and Disaster Plan will be activated to provide assistance to the rural and remote areas if it is required. Assistance will be provided in the form of medical teams, equipment or receipt of casualties.

#### 2.4.7 Hospital Management

Hospital Management, from an emergency management context, relates to hospitals being prepared for the impact of emergencies. Hospitals are required to plan for internal and external emergencies on an individual basis. They are also required to ensure that their local plans integrate with the district or Metropolitan plan (whichever is relevant) in order that a cohesive response can be mounted should activation of these protocols be required. These plans should make provision for:

- ◆ Provision of Medical Response Teams to work at the emergency site.
- ◆ Act as a receiving hospital for casualties transferred from an emergency site.
- ◆ Receive patients transferred from other hospitals where bed space is required by the receiving hospital for the admission of multiple trauma cases.
- ◆ Act as a triage hospital in extreme mass casualty situations.

#### 2.4.8 Rural and Remote Areas

The overall operational management, preparation and assessment of victims in a major emergency will be managed under the District/Regional Health Disaster Plans (however titled). In the event that the level of management response required is beyond the capabilities of that District/Regional Health Disaster Plan, this and/or the State Trauma Response Plan will be activated to provide support to that district.

#### 2.4.9 Medical Response Team (Rural and Remote)

The local hospital should be able to provide a Medical Response Team, which is capable of providing initial resuscitation treatment to victims at the site of the disaster. The composition of the team will vary according to the hospital size, but may include 1 medical practitioner and 1 or 2 nurses. If the local hospital cannot provide a Medical Response Team, then the District Health Coordinator should be contacted to provide a Medical Response Team from within the Regional Health Service.

#### 2.4.10 Emergency Site Management

Emergency Site Management relates to the medical/health structure established at the site of an emergency and embraces the provision of triage, resuscitation, patient treatment and the loading and transportation of casualties. It is generally established when mass casualties have occurred.

This responsibility is generally undertaken, in the first instance, by St John Ambulance, WA Ambulance Service Inc. and/or the RFDS who are usually first on site. Depending on the magnitude of the emergency, they will be supplemented by a Medical Response Team(s) and a Medical Commander.

An overview of the emergency site management organisation and staff is given at **APPENDIX 5**.

#### 2.4.13 Patient Transport to the Perth Metropolitan Area

It is preferable to transfer patients to definitive care as quickly as possible to optimise the patient's outcome. Patients can be transferred in a number of ways:-

- ◆ The Royal Flying Doctor Service will transfer all critically ill patients to the Perth Hospitals via Jandakot airport.
- ◆ Helicopter
- ◆ Patients that are stable enough can be transported to Perth via commercial airline accompanied by health professionals.
- ◆ In the event of large numbers of patients requiring transport to Perth the State Health Coordinator may request the assistance of external agencies such as the Royal Australian Air Force via the SEMC and Emergency Management Australia to transfer the patients.

#### 2.4.14 Management and disposal of bodies.

The coroner should be informed of all deaths resulting from the disaster. The coroner will decide whether or not the death will be formally investigated.

When the victims have deceased at the scene of the disaster they should remain at the scene until such time as the police identification process is complete or if the police advise that they can be moved to a suitable storage facility.

Victims who die en route or at a health care facility should remain at the health facility until such time as the coroner and police advise otherwise. Depending on the number of fatalities and the storage capacity of the health service there may be a requirement for temporary morgue facilities to be utilised. If this should be required the police will assist with the organisation of the temporary morgue facilities and liaise with health staff accordingly.

#### 2.4.16 Health Assistance to or from Interstate or Overseas Agencies

##### Assistance from Commonwealth, Interstate and Overseas Agencies.

Where the Western Australian health emergency management services are unable to cope with the magnitude and nature of health services required, the State Health Coordinator may request, through the Executive Officer, SEMC, for Commonwealth, interstate or overseas assistance from Emergency Management Australia.

## **2.5 Communications**

The provision of communications for the Subplan is based on the use of the normal communication facilities required for the day-to-day activities of participating organisations. Supplementary communication facilities such as radios and a satellite phone will be distributed as appropriate to the Medical Response Team(s) to ensure that they can communicate with the emergency coordination centre, District Health Coordinator or Metropolitan Areawide Medical Coordinator.

The communication cascade from the site of the disaster will be as follows (see appendix 12 for a diagram):

- ◆ Medical Response Team shall communicate via the Medical Commander or most senior staff member at the site.
- ◆ The Medical Commander at the site shall communicate via the Metropolitan Areawide Medical Coordinator in the Metropolitan

Emergency Coordination Centre in the Metropolitan area and the Hospital Health Coordinator in the rural/remote area.

- ◆ The Areawide Medical Coordinator shall communicate with both the Hospital Health Coordinator and the State Health Coordinator.
- ◆ The Hospital Health Coordinator shall communicate with both the Areawide Medical Coordinator and the District Health Coordinator.
- ◆ In the Metropolitan area, the Transport Nurse shall also communicate with the Metropolitan Areawide Medical Coordinator with regards to patient distribution from the site to hospital.

For further information regarding the communication and organisational structure see **APPENDIX 1**.

## **2.6 Coordination**

### **2.6.1 Public Relations and Media Coordination**

Intense media and public interest can be anticipated following the impact of an emergency. The following actions will assist with the handling of the media and public inquiries.

Overall responsibility for the preparation of Department of Health media statements and coordination of media inquiries during an emergency event lies with the Manager, Public Affairs or nominated delegate. No health personnel are to make media statements without the approval of the State Health Coordinator and the Manager, Public Affairs, Department of Health.

The State Public Information Emergency Management Support Plan can provide additional media relations support for the health emergency management functions if required. The State Health Coordinator, with advice from the Manager Public Affairs, is responsible for determining if such assistance is needed.

### **2.6.2 National Registration and Inquiry System (NRIS)**

The National Registration and Inquiry Supplementary Plan establishes a system to enable details of victims of an emergency, including those admitted to hospitals, to be entered into the National Registration and Inquiry System (NRIS).

The State Health Coordinator will liaise with the State Welfare Coordinator to determine the status of the NRIS. When informed that the NRIS has been activated, the State Health Coordinator will advise the Areawide Medical Coordinator and District Health Coordinators who will inform the Health Care Units of the contact details. This will enable Health Care Units to refer callers to the NRIS system.

Health Service Units' emergency plans should incorporate procedures to register the details of persons presenting as a result of an emergency, whether they are injured or not, using the Health Service Unit's normal medical record documentation. From these records a listing of all such persons is to be forwarded to the State Health Emergency Coordination Centre by the most expedient/practical method available. This list is to include the following details:

Name of Health Service Unit

Full name of person

Address

Sex

Age or Date of Birth

In addition, local information regarding disaster victims shall be entered in the metropolitan public hospital's The Open Patient Administration System (TOPAS) disaster flag system.

### 2.6.3 Crisis Counselling

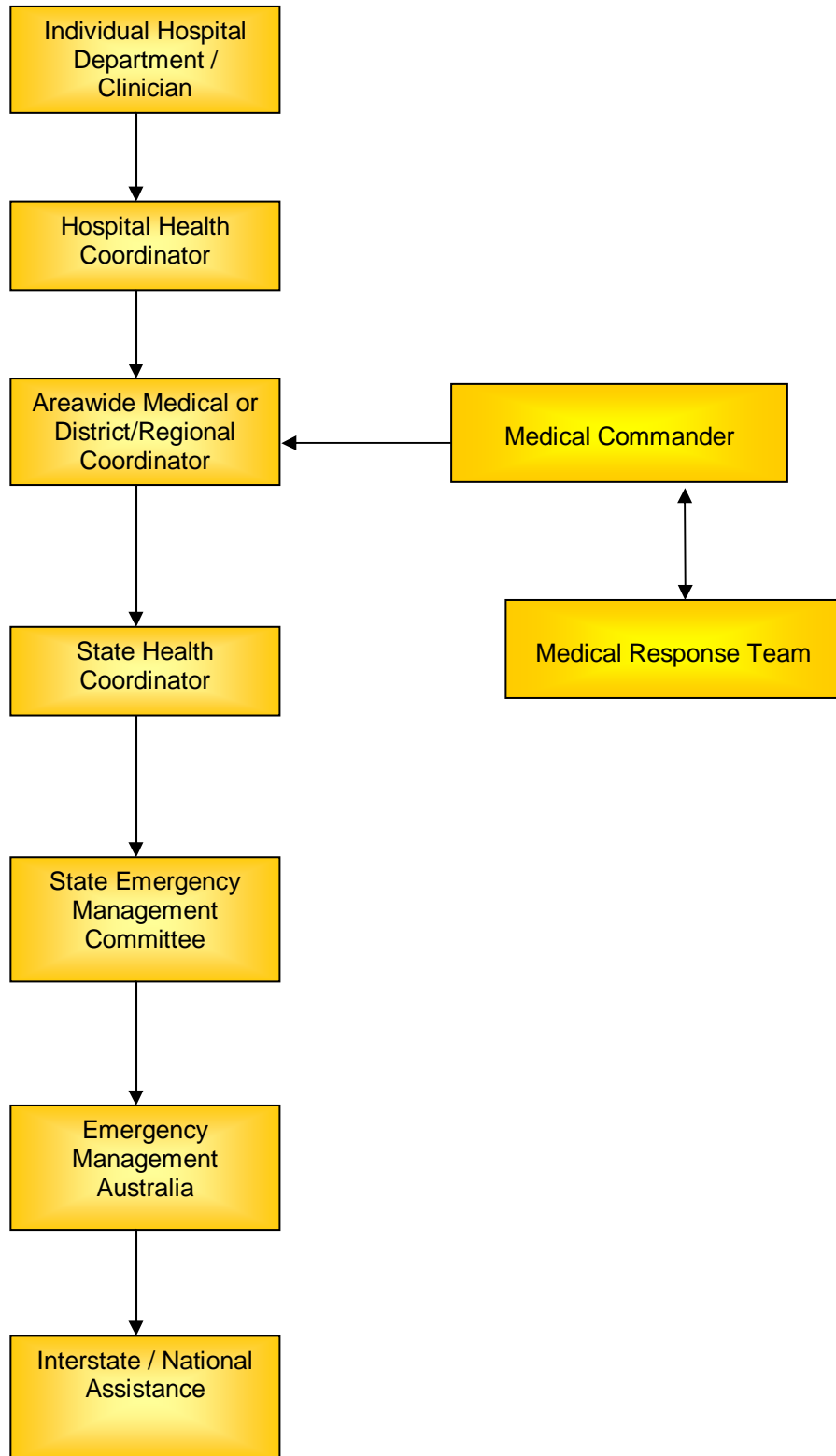
Mental health professionals provide acute assessment and intervention and may need to do so alongside emergency support agencies involved in the recovery process. Mental health responsibilities with respect to the emergency site may include provision of general support and comfort to disaster affected persons; provision of psychological first aid; providing information about normal responses to disaster; triage; screening for acute stress reactions; keeping adequate records of all persons seen and interventions conducted.

Specialist referral may be necessary in some instances and should be carried out supportively. Many people present to their local primary care provider in the post disaster period, therefore mental health services should provide information to general practitioners about mental health issues post disaster, as well as ensuring consultative processes are available.

The provision of post-disaster psychological support, counselling and welfare services is conducted by a number of services. Establishing cross linkages between fellow professionals who have emergency responsibilities ensures that appropriate physical and psychological resources are brought to bear in a timely fashion. Mental health services have a key role in this process.

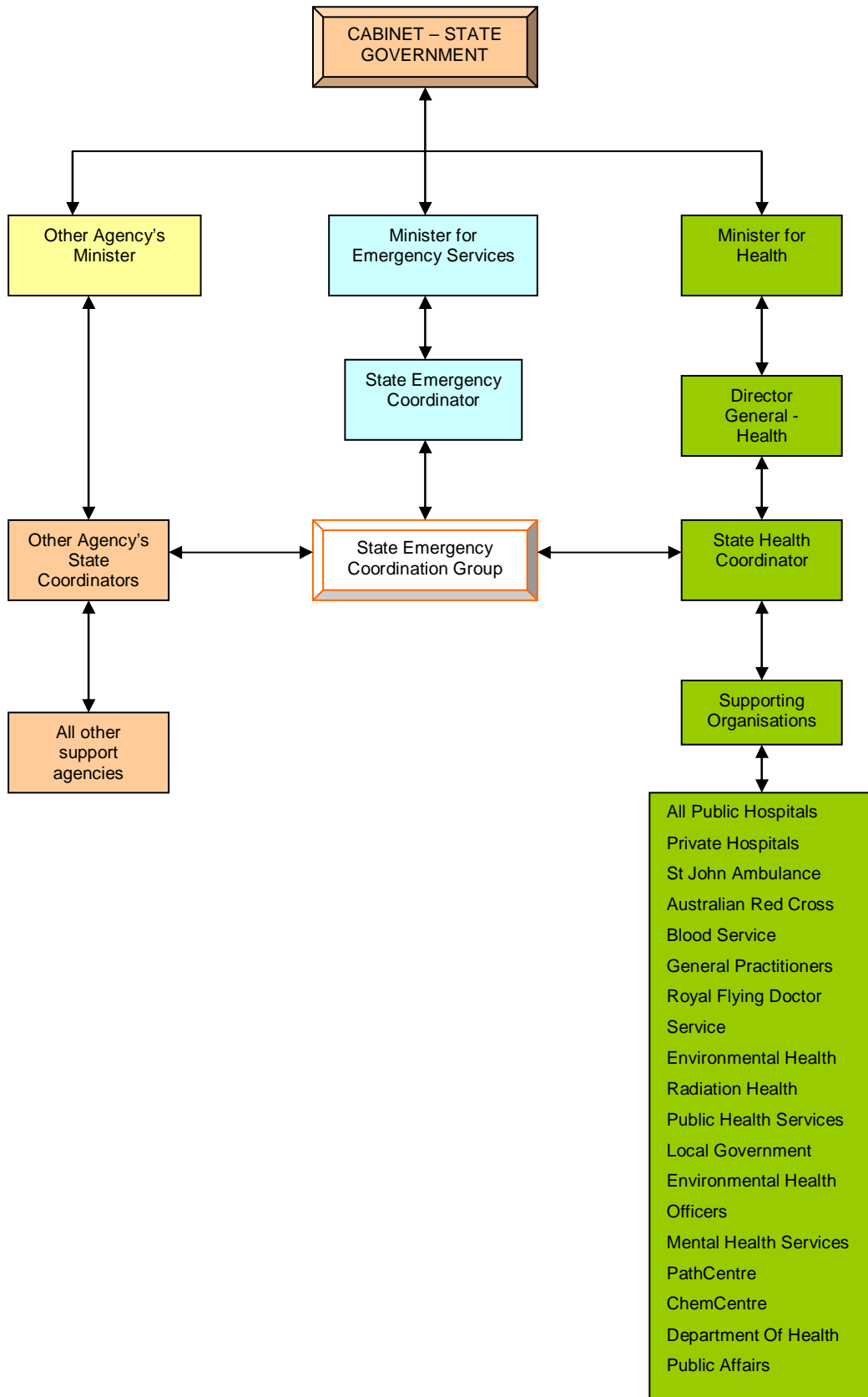
Appendix 1

Disaster Response – State Organisational Chart



Appendix 2

State Emergencies – Organisational Structure



## Appendix 3

## Contact Details

Name/Position	Location/Address	Telephone No
State Health Coordinator Dr Andrew Robertson	Department of Health	☎ 08 9328 0556
Metropolitan Areawide Medical Coordinator  Dr Robyn Lawrence Director of Clinical Services	Royal Perth Hospital 08 9224 2244	☎ 08 9224 2244 <b>Ask for the Medical Administrator on call</b>
<b>DISTRICT / REGIONAL COORDINATORS</b>		
Goldfields and SE Coastal Regional Health Service	Dr Charles Douglas (Temp)  Ms June Doyle	☎ 0427 470 806 / 08 9080 8200  0419 906 024 / 08 9080 5700
Great Southern Regional Health Service	Keith Symes Regional Director	☎ 08 9892 2675 / 0419 952 655
Kimberley Health Service	Ms Kay Attfield Regional Director  Dr John Keenan Director Medical Services  Mr Glen Bowers Risk Mgt Coordinator	☎ 0419 862 664  0407 779 200  0418 931 449
Midwest and Murchison Health Service	Shane Matthews Regional Director  After Hours Nurse Manager at Geraldton Regional Hospital	☎ 9956 2210  08 9956 2222 pager 245
Pilbara and Gascoyne Health Service	Patrick Mellberg Regional Director	☎ 0429 372 812
South West Health Service	Mr David Naughton Director Direct Care	☎ 1800 794 767
Wheatbelt Health Service	Mr Tim Shackelton Regional Director	☎ 0429 784 073
Royal Flying Doctor Service	Operations Centre 3 Eagle Drive Jandakot Airport JANDAKOT WA 6164	☎ 9414 1200 or 1800 625 800
St John Ambulance Australia, WA Ambulance Service.	Team Leader Operations Centre 209 Great Eastern Highway BELMONT WA 6104	☎ 9334 1222

## Appendix 4

### State Health Disaster Management Committee

The State Health Disaster Management Committee is comprised of representative members from the following organisations and departments.

<i>Member</i>
Divisional Director, Health Protection Group, as Chair
Director, Communicable Disease Control, DOH
Director, Office of Mental Health (or delegate), DOH
Director, Environmental Health (or delegate), DOH
Principal Medical Consultant, Health Protection Group, DOH
Deputy Executive Director, Sir Charles Gairdner Hospital
Executive Director Medical Services WCHS
Medical Director, Country Services
Medical Director, Royal Perth Hospital / Metropolitan Areawide Medical Coordinator
Medical Director, Fremantle Hospital / MIMMS training representative
Metropolitan Secondary Hospitals representative
PathWest representative
Public Health Laboratory Network representative
Australian College for Emergency Medicine representative
Clinical Toxicologist
St John Ambulance Australia (WA) representative
State Coordinator, WA General Practice Network
Royal Flying Doctor Service representative
Manager, Disaster Preparedness and Management
Senior Policy Officer, Disaster Preparedness and Management

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## Appendix 5

### Medical Response Team and Emergency Site Management

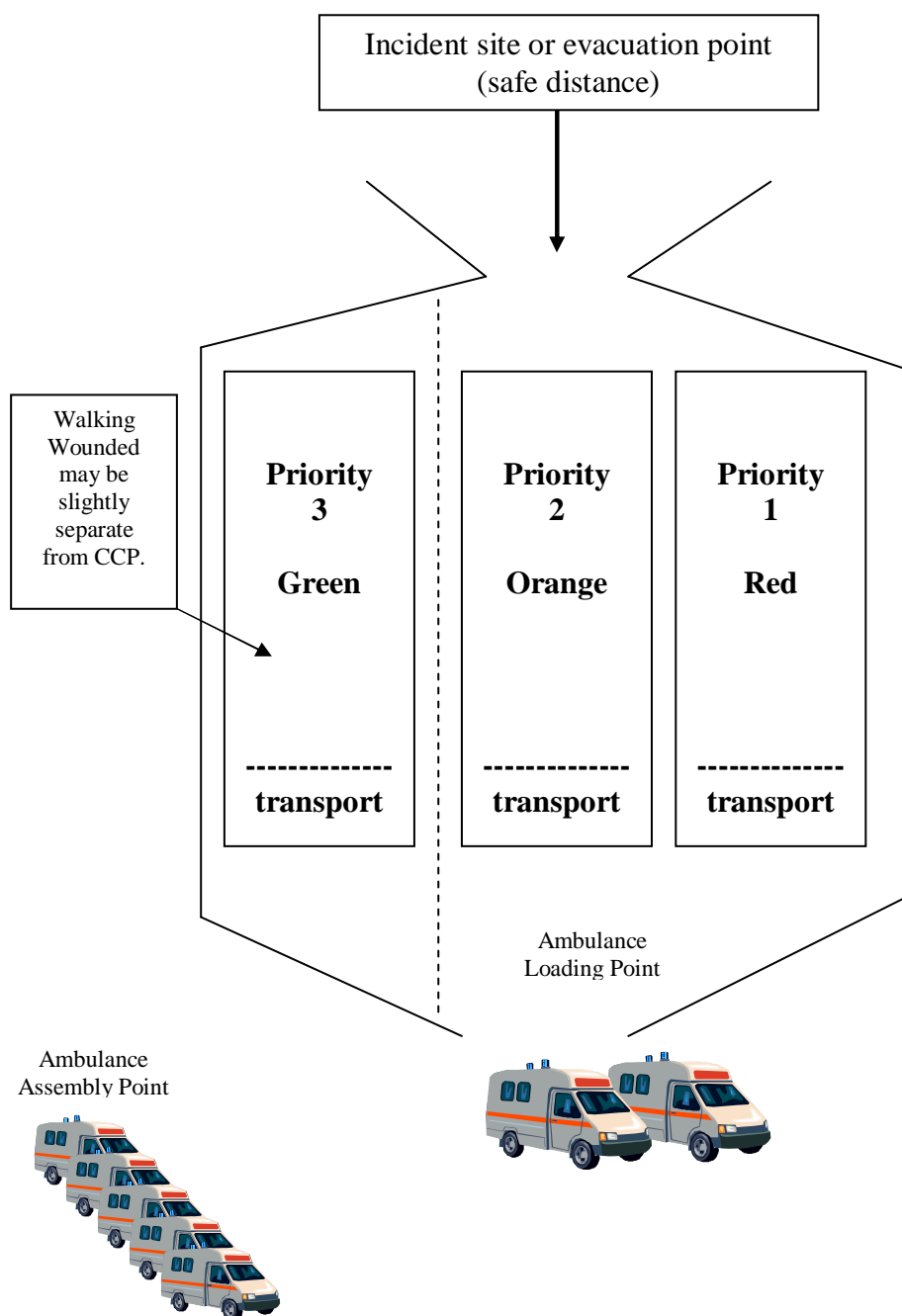
#### 1. INTRODUCTION

- a. Dependent upon the size of the emergency and geographic location, the availability of rapid medical response and the initial level of special services, may vary considerably.
- b. The following is a general description of the medical emergency management and site organisation for a mass casualty situation within the Perth Metropolitan Area. Outside the Perth Metropolitan Area, and especially in remote areas of the State, the response will be modified consistent with available medical resources.

#### 2. SITE ORGANISATION

The emergency site organisation is based on the following:

- a. **Forward Command Post** – the Hazard Management Agency for the emergency shall determine the safe location for the Forward Command Post at the emergency site. Both the Medical Commander and the Ambulance Commander are located within the Forward Command Post.
- b. **Primary Triage Area** - the area in which casualties are initially assembled and triaged. This facility may be in one of two locations:
  - (1) within the incident site; or
  - (2) if rescue services are extracting casualties from a hazardous area:
    - (a) as near as possible to the incident site to alleviate long distance stretcher carrying, and
    - (b) in an area safe for personnel to perform their duties.
- c. **Casualty Clearing Post** (CCP) – the area established for triage and treatment of casualties. The CCP should be:
  - (1) in an area safe from the effects of the event and upwind from the site.
  - (2) as near as possible to the Primary Triage Area to alleviate long distance stretcher carrying;
  - (3) large enough to accommodate the casualties and staff, with ease of access and egress, ideally in an area protected from the elements, sufficient lighting, and



Idealised Casualty Clearing Post Layout

- d. **Safe Holding Area** – the area established for the initial holding of non injured victims and those with minor injuries (*delayed patients*) pending registration and non ambulance evacuation from the site. The safe holding area should be:
- (1) within reasonable proximity but not immediately adjacent to the CCP,
  - (2) in an area safe from the effects of the event, and
  - (3) have easy access with good egress.

- e. **Ambulance Loading Point** – the area where patients are loaded and the patient identity and destination recorded, which should be:
  - (1) as near as possible to the CCP,
  - (2) large enough to accept more than one vehicle with easy access and egress, ideally with movement in one direction only, and
  - (3) located in a safe area, particularly in relation to other traffic.
  
- f. **Ambulance Assembly Point** – the area where vehicles are marshalled if the Ambulance Loading Point is unable to accommodate them and should be:
  - (1) as near as practicable to the Ambulance Loading Point, but not to cause traffic congestion,
  - (2) easily accessible with good egress,
  - (3) large enough to accommodate all responding ambulances, and
  - (4) in an area with proven communications with the Ambulance Loading Point.

### 3. **OFF-SITE ORGANISATION**

The off-site organisation is based on the following:

- a. **Ambulance Emergency Operation Centre** – located at the St John Ambulance, WA Ambulance Service Inc. facility at the State Office, Belmont.
- b. **Incident Coordination Group (ICG)** – the group of ambulance personnel located at St John Ambulance State Office, who are responsible for providing strategic support to the ambulance field operations.
- c. **Metropolitan Emergency Coordination Centre** – the Metropolitan Emergency Coordination Centre is located at Royal Perth Hospital from which the off site Hospital response for the Perth Metropolitan Area is coordinated by the Areawide Medical Coordinator.
- d. **State Health Emergency Operations Centre** – the Department of Health location from which the coordination of the overall State level health response takes place.

#### 4. SITE - KEY HEALTH PERSONNEL AND THEIR FUNCTIONS

The key personnel and their functions are as follows:

<b>ACTION CARD: MEDICAL COORDINATOR</b> (District or Metropolitan Areawide Medical Coordinator)	
<b>1. HOSPITAL</b>	METROPOLITAN EMERGENCY COORDINATION CENTRE – Royal Perth Hospital Regional or District Office or Hospital
<b>2. SITE</b>	Emergency Coordination Centre
<b>3. FUNCTION</b>	<ul style="list-style-type: none"> <li>• Liaise with other hospitals to determine receipt and treatment capabilities.</li> <li>• From information provided at the site through the Transport Co-ordinator, determine appropriate hospital destinations and the mode of transport [usually road ambulance] for individually numbered injured persons and the mode of transport.</li> <li>• Ensure that the receipt status at various hospitals is regularly provided to the Medical Commander.</li> <li>• Ensure that a log of patient movement is maintained at the Emergency Coordination Centre Post detailing: <ul style="list-style-type: none"> <li>i) movements from the CCP</li> <li>ii) to the receiving Hospitals.</li> </ul> </li> <li>• Respond to information requests initiated by the Incident Manager through the Medical Commander.</li> <li>• Regularly update and liaise with the State Health Coordinator and State Health Emergency Operations Centre to secure additional resources (beds, equipment, and other specialist medical needs).</li> </ul>
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Proceed to the Metropolitan Emergency Coordination Centre, Royal Perth Hospital or Regional/District Office/Hospital.</li> <li>• If necessary activate the Metropolitan Area Wide Business Continuity Plan to ensure resources are available for hospital system to respond to disaster</li> </ul>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>• Conduct debriefing and post incident analysis of medical activities</li> <li>• Assist the State Health Coordinator in the overall health post incident analysis</li> </ul>

<b>ACTION CARD: MEDICAL COMMANDER</b> (designated medical/nursing practitioner nominated by the District Health Coordinator or roster for metropolitan area)	
<b>1. HOSPITAL</b>	If able, meet medical team members in Emergency Department and don Personal Protective Equipment (PPE), Collect radio and mobile/satellite telephone. Otherwise, proceed to site.
<b>2. SITE</b>	<ul style="list-style-type: none"> <li>• Proceed to green flashing light and identify yourself to Senior Doctor / Senior Nurse.</li> <li>• Then proceed to the Forward Command Post and identify yourself to Incident Manager and Ambulance Commander</li> </ul>
<b>3. FUNCTION</b>	<ul style="list-style-type: none"> <li>• Liaise continuously with Ambulance Commander (at Forward Command Post)</li> <li>• Liaise with other liaison officers and Commanders – all agencies at the Forward Command Post.</li> <li>• Provide communication link between the SENIOR DOCTOR (at site) and the Medical Coordinator at the Emergency Coordination Centre, and agencies within the Forward Command Post.</li> <li>• Provide assistance and information to the SENIOR DOCTOR as required.</li> </ul>
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Co-ordinate the supply and re-supply of resources including staffing to the CCP.</li> <li>• Provide status reports to the Forward Incident Controller collated from information initiated from both the Senior Doctor at the CCP and the Metropolitan Areawide Medical Coordinator.</li> <li>• Liaise with Police Commander to determine where the temporary mortuary is to be established. Relay this information to the SENIOR DOCTOR.</li> </ul>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>• Ensure the welfare of medical teams on site.</li> <li>• Assist the Medical Coordinator – debriefing and post incident analysis.</li> <li>• ALWAYS be aware of own safety .</li> <li>• Note any problems for later debriefing.</li> <li>• Resources are limited, you are NOT in a hospital</li> <li>• Do the most for most.</li> <li>• Keep ALL property with patient.</li> </ul>

<b>ACTION CARD: SENIOR DOCTOR</b> (Most Senior Emergency Physician - as per roster for metropolitan area or as designated by Medical Coordinator/Commander)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department and provide briefing, don Personal Protective Equipment (PPE).
<b>2. SITE</b>	<p>i) Proceed to flashing green light and identify yourself to</p> <ul style="list-style-type: none"> <li>• Communications Officer,</li> <li>• SENIOR NURSE,</li> <li>• St. John Ambulance Casualty Clearing Officer (AMBULANCE CCO) and</li> <li>• Medical Commander.</li> </ul> <p>ii) Together with the AMBULANCE CCO and SENIOR NURSE , establish CCP “Guide for Allocation of staff within CCP” as a guide.</p> <p>iii) Allocate Medical Staff to area’s ( see allocation sheet).</p> <p>This task may be delegated to SENIOR NURSE.</p> <p>iv) Ask Medical Commander where the temporary mortuary has been positioned.</p>
<b>3. FUNCTION</b>	Together with the SENIOR NURSE and the Ambulance Casualty Clearing Officer (CCO), responsible for management and coordination of Casualty Clearing Post (CCP) and Medical Teams.
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Re-assign medical tasks within the CCP as necessary.</li> <li>• Determine the clinical interventions that may be inappropriate to use within the CCP due to limited resources, such as intubation or inter-costal catheters.</li> <li>• Manage any problems within the CCP, liaising with Medical Commander via Communications Officer.</li> <li>• Manage requests for medical assistance outside the CCP.</li> <li>• Liaise with Medical Commander to ensure 8 x State Emergency Service (SES) staff have been allocated to the CCP to be used as “stretcher bearers”</li> </ul>

<p><b>5. RESPONSIBILITY</b></p>	<ul style="list-style-type: none"> <li>• Responsible for the overall clinical care at the Casualty Clearing Post.</li> <li>• Responsible for the safety and welfare of clinical staff at the Casualty Clearing Post.</li> <li>• Is the final arbitrator to resolve any conflict at the CCP in respect to: <ul style="list-style-type: none"> <li>Treatments required</li> <li>Location of medical resources</li> </ul> </li> <li>• Ensures that regular updates are provided to the Medical Commander. <ul style="list-style-type: none"> <li>Ongoing situation at the CCP</li> <li>type, overall numbers and nature of injuries (obtained from Transport Nurse coordinator or SENIOR NURSE)</li> <li>details of medical evacuation requests</li> <li>Staffing and other resource requirements</li> </ul> </li> <li>• Liaises closely with the SENIOR NURSE and Ambulance Casualty Clearing Officer.</li> <li>• Ensure that safe working practice is maintained within the CCP.</li> <li>• Assist in the CCP staff debrief and the subsequent Post Incident Analysis.</li> <li>• ALWAYS be aware of own safety</li> <li>• Note any problems for later debriefing.</li> <li>• Resources are limited, you are NOT in a hospital</li> <li>• Do the most for the most.</li> <li>• Keep ALL property with patient</li> </ul>
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<b>ACTION CARD: SENIOR NURSE</b> (Most Senior Emergency Nurse as per rostering arrangement or as designated by Metropolitan Areawide Medical Coordinator/Commander)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department and provide briefing, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	1) Proceed to flashing green light and identify yourself to, <ul style="list-style-type: none"> <li>• SENIOR DOCTOR,</li> <li>• Communications Officer,</li> <li>• Ambulance Casualty Clearing Officer (Ambulance CCO) and</li> <li>• Medical Commander.</li> </ul> 2) Allocate Nursing Staff to area's ( see allocation sheet), May be asked by SENIOR DOCTOR to allocate medical staff
<b>3. FUNCTION</b>	Together with the SENIOR DOCTOR and AMBULANCE CCO, responsible for management and coordination of Casualty Clearing Post (CCP) and Medical Teams
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Coordinate the allocation of sequential numbering by triage personnel (including AMBULANCE staff) and allocate a letter to their numbering system (e.g. A, B, C, D)</li> <li>• Keep track of the number of "Casualty Logs" in circulation and collate the number of casualties triaged.</li> <li>• Re-assign nursing tasks within the CCP as necessary.</li> <li>• Manage any problems within the CCP, liaising with SENIOR DOCTOR.</li> <li>• Using the AMBULANCE CCO as a resource, manage requests for human and material resources within the CCP.</li> <li>• Check with SENIOR DOCTOR that stretcher-bearers have been requested.</li> </ul>
<b>5. RESPONSIBILITY</b>	<b><u>Within CCP</u></b> <ul style="list-style-type: none"> <li>• Is the final arbitrator to resolve any conflict at the CCP in respect to Triage Decisions</li> <li>• For overall Nursing care</li> <li>• Allocation of nursing resources.</li> <li>• Maintenance of staff log</li> <li>• Prioritisation of patient care</li> </ul>

	<ul style="list-style-type: none"><li>• Resource for difficult triage / clinical decisions.</li><li>• For safety and welfare of nursing staff, including relief breaks</li><li>• ALWAYS be aware of own safety</li><li>• Note any problems for later debriefing.</li><li>• Resources are limited, you are NOT in a hospital</li><li>• Do the most for most.</li><li>• Keep ALL property with patient</li></ul>
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<b>ACTION CARD: COMMUNICATIONS OFFICER</b> As per roster (Emergency Department Clerk with radio skills)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department, collect and check radio, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	Proceed to flashing green light and identify yourself to SENIOR DOCTOR and SENIOR NURSE.
<b>3. FUNCTION</b>	Administrative and communications support to SENIOR DOCTOR
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• <b>Provide communication link between SENIOR DOCTOR and the Medical Commander.</b></li> <li>• Document and relay specific requests for and from the SENIOR DOCTOR and Medical Commander.</li> <li>• Relay progressive casualty numbers to the Medical Commander. (Obtained from Transport Coordinator)</li> <li>• Deliver documentation to the Metropolitan Areawide Medical Coordinator at the conclusion of the mass casualty incident.</li> <li>• Document timed log of events / requests on behalf of SENIOR DOCTOR.</li> </ul>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>• Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li>• ALWAYS be aware of own safety</li> <li>• Note any problems for later debriefing.</li> </ul>

<p><b>ACTION CARD: TRIAGE RN</b> As per roster (Most Senior Triage Nurse)</p>	
<p><b>1. HOSPITAL</b></p>	<p>Meet medical team members in Emergency Department, ensure equipment is assembled, don Personal Protective Equipment (PPE)</p>
<p><b>2. SITE</b></p>	<p>Stay in ambulance until instructed by the SENIOR NURSE, then proceed to green flashing light in Casualty Clearing Post (CCP).</p>
<p><b>3. FUNCTION</b></p>	<ul style="list-style-type: none"> <li>• Perform Secondary Triage Assessment (TRIAGE SORT) / re-triage RED and ORANGE priority patients as they arrive at the CCP.</li> </ul>
<p><b>4. ACTION</b></p>	<ul style="list-style-type: none"> <li>• Identify yourself to AMBULANCE Triage Officer and other staff present at CCP entrance.</li> <li>• Sequentially allocate Casualty ID numbers on the triage cards of victims as they enter CCP e.g. A1, A2, A3.....A999.</li> <li>• Where 2 or more triage nurses are available then the 2<sup>nd</sup> nurse shall number casualties B1, B2, B3....etc, and the 3<sup>rd</sup> Triage Nurse shall use C1, C2, C3....etc</li> <li>• Check with Senior Nurse, who will provide you with a log sheet and allocate you a letter to use.</li> <li>• Maintain casualty tally sheet and provide information to SENIOR NURSE who will maintain a tally.</li> <li>• Perform other duties as requested by SENIOR NURSE once all triage completed.</li> </ul>
<p><b>5. RESPONSIBILITY</b></p>	<ul style="list-style-type: none"> <li>• Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li>• <b>WAIT FOR PATIENTS TO BE BROUGHT TO YOU</b></li> <li>• ALWAYS be aware of own safety</li> <li>• Note any problems for later debriefing.</li> <li>• Resources are limited, you are NOT in a hospital</li> <li>• Do the most for most.</li> <li>• Keep ALL property with patient</li> </ul>

<b>ACTION CARD: TRANSPORT COORDINATOR</b>	
As per roster (Nurse with radio communication skills)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department, collect and check radio, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	Stay in ambulance until instructed by SENIOR NURSE, then proceed to the Green Flashing light in the Casualty Clearing Post (CCP).
<b>3. FUNCTION</b>	Communication with Metropolitan Areawide Medical Coordinator at Command Post of casualties awaiting hospital transport.
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Provide assistance within CCP as directed by SENIOR NURSE until casualties are ready for transfer.</li> <li>• Identify yourself to Ambulance Loading Officer.</li> <li>• Utilise the coloured cones (Red, Orange and Green) and set up squared area's to identify transport priorities area's within the transport area.</li> <li>• Once the transport area gets busy, forward a request to the AMBULANCE Casualty Clearing Officer, for a paramedic to perform the role of "Transport Priority Officer". This person will review casualties in the transport area, and assign them a priority for transport.</li> </ul> <p>Once Casualties are ready for transport</p> <ul style="list-style-type: none"> <li>• Liaise with Metropolitan Areawide Medical Coordinator via radio to establish transfer destination of each casualty. Information required by Metropolitan Areawide Medical Coordinator <ul style="list-style-type: none"> <li>- Casualty ID number (i.e. A1, B3 etc)</li> <li style="padding-left: 20px;"><b>Use Phonetic alphabet to relay this information</b></li> <li style="padding-left: 20px;"><b>e.g. alpha, bravo, charlie etc.</b></li> <li>- Triage priority of casualty (i.e. red, orange, green)</li> <li>- Casualty's main injuries (i.e. major burns, # femur, severe head injury, etc)</li> <li>- Sex and approximate age (eg infant, young child, teenager, young adult, middle aged)</li> </ul> </li> </ul>

	<p>adult, elderly, frail aged).</p> <ul style="list-style-type: none"> <li>• Once Metropolitan Areawide Medical Coordinator has informed you of patients required destination, liaise with Ambulance Transport Officer regarding transport requirements.</li> <li>• Advise Metropolitan Areawide Medical Coordinator at the time of each ambulance departure from CCP, information required             <ul style="list-style-type: none"> <li>- Patients ID Number</li> <li>- Destination</li> <li>- Time of Departure</li> </ul> </li> <li>• Maintain a log of transferred patient numbers, destination and time of ambulance departure and present this to the Communications Officer at the completion of the mass casualty incident.</li> <li>• If casualties are transported in vehicles other than ambulances (i.e. bus), ensure that a trained ambulance officer / First Aider accompanies the casualties.</li> </ul>
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<p><b>ACTION CARD: TRANSPORT NURSE</b> (ALL TEAMS)</p>	
<p><b>1. HOSPITAL</b></p>	<p>Meet medical team members in Emergency Department, ensure equipment is assembled, don Personal Protective Equipment (PPE)</p>
<p><b>2. SITE</b></p>	<p>Stay in ambulance until instructed by SENIOR NURSE, and then proceed to the “Green Flashing Light” in the Casualty Clearing Post (CCP).</p>
<p><b>3. FUNCTION</b></p>	<p>Management of casualties awaiting hospital transport.</p>
<p><b>4. ACTION</b></p>	<ul style="list-style-type: none"> <li>• Provide assistance within CCP as directed by SENIOR NURSE until casualties are ready for transfer.</li> <li>• Identify yourself to Transport Coordinator and Ambulance Transport Officer.</li> <li>• Together with Transport Doctor and Ambulance Paramedics, provide ongoing treatment to casualties and assign transport priority.</li> <li>• Liaise with the Transport Priority Officer regarding transport requirements or change in priority for specific casualties</li> </ul>
<p><b>5. RESPONSIBILITY</b></p>	<ul style="list-style-type: none"> <li>• Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li>• <b>WAIT FOR PATIENTS TO BE BROUGHT TO YOU</b></li> <li>• ALWAYS be aware of own safety</li> <li>• Note any problems for later debriefing.</li> <li>• Resources are limited, you are NOT in a hospital</li> <li>• Do the most for most.</li> <li>• Keep ALL property with patient</li> </ul>

<b>ACTION CARD: TRANSPORT DOCTOR</b> (ALL TEAMS )	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department, ensure equipment is assembled, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	Stay in ambulance until instructed by SENIOR DOCTOR, then proceed to the “Green Flashing Light” in the Casualty Clearing Post (CCP).
<b>3. FUNCTION</b>	Management of casualties awaiting hospital transport.
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Provide assistance within CCP as directed by SENIOR DOCTOR until casualties are ready for transfer.</li> <li>• Identify yourself to Transport Coordinator/ Ambulance Loading Officer.</li> <li>• Together with Transport Nurse and Ambulance Paramedics, provide ongoing treatment to casualties and assign transport priority</li> <li>• Liaise with the Ambulance Loading Officer regarding transport requirements or change in priority for specific casualties</li> </ul>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>• Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li>• <b>WAIT FOR PATIENTS TO BE BROUGHT TO YOU</b></li> <li>• ALWAYS be aware of own safety</li> <li>• Note any problems for later debriefing.</li> <li>• Resources are limited, you are NOT in a hospital</li> <li>• Do the most for most.</li> <li>• Keep ALL property with patient</li> </ul>

<b>ACTION CARD: RED / ORANGE AREA NURSE</b> (All Teams)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department, ensure equipment is assembled, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	<ul style="list-style-type: none"> <li>Stay in ambulance until instructed by SENIOR NURSE, and then proceed to the Green Flashing Light in the Casualty Clearing Post (CCP).</li> <li>The SENIOR NURSE may allocate you to either the red or orange tarpaulin.</li> </ul>
<b>3. FUNCTION</b>	<ul style="list-style-type: none"> <li>With an allocated Doctor and Ambulance Paramedics, systematically perform a secondary survey of casualties, including observations and after treatment, re-prioritise patients as required.</li> </ul>
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>Provide treatment and document treatment / observations on casualty labels. Transfer patient to TRANSPORT AREA when stable, and hand over casualty to staff.</li> <li>Liaise with SENIOR NURSE regarding supply of extra equipment.</li> </ul>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li><b>WAIT FOR PATIENTS TO BE BROUGHT TO YOU</b></li> <li>ALWAYS be aware of own safety</li> <li>Note any problems for later debriefing.</li> <li>Resources are limited, you are NOT in a hospital</li> <li>Do the most for most.</li> <li>Keep ALL property with patient</li> </ul>

<b>ACTION CARD: RED / ORANGE AREA DOCTOR</b> (All teams)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department, ensure equipment is assembled, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	<ul style="list-style-type: none"> <li>Stay in ambulance until instructed by SENIOR DOCTOR, and then proceed to the Green Flashing Light in the Casualty Clearing Post (CCP).</li> <li>The SENIOR DOCTOR may allocate you to either the red or orange tarpaulin.</li> </ul>
<b>3. FUNCTION</b>	<ul style="list-style-type: none"> <li>With an allocated Nurse and/or Ambulance Paramedics, systematically perform a secondary survey of casualties, including observations and after treatment, re-prioritise patients as required.</li> <li>Begin basic medical management, i.e. Oxygen, IVC / IVT</li> </ul>
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>Provide treatment and document treatment / observations on casualty labels. Transfer patient to TRANSPORT AREA when stable, and hand over casualty to staff.</li> <li>Liaise with SENIOR DOCTOR regarding supply of extra equipment..</li> </ul>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li><b>WAIT FOR PATIENTS TO BE BROUGHT TO YOU</b></li> <li>ALWAYS be aware of own safety</li> <li>Note any problems for later debriefing.</li> <li>Resources are limited, you are NOT in a hospital</li> <li>Do the most for most.</li> <li>Keep ALL property with patient</li> </ul>

<b>ACTION CARD: NURSE</b> (ED / ICU Nurse with Advanced Life Support Skills)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department, ensure equipment is assembled, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	Stay in ambulance until instructed by SENIOR NURSE, then proceed to the Green Flashing Light in the Casualty Clearing Post (CCP).
<b>3. FUNCTION</b>	Team up with a DOCTOR, and treat / stabilise casualties in the area allocated to you by the SENIOR NURSE.
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Provide treatment and document treatment / observations on casualty labels. Transfer patient to TRANSPORT AREA when stable, and hand over casualty to transport area staff.</li> <li>• Liaise with Ambulance CCO regarding supply of “Orange equipment Boxes” containing additional IV equipment.</li> </ul>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>• Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li>• <b>WAIT FOR PATIENTS TO BE BROUGHT TO YOU</b></li> <li>• ALWAYS be aware of own safety</li> <li>• Note any problems for later debriefing.</li> <li>• Resources are limited, you are NOT in a hospital</li> <li>• Do the most for most.</li> <li>• Keep ALL property with patient</li> </ul>

<b>ACTION CARD: DOCTOR</b> (Doctor with Advance Life Support Skills)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department, ensure equipment is assembled, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	Stay in ambulance until instructed by SENIOR DOCTOR, then proceed to the Green Flashing Light in the Casualty Clearing Post (CCP).
<b>3. FUNCTION</b>	Team up with a NURSE, and treat / stabilise casualties within area allocated to you by the SENIOR DOCTOR.
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Provide treatment and document treatment / observations on casualty labels. Transfer patient to TRANSPORT AREA when stable, and hand over casualty to transport area staff.</li> <li>• Liaise with Ambulance CCO regarding supply of “Orange equipment Boxes” containing additional IV equipment.</li> </ul>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>• Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li>• <b>WAIT FOR PATIENTS TO BE BROUGHT TO YOU</b></li> <li>• ALWAYS be aware of own safety</li> <li>• Note any problems for later debriefing.</li> <li>• Resources are limited, you are NOT in a hospital</li> <li>• Do the most for most.</li> <li>• Keep ALL property with patient</li> </ul>

<b>ACTION CARD: DELAYED PRIORITY NURSE</b> (ED Nurse with ability to Triage and treat minor injured casualties)	
<b>1. HOSPITAL</b>	Meet medical team members in Emergency Department, ensure equipment is assembled, don Personal Protective Equipment (PPE)
<b>2. SITE</b>	Stay in ambulance until instructed by SENIOR NURSE, then proceed to the Green Flashing Light in the Casualty Clearing Post (CCP).
<b>3. FUNCTION</b>	<ul style="list-style-type: none"> <li>• Together with the AMBULANCE Delayed Priority Officer, assessment and management of Walking Wounded / delayed priority casualties.</li> </ul>
<b>4. ACTION</b>	<ul style="list-style-type: none"> <li>• Identify yourself to AMBULANCE Delayed Priority Officer and other staff present in the Delayed Priority Area.</li> <li>• Liaise with St John Ambulance Casualty Clearing Officer (AMBULANCE CCO), SENIOR DOCTOR and SENIOR NURSE where Delayed Priority patients are to be placed.</li> <li>• Should a casualty's condition deteriorate and you need to re triage to a RED or ORANGE priority, upgrade priority and redirect the casualty to the TARPAULIN area. <b>DO NOT CHANGE THE ID NUMBER ALREADY ALLOCATED e.g. A3</b></li> <li>• Together with Ambulance Paramedics, provide first aid to the DELAYED PRIORITY Casualties.</li> <li>• Liaise with SENIOR DOCTOR / SENIOR NURSE, providing information as requested.</li> <li>• Check with SENIOR DOCTOR / SENIOR NURSE prior to allowing patients to leave site.</li> <li>• Perform other duties requested by SENIOR NURSE once all Delayed Priority / Walking Wounded casualties have left the site.</li> </ul> <p><b>Note:</b> Do not leave site with Delayed Priority Casualties unless directed by SENIOR NURSE. A Paramedic or First-Aider MUST accompany DELAYED PRIORITY off site.</p>
<b>5. RESPONSIBILITY</b>	<ul style="list-style-type: none"> <li>• Stay in your designated area unless instructed by SENIOR DOCTOR / SENIOR NURSE</li> <li>• <b>WAIT FOR PATIENTS TO BE BROUGHT</b></li> </ul>

	<p><b>TO YOU</b></p> <ul style="list-style-type: none"><li>• ALWAYS be aware of own safety</li><li>• Note any problems for later debriefing.</li><li>• Resources are limited, you are NOT in a hospital</li><li>• Do the most for most.</li><li>• Keep ALL property with patient</li></ul>
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## Appendix 6

### Medical Response Team - Guidelines for Equipment Pack Contents

The following lists are guidelines for hospitals preparing packs of equipment to be taken to an incident site by a hospital team. The intent is to provide enough equipment for team members to begin treating patients, however further equipment will need to be taken to the site if the numbers exceed equipment carried or if a prolonged response is required. Equipment to be taken to a site needs to be considered in relation to:

- the number of staff attending;
- the skill level of the team members; and
- access to further equipment.

Arrangements for re-supply need to be planned.

#### 5.1. Airway (Green Bag) x 2 each containing

Section	Quantity	Description	Size / Comments	
<b>Front Pocket</b>	12 pairs each	Gloves	S, M, L	
	1 x	375 ml Alcohol Handgel		
<b>Upper Left Section</b> <b>Lower Left Section</b>	1x	2.5cmx3m Elastoplast elastic tape and cotton tape	For securing endotracheal tubes	
	1x	Scissors		
	2 x	Syringe	10ml	
	1 x	Laryngoscope Handle		
	1 x	Adult Blade	Mac 3 - Fibre optic preferred	
	1 x	Paediatric Blade	Miller 1- fibre optic preferred	
		Batteries with spares to fit handle		
	2	Globes – spare to fit blades		
	2 each	Naso-gastric Tubes	8F, 12F	
	2 x	Syringe	20ml	
<b>Middle Section</b>	1 each	Endotracheal Tubes	Uncuffed 3.0, 3.5, 4.0, 4.5	
	2 each	Endotracheal Tubes	Uncuffed 5.0, 5.5, 6.0 Cuffed 6.0, 7.0, 8.0, 9.0 mm	
<b>Right Section</b>	1 each	Nasopharyngeal airways	24mm, 28mm, 32mm	
	1 each	Cricothyrotomy set Adult Cricothyrotomy set Child		
	2 x	Scalpel disposable size 11		
	1 each	Laryngeal Mask Airway	1.5, 2, 2.5, 3, 4 (Disposable Portex)	
	2 x	Yankauer Suckers	Disposable	
	<b>Inner Zipped Pocket</b>	2 each	Y Suction Catheters	6F, 8F, 10F, 12F, 14F
		<b>Inside Flap</b>	1 each	Guedel Airway
2 x	Cobb Connectors (liquorice stick)			
1 each	Magill's forceps		Adult, Paed.	
1 each	Endotracheal introducer		Adult, Paed., Neonatal	
2 x	14g / 2" Cannulas			
4 x	Lubricant sachets			
1 x	13" tubing clamp			

<b>Hidden Compartment</b>	5 x	Anaesthetic Charts	
	1x	Paed. Resus Card or Broselow Tape	

## 5.2. Breathing (Blue Bag) x 2 each containing

Section	Quantity	Description	Size / Comments
<b>Front Pocket</b>	12 pairs each	Gloves	S, M, L
	1 x	375 ml Alcohol Handgel	
<b>Inner Flap</b>	2 x	Cook Emergency Pneumothorax Kit or Heimlich Chest Drains	
	2 x	14g / 2" Cannulas	
	2 x	0/0 Silk on Hand Needle	
	2 x	Scalpels Disposable	23 blade size
	5 x	Chlorhexidine and Cetrimide irrigation solution ampoules	30 ml
<b>Central Compartment</b>	1 x	Paed. and Adult Self-inflating Resuscitator Bags (Laerdal)	
	1 each	Face Masks (clear)	0/1, 2, 3, 4, 5
	2 x	Bile Bags	Bags are used as drainage bags for ICC (connectors may be required if using a Urinary Drain Bag that does not fit the ICC, and bags are not required if Cook pneumothorax kit is used)
	1 x	Torch with batteries	To illuminate work area
		Batteries with spares	To fit torch
	2 each	Oxygen masks	Adult, Paed.
	2 x	Oxygen tubing	
	2 each	Non Rebreathing Masks	Adult, Paed.
	2 each	Intercostal Catheters	12F, 16F, 20F, 24F, 28F
	4 x	Small Combines	9cm x 20 cm
	4 x	Large Combines	20cm x 20cm
	4 x	Drain sponges or gauze packs	
	4 x	Tegaderm	10 x 12 cm
	1 x	Fixomull	10m x 5 cm
	1 x	Roll Sleek	5 m x 5 cm
1 x	Portable manual suction unit		

**5.3. Circulation (Red Bag) x 2 each containing**

Section	Quantity	Description	Size / Comments
<b>Front Pocket</b>	12 pairs each	Gloves	S, M, L
	1 x	375 ml Alcohol Handgel	
<b>Side Compartment</b>	1 x	Surgical stapler	
	2 x	Tourniquet	
	5 x	Large Combines	20cm x 20cm
	2 x	Intraosseous Needles	Cook 15.5 g
	1 x	Box Fixomull	10 m x 5 cm
	1 x	Dressing Scissors	
	10 x	Packets gauze swabs	
<b>Main Compartment</b>	6 x	Normal Saline IV 0.9%	500 ml
	6 x	IV Giving set with pump	
	4 each	IV Cannula	14g, 16g, 18g, 20g, 22g, 24g
	20 x	IV bungs	
	1 x	Sphygmomanometer	
	4 x	Elbow Splints	Various sizes
	1 x	Sharps Container	
	3 x	Bandages crepe	7.5cm
	1 x	Bandage crepe	2.5cm
	12 x	Triangular sling	
	1 x	Foil Space Blanket	
<b>Inner Flap</b>	5 each	Syringes	10 ml, 20 ml
	10 each	Syringes	2 ml, 5 ml
	12 x	0.9% NaCl 10 ml	For IV Flush
	6 x	10 ml Syringes	
	6 x	3M Tegaderm IV dressing with Steristrips	
	10 x	Alco wipes	
	3 each	Butterfly Cannula	21g, 23g

Tertiary / teaching hospitals should prepare, maintain and take to the incident site, two sets of bags containing medical equipment listed. Secondary / General, Regional and District hospitals should prepare, maintain and take to the incident site at least one set of bags.

The above listed equipment will only prepare a medical response team to be able to manage limited numbers of casualties. Whilst preparing equipment, Regional and District hospitals need to consider what extra resources may be required at incident site by the ambulance service or other service, the resupply capability and whether extra supplementary equipment needs to be on stand-by to be taken to the site.

#### 5.4. Drug (Green Bag) containing

##### Start with Front Label Facing the Front

Quantity	Description	Dosage	Size / Comments
5 x	Adrenaline	1:1000	
5 x	Atropine	0.6mg / ml	
1 x	Paracetamol suspension	250 mg/ 5ml	
10 x	Medicine measures		
10 x	Midazolam	5mg / 5ml	Keep in foil packet
5 x	Marcaine (Bupivacaine) or Ropivacaine (Naropin)	0.5% Plain 0.75% / 10ml	
5 x	Naloxone	0.4mg / ml	
10 x	Metoclopramide (Maxolon)	10mg/2 ml	
3 x	Sodium Bicarbonate	100 ml 8.4%	Bottle NOT Minijets
10 x	Normal Saline	0.9% / 10ml	
5 x	Flumazenil (Anexate)	500 mcg / 5ml	
24	Panadeine forte	500mg/30mg	
3 x	10ml Syringes		
3 x	5ml Syringes		
1 x	20ml Syringe		
5 x	2.5ml Syringes		
10 x	Drawing up needles		
5 x	21g Needles		
20 x	Alco wipes		
2 x	Schedule 8 Log sheets		
<b>ADD to ONE BAG when called out</b>			
10 x	Ketamine (Ketalar)	200mg / 2ml	
50 x	Morphine	10mg / ml	
10 x	Pancuronium (Pavulon)	4 mg/ 2 ml	
10 x	Suxamethonium	100mg / 2ml	
<b>St John Ambulance Carry</b>			
<ul style="list-style-type: none"> <li>• Sublingual Isosorbide dinitrate</li> <li>• Salbutamol (Ventolin) Nebulizer Solution and Masks</li> <li>• Glucagon</li> <li>• Midazolam</li> </ul>		<ul style="list-style-type: none"> <li>• Naloxone (Narcan)</li> <li>• Aspirin</li> <li>• Cophenylcaine Forte Spray</li> <li>• Adrenaline</li> <li>• Fentanyl Intranasal Spray</li> </ul>	

Tertiary / teaching hospitals should prepare, maintain and take to the incident site, three bags containing medical drugs listed above. Secondary / General, Regional and District hospitals should prepare, maintain and take to the incident site at least one bag.

Several St John Ambulance metropolitan ambulance stations and some country subcentres have disaster boxes of supplementary equipment for quick dispatch to disaster sites.

**5.5. Personal Packs (Green Waist Bag) x 6 each containing**

Section	Quantity	Description
<b>Right Hand Small Pocket</b>	10 x	Paracetamol
	8 x	Band-aids
<b>Left Hand Small Pocket</b>	1 x	Large Plastic bag (for rubbish)
	2 x	Plastic Ziplock Bag (for patient valuables)
<b>Top Pocket (behind top section)</b>	1 x	Stethoscope
	20 x	Medium Gloves NB Boxes of gloves should be stored within the store cupboard and team member can obtain supplies of personal size gloves if other than medium.
<b>Top Section</b>	1 x	Pen Torch
	4 pairs x	Ear plugs
	2 x	Surgical mask
	1 x	Surgical scissors
	1 x	Trauma scissors (for clothing)
	1 x	Safety glasses with securing strap
	1 x	Artery Clamps
	1 x each size	Guedel Airways 1, 2, 3
	1 x	Biro Pen
	1 x	Permanent marker pen
	1 x	Spiral notebook
	6 x	Plastic bag containing: Alco wipes x 2 16g IV Cannula Fixomull strips x 2 IV Bung Normal saline 0.9% 10ml ampoule 5ml syringe
	<b>Between top and Middle Sections</b>	2 x
2 x		Triangular bandages
<b>Middle Pocket (Behind Middle Section)</b>	4 x	Large Combines 20 x 20 cm
	4 x	Gauze 10 x 10 cm
	50cm	Length Fixomull
<b>Middle Section</b>	1 x	Tourniquet
	1 x	1cm pink Elastoplast tape
	1 x	1cm Dermacell/ 3M Transpore tape
<b>Bottom Section</b>	10 x	Triage Disaster Cards with large safety pins or rubber bands
	1x	MIMMS Aide Memoire
Water Container holder (for personal use)		

**5.6 Comfort bag** (To be taken to the site – contains extra supplies which team members may require)

Quantity	Description
500ml	Sun screen
100-500 ml	Insect repellent
Box	Tampons
3	Toilet rolls
Pack	Large (bin size) plastic bags
	Wet weather gear
Box	Extra ear plugs
Number in team	Torches for helmets
Box	Surgical masks
	Spare designation labels for vests

**5.7 Extra and Supplementary Equipment**

St John Ambulance Australia Head Office at Belmont, has equipment contained in trailers, which can be taken to the incident site/s for ambulance and medical response teams to use. Some country ambulance sub centres also have limited supplies in trailers, which may also be taken to incident site/s.

Hospital staff must be aware of the local arrangements and the contents of any trailers or other disaster designated vehicle within their area, to ensure any supplementary equipment kept on stand-by, complements this equipment and no unnecessary duplication is in place.

**5.8 Resupply**

Local arrangements must be in place to organise the resupply of equipment to be taken at short notice to the incident site. This could be through:

1. St John Ambulance HQ or local Sub Centre stores
2. Health Service Supply Centres
3. Hospital Main Stores Department
4. Hospital Pharmacy Departments
5. Community Pharmacies
6. Other hospitals not directly involved in the disaster response

Taking equipment from the Emergency Department for resupply must be avoided, unless no other options are available.

The preferred option is that equipment is taken to the site by ambulance. although alternatives such as patient transport vehicles, hospital ambulances or cars, police vehicles, SES vehicles could be utilised . In some situations air or water craft may need to be used.

Precautions will need to be taken to ensure the resupply of drugs are taken to the incident site, where required, by an appropriate person.

## Appendix 7

### Guidelines for Personal Protective Equipment for Medical Response Teams

Guidelines produced by Emergency Management Australia (Disaster Medicine Manual 2<sup>nd</sup> Edition) pages 189-191, recommend the following personal protective equipment to be worn/made available to any hospital staff attending the site of a major incident. All equipment must, where applicable, comply with Australian Standards and Occupational Health & Safety legislation/best practise.

#### Helmet

- safety
- dark green in colour
- marked with designation
- chin strap attached and
- size adjustable.

Torch for helmet with batteries

Eye protection

Respiratory protection

#### Overalls

- low flammability
- green
- appropriate for climate
- belt capability.

#### Footwear

- high rubber soles
- leather suede uppers
- ankle support
- mid calf in length
- sewn in tongues.

#### Gloves

- Suitable for sharp objects, debris, body fluids.
- Different gloves dependant on activity.

Comfort Kit

Personal Identification

Other considerations

- Reflective vests with designation
- Wet weather protection

- Equipment for special hazards.

Chemical Biological and Radiological Emergencies and equipment are addressed in the CBR Subplan.

## Appendix 8

### External Disaster Multiple Site Management

#### 8.1 Multiple Sites

Multiple site management may include:

Type of incident	Example
One incident site with two or more sectors	An aircraft crash at an airport where the fuselage is spread across the runway at a distance of 400m.
One incident but due to the nature of the incident it requires separate support management.	An aircraft crash where wreckage has landed some considerable distance apart.
An incident where the terrain requires more than one casualty clearing posts (CCP) for casualties, but managed as one incident	An incident within a tunnel, or a collapsed building requiring overall management but casualty extraction from more than one location.
A situation where more than one incident has occurred, and are separated by distance, each requiring support management	Madrid and London train bombings in 2004 & 2005 or an earthquake involving damage over widespread areas.

The management of such situations will depend on:

- The numbers and types of casualties,
- The number of incidents/sites,
- The hospital resources available,
- The ambulance resources available,
- Equipment availability and
- Hospital destinations and capability.

#### 8.2 Command and Control

The decision as to how the incident/s will be managed shall be made by the Ambulance Commander and Medical Commander at the scene (if available) in consultation with SJA Belmont, the District or Metropolitan Area-wide Medical Coordinator and, depending on the situation, the State Health Coordinator. The Incident Manager and Hazard Management Agency for the incident/s will also need to be consulted.

Decisions will need to be made regarding the number of Medical Commanders that may be required at the various incident sites. This will invariably be related to the response of the Ambulance Service and their need for medical support. It is preferable that Medical Commanders should have attended and passed the MIMMS Commander Course.

#### 8.3 Medical Response Teams

The use of medical response teams at multiple incident sites, will need to be considered carefully, to ensure the greatest good can be achieved for the greatest number of casualties.

The limited resources available may result in an incident site not receiving any medical support to assist the ambulance service. Similarly, it may be deemed more appropriate for all medical resources to remain in the hospitals until casualties may be brought there. This situation could change if more resources become available later on.

Accurate communication is essential to ensure Medical Response Teams and resources are directed to the correct location.

#### **8.4 Radio Communication at Multiple incident sites**

Radio communication shall be used as appropriate. **Appendix 12** outlines the channels to be utilised with the Department of Health's radio network. The Medical Commander and Transport Coordinator must ensure that the correct site is made clear to the Metropolitan Areawide Medical Coordinator to ensure location of where casualties are from is accurate.

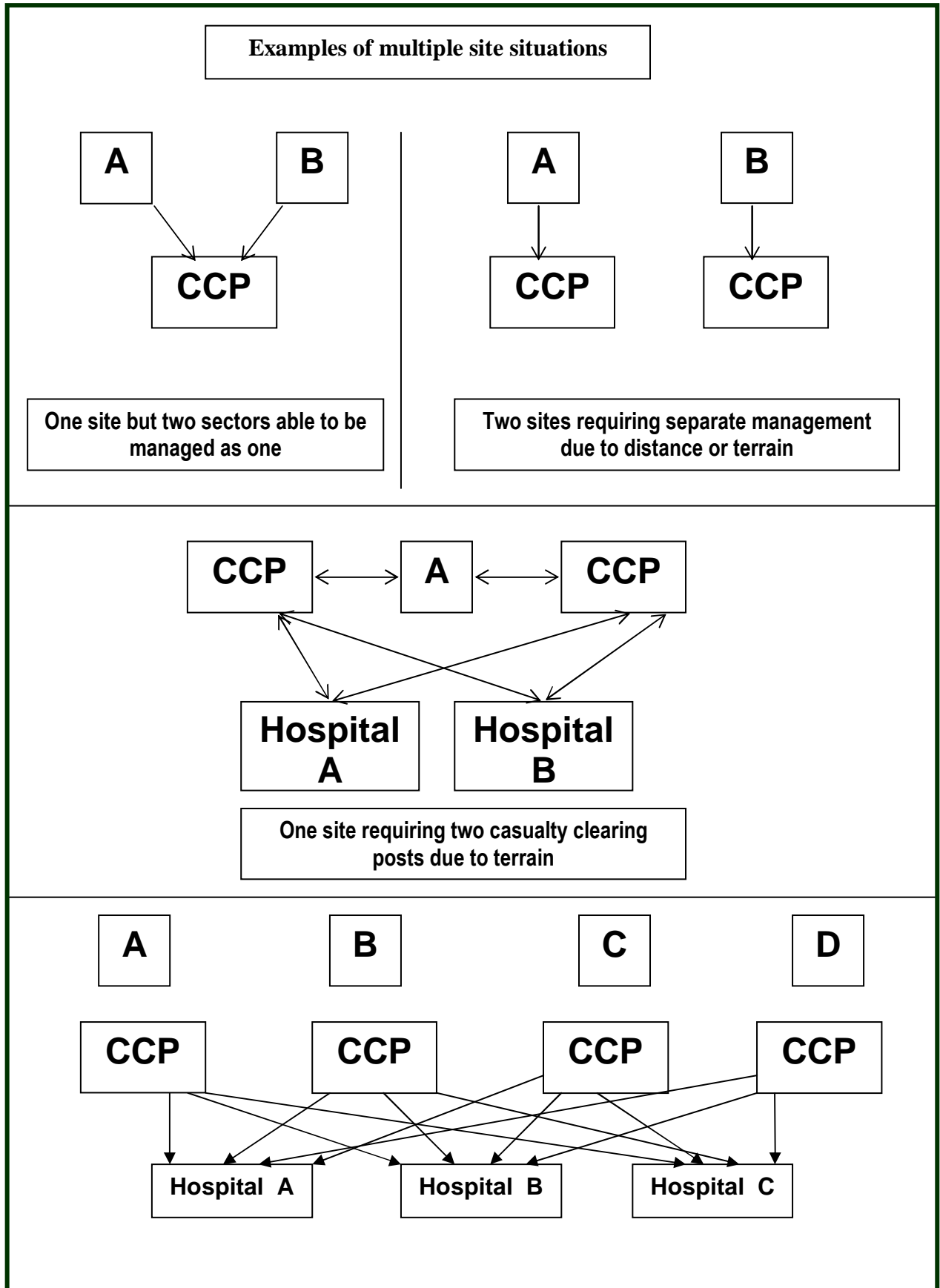
#### **8.5 Triage and Casualty Numbering**

Triage nurses will need to include an identifier on the triage card to be able to identify from which site/CCP the casualty is evacuated from. Where locations are involved, this may be added. However, if differing sectors or Casualty Clearing Posts, then an extra letter or number may be added to the beginning of the triage number. Consultation through the Senior Doctor/Nurse to the Metropolitan Areawide Medical Coordinator or District Coordinator will need to be made to avoid duplication.

In some situations, such as a chemical, biological or radiological incident, an identifying number may already be allocated by other emergency services (eg FESA). This may be by an identity tag or band around the casualty. This number should be recorded on the triage card.

#### **8.6 Casualty Distribution**

Casualty distribution will follow the same principles as a single site with the Transport Coordinator liaising with the Metropolitan Areawide Medical Coordinator. It is likely that delays could occur as a result of resources having to be distributed across multiple locations.



**Appendix 9**

**Multi-Casualty Triage**

(Acknowledgments to Cato, D and Advanced Life Support Group)

According to Advanced Life Support Group, the objective of the triage process in a multi casualty incident is to achieve the greatest good for the greatest number of casualties. The outcomes are not only to deliver the patient to the right place as quickly as practical, in order to provide optimum treatment, but also to *'do the most for the most'*.

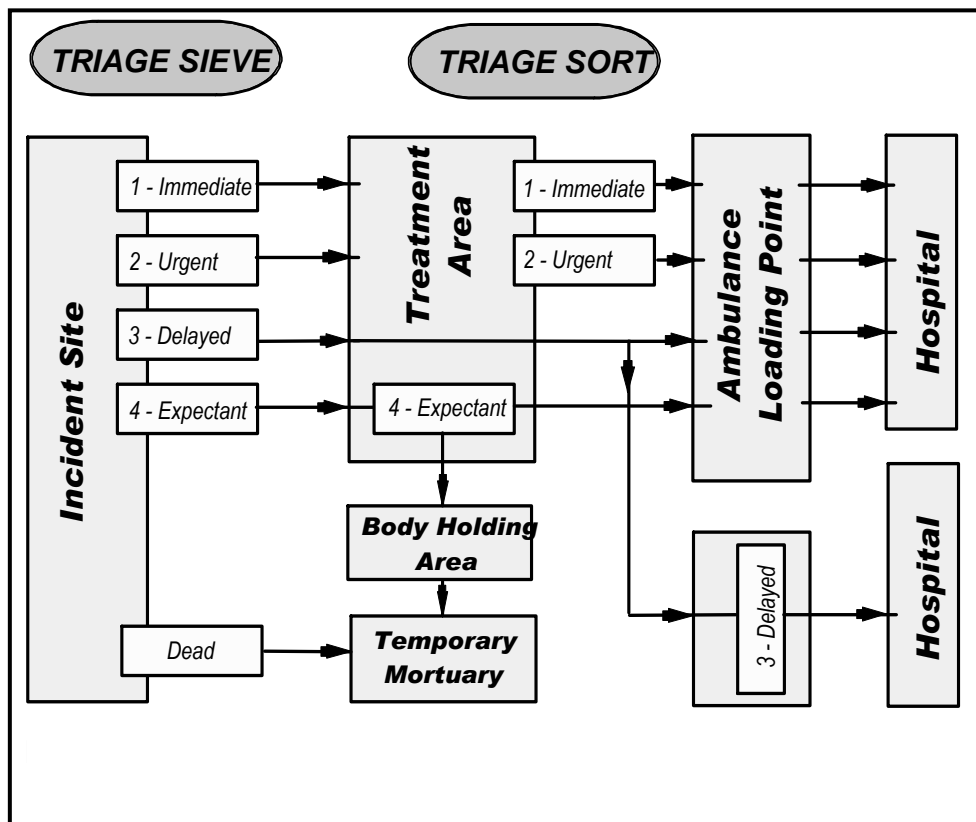
In a restricted impact disaster, such as the crash site of a vehicle or an aircraft, casualty evacuation to a staging area by first responders may occur without triage. For the more localised incident, the first triage decision is ideally taken at the location where the casualty is found. After this subsequent triage should occur at the Casualty Clearing Post.

In Western Australia, the MIMMS (Major Incident Management and Support) system is followed. A triage label in the shape of a cruciform is used for the labelling of casualties. The label should be secured to the casualty by means of a safety pin, rubber band or tie strips.

**Triage at an incident site**

A typical triage evacuation map is shown below (acknowledgment to Cato, D. 2003. Health Aspects of Dealing With Disasters in Australia)

Note that ambulatory casualties with minor or no injuries (Priority 3) may be directed to a separate holding area and moved by non-ambulance transport.



Triage and evacuation diagram

### Triage Priorities

The desired outcome of any triage system is to deliver the casualty to the right place at the right time. As a first step casualties are assigned to different casualty, or priority, groups. In Australia the system varies from State to State and varies from two to five levels and even more depending on local plans <sup>(63)</sup>.

The table below shows the triage priorities. The ‘P’ classification is for field priority to manage evacuation from the incident site to the Casualty Clearing Post (CCP) and the ‘T’ system for treatment priority on arrival to the CCP.

‘P’ Priority	‘T’ Treatment	Description	Colour Identifier
1	1	Immediate	Red
2	2	Urgent	Yellow/Orange
3	3	Delayed	Green
	4	Expectant	Orange with 2 black lines
Dead	Dead	Dead Unsalvageable	Black/White

Triage Priorities

The major difference between the two systems is the inclusion of the *expectant* category. Using the ‘T’ system, categories are defined as:

Priority	Intervention
• Priority 1 (Immediate)	Immediate life saving procedures required
• Priority 2 (Urgent)	Intervention required within 4 - 6 hours
• Priority 3 (Delayed)	Less serious cases where treatment is not essential within the times given above
• Priority 4 (Expectant)	Casualties whose injuries are so severe that they are either unlikely to survive in the circumstances or would require so much input from the limited resources available that their treatment would seriously compromise the treatment of large numbers of other less serious casualties.

Priority and intervention required.

The use of the EXPECTANT category will need to be determined by the Medical Commander in consultation with the Metropolitan Areawide Medical Coordinator, District, or Regional Medical Coordinator depending on the location of the incident. However, where all red priority casualties have been managed, then the expectant casualties should receive treatment.

### Triage Sieve and Sort

Triage is a dynamic process and a casualty may be reassessed many times depending upon locations and circumstances. The system used must be quick, simple, safe and reproducible.

The 'first look' process is usually by necessity a 'quick look'. Later when the casualty reaches the Casualty Clearing Post then more time will be available for a more detailed assessment. These two stages of the triage process are referred to as the *triage sieve* and the *triage sort* respectively.

### **Triage Sieve**

The principal objective of the triage sieve is to quickly separate the casualties into a priority order. While it is quick, it is not perfect although care must be taken to err on the safe side. Any mistakes at this stage can be corrected later at the *triage sort* stage.

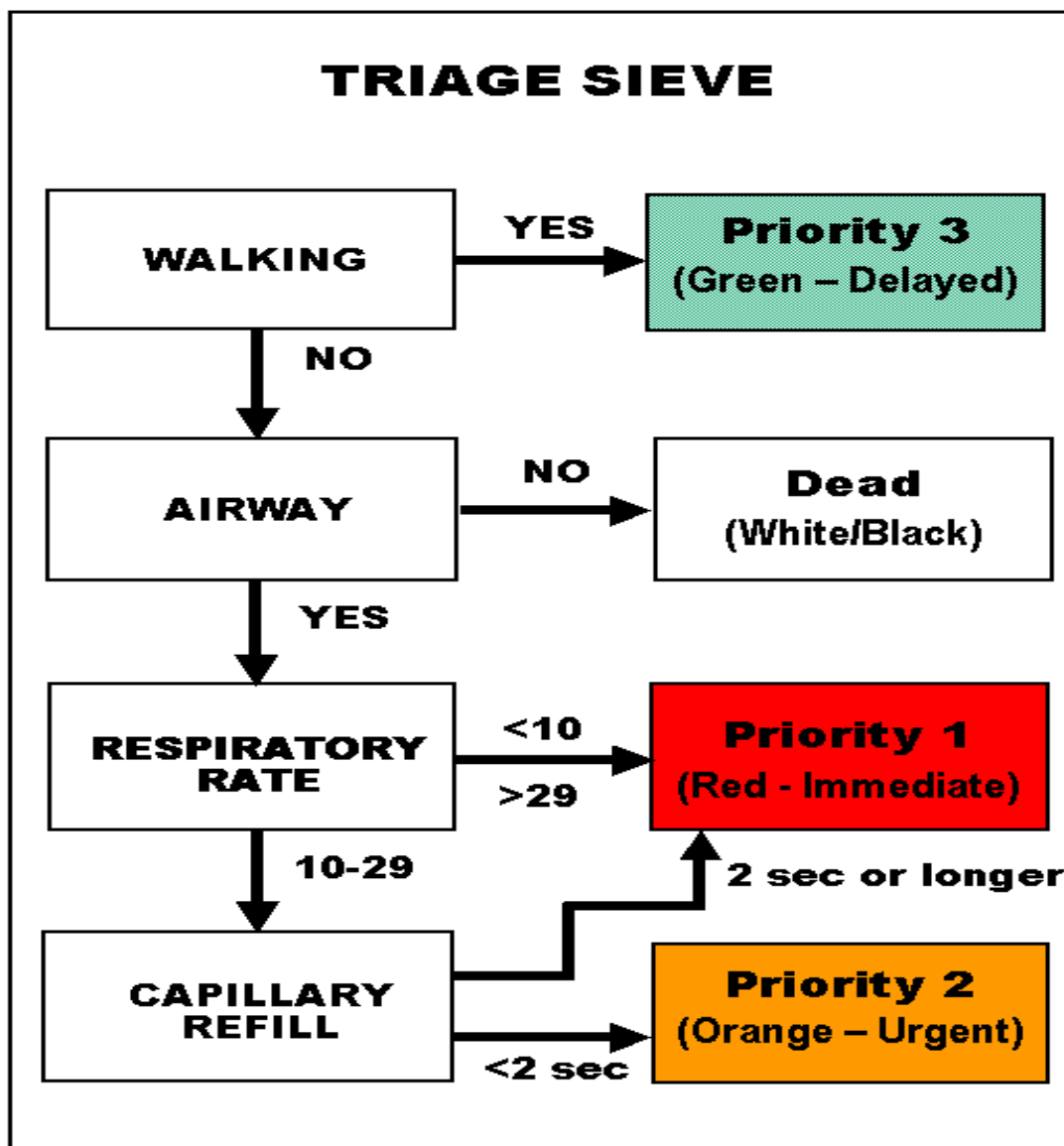
Mobility is the first stage of the sieve. Any walking casualties, regardless of injury type, are categorised as Priority 3 (Delayed) and are moved from the site.

Those casualties who are not walking will initially be classified as Priority 1 (Immediate) or Priority 2 (Urgent). The distinction is made according to the airway, breathing and circulatory (ABC) parameters described below.

Airway patency can be checked by the simple chin lift - jaw thrust manoeuvre and observing whether or not breathing occurs. Those casualties who do not breathe in spite of this manoeuvre are dead or unsalvageable.

Where breathing occurs then the second assessment, that of respiratory rate, is made. If the respiratory rate is less than ten per minute or is greater than twenty nine per minute then the casualty is classified as Priority 1 (Immediate). If the rate is normal, that is between ten and twenty-nine breaths per minute, then an assessment of circulation is performed.

The circulatory assessment is not easy under ideal circumstances and can be very difficult in the pre-hospital situation. Capillary refill time is assessed in the nail bed and where it is greater than two seconds then the casualty is classified as Priority 1 (Immediate). The heart rate may be used where the capillary refill time can not be taken. A heart rate greater than 120 would be classified as a Priority 1 (Immediate).



The Sieve Protocol

Severe bleeding should be managed at this stage. Where capillary refill time is two seconds or less then the casualty is classified as Priority 2 (Urgent).

### Triage Sort

On arrival at the Treatment Area casualties are re-triaged using a more detailed approach. This process is called the *triage sort*.

Triage sort involves working out the Triage Revised Trauma Score (TRTS). The TRTS is based on three parameters as shown in the table below. This allots a value to each of the parameters with a possible score of 12 for little or no injury and a level of zero for dead.

<b>Parameter</b>	<b>Coded Value</b>
Respiratory Rate	0 – 4
Systolic Blood Pressure	0 – 4
Glasgow Coma Scale	0 – 4

Triage Revised Trauma Score (TRTS) parameters

Each of the three sections is scored using a number of parameters. The variables are shown in the table below.

<b>Physiological Variable</b>	<b>Measured Value</b>	<b>Score</b>
Respiratory Rate	10 – 29	4
	> 29	3
	6 – 9	2
	1 – 5	1
	0	0
Systolic Blood Pressure	≥ 90	4
	76 – 89	3
	50 – 75	2
	1 – 49	1
	0	0
Glasgow Coma Scale	13 – 15	4
	9 – 12	3
	6 – 8	2
	4 – 5	1
	3	0

Triage Revised Trauma Score (TRTS) System

The third level, is a commonly used function, that of the Glasgow Coma Scale. This scale, which looks at neurological responses, is coded to give a score. The system is shown below.

<b>GLASGOW COMA SCORE</b>	
<b>EYE OPENING</b>	<b>Coded Value</b>
Spontaneous	4
To voice	3
To pain	2
None	1
<b>VERBAL RESPONSE</b>	
Oriented	5
Confused	4
Inappropriate words	3
Incomprehensible	2
None	1
<b>MOTOR RESPONSE</b>	
Obeys commands	6
Localises to pain	5
Withdraws to pain	4
Flexes to pain	3
Extends to pain	2
None	1

Glasgow Coma Scale

The Glasgow Coma Score will result in a value between 3 and 15.

The Triage Revised Trauma Score (TRTS) is calculated from the parameters shown in the table below to give a score between 0 and 12.

The Triage Revised Trauma Score (TRTS) score can then be used to assign triage priorities as shown in the Table below.

<b>Priority</b>	<b>TRTS</b>
T1	1 – 10
T2	11
T3	12
Dead	0

Triage Revised Trauma Score (TRTS) and Priority

If Priority 4 (Expectant) is in use then a TRTS of 1 – 3 should be used.

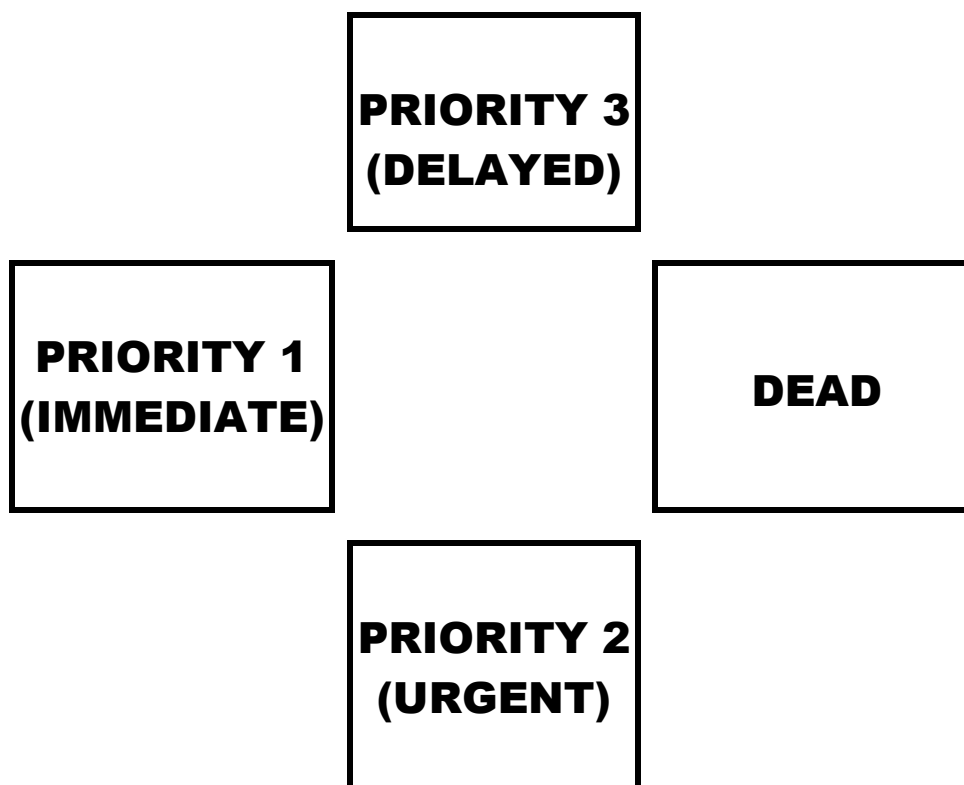
### Triage Labelling

It is essential that once assessed other rescuers are aware of the priority given to an individual casualty. In Western Australia the cruciform card is used and is shown below.

The standardised primary colours used to indicate the priorities are shown below.

Priority	Colour
Priority 1 (Immediate)	Red
Priority 2 (Urgent)	Yellow or Orange
Priority 3 (Delayed)	Green
Dead	White (black letters) Black (white letters)

Triage label colours



Cruciform Style Triage Label

Expectant casualties will be labelled by using the *PRIORITY 2 (URGENT)* label with 2 diagonal lines.



## Appendix 10

### Multiple Casualty Evacuation to Perth Hospitals via Perth Airport

This appendix will be activated when notified by the State Health Coordinator, or his designate, that:

1. the National Response Plan for Mass Casualty Incidents Involving Australians Overseas (OSMASSCASPLAN) has been activated, or
  2. a major incident has occurred intra or interstate,
- and casualties are being flown to Perth for ongoing medical management, via Perth Airport.

#### Contact Telephone Numbers

##### 1.1 Airport

Duty Manager (diverts to mobile if not answered)	9478 8501
Control Centre (24 hours)	9478 8572

##### 1.2 Health

Department of Health – Duty Officer	9328 0553
Department of Health – Disaster Preparedness and Management Unit	9222 2277 (B/H)
Royal Perth Hospital – Metropolitan Emergency Coordination Centre (when activated)	9224 2002
Switchboard	9224 2244

##### 1.3 Ambulance

Ambulance Service Communications Centre	9334 1234
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#### Emergency Coordination Centre (Airport)

The Emergency Coordination Centre is located on the ground floor of the International Terminal beyond the restricted access area. All parties will be required to report to an entrance manned by the police located between the two escalators..

#### Aircraft Arrival

Where an aircraft is able to connect to an aerobridge, subject to the working of the airport, the preferred bridge to be used is at Gate 55 Terminal 1 (International).

This gate:

- will allow for adequate space for establishing a casualty clearing/triage area,
- is at the furthest end of the arrivals section and with screening would not be open or visible to other passengers arriving on other craft,
- is close to a lift, which is able to accommodate a stretcher,
- Rooms for privacy are also nearby,

Other areas may include an external bay depending on the type of aircraft used.

## **Casualty Clearing/Triage**

One or more Casualty Clearing/Triage areas will be established close to the arriving aircraft. Depending on the type of aircraft, injuries and numbers of casualties, these may be located:

1. Within the terminal building close to the gate;
2. Adjacent to the aerobridge airside in case of casualties requiring stretchers;
3. At the side of the aircraft on Bays 50, 56, 60, 61 or 61A or 56 for any aircraft using these bays. Smaller military aircraft would not be restricted to these bays.

The Ambulance/Medical Commander in consultation with the WAC Duty Manager will determine the number and location of Casualty Clearing/Triage areas.

## **Key Personnel**

### ***Medical Commander***

Responsible for casualty management at the airport. Maintains contact with the Metropolitan Emergency Coordination Centre. Liaises between other agencies present at the airport.

### ***Hospital Team/s (Doctors and Nurses)***

Delegated as directed by Medical Commander.  
Triage and stabilises casualties for transportation to hospital.

### ***Ambulance Commander***

Coordinates all ambulance resources at the airport.

### ***Ambulance Casualty Clearing Officer***

Involved with the arrival of casualties to the casualty clearing areas and the transportation after medical assessment to hospital.  
In the absence of hospital teams, arranges for the triages and stabilises casualties prior to transport to hospital.

## **Medical Management of Casualties**

Management should be restricted to what is required to safely transport the casualty to definitive care, ie airway, breathing and circulatory management, analgesia and fracture re-stabilisation.

## **Medical Equipment**

All medical equipment will be supplied by the hospitals or ambulance service.

## **First Aid**

Depending on the type of incident and numbers of people involved, first aid services, through the Volunteer First Aid Service of St John Ambulance Australia, may need to be made

available for those not requiring urgent medical treatment. This will be provided as described in the Care of the Uninjured Plan.

### **Airside Access**

Generally airside access for Terminal 1 (International) will be via Gate 1 or Gate 3. The WAC Duty Manager with assistance from the Senior Operations Officers may determine that alternate access is required and will notify the appropriate agencies.

### **Lifts**

The controlled access lift at the rear of Terminal 1 Aerobridge 53 (Internal Terminal Building) is able to take an ambulance stretcher when slightly tilted.

### **Welfare Agencies**

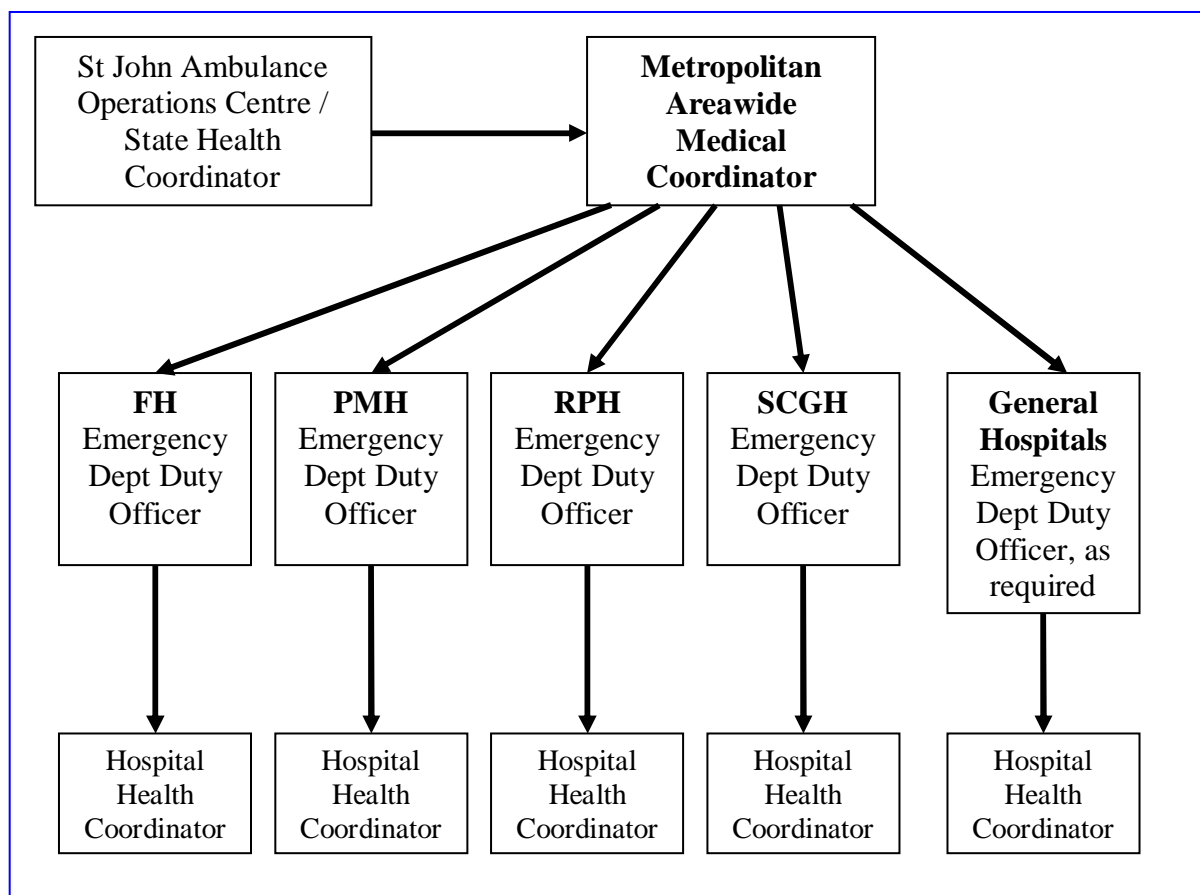
Depending on the category of the incident, the Care of the Uninjured Plan may be implemented as detailed in the AEP.

### **Stand down**

Stand down will occur when the coordinating agency declares that no further aircraft are expected, although there may be aircraft expected later requiring reactivation of this appendix.

## Appendix 11

## Perth Metropolitan Notification and Response Team Call-Out System



Notification Flow Chart

1. Notification and the need for the attendance of a mobile medical team to attend a major incident will be made by the Ambulance Operations Centre to the Metropolitan Areawide Medical Coordinator (AWMC).
2. On receipt of the notification call, the AWMC will determine which hospitals are to attend the incident site according to the roster and advise the Ambulance Operations Centre to arrange transportation of the teams.
3. The AWMC will notify the Duty Consultant/Officer, Emergency Department, of the relevant hospitals in accordance with the roster arrangement listed below.
4. The Duty Consultant/Officer will then notify the Hospital Health Coordinator as stated in the hospital's code brown external emergency procedures.
5. Hospitals will be placed on 6 monthly rosters to provide key personnel for disaster teams. In the event of an incident occurring then one of the two hospitals rostered as Group A and another as Group B will be notified by the AWMC to send a team. This system will eliminate concerns over which hospital is to provide the senior roles.

## Rostering Arrangements

<b>1.3.1.1.1 HOSPITAL</b>	<b>3<sup>rd</sup> Monday in January</b>	<b>3<sup>rd</sup> Monday in July</b>
Royal Perth	<b>A</b>	<b>B</b>
Sir Charles Gairdner	<b>B</b>	<b>A</b>
Fremantle	<b>A</b>	<b>A</b>
Princess Margaret	<b>B</b>	<b>B</b>

The change date will be linked with the Registrar change date. Education sessions to remind key personnel of the change and the roles the hospital will provide, are to be arranged through the Executive Officer, EDSSC by each hospital emergency department, and are to include medical and nursing staff.

The hospitals rostered to provide a Communications Officer are to provide radio communication education for their clerical staff

## Groups

<b>Group A</b>	<b>Group B</b>
Medical Commander Triage Nurse Transport Nurse	Senior Doctor Senior Nurse Communications Officer Triage Nurse
2 Doctors	1 Doctors
2 Nurses	2 Nurses

Should a further team be required, 2 Doctors and 4 Nurses for generic roles will be provided by a 3<sup>rd</sup> Hospital (either the second hospital rostered as A or B), and if necessary a 4<sup>th</sup> hospital. Secondary hospitals may also be asked by the AWMC to supplement a mobile medical team with 1 Doctor and 2 Nurses in generic roles.

## Appendix 12

### Radio Network – Department of Health

The Department of Health has supplied Radios to hospitals within the metropolitan area. Portable hand held radios, where issued, are to be taken to the disaster site, whilst base stations are situated within the facility's emergency coordination/control centre (ECC).

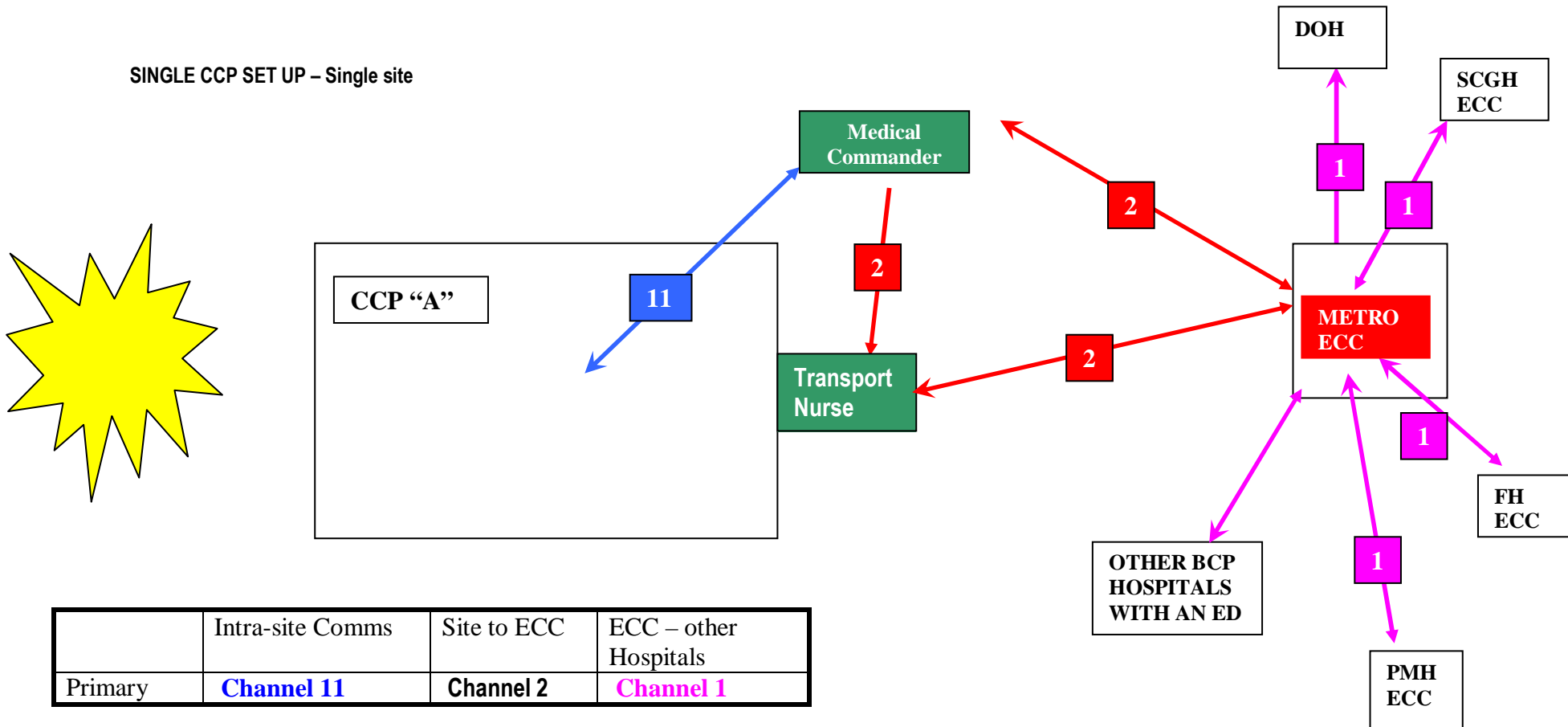
The radios work on a Department of Health licensed frequency and have a limited range. Repeater stations have been placed around the metropolitan area to allow for extended ranges.

Radio procedure should be used at all times by those using radios. This includes the use of call signs relating to position/role titles or facility location, phonetic alphabet and general courtesy rules of not blocking the airwaves and no swearing, gibberish or other non important messages.

In rural and remote areas, radios in use by St John Ambulance and the Royal Flying Doctor Service may well be the only radio communication available to be able to use. Alternatives could be arrangements through the State Emergency Service or the use of satellite telephones.

The following pages outline the channels to be used based upon single and multiple site management within the metropolitan area.

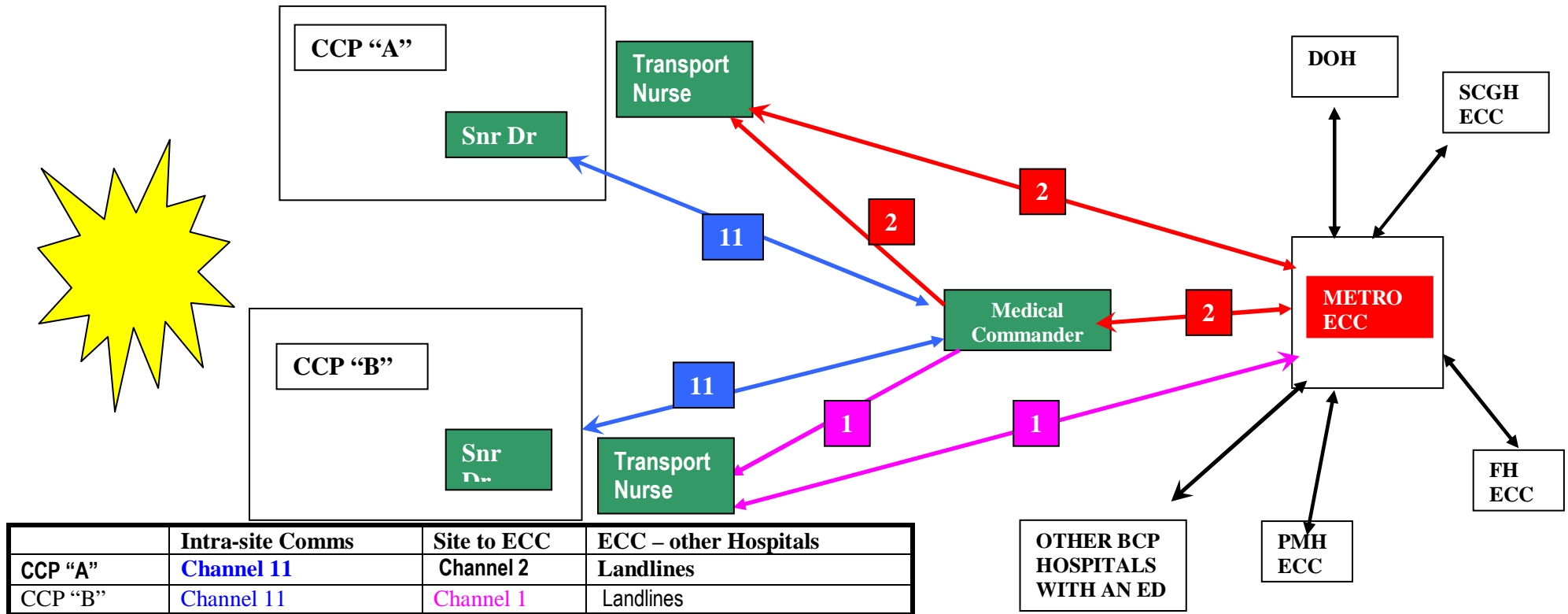
SINGLE CCP SET UP – Single site



	Intra-site Comms	Site to ECC	ECC – other Hospitals
Primary	<b>Channel 11</b>	<b>Channel 2</b>	<b>Channel 1</b>

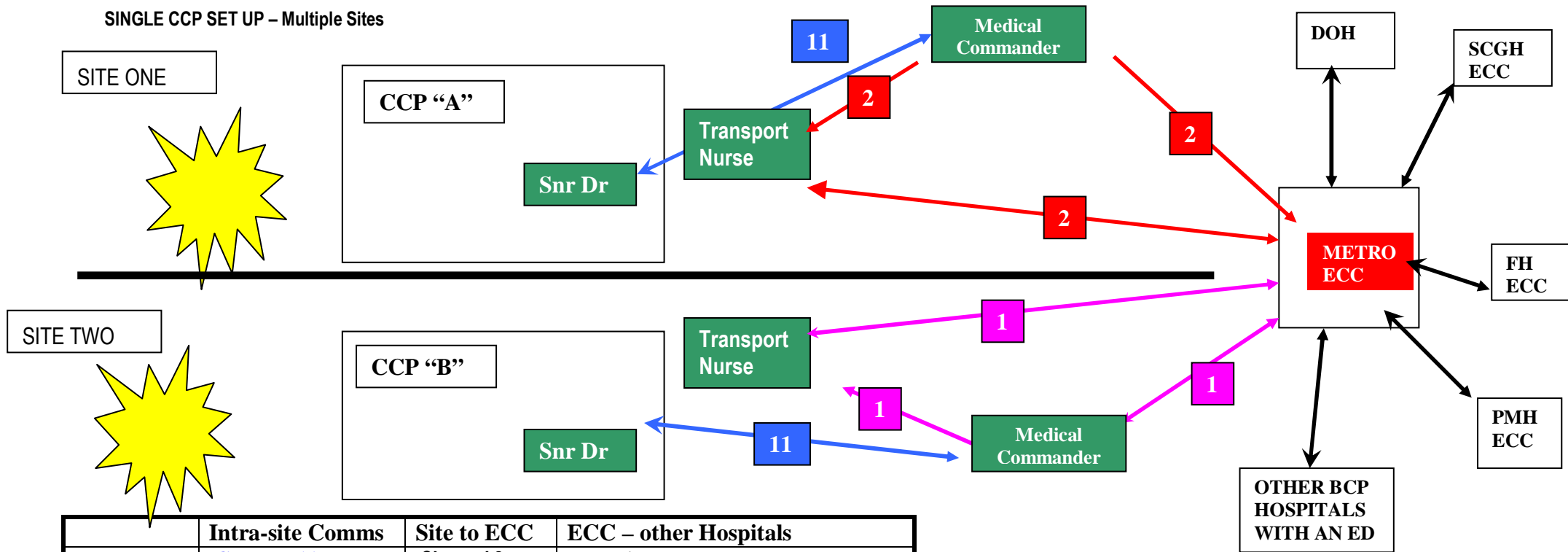
Disaster Location	Intra-site	Site to Metro ECC	Metro ECC to Metro Hospitals
Perth	11	2	1
Rockingham & Surrounds	11	4	1
Joondalup & Surrounds	11	6	1
Rottnest	11	8	1
Perth Hills	11	10	1

DOUBLE CCP SET UP – Single Site



Disaster Location	Within CCP "A"	Within CCP "B"	CCP "A" to Metro ECC	CCP "B" to Metro ECC	Metro ECC to Metro Hospitals
Perth	11	11	2	1	Landlines etc
Rockingham & Surrounds	11	11	4	3	Landlines etc
Joondalup & Surrounds	11	11	6	5	Landlines etc
Rottnest	11	11	8	7	Landlines etc
Perth Hills	11	11	10	9	Landlines etc

**SINGLE CCP SET UP – Multiple Sites**



	Intra-site Comms	Site to ECC	ECC – other Hospitals
SITE ONE	Channel 11	Channel 2	Landlines etc
SITE TWO	Channel 11	Channel 1	Landlines etc

1. Disaster Location	2. Within CCP "A"	3. Within CCP "B"	4. CCP "A" to Metro ECC	5. CCP "B" to Metro ECC	6. Metro ECC to Metro Hospitals
7. Perth	8. 11	9. 12	10. 2	11. 1	12. Landlines etc
13. Rockingham & Surrounds	14. 11	15. 12	16. 4	17. 3	18. Landlines etc
19. Joondalup & Surrounds	20. 11	21. 12	22. 6	23. 5	24. Landlines etc
25. Rottneest	26. 11	27. 12	28. 8	29. 7	30. Landlines etc
31. Perth Hills	32. 11	33. 12	34. 10	35. 9	36. Landlines etc



## Appendix 13

### References

1. Westplan Health. 2004. Western Australia, Health Emergency Management Support Plan. Department of Health, East Perth, WA.
2. Policy Statement 7. 2005. State Emergency Management Committee.
3. Emergency Management Australia. 1999. Disaster Medicine, Manual 2. 2<sup>nd</sup> ed., Commonwealth of Australia.
4. Advanced Life Support Group. 2002. Major Incident Management & Support – The Practical Approach at the Scene, 2<sup>nd</sup> ed., BMJ Books, London.
5. Cato, D. 2003. Health Aspects for Dealing with Disasters in Australia, South West Area Health Service, Sydney.