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## 3. FIELD MANAGEMENT

### A. DEFINITION

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Field management encompasses procedures used to organize the disaster area in order to facilitate the management of victims.

### B. FIELD ORGANIZATION

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#### 1. Alerting Process

##### 1.1 Definition

The alerting process is a sequence of activities implemented to achieve the efficient mobilization of adequate resources. This includes initial warning, assessment of the situation, and dissemination of the alert message.

##### 1.2 Purpose

- To confirm the initial warning
- To evaluate the extent of the problem
- To ensure that appropriate resources are informed and mobilized

##### 1.3 Dispatch Center

The core of the alerting process is the dispatch center: a communications center that receives all warning messages and is linked by radio and phone to all services involved in emergency management (e.g., "911").

The dispatch center must have the capacity to mobilize a small assessment team ("flying team"), composed of personnel from police, fire, or ambulance services, in

order to confirm a warning message when necessary.

#### 1.4 Confirmation of Initial Warning

##### 1.4.1 Warning message from general public

This message, issued by a non-qualified observer, must be confirmed, either by immediate call-back or by a second identical message from another source.

If this is not immediately possible, the dispatch center must send a "flying team" to the site, while alerting potential responders (stand-by alerting process).

##### 1.4.2 Warning message from qualified observer

Upon reception of a message from an individual working in emergency services and experienced in initial assessment, appropriate resources can be immediately dispatched.

#### 1.5 Initial Assessment

##### 1.5.1 Definition

The initial assessment is the procedure used to identify the immediate extent and the potential risk of the problem.

##### 1.5.2 Purpose

- To know exactly what is happening and what could happen
- To mobilize adequate resources
- To correctly organize the field management

### 1.5.3 Personnel

Any first responder trained in initial assessment will be appropriate to carry out this procedure.

### 1.5.4 Occasion

Any accident should benefit from an initial assessment. Any major incident needs immediate initial assessment.

### 1.5.5 Method

Initial assessment is a sequence of activities identifying the following:

- Precise location of event
- Time of the event
- Type of incident
- Estimate of number of casualties
- Added potential risk
- Exposed population

## 1.6 Report to Central Level

The initial assessment must be reported immediately to the dispatch center before any further action is taken. If the first responders start their work in the field before reporting, there will be a delay in mobilization of resources, or critical information may be lost if responders are trapped in a second accident.

## 1.7 Dissemination of Information

As soon as the warning message is confirmed, the dispatch center will issue the alert message, mobilizing necessary resources and informing specific persons and institutions.

This alert message must be rapidly circulated using pre-established procedures, such

as a cascade phone system (see Figure 2).

## 2. Field Areas Pre-Identification

The second role of the initial assessment team is to identify the field areas to be established. These will include:

- Impact Zone
- Command Post Area
- Advance Medical Post Area
- Evacuation Area
- VIP and Press Area
- Access Roads

Pre-identification of field areas will allow various incoming resources to reach their specific areas rapidly and efficiently. It constitutes the initial part of the on-site deployment.

One of the best ways to realize and present this pre-identification is to draw a simple map of the area, including the main topographical and physical features such as roads, natural/artificial boundaries, ponds, rivers, buildings, etc.

Using this map, potential risk areas, victims, access roads and the various field areas can be identified, including the boundaries of restricted areas.

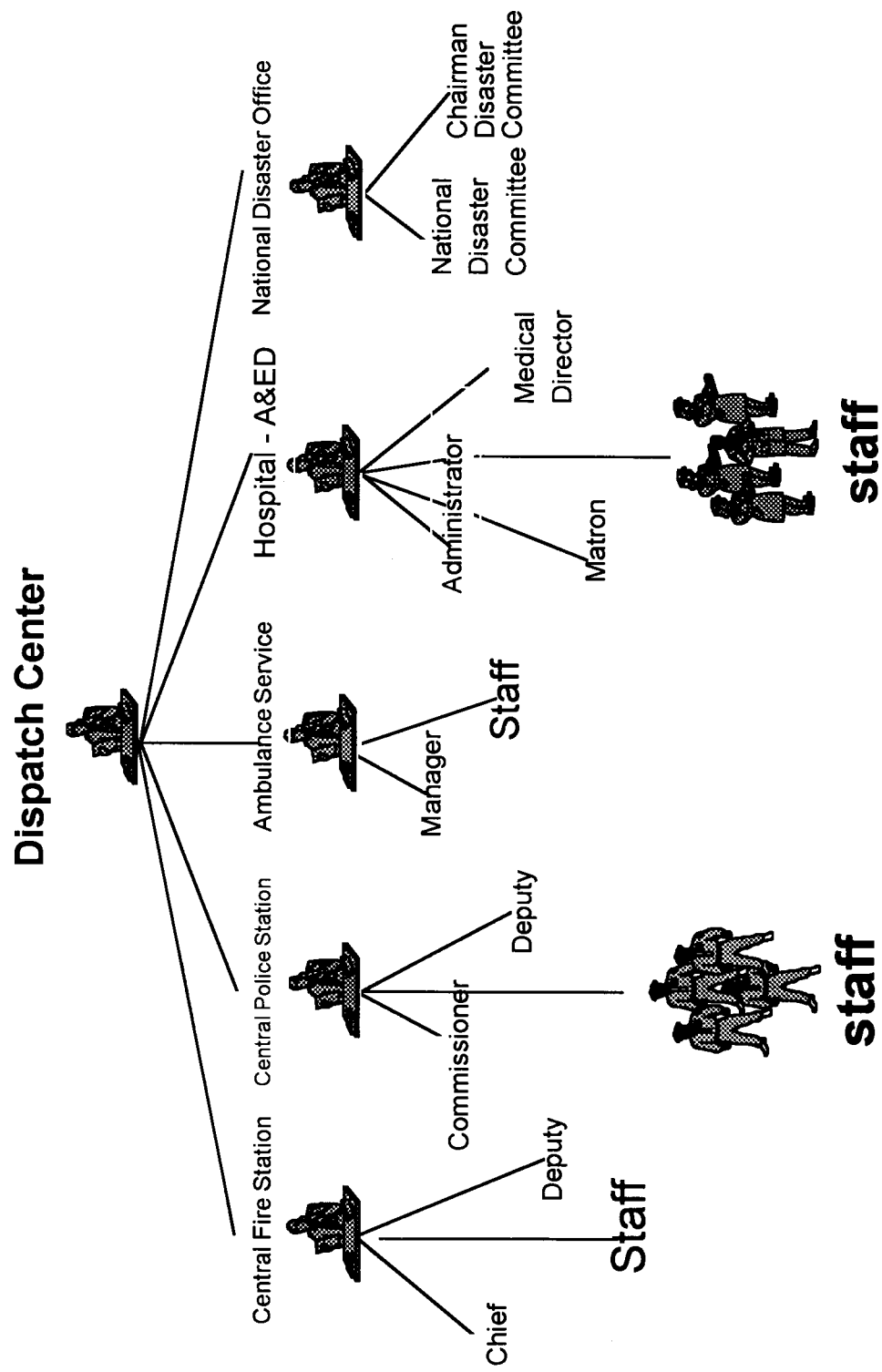
Compass rose and wind direction must also be provided.

## 3. Safety

### 3.1 Definition

Safety measures are implemented to protect victims, responders and exposed population from immediate and/or potential risk (extension of the accident, responding to traffic accidents, hazardous materials, etc.).

Figure 2. CASCADE PHONE SYSTEM



### 3.2 Safety Measures

3.2.1 *Direct action* includes risk reduction by fire fighting, confinement of hazardous material, use of protective clothing, and evacuation of exposed populations.

3.2.2 *Preventive actions* include the establishment of the following restricted areas:

- The impact zone—strictly restricted to professional rescuers; adequately equipped.
- Secondary area—restricted to authorized staff working in rescue operation, care delivery, command and control, communications, ambulance services, security/safety. The Command Post, the Advance Medical Post, the evacuation center and parking for the various emergency and technical vehicles will be set up in this area.
- The tertiary area is to be accessed by press officials and to act as a “buffer” zone to keep onlookers out of danger.

The size and design of the restricted areas depend upon the type of accident (toxic smoke, hazardous materials, intense fire, explosion risk), the wind and topography (see Figures 3-4).

### 3.3 Personnel

Safety measures will be implemented by the fire services, assisted in specific problems by specialized units (hazardous material, explosives experts, etc.). Restricted areas will be defined by fire services in coordination with specific services (for example, the airport manager, chemical plant’s chief of security) when necessary.

### 4. Security Measures

Security measures are implemented to keep external elements from interfering with the rescue organization. Restricted access of each safety area is maintained by implementing crowd and traffic control.

Security measures contribute to safety by:

- Protecting workers from external influences (additional stress),
- Avoiding obstruction of flow of victims and rescue resources,
- Protecting the general public from exposure to risk.

Security is ensured by police force, special units (defence force, national guard), government security officers, airport security, and hospital security.

### 5. Command Post

#### 5.1 Definition

The command post is a multi-sectoral control unit established to:

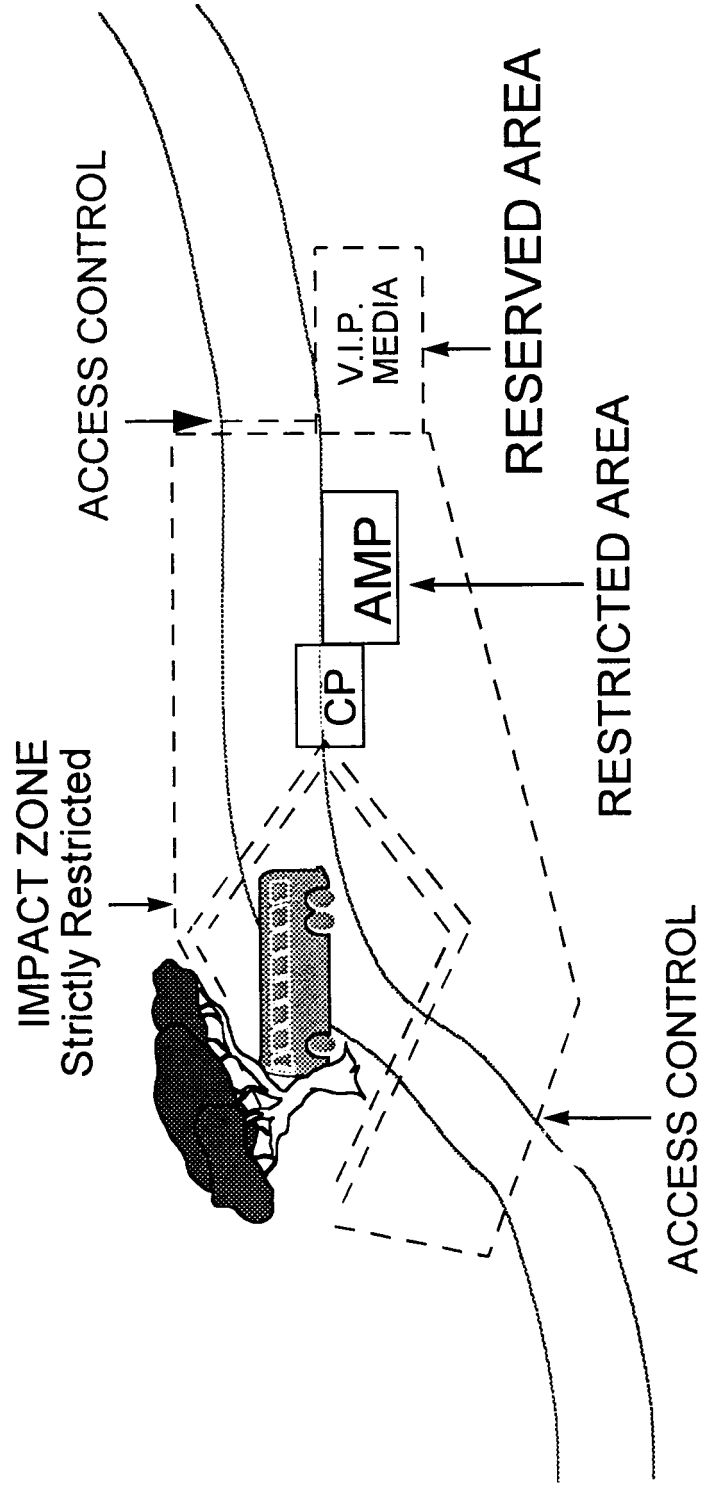
- Coordinate the various sectors involved in field management,
- Link with back-up systems to provide information and mobilize necessary resources,
- Supervise victim management.

This will only be possible if the command post has a comprehensive radio network.

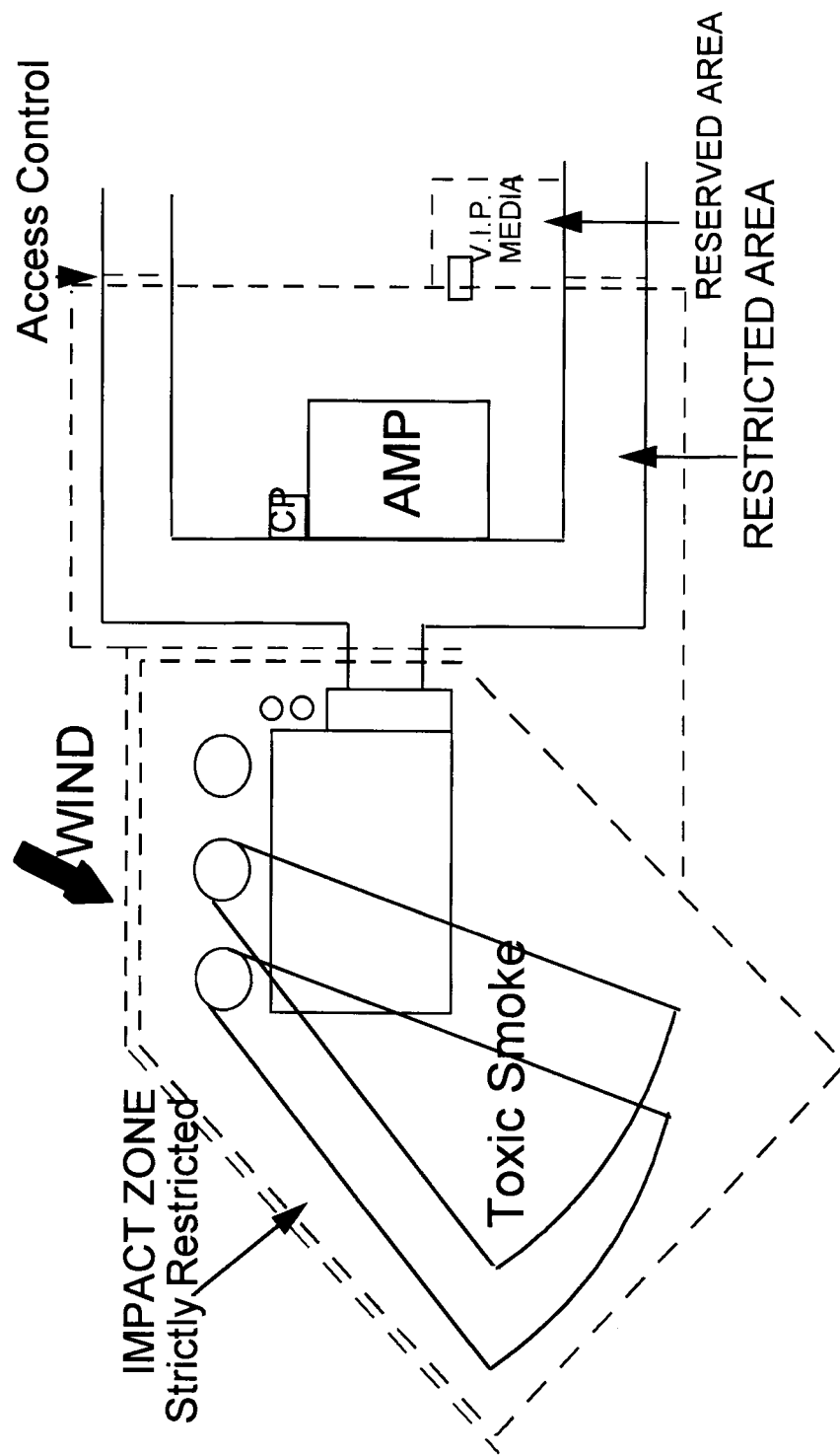
#### 5.2 Purpose

The field management of a disaster requires the mobilization and coordination of sectors which do not routinely work together. The efficiency of pre-hospital activities requires strong coordination of the various responders. In order to fulfil this need for coordination, the command post must be set up at the very beginning of the rescue operation.

**Figure 3. RESTRICTED AREAS  
Road Traffic Accident**



**Figure 4. RESTRICTED AREAS**  
**Chemical Fire**



### **5.3 Location**

The main criterion for an effective command post is radiocommunications. This can be implemented from any sort of structure, ranging from a single police car to a specific mobile command post, or from a tent to an appropriately located building.

The command post must be installed at the external boundary of the strictly restricted area (impact zone), close to the advance medical post and the evacuation area. It must be easily identified and accessible. Its location should accommodate all communication (visual, radio, road).

### **5.4 Personnel**

The command post is staffed by the highest ranking personnel available from police, fire service, health sector, and defence force (where existing).

This core group can co-opt volunteer organization representatives and, depending on the type of accident, specialized personnel (e.g., airport manager in the case of an airplane crash, prison governor in prison incident).

It is generally agreed that the coordinator of this unit is a police officer. However, depending on the specific nature of the incident, the coordinator may be more specialized (e.g., an airport manager in case of an airport accident).

Those likely to operate in the command post must be identified by name and position. They must be familiar with each other's roles, know each other, and have practiced and discussed issues during regular meetings. These meetings should include exercises to practice coordination of resources, and administrative discussions about changes in resources or procedures

as they develop. Meetings should be held on a regular basis, but they need not be frequent.

### **5.5 Method**

The command post is the communication/coordination hub of the pre-hospital organization. The command post will, by constant reassessment of a situation, identify needs to increase or decrease resources in order to:

- Release, as soon as the situation allows, the emergency services staff that are no longer needed in the field. In this way, the command post will contribute to the re-establishment of routine operations.
  - Organize the timely rotation of rescue teams exposed to stressful/exhausting situations in close cooperation with the back-up system.
  - Ensure the provision of adequate supplies of equipment and manpower.
  - Ensure comfort/welfare of rescue teams (provide food and drink).
  - Provide information to back-up systems, and keep other officials and the media informed (through an official spokesperson).
  - Determine the termination of field operations.
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## C. MANAGEMENT OF VICTIMS

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### 1. Search and Rescue

Search and rescue operations depend strictly on skilled teams from the fire service and specialized units, assisted when necessary by volunteers. These teams will:

- Locate victims
- Remove victims from unsafe location to collecting point if necessary
- Assess victim status (on-site triage)
- Provide first aid, if necessary
- Transfer victims to the advance medical post, if necessary

Search and rescue teams work in the strictly restricted area (impact zone) under the command of a fire officer or, in specific situations, of specialized personnel.

Depending on the risk (e.g., toxic smoke, hazardous materials), rescue teams will utilize special protective clothing and equipment. In exhausting working conditions, a quick turn over of rescue teams must be implemented.

The situation could arise that, due to the location of the victim (trapped under a collapsed wall, for example), extrication will need time. If the status of the victim is bad, the rescue team leader can request, through the Command Post, on-site assistance of medical personnel in order to commence stabilization of the patient during extrication. This procedure requires specifically trained medical personnel and must only be used in exceptional cases.

When the impact zone is large, it may be necessary to divide it into smaller "working areas", each assigned to a rescue team. In such a situation, or when the impact zone is unsafe, the Search and Rescue Officer will

establish a Collecting Point in a safer area adjacent to the impact zone, where victims will be temporarily assembled (see Figure 5). This collecting point will be managed by emergency medical technicians (EMTs) and volunteers, and will ensure the initial triage, first aid and transfer to the advance medical post.

### 2. Field Care

When an area does not have adequate health care facilities available to face a mass casualty incident (e.g., one small secondary/tertiary hospital), rapid transportation of all victims to a hospital with limited resources will compromise the care of the seriously injured victims. In addition, this will profoundly disrupt the hospital care system, endangering patients already in the hospital. It is not realistic to "push" 200 victims into a 300-bed hospital, with only 3 operating rooms, for example, and expect good results.

One operating theater requires at least six highly specialized people to run it. A patient suffering from "major" trauma may take 3-4 hrs to "stabilize". Each region or area must identify its own resources and limitations:

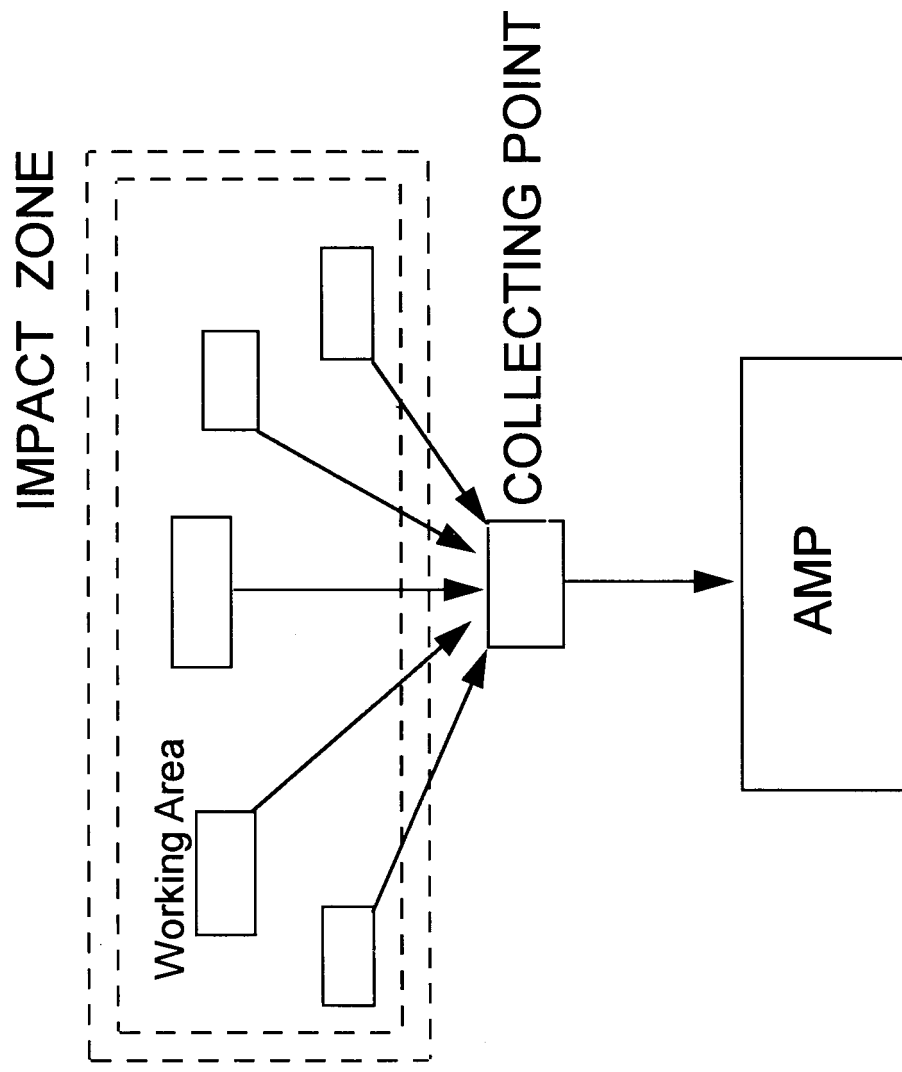
- How many operating theaters are available in a region?
- How many of these operating theaters can be adequately staffed in a crisis?

The answer to the second question may affect the answer to the first.

In limited resource conditions, due to space and care available, transport of victims to hospital should be staggered. This supposes that victims will receive adequate field treatment, allowing them to tolerate this delay.



**Figure 5. COLLECTING POINT**



Actually, in a mass casualty event, only a small number of victims will need immediate treatment in a hospital. The “Golden Hour”, here, applies essentially to victims with internal bleeding who could fully benefit from immediate “life saving” surgery.

The recent progress in pre-hospital emergency medicine allows specific skilled teams to provide good field care, through establishment of an Advance Medical Post. This “disaster field medical team” approach supposes the existence of:

- Good triage capacity
- Specifically trained medical teams
- Good radiocommunications between the field and the hospital
- Good coordination of all involved sectors.

## 2.1 Triage

The objective of “classical” field triage is to identify victims needing immediate transport to health care facilities and those who can be delayed. This triage is based essentially on urgency (victim status), and, secondly, on likelihood of survival.

In countries or areas with few resources, this second criterion is of greater importance, being strictly correlated to the health care resources available. So a new triaging approach is necessary based on urgency, likelihood of survival, as well as on care resources available.

Triage objectives will then be:

- Quick identification of victims needing immediate stabilization (field medical care)
- Identification of victims who could be saved only by immediate surgery (life-saving surgery)

The field triage process will be conducted at three levels:

- On-site triage (triage one)
- Medical triage (triage two)
- Evacuation triage (triage three)

### 2.1.1 On-Site Triage

This is the on-site categorization of victims “where they are lying” or at the collecting point. This on-site triage, due to limited medical resources, will generally be performed by first aiders, sometimes by EMTs.

A survey of 15 mass casualty simulation exercises conducted in the Caribbean area showed that when the color code triage is utilized, the percentage of incorrect classification decreased in accordance to experience (i.e., first aid workers made the most incorrect classifications followed by EMTs and then emergency medical staff, see Figure 6).

However, if we group red and yellow victims in an “acute victim” category and green in a “non-acute victim” category, the percentage of incorrect classifications is significantly lower (see Figure 7).

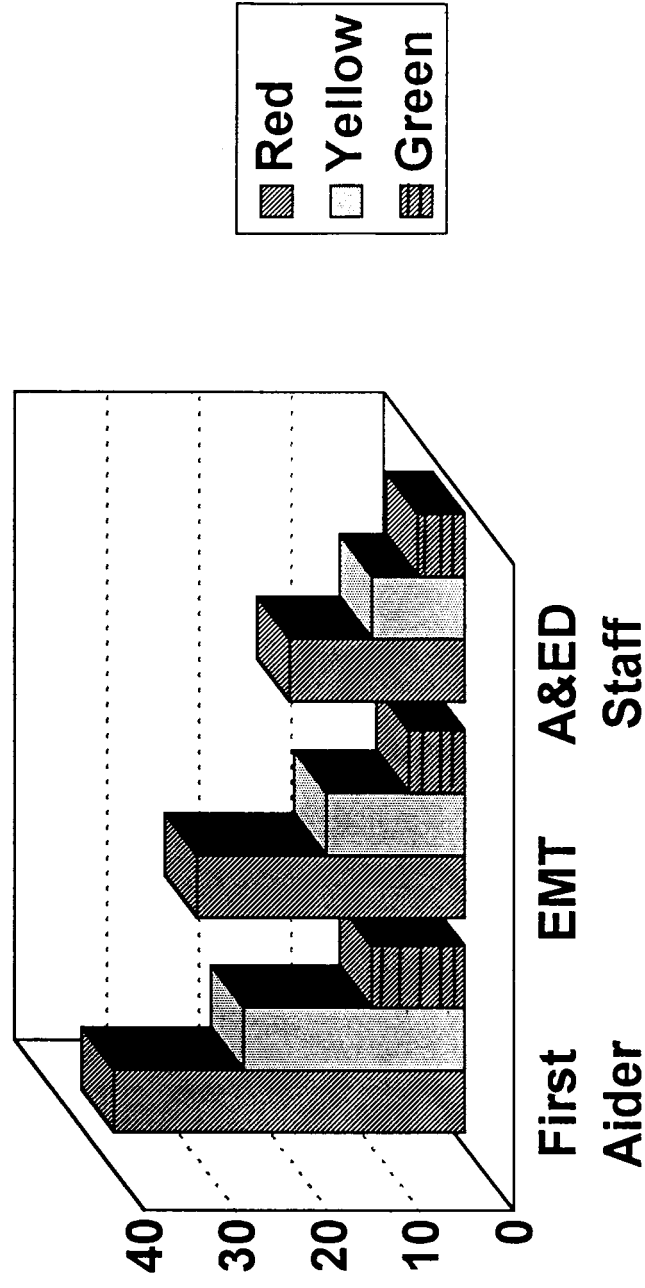
The result of this survey demonstrates that it is difficult for a volunteer/first aider, infrequently exposed to a triage situation, to accurately distinguish between some red and yellow victims, while his or her training will allow easier differentiation between acute and non acute victims. Moreover, first aiders utilize more time to fill the color code triage tag, with less effectiveness, than more skilled personnel.

In spite of the remarkable commitment of volunteers, these problems will not be solved by more theoretical training, but only by greater exposure to real situations. This may be difficult to organize for volunteers who are not involved on a daily basis in emergency rescue operations.

# TRIAGE

Figure 6.

Percentage of Incorrect Categorization

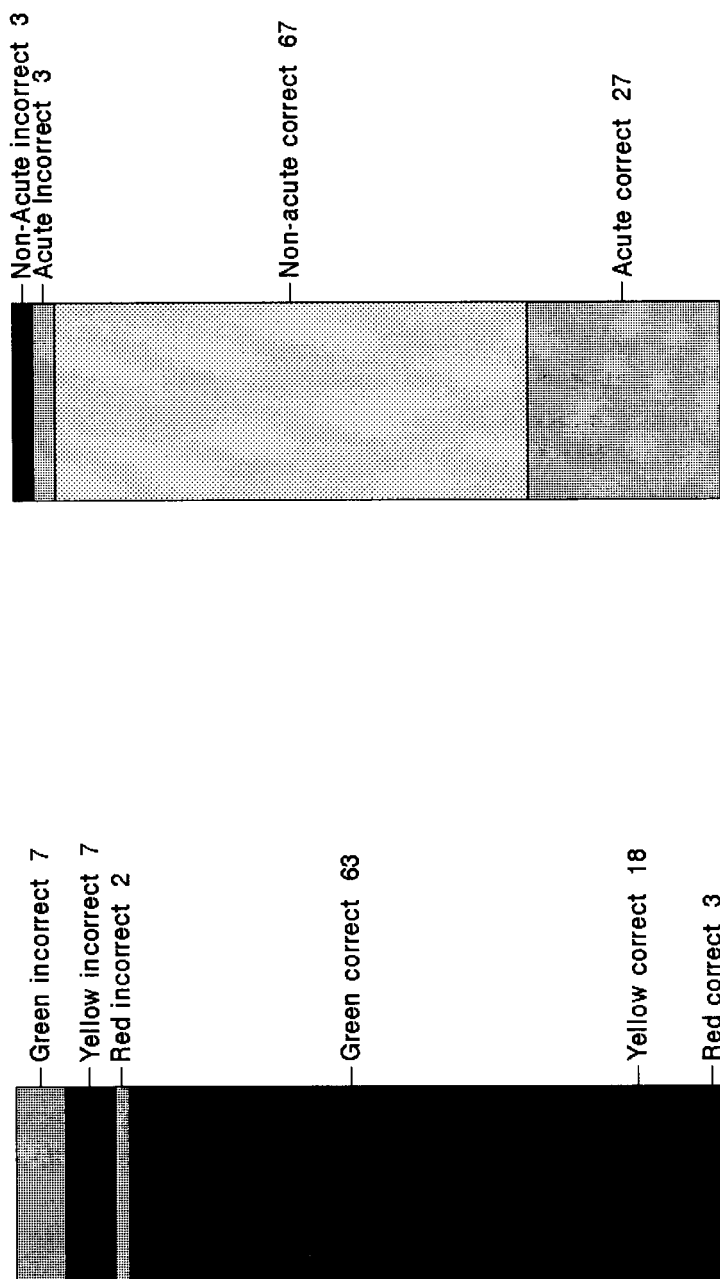


Average from 15 simulation exercises

# TRIAGE

Figure 7.

## First Aider Level



## Color Code Triage

Categorization of 100 Victims

## Acute/Non-acute Triage

The on-site triage is expected to identify those victims needing prompt medical attention (quick transport to the advance medical post) and those who can wait; in other words, to classify victims in acute (red and yellow) and non acute (green and black) categories.

Acute victims will not be tagged but marked by a large floating red ribbon, securely attached to them. Non acute victims will be identified by a green ribbon. Stretcher bearers will thus easily identify, even from some distance, acute patients to be taken immediately to the Advance Medical Post.

In this way, on-site triage time (for assessing, categorizing, marking and transporting victims to the advance medical post) will be significantly reduced, and incorrect categorization will decrease.

### 2.1.2 Medical Triage

This triage will be performed at the entrance to the Advance Medical Post by the most experienced medical personnel available who have extensive skill in triaging.

Although most disasters produce injured victims, some specific events (e.g. mass food poisoning, chemical intoxication, shipwreck) give rise to victims needing only intensive care. Moreover, primary treatment for severe shock in multiple trauma is intensive resuscitation. Hence, when possible, the preferred specialist to act as triage officer should be an emergency physician, followed by an anesthesiologist, then by a surgeon.

The objective of medical triage is to determine the level of care needed. The color code triage tag will be utilized at this stage, when more accurate information on victim status can be collected. Accordingly, the color categories assigned to the victims will be:

*Red* = requires immediate stabilization care and includes victims with:

- Shock status from any cause
- Respiratory distress
- Head injury with unequal pupils
- Major external bleeding

This immediate care (intensive field care) provided to patients with a reasonable likelihood of surviving, will allow them to tolerate transfer to health care facilities and prepare them to receive treatment. It should also allow for the recategorization of victims from "red" status to "yellow" (e.g. chest drainage for a tension pneumothorax).

*Yellow* = requires close monitoring; care can be somewhat delayed. This category includes victims with:

- Risk of shock (e. g., heart attack, major abdominal trauma)
- Compound fractures
- Femur/pelvic fracture
- Severe burns
- Unconscious/ head injury
- Victim with uncertain status

All these victims will receive an IV line (vein guard), close monitoring for any complication, and will receive treatment as soon as possible.

*Green* = requires delayed or no treatment, including victims with:

- Minor fracture
- Minor wounds and burns

These patients, after receiving dressing and/or splinting, will be transferred at the end of the field operation.

- Hopelessly injured victims, if still alive at the end of the field operation, will be transferred to health care facilities.

*Black* = Deceased

Particular circumstances will dictate different responses: A victim with 50% body surface burns is classically triaged as “red”. In fact, the immediate treatment needed is essentially infusion. In an accident with a small number of victims and substantial care resources available, this person must receive immediate attention and be quickly transferred to a specialized care unit.

In a mass casualty event where there are limited care resources, the initial treatment of such a burn victim can be delayed for an hour as long as the victim has no breathing problems. Thus the immediate transfer to a hospital is no longer a priority. This victim will then be classified as “yellow”.

### 2.1.3 Evacuation Triage

This triage will prioritize victims for transfer to adapted and ready-to-receive health care facilities.

If the Advance Medical Post is successful in its care providing role, the number of “red” victims should decrease, and re-tagging will be necessary before evacuation.

The Medical Officer in charge of the Advance Medical Post will decide, according to the status of the victims and in liaison with the Command Post and the hospital, who will be moved first to what destination, with what type of vehicle and escort.

The color code triage will be used as follows:

- Red* = to be transferred immediately or as soon as possible to tertiary hospital, by equipped ambulance, with medical escort. This includes:
- Victims needing life-saving surgery
  - Victims needing function-saving surgery
  - Victims for ICU

*Yellow* = to be transferred, after evacuation of all red victims, to tertiary hospital, by ambulance, with first aider escort. This includes:

- Victims without life threatening problems needing tertiary hospital care

*Green* = to be transferred, at the end of the field operations, to appropriate health care facilities by available vehicles, without escort. This includes:

- Minor wounds and burns → health center or polyclinic, never to main hospital.
- Hopelessly injured → main hospital

*Black* = transfer to morgue

## 2.2 First Aid

### 2.2.1 Personnel

First aid is provided by volunteers, fire and police staff, special unit staff, EMTs and medical personnel.

### 2.2.2 Location of first aid

- Directly on-site, before moving victim
- At the collecting point
- In the “Green Area” of the Advance Medical Post
- In the ambulance while transferring victims to health care facilities.

### 2.2.3 Action

Classical first aid attention can be provided, including control of airways, breathing and cardiac functions, position of victim, control of bleeding, immobilization of fracture, dressing and comfort. However, first aiders must keep in mind that, on-site, the most important priority is to transfer,

as soon as possible, acute victims to the advance medical post while ensuring key first aid actions (i.e., maintain airways, control bleeding). Since it is time and manpower consuming, CPR must never be used on site in a mass casualty event.

### **2.3 Advance Medical Post (AMP)**

#### **2.3.1 Purpose**

One of the main objectives of rescue and care services in a mass casualty event is to reduce loss of life by providing, as soon as possible, effective care for all the victims. When, due to limited resources and lack of space, a health care facility cannot provide adequate housing and effective treatment for victims of a mass casualty event, alternate solutions must be proposed. Distributing victims among various health institutions is a viable alternative, but this supposes the existence of other health facilities at a reasonable distance from the disaster or accident site and the availability of transport resources and coordination.

If distance is too great, or transport resources too few, the transfer of victims to an adapted health care facility will involve delay, and delay puts the victims at greater risk. In such a situation, victims must receive the best stabilization possible in the field, allowing them to tolerate delayed arrival to hospital.

Field care cannot be improvised and must not be managed by untrained individuals. Well prepared organization is required, with the establishment of a specific treatment area. This treatment area, a front line, light medical structure, constitutes the Advance Medical Post.

#### **2.3.2 Location**

The Advance Medical Post must be established within walking distance (50 - 100 meters) of the impact zone:

- In a safe area
- With direct access to the evacuation road
- At a short distance from the Command Post
- In a clear radio communication zone

In some circumstances, for example at a site where hazardous materials are present, the AMP will be placed further away. But it must remain as close as safely possible to the impact zone. In such a situation, transport of victims from the impact zone to the AMP will require a different organization. If weather conditions allow (i.e., rain, sun, temperature, wind), the AMP can be in the open. It is preferable, if possible, to locate it in a building or under a tent.

#### **2.3.3 Role**

The main objective of the AMP is to provide effective field stabilization for victims of a mass casualty event. As outlined above (C.2.1.2), medical triage will take place at the entrance of the AMP in order to identify victims who will benefit from immediate attention.

Field stabilization care involves intubation, tracheostomy, chest drainage, drug treatment of shock, analgesia, fluid replacement, faciotomy, fracture immobilization, and dressing.

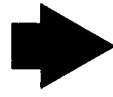
Another of the results, other than stabilization, expected from the care provided by AMP staff is to move as many patients as possible from the red to yellow category. The final role of the AMP is to organize patient transfer to adapted health care facilities.

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# Figure 8. **ADVANCED MEDICAL POST**

## **3 T Principle**

**TAG**



**TREAT**



**TRANSFER**





These functions can be represented by the three "T" rule: Tag, Treat, Transfer (see Figure 8).

#### 2.3.4 Personnel

In order to provide the level of care needed by victims in an Advance Medical Post, staff must be skilled medical personnel. The level of care provided here is similar to that expected from any hospital Accident and Emergency Department, and the most appropriate staff should be drawn from emergency physicians and nurses.

In most countries or communities, the hospital Accident and Emergency Department is likely to have, immediately available, at least one physician and nursing staff. These medical personnel must be available for immediate mobilization and will form the backbone of the Advance Medical Post.

This initial group in charge of establishing the AMP will be reinforced by other emergency physicians, anesthetists, surgeons and nursing staff as the momentum of the mobilization gathers. This hospital medical staff will be joined by paramedics, EMTs and first aiders.

#### 2.3.5 Organization of the Advance Medical Post

##### i. Internal Structure

###### Design

The design of the Basic AMP (see Figure 9) includes:

- One entrance, easy to identify
- A reception/triage area for the placement of a maximum of two victims simultaneously
- A treatment area for 25 victims simultaneously, divided into:
  - Area for acute victims (i.e., Red and Yellow tags); this will be the

largest area

- Non-acute victims area (Green and Black tags).

- One exit

The design of the Standard AMP (see Figure 10) includes:

- Two entrances (Acute - Non Acute), each entrance being easily identified by red flag (for acute victims) and green flag (for non-acute victims).
- Two adjacent Reception/Triage Areas, interconnected to facilitate victim exchange.
- An Acute Treatment Area, linked to acute triage area, divided into:
  - Red treatment area (immediately adjacent to triage area)
  - Yellow treatment area (following the red treatment area)
- A Non-Acute Treatment area, linked to non-acute triage area, divided into:
  - Black victims area (immediately adjacent to triage area)
  - Green treatment area (following the black victims area)

Each treatment area will be identified by a flag of appropriate color.

- An Evacuation Area: temporary waiting area for stabilized patients in transit to transfer.

###### Surface Area

The Advance Medical Post, being a "pass through" area, must not house many victims at one time. On an average, it should be able to accommodate 25 victims together with the AMP staff. Following are recommendations for the surface area required:

- Treatment and circulation require, as minimum field standard, 3 sq yards (2.6 m<sup>2</sup>) per victim.
- Minimum area for triage is 10 sq.

**Figure 9. BASIC ADVANCE MEDICAL POST**

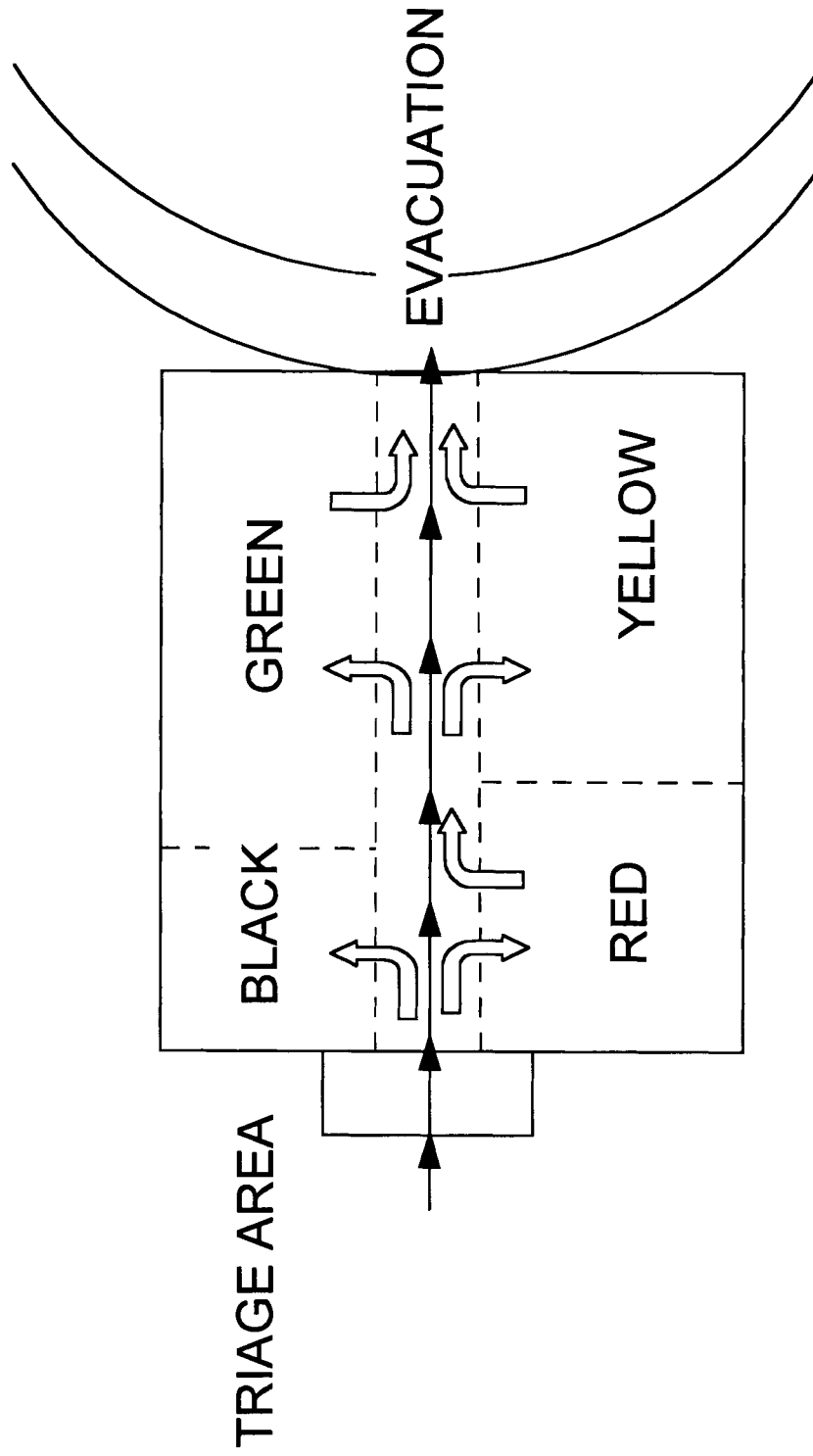
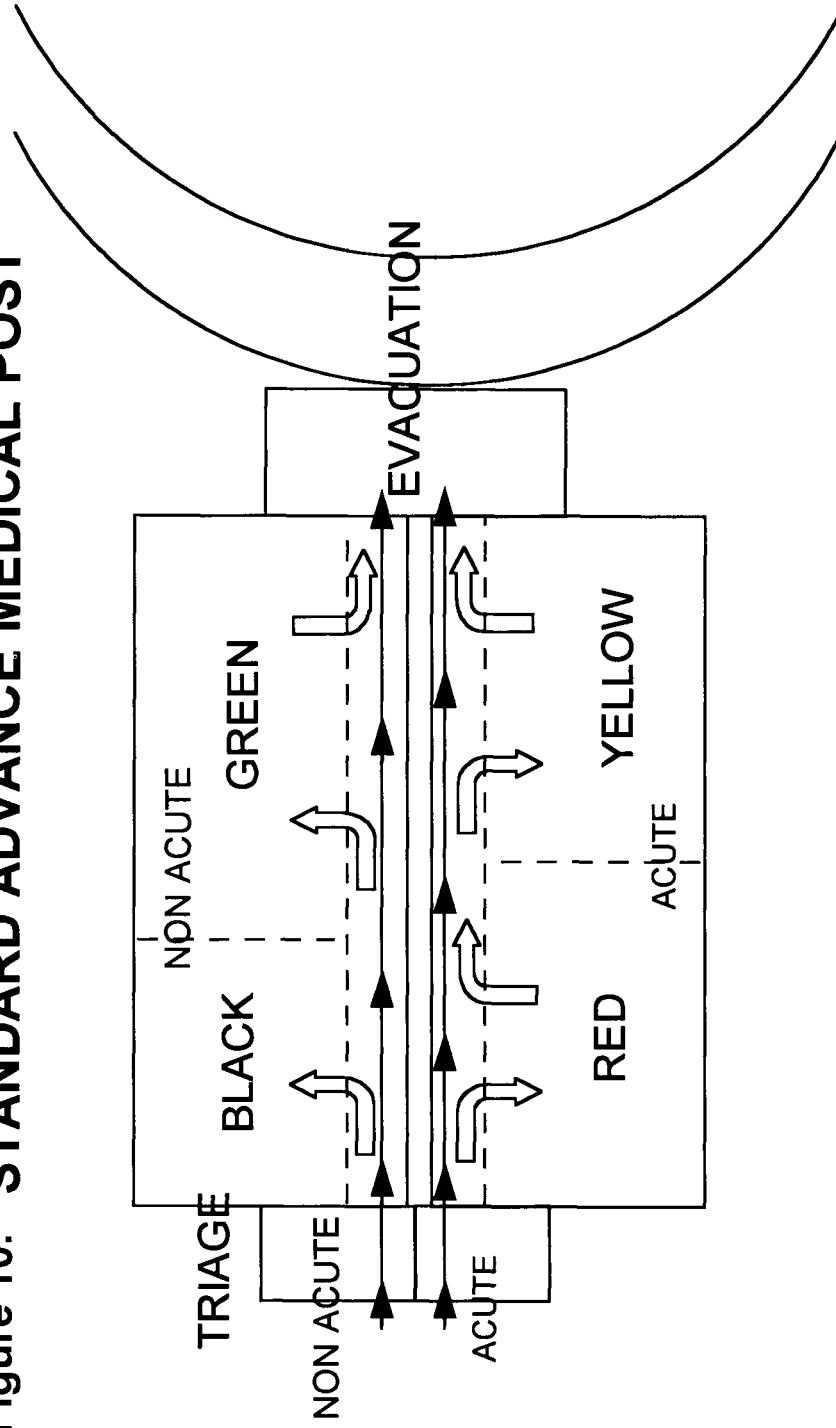


Figure 10. STANDARD ADVANCE MEDICAL POST



yards (8.3 m<sup>2</sup>), due to intense traffic.

- Minimum area for basic AMP treatment areas is 75 sq. yards (65m<sup>2</sup>).
- Minimum area for standard AMP treatment areas is 150 sq. yards (130 m<sup>2</sup>).
- An evacuation waiting area will require 30 sq. yards (26 m<sup>2</sup>).

So minimum area required for an AMP is approximately 85 sq. yards (73 m<sup>2</sup>).

## ii. Victim flow

Victims carried by stretcher bearers will arrive at the appropriate triage entrance. The triage area must not house more than two victims at a time.

Victims will be tagged in RED/YELLOW/GREEN/BLACK. Registration will be done simultaneously and victims transferred to the appropriate treatment sub-area, where they will be stabilized.

Once stable, victims will progress to the evacuation area where registration of departure will be completed.

### 2.3.6 Personnel for Standard AMP

#### i. Triage Area (reception):

##### *Acute:*

- Triage Officer: most experienced physician (preference of experience: emergency physician, anesthesiologist, surgeon). No more than one person performs triage at one time.
- Assisted by either a nurse, an EMT or a first aider (in order of preference).
- Administrative Clerk for registration (clerk/nurse/first aider).

##### *Non-Acute:*

- Triage Officer: most experienced nurse, paramedic or EMT
- Assisted by first aider
- Administrative Clerk (possible duplicated in first aider).

In a basic AMP, a single triage team will operate for all victims. This team will be constituted as the above-mentioned acute triage team.

No treatment is to be done in the triage area.

#### ii. Treatment Areas

##### *Acute Treatment:*

- a. Acute Treatment Manager: preferably a skilled paramedic or EMT, experienced in disaster organization. If there are enough trained personnel available, an experienced physician might take this responsibility. This individual must be able to supply the area, coordinate with other areas, organize disposal, and manage radio communications. This individual will also act as the Manager of the AMP.
- b. Red Treatment Team:
  - Team Leader: Anesthesiologist, emergency physician or skilled paramedic
  - Nurse/anaesthetist and/or Emergency Department nurse
  - Assisted by EMT and/or first aiders
  - Stretcher bearers
- c. Yellow Treatment Team:
  - Team Leader: Nurse (Anaesthetist or Emergency Department) or paramedic
  - Assisted by EMT and/or first aider
  - Stretcher bearers

*Non-Acute Treatment:*

## d. Green Treatment Team:

Team Leader: most experienced EMT  
Assisted by EMT and/or first aider  
Stretcher bearers

e. Deceased (Black category) victims area:  
No personnel required

## iii. Evacuation Area

a. Leader: Paramedic/experienced EMT  
able to:

- Assess stability of patient's status
- Assess security of equipment
- Monitor briefly prior to transport
- Supervise loading
- Provide brief escort

## b. Administrative Clerk

c. Transport Officer: Senior officer from  
Fire or Ambulance Service. Liaises  
with the Manager of the AMP and  
the Command Post.

## 2.3.7 Equipment (minimum requirement)

## i. Triage Area

- Identification devices for area and officer
- Triage tags
- Clerical equipment
- Trestles (only four)
- Area lighting devices
- Sphygmomanometer/Stethoscope/Flashlight/Gloves

ii. Acute Treatment Area (quantities  
required for a minimum of 25 patients):

- Identification devices for area manager (red jacket marked "Manager") and for each team leader (red/yellow arm bands).
- Area lighting devices

- Trestles
- Stretchers
- Blankets
- Clerical equipment
- Sphygmomanometer/Stethoscope/Flashlight/Gloves
- Medical disaster kit, including:  
*Airway equipment, including:*

- Oxygen
- Intubation set
- Tracheostomy set
- Chest tube set
- Ventilation bag

*Cardio-vascular equipment, including:*

- Infusion set + fluid
- Drugs for treatment of shock
- MASTrousers

*Electrical/pneumatic equipment, including:*

- Suction
- Specialized light
- Cardioscope/defibrillator
- Respirator
- Batteries and/or generator

*Dressing/Splint kit, including:*

- Compresses, bands
- Suture set
- Gloves
- Antiseptics
- Survival blanket
- Splints (including cervical collars)

## iii. Non-Acute Treatment Area

- Special lighting devices
- Dressing/splint
- Clerical equipment
- Stretchers
- Sphygmomanometer/Stethoscope/Flashlight/Gloves

iv. Evacuation Area

- Light
- Stretchers
- Clerical equipment
- Sphygmomanometer/Stethoscope/Flashlight/Gloves

**3. Evacuation Management Center (EMC)**

When disaster situations have multiple impact zones, each requiring the establishment of an Advance Medical Post (AMP), an intermediate level is required to coordinate evacuation. If each AMP dispatches directly to the tertiary care center without such coordination, the result will be loss of efficiency.

To facilitate coordination, these multiple AMPs would dispatch to a center with greater stabilizing and evacuation facilities, which will coordinate the onward transfer. This may be a “field hospital”, a polyclinic, a secondary hospital, or other ad hoc structures. This Evacuation Management Center (EMC) will:

- Collect/assemble all victims from attached AMPs
- Reassess victims
- Improve and/or follow stabilization
- Dispatch victims

**D. FIELD MANAGEMENT PLAN**

Figure 11 shows the general organization required in a field mass casualty situation.

Figure 11. FIELD MASS CASUALTY MANAGEMENT

