INTRODUCTION

J people lost their lives and more than 17,000 buildings were destroyed in the great Chicago Fire. Fire wagons and water brigades were no match for the chaos and flames.

3....The Iroqois Theater's stage curtain caught fire stirring panic among the men, women and children gathered to see actor Eddie Foy. That panic and blocked exits left rescuers helpless to save 602 people who died in the fire.

1915....A weekend cruise ship, the Eastland, capsized in the Chicago River taking the lives of 812 people. Again, panic and a city unprepared for mass casualties conspired against the saving of many lives.

1958....Fire at Our Lady of Angels School caused the deaths of 87 school children. Amid the panic and confusion, lessons learned during fire drills were forgotten.

1972....Illinois Central train crashed. 475 commuters were hurt and 31 people died.

1977....CTA elevated train derailed. 183 were injured and 11 victims perished.

1979....American Airlines DC-10 Jetliner with 276 aboard crashed on take-off at O'Hare Field...no survivors.

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NOTIFICATION

DISASTER NOTIFICATION

Modern disaster management is based upon immediate access to and activation of public protective agencies.

The initial notification of a disaster incident is made through 9-1-1 to the Chicago Police Department (CPD). The critical information is immediately fast-forwarded to the Chicago Fire Department (CFD).Thereafter, communications between personnel and equipment on the scene and police, Civil Defense, private ambulances, Command Post Hospital(Exhibit I), utility companies and Red Cross is coordinated by CFD through its Ambulance Dispatch Center (ADC).

ACTIVATION OF MEDICAL EMERGENCY PLAN

The Chicago Fire Department is responsible for management of the disaster site. The highest ranking fire official on the scene will activate the medical emergency plan, based upon the number of injured and the extent of the injuries. ADC personnel notify every person and agency on the CFD notification list. This listing is updated annually by the Chicago Fire Department in cooperation with the Chicago Hospital Council (CHC).

Disasters * of such magnitude are infrequent, but they cannot be ignored. While it is safe to assume that a city, however sophisticated and technologically advanced, cannot prevent the possibility of future disaster, it can call together enough resources and cooperation among its experts to respond efficiently to a disaster and optimize the chances for survival of the victims. That, in fact, is the purpose of this manual and the goal of the Medical Emergency Plan described herein.

This manual is for all agencies and institutions and people involved in the handling of disaster incidents in Chicago--to make each one aware of the roles and interrelationships of all participants.

Development of the City of Chicago Medical Emergency Plan was coordinated by the Emergency Medical Services Commission (EMSC) of Metropolitan Chicago, a multi-agency commission created in 1971 to coordinate and improve areawide emergency medical services in Metropolitan Chicago.

Members of the Commission are representatives from the three founding organizations, the Chicago Hospital Council, Chicago Department of Health and Cook County Department of Public Health, as well as from the Chicago Police and Fire Departments, Chicago area hospitals, community health planning organizations and allied health agencies.

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* A disaster is a sudden and unforeseen incident which injures numerous people and/or destroys lives and property. Resultant needs exceed usual available resources.

The Command Post Hospital will receive two notification calls from CFD--the first, a DISASTER ALERT, indicating that a large number of casualties may require immediate care by area hospitals. A second call will inform the Command Post Hospital that a MEDICAL EMERGENCY PLAN IS IN EFFECT.

Both the Chicago Fire and Police Departments have determined the appropriate numbers and types of equipment and manpower which will be required in any disaster situation. This is based upon the immensity of the situation and the number and types of injuries involved.

Additional men and equipment are dispatched as needed. The response of each agency involved in disaster management in the Chicago area is similarly calibrated.

MEDICAL COMMUNICATIONS

COMMAND POST HOSPITAL

The Chicago Fire Department will notify the Mobile Intensive Care (MIC) Resource Hospital in the geographic area of the disaster to serve as the Command Post Hospital(CPH).

COMMAND POST HOSPITAL	GEOGRAPHIC AREA
Illinois Masonic Medical Center	Fullerton (2400N) to Northern City Limits
Northwestern Memorial	Cermak Road (2200S) to Fullerton (2400N)
University of Chicago (Billings)	138th Street (13800S) to Cermak Road (2200S)
Northwest Community Hospital	O'Hare Field

If the disaster occurs close to a suburban area, CFD will notify the MIC Resource Hospital in that suburban area.

First notification from CFD to CPH is a DISASTER ALERT, indicating that a major incident has occurred. A second call to the CPH will indicate that the MEDICAL EMERGENCY PLAN has been implemented.

All medical communications between the CPH and the receiving hospitals will be maintained through dedicated phone lines. It is imperative to the fast, efficient flow of information that the person answering this phone at the receiving hospital be knowledgeable and trained in disaster communications.

In the event of disruption of communications between ADC and the CPH, communications will be handled by the MERCI system or direct dial telephone.

MEDICAL TEAMS

The highest ranking fire official on the scene and/or the medical officer in charge at the scene of the disaster will notify the CPH when it is determined that hospital medical teams are needed on-site.

The CPH will determine the number of medical teams required, based upon the number of victims and types of injuries and determine the hospitals that will be asked to send teams. It is understood that primary receiving hospitals will need all medical personnel to care for victims received. In most instances, it would be inappropriate to request that a hospital which will serve as a primary receiving hospital send a medical team to the site. Medical teams, therefore, should be dispatched only from comprehensive emergency departments of hospitals located at some distance from the disaster site.

RECEIVING HOSPITALS

In consultation with the highest ranking officer of the CFD Bureau of Emergency Medical Services, the CPH will select receiving hospitals based on the location and size of the disaster and access routes from the site to surrounding hospitals. Upon notification from CPH, the selected receiving hospital(s) will implement their disaster plan.

The CPH will also ascertain the ED status and inpatient bed availability of each receiving hospital and relay this information on a continuous basis to the ADC. This will permit the most effective distribution of victims among the receiving hospitals.

ED status will be reported as OPEN, LIMITED or FULL:

OPEN ED.....can accept victims of any triage category.

LIMITED ED...can accept victims of some triage categories; categories are to be specified.

FULL ED.....cannot accept any victims at this time.

It is understood that ED status will change continuously due to disaster victims received and ED patient flow unrelated to the disaster. To insure quality patient care, it is imperative that receiving hospitals keep the CPH informed of any change in their ED status. The CPH will maintain a disaster log sheet (Exhibit II) and, through ADC, will inform the ambulance dispatch officer of any change in any receiving hospital's ED status.

If necessary, the CPH will notify additional hospitals that they are being placed on STANDBY-ALERT which indicates that a disaster has occurred but that an influx of disaster victims at that hospital is not anticipated.

The CPH will be notified by ADC of each ambulance being dispatched from the site. Information will include the name of the receiving hospital, number of victims and the triage category of each victim. The CPH will immediately notify the receiving hospital so that necessary preparations can be made for receipt of the victims. CPH will notify the receiving hospital of each subsequent ambulance run and will request an update on ED status.

MEDICAL RESPONSE

MEDICAL TEAMS

During the time that ED status and bed availability information is being collected from the receiving hospitals, medical teams from hospitals requested to send teams to the site should be organized and dispatched. Medical teams should be composed of, at least:

- one physician trained in emergency care
- one nurse with emergency care experience
- an additional person (ex. aid/orderly/EMT)

To gain admittance to the disaster site, members of the medical team must be wearing green hardhats with an "Emergency Medical Team" label on the front and the hospital name on the back (Exhibit III). Hardhats should be labeled "M.D." or "R.N." to differentiate personnel. The hardhat serves a dual purpose in protecting medical personnel at the disaster site and immediately identifying personnel that should be allowed access to the site.

Police will provide transportation for the medical team from the hospital to the site. The hospital must call 9-1-1 to request such transportation. All medical teams should report immediately to CFD vehicle 472 to sign in and be directed by the Chief Medical Officer for appropriate assignment.

In the event that the CFD physician director of EMS, who serves as Chief Medical Officer on the site, has not arrived prior to the arrival of the first medical team, the physician member of the first arriving medical team shall assume medical command on the site.

The most common assignment for medical teams is field stabilization, attending first to the needs of victims that have been triaged as category RED. Field stabilization will require the use of drugs and equipment, some of which will be available from the ambulances on site and from the CFD vehicle 472 (Exhibit IV). Each medical team should bring a disaster trunk including drugs and equipment appropriate for field stabilization (Exhibit V).

Depending on the extent of the disaster and time factors, the victims may be scattered throughout the disaster area or they may have been collected and divided by triage category into field hospitals.

Field hospitals are set up at the discretion of the Chief Medical Officer and are staffed by a combination of medical teams and paramedics. Each field hospital is set up to handle victims according to triage category. The category RED field hospital, handling the most serious injuries, will be established closest to the ambulance dispatch site.

CHIEF MEDICAL OFFICER

The physician acting as Chief Medical Officer is responsible for the direction and supervision of all medical care at the site. He is responsible for establishing contact with police and fire officials and jointly determining the appropriate area to establish medical command and ambulance dispatch. He must assign responsibilities to each arriving medical team and ambulance crew and determine the need for and location of field hospitals.

PARAMEDICS

Due to the time involved in organizing and transporting medical teams, paramedics will have arrived at the site prior to the medical teams. Paramedics are responsible for immediately implementing rapid field triage. Following the initial assessment, each victim will be tagged with a METTAG (Exhibit VI) which identifies the extent of the injury by a color code.

RED:	Critically injured; immediate life threatening injuries. Survival is dependent upon immediate care.
YELLOW:	Seriously injured; stabilization is necessary prior to transport. Survival is not dependent on immediate care.
GREEN:	Ambulatory wounded. Emergency transportation is not needed.
BLACK:	No vital signs. The victim is dead. Victim who might be labeled "expectant dead" may be categorized as BLACK or RED depending on the personal feelings of the individual doing the triage, keeping in mind the extent of the disaster and the type of injuries.

Rapid categorization of all victims permits the use of manpower and resources to the maximum benefit of the greatest number of victims.

AMBULANCE DISPATCH

The ambulance dispatch station at the site will be staffed by members of CFD Bureau of EMS. Victims will be loaded into ambulances according to triage category. Victims categorized as RED will be removed from the scene first. When the ambulance is completely loaded, the driver will inform the CFD Ambulance Dispatch Officer of the number and categories of victims in the vehicle. The CFD Ambulance Dispatch Officer is responsible for directing each ambulance driver to a specific hospital. The Ambulance Dispatch Officer maintains a log sheet listing each ambulance, its hospital destination, number and category of victims transported on each ambulance run. The Ambulance Dispatch Officer will receive from the CPH continuous reports on the ED status of each receiving hospital so that victims may be distributed appropriately. Upon completion of responsibilities at the receiving hospital, the ambulance will return to the disaster site unless otherwise directed.

PRIVATE AMBULANCES

At the request of the CFD, private ambulance companies will dispatch all available ambulances to the disaster site. All arriving private ambulances will follow instructions from CPD regarding proper approach to the scene and line-up at the ambulance dispatch point. All private ambulance attendants will remain with the vehicle unless otherwise instructed by the CFD Ambulance Dispatch Officer. Private ambulances will be loaded under the direction of the Chief Medical Officer and dispatched to the specific hospital by the Ambulance Dispatch Officer. Upon completion of responsibilities at the receiving hospital, the ambulance will return to the disaster site unless otherwise directed.

AGENCY RESPONSIBILITY

AMERICAN RED CROSS

Upon notification by CFD, the American Red Cross (ARC) will inform its disaster service volunteers via the Red Cross Radio System. Red Cross Disaster Services will dispatch radio-equipped vehicles to the scene and to each selected receiving hospital.

Red Cross personnel trained in first aid will report to the Chief Medical Officer on site for assignment.

A Red Cross volunteer, with communications capability to the Red Cross volunteer at each receiving hospital, will station himself at the on-site ambulance dispatch point. As each ambulance arrives at the receiving hospital, the Red Cross volunteer at that hospital will notify the Red Cross volunteer at ambulance dispatch. Should any ambulance arrive at other than its assigned destination, the Red Cross volunteer will notify the CFD Ambulance Dispatch Officer thereby, allowing adjustments to be made in the planned distribution of victims.

The Red Cross Nursing Service will send a disaster nurse to each receiving hospital to obtain welfare information and to assist the victims' families. (Exhibit VII)

In order to collect welfare information, the Red Cross Disaster Nurse must have access to ED personnel who can supply the names of victims and their medical status as well as the hospital representative who can authorize the release of this information.

Welfare information is collated from all receiving hospitals at the central office of the ARC. The ARC Disaster Nurse must therefore have access to a telephone which should be at some distance from the press area. This system will allow each receiving hospital to shift to the ARC the added burden of responding to medical condition inquiries.

All inquiries about victims received at hospitals should be referred to ARC (440-2000). Red Cross will provide sufficient personnel at their central office to collect all welfare information and contact the families of all victims.

In addition to the above responsibilities, the Red Cross, if necessary, can provide food, shelter and clothing to the victims as well as transportation for victims released from the hospital.

BLOOD AVAILABILITY

Upon notification from CFD that a disaster has occurred, American Red Cross Disaster Services will notify the director of American Red Cross Blood Services, or his designee, who will coordinate all communications regarding blood supply. This includes contacting directors of blood centers throughout the Metropolitan Blood Sharing System (MBSS) to inform them of the details of the disaster and of the names of the hospitals which will receive victims. Each blood center will then assess its available blood supply and report the findings to Red Cross.

The blood bank at each receiving hospital will be contacted by the blood center from which it normally receives blood and/or components. If the blood center which normally supplies a particular hospital is unable to meet the need, that blood center will contact the Metropolitan Blood Sharing System (MBSS), coordinated by Red Cross, to locate and arrange for delivery of all blood products.

If an assessment indicates the necessity of securing blood from outside the Chicago metropolitan area, Red Cross will handle those arrangements. CPD and CFD may, when necessary, assist blood centers in transporting blood.