PROCEDURE
Corewell Health Beaumont Troy Hospital - Mass Casualty Annex

This Procedure is Applicable to the following Corewell Health sites:
Corewell Health Beaumont Troy Hospital, Corporate (Corewell Health East)

Applicability Limited to: N/A

Reference #: 31707

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Effective Date: 06/03/2025

Functional Area: Disaster Response, Emergency Preparedness

Department Area: Disaster

1. Purpose

The Mass Casualty Annex is designed to support an effective response to a rapid influx of injured patients presenting to the hospital as a result of a mass casualty incident. The procedures detailed within the plan differ from normal daily operations and were developed for the purpose of triaging and treating a rapid influx of patients in a manner that minimizes mortality and morbidity, minimizes the impact to other patients, and to hospital operations.

2. Definitions

A. Hospital Command Center (HCC) - The location where the Incident Commander and Command staff coordinate all activities related to the incident. (Used interchangeably with Incident Command Center (ICC), Emergency Operations Center (EOC))

B. Hospital Incident Command (HICS) - A system based on the use of checklists and organizational charts to assure each task during a disaster is considered, and staff is made available to complete those tasks. In many cases individuals may be able to accomplish tasks from several lists, and the system is designed to be scalable from small to very large incidents. The HICS process also allows for planning staff to look ahead, and determine when more staff should be called in, and when staff on duty should be relieved to provide rest and breaks.

C. Incident Command System (ICS): A management system that is applicable to small incidents as well as very large complex incidents/disasters. The system consists of procedures for controlling personnel, equipment and communications during disasters. It is designed to be utilized from the time an incident initially occurs, continues until the incident/disaster does not require management, and potentially extends through recovery.

D. Incident Command Center (ICC): Specific to a site and in close proximity to an emergency situation. The Incident Commander and Command Staff are located in the Hospital Command Center. (Used interchangeably with Emergency Operations Center (EOC))

E. Mass Casualty Incident – Any event that overwhelms, or threatens to overwhelm, the hospital where the number of casualties vastly exceeds the on-site resources and capabilities in a short period of time

3. Procedure

A. Recognition: The Emergency Center (EC) is notified of potential incoming patients by an agency of an incident that may result in a sudden influx of a large number of patients. This may be from Police, Fire, Emergency Medical Services (EMS), Oakland County, Macomb County, Security, Hospital Administration or others. Personnel may also be notified via patients arriving in the facility. The patients can be from an internal or external incident.

1) Assessment

a. The Emergency Center will assess its ability to treat the expected incoming patients. Assessment criteria include but is not limited to:

i. Type of Incident
ii. EC staffing levels
iii. Number of current EC patients
iv. Acuity of current EC patients
v. Ability to quickly admit or discharge current EC patients
vi. Expected number of incoming patients
vii. Expected condition/severity of incoming patients
viii. Anticipated resources needed (personnel, supplies, etc.)

b. The Incident Commander will perform a preliminary situational assessment using the following criteria:

i. Incident type
ii. Hazards involved and magnitude of the event (Number and type of casualties)
iii. Resources threatened (supplies, personnel, facilities)

2) Notification

a. The Emergency Center will notify House/Nursing Supervisor, or Administrator On Call (AOC) if no House/Nursing Supervisor is available.

- The AOC will coordinate any duty that is the responsibility of the House/Nursing Supervisor if they are not on duty or unable to fulfill the task.

b. The Emergency Center will notify Emergency Center Leadership.
c. The Emergency Center will notify the On Call and Backup Trauma Surgeon
d. House Supervisor will contact Business Assurance/Emergency Management to discuss current situation and needs.
e. House Supervisor will contact the Administrator On Call.
f. The Administrator On Call will contact Business Assurance to initiate a Plan Mass Casualty Incident (MCI) response to support the management of the incident.
g. The Operators will page and make an overhead announcement following the incident script.
h. The Security Operations Center will notify all Security Officers on duty of the incident.
i. Managers from all units will Communicate to the Hospital Command Center (HCC) their initial staffing and patient counts.

- Incident Command may assign this function to Mission Control, if applicable.

j. Managers will then assess patients on their units that are eligible for discharge and update ICS with new patient counts.

- Incident Command may assign this function to Mission Control, if applicable.

B. Initial Response

1) Hospital personnel are to return to their departments and remain unless relieved by their supervisor, as directed by the Hospital Command Center.
2) Supervisors will assess staffing and workloads to determine which staff (as appropriate) may be deployed to the labor pool (Staff are not to report to the labor pool until requested by the Labor Pool).
3) Supervisors will notify the Labor Pool of the available number of staff that may be deployed.

C. Termination and Recovery

1) All or portions of the ICS may be terminated when no longer needed. When the Incident Commander (IC), or designee, determines that the normal resources and organization can handle the situation, they may terminate the overall hospital response. The IC will contact the Hospital Operator and place the hospital in an All-Clear alert.
2) The Incident Commander will implement a demobilization plan if needed.
3) The Incident Commander will implement a recovery plan as needed.
4) A post incident assessment and debriefing of every incident will be performed.
5) Action Report will be completed following incident, including any opportunities for improvement identified and action plans for resolution.

4. Department Resources

A. Incident Command

1) The EC Administrator or Manager is in charge until the Hospital/Nursing Supervisor, Administrator On-Call, or Business Assurance responds and takes command.
2) The Incident Commander will initiate the Incident Command System and open the Hospital Command Center, as appropriate.
3) The EC staff will establish the patient care areas within the unit as necessary. Pre-assigned staff will respond to staff the Hospital Command Center and receive their ICS assignments.

B. Patient Access Registration

1) Rapidly create an appropriate quantity of “Unknown” patient records prior to victim arrival, following current naming convention (E.G.Undoe)
2) Utilize ‘undoe” records for the temporary registration of critical victims to avoid any delay in providing life-saving interventions.
3) Full capture of patient registration information will occur, as appropriate, after the provision of medical care has been initiated.
4) Upon receiving the initial notification, the Director of Patient Access Registration (PAR), or designee, will contact PAR staff at the Responding site to determine potential staffing needs.
5) The Director of PAR, or designee, will contact PAR operational leaders to begin notification process to deploy Response Team staff as appropriate to the Responding site location(s) and anticipated patient count.

Additional Patient Access Registration support during a large-scale mass casualty event will be provided by Financial Clearance Center (FCC) staff. During normal business hours, FCC staff will be deployed to assist the Responding site either virtually or in person, response times may be delayed. The FCC has organized PAR Response Teams to provide support after normal business hours.

C. Security

1) Campus Access - Upon receiving initial notification of a potential MCI from external authorities, onsite Security staff will secure all campus access points from main

roadways, as able. Access to facility for EMS/victim traffic and arriving staff will be controlled from pre-determined entrances.

2) Security Staffing – Additional Security resources will be deployed from partners through pre-developed mutual aid procedures. Operational coordination and dispatch of additional Security resources from Hospital Command Center.
3) Identification - All staff deployed from supporting sites wear a Corewell Health Staff ID badge, upon check-in at the Responding Site Labor Pool Emergency Assignment badges may be issued and are to be worn in addition to their existing Corewell ID badge. The Emergency Assignment Badges may indicate clinical specialty or job classification to facilitate rapid and appropriate task assignment.

D. Triage-Emergency Center

1) Preparation
   a. As part of the MCI response plan, the hospital should designate areas for patient arrival. If possible, line up stretchers, with head-end lifted.
   b. Based on best practice, ECs should set up an initial triage area and a separate triage area further inside. A senior physician paired with a nurse should lead triage efforts.
   c. Consider bringing in other clinicians trained in triage from other areas to free up EC staff.
   d. Initiate SALT (Sort, Assess, Life Saving Interventions, Treatment/Transport) Triage Algorithm.
2) Triage area and team
   a. A Triage station will be set up in the Former Ambulance Bay driveway (weather permitting, inside Former Ambulance Bay doors if not able to be outside)
   b. The triage team for large events will consist of 1 EC Registered Nurse (RN) and 1 EC physician.
3) Patient Care Areas
   a. Immediate (Red) Treatment Area- Resuscitation, Ambulance Bay and Rooms 506, 507, 508,509, 510, 201, 202, 205, 206
      - The purpose of the Immediate Treatment Unit is to provide medical care to Category I patients.
   b. Delayed (Yellow) Treatment Area- Green and Red Teams
      - The purpose of the Delayed Treatment Unit is to provide medical care to Category II patients.
   c. Minor (Green) Treatment Area- Purple Team, Peds, Radiology Prep, and Waiting Room.
      - The purpose of the Minor Treatment Unit is to provide medical care to Category III patients and comfort care to unexpired Category IV patients.
   d. Overflow area – Clinical Decision Unit (CDU), Orange Team, CDU Hall, Orange Hall
4) The Emergency Center Staff Nurses, as assigned, will assume the roles of the Immediate Treatment Unit Leader and the Delayed Treatment Unit Leader.
   a. They will coordinate the care given to patients received from the triage area; assure adequate staffing and supplies in the Immediate Treatment and Delayed Treatment Areas.
   b. They will facilitate the treatment and disposition of patients in the Immediate and Delayed Treatment Areas.
   c. They will also aid those individuals who are responding to assist with care.
5) Nurses that are assigned to the EC from other areas may assume the role of Minor Treatment Unit Leader located in the hall zones.
6) Alternate Care Areas
   a. MCI carts or supplies can be deployed to the Alternate Care areas.

i. Cart 1 shall be maintained by the EC Supply Coordinator.
ii. Each Alternate Care Area will have its own treatment team labeled on the back of the clipboard designated to that area.

7) Managing Patients with Grave Injuries
   a. Recognizing when patients are expectant and that critical resources should not be expended on them is one of the most difficult aspects of MCI response.
   b. Consider a pre-designated area where expectant patients can get care and comfort.
   c. Clinicians with pain management and end-of-life care expertise should be assigned to work in this area.
   d. There should be close coordination between staff here and staff responsible for family reunification and fatality management.

E. Patient Care Units

1) The floor manager, ANM or shift lead will assume the role of Unit Leader.
2) These individuals will supervise and maintain the nursing services in their areas to the best possible level to facilitate the maintenance of the care needs of the in-house and newly admitted patients.
3) The Charge Nurse will complete a list of the patients that can be safely discharged from the hospital.
4) The Charge Nurse will call the physician in charge of the patient to obtain the discharge orders.
5) The charge nurse will do the following to facilitate the discharge.
   a. Obtain a discharge order.
   b. Enter it in the patient's chart as a telephone or verbal order from the physician.
6) When completing the In-Patient Discharge list do the following:
   a. Be sure to include the patient's name, room number, and physician in charge of the case.
   b. Attempt to group the patients according to physician.
7) The completed list will be forwarded to the In-Patient Area Supervisor or designee.
8) The Charge nurse will assign the nurse on the unit to inform the patient of the discharge and complete all appropriate discharge paperwork (med rec, discharge instructions, prescriptions, follow up appointments, etc.) with the patient.
9) The Charge Nurse will assign personnel to assist the patient with arrangements for pick-up.
10) Plan to cohort patients if needed.
11) The individual picking up the patient will be instructed to pick him/her up at a designated entrance.

F. Surgical Services

1) The OR Nurse Manager, or designee, will assume the role of the Surgical Services Unit Leader.
2) Notify the Operations Chief as to the readiness of the OR to accept patients needing immediate surgery.
3) Critical Personnel
   a. Trauma Surgeons
   b. Trauma Providers/Staff
   c. Subspecialty Surgeons
   d. Trauma Leadership
   e. OR Leadership
   f. Anesthesia
   g. OR Staff (Including but not limited to: Surgical RN, Surgical Tech, Surgical Assistant, etc.)
   h. Radiology

i. Respiratory (As needed)
j. Central Sterile Processing
k. Materials Management/Supply Chain
l. Environmental Services
m. Security

4) Receive briefing of expected victims from Emergency Center and/or Trauma Services.
5) OR Leadership to prepare for incoming victims and expand surgical room capacity.
   a. Stop surgical procedures from being initiated.
   b. Evaluate if procedures underway can be expedited.
   c. Identify if scheduled surgeries can be suspended and/or canceled.
   d. Determine OR availability.
   e. Expedite disposition of PACU patients
6) Means of Contact:
   a. Initiate surgical team call-trees (Surgeons, Anesthesia, Clinical Staff, Support Staff)
   b. If one team is needed, and the team is not currently on site, the House Supervisor will notify the first team on call.
   c. If other teams are required, on site leadership will activate additional resources as appropriate.
   d. Mass communication page to be sent to site leadership
   e. Page "All Trauma" Surgeon page
   f. For individual patients if other Sub-Specialty services are needed for:
      i. patient in the EC or an inpatient unit:
         1. The provider will place the order in the electronic medical record. It will then go to the unit secretary's work list. They will then page the required service via paging options listed for each provider.
         2. If there is no secretary, the RN assigned to the patient, having received the same order in their work list, will page the provider.
      ii. A patient that has been taken to the OR:
         1. During regular business hours: The provider makes the request. The charge nurse will page the provider via paging options listed for each provider.
         2. After hours or holidays: The house supervisor assists the OR in paging the providers.
   g. In the event the whole department, or multiple departments, are needed the Medical Labor Pool will be implemented.
7) Initial Surgical Triage

Triage color	Description
Red	1. Serious Injuries Immediate life-threatening problems 2. Potential for survival 3. All viable infants (<12 months) are automatically red tagged
Yellow	1. Serious injuries 2. Require care, but management can be delayed
Green	1. Minor injuries 2. May require surgical services evaluation and/or intervention(s) 3. Require minimal or no care without adverse effects

8) Subspecialty Triage:
At the discretion of the Trauma Medical Director / On-Call Trauma Surgeon service lines will receive assignment based on maximized impact on life saving interventions. Staff, resources and operating space will be allocated first to Surgical Services with the

greatest impact. For example: Neurosurgery would receive prioritization over Plastic Surgery

Subspecialties may include but is not limited to the following:

- **i.** Adult General Surgery
- **ii.** Pediatric General Surgery
- **iii.** Orthopedic Surgery
- **iv.** Neurosurgery
- **v.** Hand Surgery
- **vi.** Urology
- **vii.** Plastic Surgery
- **viii.** Thoracic Surgery
- **ix.** ENT
- **x.** Podiatry
- **xi.** Oral
- **xii.** Vascular Surgery
- **xiii.** OB/Gyn

9) Coordination of secondary procedures:

a. At the discretion of Trauma Medical Director / On-Call Trauma Surgeon resources and operating space will be allocated first to Surgical procedures with the greatest impact. Possible secondary procedures include but are not limited to: Abdominal washout following laparotomy or internal fixation of pelvis or extremity fractures following external fixation.

G. Lab/Blood Bank

1) The Laboratory Manager, or designee, will assume the position of the Laboratory Unit Leader.
2) The Laboratory Manager, or designee, will maintain the Laboratory Services, blood and blood products at appropriate levels. Prioritize and manage the activity of the Laboratory Staff. Assess the situation from the information given and determine if additional staffing is required.
3) The Laboratory Manager, or designee, will call in the necessary people.
4) On the day shift, one Laboratory assistant is to report to the Emergency Center with a full drawing tray.
5) The available tech is to prepare instruments for stats.
6) One tech must take an inventory of the units in the blood bank and alert the Blood supplier about the emergency.
7) The most senior medical technologist is responsible to coordinate laboratory operation until management arrives on site.

H. Respiratory

1) Send list of available staff and equipment (ventilators, BiPAP, CPAP, etc.) to HCC
2) Reassign staff to the EC.
3) Call in extra staff if requested by HCC.

I. Transporters/Volunteers

1) Transporters will obtain additional carts from Post Anesthesia Care Unit (PACU) and outpatient surgery and take them to a staging area and stage them until needed.
2) Transporters will be prepared to assist with transportation of patients as directed.
3) A transporter will oversee the morgue key and sign patients into the morgue.
4) A transporter may be assigned to act as a runner between floors if necessary.

J. Environmental Services (EVS)

1) Upon receiving the initial notification, the EVS leadership or designee, will contact the Responding site EVS Director to determine initial site response actions and potential need for additional staff.
2) The EVS leadership or designee, will coordinate directly with Supporting site EVS Directors to provide additional EVS resources (supervisory and labor) to Responding site as needed.
3) The EVS leadership or designee will assume the role of the Sanitation Systems Officer. Environmental Services personnel will assist with additional sanitation and equipment as needed and as directed by the Sanitation System Officer.
4) EVS leadership or designee, will check with other hospitals or commercial sources for alternate supplies of clean or disposable linen if indicated, the availability of these resources will then be reported to the Logistics Chief.
5) EVS leadership or designee, will be responsible for calling in additional staff utilizing the department call list.

K. Medical Staff

1) The Vice President Medical Affairs (VPMA), or designee, will assume the positions of the Medical Staff Unit Leader and the Medical Care Director.
2) All EC and Trauma physicians in Corewell Health's Beaumont Troy Hospital at the time of the disaster who are able to assist in the EC should report to EC if it is paged overhead. Other physicians should report to the Medical Staff Lounge and be prepared to provide assistance.
3) The EC Secretary, or assigned staff, will activate the "All Trauma Surgeon" pager. The Trauma Surgeons are to report to the EC.
4) The Vice President Medical Affairs (VPMA), or designee, will assist with the assignment of available medical/surgical staff as needed.
5) The Vice President Medical Affairs (VPMA), or designee, will organize, prioritize and assign physicians to areas where medical care is being delivered.
6) The Vice President Medical Affairs (VPMA), or designee, will also advise the Incident Commander on issues related to Medical Care. If appropriate, s/he will assign a physician to review the patient population for possible emergency discharge.
7) All physicians are required to wear Corewell Health Identification badges.
8) Physicians on current Emergency Center Call Schedule will be contacted first.

L. Food and Nutrition Services

1) The Dietary Manager, or designee, will assume the role of the Nutritional Unit Leader.
2) Tray Line Personnel and production personnel will continue duties as usual unless notified by the Nutritional Unit Leader to do otherwise.
3) Cafeteria Personnel will stay in their area and prepare for the relatives and victims to enter the cafeteria.
4) Refreshments for personnel will be sent to the various areas.
5) The status of available food will be reported to the Logistics Chief.
6) The Dietary Manager, or designee, will call in additional staff using the department call list if it is determined that additional staff is necessary.
7) The Dietary Manager, or designee, will call the contracted vendors to inform them of the incident and possible need for resources. If/when resources are required, they will call to request the needed materials.

M. Service Excellence/Social Work/Spiritual Support

1) Supervisors send list of available staff to the HCC.
2) Patient Experience will lead implementation of the Family Information/Reunification Area in the designated area, which may be off-site.
3) Social Work and Spiritual Support assist in the Family Information/Reunification Area and others as assigned by the Command Staff in the HCC.

4) Additional resources will be coordinated directly by the Social Work and Spiritual Support administrative leads or on-call personnel at the Responding site. Social Work and Spiritual Support staff rosters and contact information are maintained at each Corewell Health hospital. The Social Work administrative leaders or Spiritual Support leads /on-call personnel at all sites will receive the system-wide mass casualty notification to begin preparation for deployment of staff to assist the Responding site if it becomes necessary.
5) Contact Ulliance to come in to provide Employee Assistance Program (EAP) services along with debriefing of staff as indicated.

N. Care Management
1) Review inpatients for potential discharge with or without home care services.
2) Facilitate/expedite transfers to other facilities as indicated.

5. Additional Procedures

A. Labor Pool

1) The Labor Pool and Credentialing Unit
   a. The Labor Pool and Credentialing unit will be opened, in the Administrative Conference Room.
   b. Hospital personnel will report to the Labor Pool as designated by their supervisor.
2) Physicians Pool
   a. All available Physicians within the hospital will report to the Physicians Pool located in the Medical Staff Lounge.
   b. All available Residents within the hospital will report to the Resident Pool located in the Family Medicine Residency Program room.
   c. Each physician and resident will be expected to record name, pager number, specialty and time-in on the Physician's/Resident's Pool Signature Log.
   d. Physician's/Resident's assignments will also be tracked.
   e. All physicians/residents "signed-in" must remain available in the hospital to assist in incident activity if requested.
   f. The decision to notify medical staff outside the hospital will be made by the Medical Staff Director in the Incident Command Structure. Each department Medical Chief then begins the call-in procedure.
   g. All medical staff called in from outside of the hospital for disaster duty will report to the Physician Pool, in the Medical Staff Lounge and complete the sign-in procedure.
3) External Volunteers/Physicians credentialed at other Corewell facilities: See (REF 29320) Corewell Health East - Use and Assignment of Licensed Independent Practitioners During a Disaster and (REF 29321) Corewell Health East - Use and Assignment of Volunteer Practitioners During a Disaster

6. Revisions

Corewell Health reserves the right to alter, amend, modify or eliminate this document at any time without prior written notice.

7. Procedure Development and Approval

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