VIRGINIA
MASS CASUALTY INCIDENT MANAGEMENT

Module I
AWARENESS LEVEL
INSTRUCTOR MANUAL

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3rd Edition

Office of Emergency Medical Services
Virginia Department of Health
Richmond, Virginia

PART I

PLAN OF INSTRUCTION

Plan Of Instruction
MASS CASUALTY INCIDENT MANAGEMENT
Module I
RESPONDER LEVEL
and EMT-Basic Supplement
3rd Edition

COURSE TITLE

Virginia Mass Casualty Incident Management Module I - Responder Level.

COURSE TOPIC

Topic #: 03700 Mass Casualty Incident Management - Module I**.**

COURSE GOAL

Module I will prepare students who are the first responders to a mass casualty incident to take appropriate initial control actions of the medical problem and perform the initial triage of patients.

COURSE OBJECTIVES

On completion of this course each student will:

1. Define mass casualty incident.
2. List the three goals of mass casualty incident management.
3. Describe the initial response actions to mass casualty incidents.
4. Triage simulated patients correctly using START algorithm.
5. Tape simulated patients using triage ribbons.
6. Establish an accurate count of casualties.
7. Complete the Virginia Triage Tags.

COURSE LENGTH

Approximately 60-120 minutes, depending on student experience. A class composed of experienced responders will complete the course in less time.

STUDENT QUALIFICATIONS

There are two target audiences for this course:

1) Currently certified Virginia Emergency Medical Services providers at the level of First Responder or higher qualification.

2) Students in Emergency Medical Technician-Basic certification courses.

In addition, other health care professionals with a mass casualty response role (including nurses and physicians) are encouraged to take the course.

INSTRUCTOR QUALIFICATIONS

Instructors will meet the following criteria:

A. Be a minimum of twenty-one (21) years of age.

B. Hold EMT-B certification or higher and/or licensure in one of the following:
   1. Registered Nurse
   2. Physician Assistant
   3. Physician

C. Submit an "Emergency Operations Instructor Application" form with the required recommendations and supporting documentation of qualifications to the Office including:

   1. A recommendation for acceptance from an EMS Physician knowledgeable of the applicant's qualifications.

   2. If the applicant is an EMS Physician, the support of another EMS physician is not required on his "Emergency Operations Instructor Application."

   3. Hold a valid "Methods of Instruction" certification or teaching certificate as approved by the Office of EMS.

D. An Emergency Operations Instructor Candidate meeting the requirements for endorsement must complete an instructor's course for each Emergency Operations course he or she plans to coordinate or instruct.

E. An Emergency Operations Instructor Candidate that completes all requirements for Emergency Operations endorsement may be issued an endorsement that is valid for two (2) years.

1. Current EMT-B Instructor

2. Emergency Medical Technician or higher certification with certification as an instructor in some other discipline and certification as a Virginia Mass Casualty Incident Management Module II Instructor.

3. Designation by the Office of Emergency Medical Services as an Instructor based on other appropriate qualification and completion of Module I, Module II, and Module II Train-The-Trainer courses.

In addition it is desirable that Instructors have at least one of the following:

Recent experience in actual or drill mass casualty incidents.

Knowledge of regional, jurisdiction, and agency emergency operations plans.

Membership on a regional mass casualty incident management team.

DELIVERY

This course will be taught throughout Virginia at emergency medical services agencies and other training sites by qualified instructors.

Primary methods of delivery will be lecture and demonstration-performance as indicated in the Teaching Plan. Both lecture and demonstration-performance will be supported by audio-visual aids.

CONTINUING EDUCATION CREDIT

All approved courses taught by a qualified instructor will receive EMS Continuing Education credit through the Virginia Office of Emergency Medical Services. Applications for course approval must specify **MCIM Module I** as the course title.

CLASS SIZE

Recommended maximum class size for the course is 30 students. Recommended minimum class size is 5 students.

FACILITY REQUIREMENTS

The course may be taught in any standard classroom that provides adequate seating and desk or table workspace for students.

Classroom should provide level floor space for the practical exercise scheduled as the last item of the course. Floor space requirement depends on the number of students, but should allow approximately half of the students to lie on the floor with sufficient area for personnel doing triage to work around them. Additional space for simulated treatment area may be outside the classroom in a hall if necessary.

Lectern or podium, preferably with lighting to allow instructor to reference the Teaching Plan in the Instructor Manual.

AUDIO-VISUAL REQUIREMENTS

One projection screen.

Depending on whether overhead vu-graph transparencies, 35 mm slides, or PowerPoint presentations are used, either an overhead projector, a 35 mm slide projector, or a computer/projector.

Video Cassette Recorder (VCR) and a television (TV) if the supplemental Virginia Triage System videotape is to be used. Television screen size should allow easy viewing from throughout the classroom.

Stands for projector and VCR/TV. If an overhead projector is used, it is preferable that the projector stand or working area be large enough to hold the transparencies not being projected.

Extension cords for projector and VCR/TV if required.

INSTRUCTIONAL MATERIALS

Instructor Manual

Participant Manual (1 per student)

Triage Taping Kits (1 per student). These may be locally made training kits with a limited number of ribbons of each color.

Triage Tags - 1 per student (either actual tag, training variant, or copy)**.**

MCIM I audio visuals (vu-graph transparencies, 35 mm slides, or PowerPoint presentation).

Video: Virginia Triage System.

REFERENCES

American Society for Testing and Materials. F 1288 Standard Guide for Planning for and Response to a Multiple Casualty Incident. Current edition. Philadelphia, PA: ASTM.

Brunacini, Alan V. Fire Command. Quincy, MA: National Fire Protection Association, 1985.

Carlson, Gene P., ed. Incident Command System. Stillwater, OK: Fire Protection Publications, 1993.

Commonwealth of Virginia. Department of Health. Office of Emergency Medical Services. Basic Life Support Protocols. Current edition. Richmond, VA: Virginia Office of Emergency Medical Services.

Commonwealth of Virginia. Department of Health. Office of Emergency Medical Services. Virginia Emergency Medical Mass Casualty Incident Response Guide. Current edition. Richmond, VA: Virginia Office of Emergency Medical Services.

National Fire Protection Association. NFPA 1561 Standard on Fire Department Incident Management System. Current edition. Quincy, MA: National Fire Protection Association.

National Fire Service Incident Management System Consortium. Model Procedures Committee. Model Procedures Guide for Mass Casualty Incidents. Current Edition. Stillwater, OK: Fire Protection Publications.

COURSE AUTHORSHIP

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COURSE REVIEW DATE

Next course review and revision is scheduled for May 2006.

PART II

TEACHING PLAN

Teaching Plan
MASS CASUALTY INCIDENT MANAGEMENT
Module I
RESPONDER LEVEL
and EMT-Basic Supplement
3rd Edition

Instructor Note: All notes to Instructors are in italics text and parenthesis.

I. COURSE INTRODUCTION

(Slide No. 1 - TITLE SLIDE)

A. **Welcoming remarks** *(Give course title and required information for completion of continuing education records (if applicable). If students are not familiar with facility, provide standard information on facility - exits, bathrooms, smoking area, vending machines, etc.)*

B. **Instructor introduction** *(Name, organization, duty title, short summary of why qualified to teach course. If the normal course instructor is teaching this module as part of an EMT-B course, this step is not required.)*

C. **Student introduction** *(Ask students to give name, EMS agency, and how long they have been a field provider. If this module is being taught as part of an EMT-B course, this step is not required.)*

(Slide No. 2 - COURSE OBJECTIVES)

D. On completion of the course students will be able to:

1. **Define mass casualty incident.**
2. **List the three goals of mass casualty incident management.**
3. **Describe the initial response actions to mass casualty incidents.**
4. **Triage simulated patients correctly using START algorithm.**
5. **Tape simulated patients using triage ribbons.**

6. **Establish an accurate count of casualties.**
7. **Complete the Virginia Triage Tags.**

II. INCIDENT MANAGEMENT SYSTEMS

(Slide No. 3 – MASS CASUALTY INCIDENTS)

A. **Given Virginia's geographic location, population centers, major transportation routes, and unique hazards, there is an enormous potential for incidents to occur which injure people in numbers that could overwhelm any EMS system.**

(Slide No. 4 – DISASTERS)

B. **Some people call these types of incidents disasters**. It is important to remember that the term **disaster has a specific legal meaning**.

1. **States and localities declare "state of emergency."**
2. **The President declares "major disasters."**

(Other terms are used to describe such large and complex situations. In this course we will introduce one way to classify incidents that create large numbers of injured people - make sure students are familiar with the system in use their jurisdiction.)

(Slide No. 5 – TYPES OF DISASTERS)

C. These events can cause mass casualty incidents. *(Highlight those specific hazards that are most likely in the local area and provide recent examples that students will be familiar with.)*

1. **Natural disasters** (floods, hurricanes)

2. **Technical hazards** (HAZMAT incidents, building collapse)

3. **Transportation accidents** (road, rail, aircraft, ship, etc.)

4. **Civil and political disorder** (demonstrations, strikes, riots)

5. **Criminal or terrorist incidents**

(Slide No. 6 – MCI – MASS CASUALTY INCIDENT)

D. **A mass casualty incident (or MCI) is any incident that injures enough people to overwhelm the resources usually available in a particular system or area.**

(Slide 7 – GOALS OF MCIM)

E. **Do the Greatest Good for the Greatest Number**

F. **Manage scarce resources**

G. **Do not relocate the disaster**

(Slide No. 8 – GREATEST GOOD)

H. *(Scarce resource management recognizes that you do not have enough providers, equipment, vehicles, or time to provide the normal level of prehospital care. Therefore you have to use what you have to do the best you can for the greatest number of people. Available personnel must salvage the most patients they can while waiting for additional resources.)*

1. **Heroic resuscitative efforts are not appropriate**.

a. **Take too much time**

b. **Requires equipment that can be used for salvageable patients**

c. **Staffing intensive** *(In normal responses four or more providers may work on a single patient - in mass casualties this ratio is reversed.)*

2. **Concentrate on salvageable patients**.

(Slide 9 - RESOURCE DEMANDS)

I. It places great demands on

1. **Equipment**
2. **Responding personnel**
3. **Facilities.**

(Slide No. 10 - DON'T RELOCATE THE DISASTER)

J. **Patient prioritization at the scene is important for casualty distribution**.

K. **Don't send all of the red patients to one hospital**. *(Work through the Command Hospital to determine medical facilities' capacities and capabilities.)*

III. EMS INITIAL RESPONSE ROLES AND RESPONSIBILITIES

(Slide 11 - EMS INITIAL RESPONSE ROLES AND RESPONSIBILITIES)

A. **EMS is a specific component of the overall incident management system.** The first arriving unit should start the following actions - to help you remember them, think of them as the 5 Ss.

(Although these steps are presented in a specific order, in actuality many steps are done at the same time or nearly so. The first two steps, Safety and Survey, are difficult to separate - when you are assessing for safety, you also get an excellent idea of how bad the incident is. The last three steps do require the first two to be done, but depending on resources, you may direct one person to start triage, have another get on the radio to call for more assistance based on your survey, and at the same time be making decisions about how you will organize the response and where you will put things.

For entry level students it may be better to provide these as a series of steps without comment; for experienced providers it is important they understand that many things may be happening nearly at the same time.)

(Slide No. 12 - FIRST ARRIVING UNIT)

B. **Begin the following actions**:

The first emergency response unit to arrive at a mass casualty incident is by default "In Charge" (the Incident Commander) until relieved. As a result, the individuals on the first emergency response unit must take immediate actions to begin to manage the entire incident. These actions may be **the most important steps taken** in the entire incident. The initial unit must resist the "temptation" to begin one-on-one patient care**. <u>The success of the operation will be the effective use of the 5-Ss.</u>**

(Slide No. 13 - SAFETY ASSESSMENT)

C. **S-1 Assess Scene for safety:** No one else gets hurt. Assess the scene for safety much as you would for a normal response to any EMS incident - except that the scene is much bigger and requires a wider look.

The following may pose a hazard: (1) fire, (2) electrical hazards, (3) spilled or contained flammable liquids, (4) hazardous materials, (5) other life threats including possible secondary devices or indications of weapons of mass destruction, (6) debris that poses a threat to rescuers or their vehicles.

(Slide No. 14 - SCENE SIZE-UP)

D. **S-2 Scene Size-up: How big is the incident and how bad is it?**

1. **Type of incident.**

2. **Approximate number of patients.**

3. **Severity of injuries.**

4. **Area involved, including problems with scene access.**

(Slide No. 15 - SEND INFORMATION)

E. **S-3 Send information:**

1. **Report situation** – contact dispatch with your size-up information.

2. **Request assistance** - Resources and mutual aid if needed.

3. **Insure rapid hospital notification** *(Familiarity with the local hospital notification system will enhance this section).*

(Slide No. 16 – SET-UP)

F. **S-4 Set-up:** Set-up the scene for the best management of mass casualties by on-scene and responding resources, including:

1. **Staging**

2. **Secure Access and Egress** *(Especially critical when there is limited access to the scene, i.e., single roadway).*

3. **Secure adequate space** for work areas – THINK BIG

   a. **Triage**
   b. **Treatment**
   c. **Transportation**

(Slide No. 17 – START)

G. **S-5 START:** This triage method **assures rapid initial assessment of all patients as the basis for assignment to treatment** and as the first medical assessment of the incident.

1. Begin where you are.
2. Relocate Green (Minor) patients
3. Move in Orderly Pattern
4. Maintain Count

5. Minimal Treatment

Triage: Triage is a **French word meaning "to sort."**

IV. TRIAGE

(Slide No. 18 - PURPOSE OF TRIAGE)

A. **Assigns treatment priorities.**

B. **Separates victims into easily identifiable groups**.

(Slide No. 19 – PURPOSE OF TRIAGE)

1. **Determines required resources for:**
   a. **Treatment**
   b. **Transportation**
   c. **Definitive care**

2. **Prioritization of patient distribution and transportation**

(Slide No. 20 – BENEFITS OF TRIAGE)

C. **Identifies patients who require rapid medical care to save life and limb**

D. **Provides rational distribution of casualties**

E. By separating out the minor injuries, **reduces the urgent burden on each hospital – average 10-15% of MCI patients are serious enough to require extended hospitalization**

(Slide No. 21 – PROBLEMS WITH TRIAGE SYSTEMS)

F. **Some rely on specific injuries and physical findings in order to categorize and prioritize patients**

G. **In-depth assessment requires too much time**

(Slide No. 22 - IDEAL TRIAGE SYSTEM)

H. Should be **simple**

I. **Does not require advanced assessment skills**

J. **Does not rely on specific diagnosis**

(Slide No. 23 – IDEAL TRIAGE SYSTEM)

K. E**asy to perform**

L. P**rovides rapid and simple life-saving interventions**

M. **Easy to teach and learn**

(The Simple Triage and Rapid Treatment (START) system meets these requirements.)

(Slide No. 24 - Simple Triage and Rapid Treatment (START) System)

N. **Triage ribbons. Surveyor's tape is used to make the ribbons**. *(Show the students either a complete ribbon kit or samples of the individual ribbons. Refer students to the Triage Ribbon Kit handout material.)*

O. **Universal colors are used**. *(In the START system we do not classify by injury - point out to students that the injuries that START will identify as falling into each category are typically those on the slides.)*

(Slide No. 25 – RED)

P. **RED: <u>Immediate</u> (highest priority)**. **Typical problems are**:

1. **R- respirations/airway**
2. **P – perfusion/pulse**
3. **M – mental status**

4. **Severe burns which compromise airway**

(Slide No. 26 – YELLOW)

Q. **YELLOW: <u>Delayed</u> (second priority). Typical problems are**:

1. Burn patients without airway problems

2. Major or multiple bone or joint injuries

3. **Back and spine injuries**

(Slide No. 27 – GREEN)

R. **GREEN: <u>Minor</u> (third priority). Typical problems are**:

1. **"Walking Wounded"** (The ability to "walk" does not necessarily mean that this is a "minor" patient. Minor cuts and bruises are acceptable criteria for this type of patient.)

2. **Minor painful swollen deformities**

3. **Minor soft tissue injuries**

(Slide No. 28 – BLACK)

S. **BLACK: <u>Dead/non-salvageable</u> (lowest priority)**

1. These are **non-breathing patients on whom resuscitation would normally be attempted but who are not salvageable given the resources available early in a MCI response.**

V. THE START PROCESS

(Slide No. 29 – Introduction to S.T.A.R.T. Process)

A. **Begin where you stand**

B. **Identify those injured who can walk**. Make a clear announcement that **those who can walk should get up and do so to an easily recognized place**. *(These patients should be supervised at all times. Someone should be designated to stay with them.)*

(Slide No. 30 – Relocate Green)

C. **To a designated area**

1. **Away from immediate danger**
2. **Outside the initial triage area**

D. **In Virginia we tape each of these as a GREEN patient**. Some systems do not tag GREEN patients. We do - without taping you cannot identify them easily as part of the MCI.

(Slide No. 31 – Move in Orderly Pattern)

E. Move through the patients in an **orderly pattern**.

1. **Assess each casualty you come to**
2. **Mark the category using triage ribbons**

(Slide No. 32 - Maintain Count)

F. **Maintain a count of the casualties**

G. **Mark on 2-3 inch tape on thigh**

H. **Save a small piece of triage ribbon** *(Other systems for keeping track of the count of casualties may be used.)*

(Slide No. 33 – Minimal Treatment)

I. Give only minimal treatment. **Only two patient interventions** are used:

1. **Open the airway**

2. **Stop gross bleeding**

(Slide No. 34 – Keep Moving!)

J. **Keep moving!** EMT-Basics are provided 10 minutes to conduct a full patient assessment and begin treatment in the State EMT-Basic Practical Examination. In an MCI, such lengthy patient assessments are not practical. S.T.A.R.T. assessments should last approximately 10 - 15 seconds per patient.

(Slide No. 35 – Steps in Assessment)

K. **Step 1 -- Moving Green Patients**. This has **already been done** when you made the first announcement.

(Slide No. 36 - Respiration)

L. Step 2 - **RESPIRATION.** Check for respiratory compromise.

1. If airway closed, open the airway.

2. No respirations - BLACK ribbon (dead).

3. More than 30 per minute - RED ribbon (immediate). *(More than 30 per minute means that the patient is breathing once every other second. That rate is so fast that it can be recognized without actually having to count respirations.)*

4. Less than 30 per minute - FURTHER EVALUATION REQUIRED - go to step 3 (Perfusion)

(Slide No. 37 - Perfusion)

M. Step 3 - **PEFUSION.** Radial Pulse Check. *(Some systems use capillary refill. In Virginia, we do not - it is an unreliable indicator, especially in cold situations.)*

1. Not palpable - RED ribbon (immediate).

2. Control severe bleeding – bystanders use direct pressure, raise legs.

3. Palpable - FURTHER EVALUATION REQUIRED - go to step 4 (Mental status).

(Slide No. 38 - Mental Status)

N. Step 4 - **MENTAL STATUS.** Check for compromise of mental status.

1. Altered mental status - RED ribbon (immediate).

2. Mental status appropriate - YELLOW ribbon (delayed) or GREEN (minor) according to other findings (obvious injuries or illnesses).

(Slide No. 39 - S.T.A.R.T. Algorithm)

O. *(Entire Algorithm can be used to review S.T.A.R.T. decision process.)*

(Slide No. 40 – JumpSTART)

P. With children, the algorithm is a little different. *(Entire Algorithm can be used to review JumpSTART decision process.)*

(Slide No. 41 – Secondary Triage)

Q. Secondary triage and tagging could be done:

1. **On a stretcher on the way to a treatment area**,
2. **In the treatment area**, or
3. **In the ambulance on the way to the hospital**.

R. Secondary triage is an **in-depth reassessment based on clinical experience and judgment**. (*For small numbers of patients, if START is performed, it will be followed immediately by secondary triage at the scene or in the ambulance. In this case ribbon use could be optional, with standard triage tags being used instead.)*

(Slide No. 42 – Triage)

S. Triage is an **on-going process and should be done continuously**.

VI. THE VIRGINIA TRIAGE TAG

(Slide No. 43 – Virginia Triage Tag)

(Provide students with either practice tags or a copy of the tag.)

A. **Made with white weather resistant material - designed for use with a ballpoint pen**. *(This tag has been successfully tested for its durability and use in mass decontamination situations.)*

(Slide No. 44 – Capabilities)

B. **Multiple triage assessments of the patient**

C. **Continuous patient information recording**

D. **Continuous patient accountability and tracking**

E. **Designed for easy interface with patient hospital records**

(Slide No. 45 – Format/Front)

F. Front contains **patient information section**:

1. During MCIs the **information not always obtainable**.

2. Information **can be added throughout triage, treatment, transportation and hospital reception phases**

(Slide No. 46 – Triage Status Section)

G. **INITIAL - START assessment**

H. **SECONDARY - reassessment at the scene or in the treatment area**

I. **BLANK - can be used in the treatment area or during transportation**

J. **HOSPITAL - initial reassessment at the receiving hospital**

(Slide No. 47 – Chief Complaint Section)

K. **Major obvious injuries or illnesses can be circled**

L. **Indicate injuries on the human figure**

M. **Additional information is added on the Comments line**

(Slide No. 48 – Transportation Line)

N. The **transporting unit notes**:

1. **Agency information**,

2. **Destination hospital**, and

3. The **time the patient actually arrived**.

(Slide No. 49 – Pull-Off Label Section – Six)

O. A total of six labels are provided:

1. **"Treatment**" - to document on patient information worksheets.

2. **"Hospital"** - to tie the triage tag and scene patient number to the patient's hospital records.

3. **"Other**" labels can be used for a variety of purposes, based on incident needs:

a. **Other tactical worksheet needs on scene**, including transportation accountability.

b. **Marking personal effects**

c. **Use within the hospital**

(Slide No. 50 – Transportation Record Section)

Q. **Detachable by tear off or as a pull off label**

R. **Document patients transported to hospital or other facility**. *(This tag can be used by medical examiners in a mass casualty incident - in this case pull offs and transportation record would be used for deceased remains removal.)*

S. **Can be fixed to the transportation tactical worksheet - make certain to mark hospital destination**

(Slide No. 51 – Back)

T. **<u>Vital Signs</u>** section - space is provided to record three sets of vital signs.

U. **<u>Medical History</u>** section.

1. Information can be obtained from **Medic Alert identification devices.**

V. **<u>Treatment Record</u>** section.

1. **Additional treatments and remarks**

2. **Time treatment actions taken & provider initials**

(For the Triage Tag to be an effective patient record, it must be recognized by local hospital personnel and included as part of the patient's in-hospital record. In mass casualty situations, under the Rules and Regulations Governing EMS, Virginia Triage Tags can be used in place of PPCRs as the official patient record.)

VII. SUMMARY

(Slide No. 52 - Summary)

A. **Incidents of any kind have the potential to overwhelm EMS system personnel, equipment, resources, and medical facilities.**

(Slide No. 53 – Preparation and Pre-Planning)

B. **Preparation and preplanning will help EMS systems and personnel be more efficient in all elements of mass casualty management.**

(Slide No. 54 – Do the Greatest Good for the Greatest Number)

C. Remember, that in Mass Casualty Incidents our goal is to **do the greatest good for the greatest number.**

(Slide No. 55 – First On-Scene)

D. **The first arriving emergency response unit on scene is by default, "In-Charge" until relieved**

E. **Must take first steps toward a successful solution to the problem.**

(Slide No. 56 – Five S's)

F. **The Five Ss:**

S-1 Scene Safety
S-2 Scene Size-Up
S-3 Send Information
S-4 Set-up Scene
S-5 START/JumpSTART

(Slide No. 57 – S.T.A.R.T. Algorithm)

G. **START:** *(May also include JumpSTART, as needed.)*

1. The START algorithm provides a **simple and efficient process for initial triage.**

2. This process should be **practiced and used in all MCIs**.

(EMS providers must become competent in the use of triage ribbon for faster identification of critical patients.)

(Slide No. 58 – Treatment Phase)

H. The treatment phase requires secondary triage as a more in-depth assessment to prioritize patients for treatment and transportation.

(Slide No. 59 – Virginia Triage Tag)

I. **Designed to make patient categorization easier** and

J. **Provide a continuous documentation tool**.

(Slide No. 60 – Incident Management System)

J. **Expands to meet the needs of organizations responding to MCIs**.

K. **Virginia MCI procedures and incident management systems are covered in more detail in Module II of the Virginia Mass Casualty Incident Management Program.**

(Slide No. 61 – Questions?)

L. ***(Solicit any student questions.)***

SCENARIO

A simulated MCI scenario should be used as a closing activity for the class to reinforce concepts learned. To set up the scenario take the following steps:

1. *Clear an area large enough for students to safely carry out the actions.*

2. *Prepare a simple set of instructions keyed to START criteria for a number of patients. You may use the Mass Casualty and Mass Fatality Incident Exercise Casualties Book published by the Office of EMS as a starting point.*

3. *Designate about half the class to be patients. Provide each patient with the casualty instructions.*

4. *Position patients on the floor in the exercise area. Have student rescuers wait outside in the hall while this is completed.*

5. *Team the rescuers into crews of the normal crew size used in your local agencies. Designate one crew as the first responders.*

6. *When ready, dispatch the first crew into the scene. All actions then flow as though it were a real incident. Continue play until the first patients arrive in the treatment area and the first several secondary triages are completed.*

7. *Hold a short debriefing. Encourage students to critique their own performance and to ask questions.*