Department of Health

health

State health emergency response plan

Victorian pre-hospital and hospital response plan for emergency incidents

Third edition

A subplan of the *State emergency response plan*

State Government Victoria

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Document history

Edition	Date	Comment
Edition 1	2006	First Edition
Edition 2	2009	Updated to reflect changes in the State Emergency Response Plan
Edition 3	2013	Updated to incorporate and replace: • Victorian State Health Command Plan 2012 • Hospital resilience Code Brown policy framework 2008 • Victorian Burns Plan 2006 • General Practice Subplan • Field Primary Care Response Subplan

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The plan is reviewed as per the ‘Plan review’ section of this document.

Contents

1. Introduction

The *State health emergency response plan* (SHERP) outlines the arrangements for coordinating the health response to emergency incidents that go beyond day-to-day business arrangements.

Emergencies are complex incidents and local resources may not be able to respond effectively to events such as mass casualty incidents, complex trauma events, mass gatherings and other incidents that affect the health of Victorians.

SHERP is a subplan of the Victorian *State emergency response plan*. It is an all-hazards, scalable plan and now includes detailed arrangements for regional and state health responses.

This edition of SHERP also incorporates contemporary directions in emergency management, with an increased focus on the needs of children in emergencies and on psychological support to prevent long-term health impacts.

To ensure that SHERP is relevant to the current environment, experiences from significant events in Victoria and other jurisdictions have been reviewed alongside a targeted literature review.

The basis for the Department of Health's emergency management responsibilities come from its portfolio responsibilities in health, the *Emergency Management Act 1986* and the *Emergency management manual Victoria* (EMMV). The department's two key responsibilities are: to act as the Control Agency for the protection of health; and to manage pre-hospital and hospital responses to emergency incidents. SHERP describes the arrangements for this second responsibility.

1.1 Aim

The aims of SHERP are:

- to reduce preventable death and permanent disability
- to improve patient outcomes by matching the needs of injured patients to an appropriate level of treatment in a safe and timely manner.

1.2 Purpose of this document

SHERP ensures a safe, effective and coordinated health and medical response to emergencies by:

- clarifying who is accountable for command and coordination of the health response
- outlining the arrangements for escalating the health response
- describing how available clinical resources are organised
- describing how the health emergency response connects with the broader state and national emergency management response and recovery arrangements.

1.3 Scope

SHERP describes the principles, command and coordination arrangements, and roles and responsibilities for a health emergency response that involves pre-hospital care, patient transport, receiving hospitals and other healthcare facilities.

SHERP also provides the framework for planning the health response for emergency incidents and mass gatherings.

SHERP does not describe the responsibilities of the Department of Health as the Control Agency for the protection of health. These are described in the Department of Health *Public health control plan*, which outlines how the department will undertake its responsibilities for incident control in cases involving retail food contamination, human disease (including pandemics), biological materials, radioactive materials and food/drinking water contamination.

1.4 Relevant organisations and individuals

SHERP should be used by all individuals and organisations that operate under the plan, or are connected with the plan through other emergency management arrangements, to undertake their planning and preparedness activities. These include:

- community members
- incident control agencies
- Department of Health
- Ambulance Victoria
- first aid providers
- medical providers (including general practitioners)
- health services (public and private hospitals)
- residential and aged care services
- relief agencies
- local government authorities
- event organisers.

1.5 Principles of SHERP

SHERP is underpinned by several principles guiding the application of the plan.

Safety of health responders is paramount

The physical and psychological health and safety of emergency personnel is paramount. Agencies and personnel responding under SHERP have a duty of care to ensure the principles of occupational health and safety extend to the emergency environment and that personnel work in a manner that is not harmful to their own physical or mental health and safety.

Providing information to people involved in emergencies

People involved in emergencies should receive clear, simple information and instructions from health responders about their care or movement.

Planning is integrated

SHERP ensures that a health strategy and management plan is integrated into the incident strategy and incident action plan developed by the Control Agency. Where there is a health consequence, the Health Commander will inform the Incident Controller, to effect risk mitigation.

Lines of command and coordination

There are two key lines of communications within SHERP: 'health command' in the pre-hospital environment and 'health coordination' (hospital / health service coordination) as a function of the Department of Health coordinating health and aged care services. It is vital that these two lines of communication have strong linkages at each tier of incident management.

Collaboration at all levels

The success of the Health Incident Management Team (HIMT) depends upon adopting a collaborative approach, resulting in an understanding of each others roles and a joint contribution to effective coordination and management.

Incident management principles are followed

Part 3 of the EMMV describes the incident management system (IMS) used for incident control. The IMS principles (management by objectives, functional management and span of control) should also be used by HIMTs and Hospital Incident Management Teams (HoIMTs).

All-hazards approach

SHERP applies an all-hazards approach to emergency incidents. It advocates a consistent approach to the health response to transport incidents, fires, floods and so on. It also recognises that mass gatherings and public events increase the risk of mass casualties or complex trauma. In addition, multiple separate incidents can affect the health system in a similar way to one major incident. To allow for a scalable response, the SHERP framework and arrangements should be applied for all hazards.

2. Actions for those first on the scene

Community members, paramedics, first aid agencies, police, firefighters or other emergency officers will be the first people at the scene of an emergency incident.

2.1 Role of community members in health response

The community plays a vital role in life-threatening emergencies. Concepts such as the 'chain of survival'[1] in response to cardiac arrest demonstrate that immediate community response increases the chances of saving lives.

In a mass casualty setting the community response can be critical to good patient outcomes. There are many examples of this, such as the 2013 Boston Marathon bombings.[2]

What can a community member do in response to a health emergency?

- Ensure they and those around them are safe.
- Call triple zero for further assistance for life-threatening emergencies.
- Render assistance to the best of their ability.
- Hand over care for the patient to health response agencies when they arrive.
- Assist the health response agencies if requested.

What can a community member do to prepare for a health emergency?

- Register themselves and their family for an eHealth record (visit: http://eHealth.gov.au).
- Have an all-hazards emergency kit (including a first aid kit).[3]
- Complete a first aid course.
- Join a volunteer first aid organisation.

What if they already have some training or are a healthcare professional?

- They must tell the health responders of their training.
- They must be prepared to verify their credentials.
- They must take direction from the health responders.

1 'Part 12: From science to survival: strengthening the chain of survival in every community', *Circulation* 2000;102:I-358-I-370
2 Walls RM, Zinner MJ 2013, 'The Boston Marathon response: Why did it work so well?' *JAMA*, vol. 309, no. 23, pp. 2441–2442
3 See <www.ses.vic.gov.au/prepare/stormsafe/emergency-plans-and-kits> for emergency plans and kits, <www.cfa.vic.gov.au/plan-prepare/fire-ready-kit/> for fire ready kits and <www.redcross.org.au/prepare> for emergency REDiPlans.

2.2 How to get health and medical specialists on scene

SHERP provides a range of health and medical specialists to be responders to an incident.

The Incident Health Commander is responsible for requesting these specialists by notifying the Regional and/or State Health Commander.

If an Incident Health Commander has not yet arrived, those at the scene should inform the Ambulance Communications Centre of any special needs of the incident. The public can do this by calling triple zero.

Health and medical specialists come from a range of nominated agencies (see Appendix 5) and include:

- health commanders
- paramedics
- first aiders
- medical practitioners
- medical teams
- public health workers
- psychological support staff.

3. Context

3.1 Health emergency response within the Victorian health system

Victoria has a population of approximately 5.5 million people in an area of about 227,000 square kilometres.

The Victorian health system is made up of a diverse range of providers of services that are managed and funded by Commonwealth, state and local governments, and by private and not-for-profit organisations. These include ambulance services, hospitals, community health services, private practices and more than 700 residential aged care facilities.

Given the complexity of the Victorian health service system, it is vital that all health services and agencies follow these SHERP arrangements. SHERP relies on arrangements with health agencies to achieve the best possible outcomes for Victorians affected by an emergency.

Each year Ambulance Victoria receives approximately 490,000 calls for emergency health response and the Victorian health system receives 1.51 million emergency department presentations in Victoria's public hospitals.

As most hospitals with emergency departments already work at optimal capacity every day, planning needs to be done to prepare for an unexpected influx of patients.

In Victoria, emergencies that most commonly require a health emergency response include transport incidents, chemical spills and natural emergencies such fire and flood. Incidents at mass gatherings and public events can sometimes also require a health emergency response.

When hospitals and health services respond to an external emergency, they will activate their Code Brown plan (for an external emergency or disaster). Code Brown plans provide the additional capacity that hospitals need to receive an influx of patients. This version of SHERP includes planning information to support Code Brown planning by hospitals and health services.

3.2 State emergency management arrangements

The Victorian *State emergency response plan* defines the fundamental principles of command, control and coordination that also apply to SHERP. These summaries provide context for the SHERP concept of operations.

3.2.1 Incident control

Control involves the overall direction of response activities in an emergency and is undertaken by a Controller. Authority for control is established in legislation, and carries with it the responsibility for tasking other agencies according to the needs of the situation. Part 7 of the EMMV identifies which agency is responsible for controlling different emergency types.

3.2.2 Tiers of incident control

There are three tiers of incident control for emergency response in Victoria. These tiers are reflected in the SHERP emergency management structures:

- incident tier – leadership and management at the incident site
- regional / area of operations tier – leadership and management within a defined area of operations
- state tier – strategic leadership for resolution of emergencies across Victoria.

3.2.3 Incident management levels

There are three classifications of emergency response. For the purposes of SHERP, they are described as:

- level 1 – medium impact on normal operations; resolved through use of local or initial response resources
- level 2 – major impact on normal operations; more complex management of emergency response in size, resources or risk
- level 3 – severe impact on normal operations; complexities requiring substantial management of response.

3.2.4 Coordination

Coordination involves bringing together agencies and resources to ensure effective response to and recovery from emergencies. Part 3 and 4 of the EMMV describe the authority for coordination in response, relief and recovery.

3.2.5 Incident Management Team

An Incident Controller may, depending on the complexity and duration of the emergency, decide to form an IMT to manage the delegated responsibilities of planning, operations, logistics, public information, investigation and intelligence relating to overall control of the incident. In some instances, a medical services unit may operate within the logistics function of an IMT, to provide medical support to the Control Agency responders. The IMT contributes to and carries out the objectives and strategies set by the Incident Controller.

3.2.6 Emergency Management Team

If an emergency requires a response by more than one agency, the Controller will form an EMT. The EMT consists of the Controller, support and recovery functional/agency commanders, Emergency Response Coordinator and other specialists. The EMT provides expert advice, support and management strategies for potential consequences of the emergency to the Controller.

3.2.7 Incident strategy

This is the overall strategy that describes the direction of actions based on the conditions prevailing at a given time. The Incident Controller, the IMT and the EMT collaborate on the incident strategy to ensure a common understanding and a unified approach.

3.2.8 Agency command

Command relates to agencies and operates vertically within an agency. It involves directing personnel and resources to undertake the agency's role and tasks. Authority to command is established in legislation, or by agreement within an agency.

3.2.9 Functional command

This is the integrated command of associated activities, resources and capabilities that may normally exist across a number of organisations. Where there are agreed, pre-existing arrangements, a Functional Commander can direct members and resources of a number of agencies. A Functional Commander supports the Incident Controller.

3.3 SHERP relationship to national plans

National arrangements coordinate the support of inter-jurisdictional and Commonwealth resources to a state-based response when the state government requests more capacity. SHERP may be used as a framework to support national arrangements within Victoria.

Any requests for Commonwealth support under SHERP will be made by the State Health and Medical Commander via the State Emergency Response Coordinator within Victoria Police. This will be actioned according to Part 8 Appendix 4 of the EMMV.

Table 1: National plans relating to SHERP

AEMA	These are the *Australian emergency management arrangements*, which provide an overview of how federal, state, territory and local governments collectively approach the management of emergencies, including catastrophic disaster events.
COMDISPLAN	This is the *Commonwealth Government disaster response plan*, which provides the framework for addressing state and territory requests for Commonwealth physical assistance arising from any type of emergency.
AUSTRAUMAPLAN	This is the *Domestic response plan for mass casualty incidents of national consequence* and provides the planning for sudden impact emergencies causing mass casualties (incorporating mass trauma and burns).
OSMASSCASPLAN	This is the *National response plan for mass casualty incidents involving Australians overseas*, which details the primary response arrangements to overseas incidents involving Australian nationals and other approved persons.
NatHealth arrangements	These are the *National health emergency response arrangements*, which direct how the Australian health sector (incorporating state and territory health authorities and relevant Commonwealth agencies) would work cooperatively and collaboratively to contribute to the response to, and recovery from, emergencies of national consequence.
National arrangements for mass casualty transport	These are the national arrangements to plan for and coordinate medical transport within Australia in response to a mass casualty event.
AHMPPI	This is the *Australian health management plan for pandemic influenza*, which is a national health plan for responding to an influenza pandemic based on international best practice and evidence. It outlines the measures that the health sector will consider in response to an influenza pandemic. Under this plan, the Victorian *Public health control plan* may call on elements of SHERP in support.
National counter terrorism plan	This plan outlines responsibilities, authorities and the mechanisms to prevent (or if they occur, manage) acts of terrorism and their consequences within Australia.

4. Concept of operations

4.1 Response tiers and levels

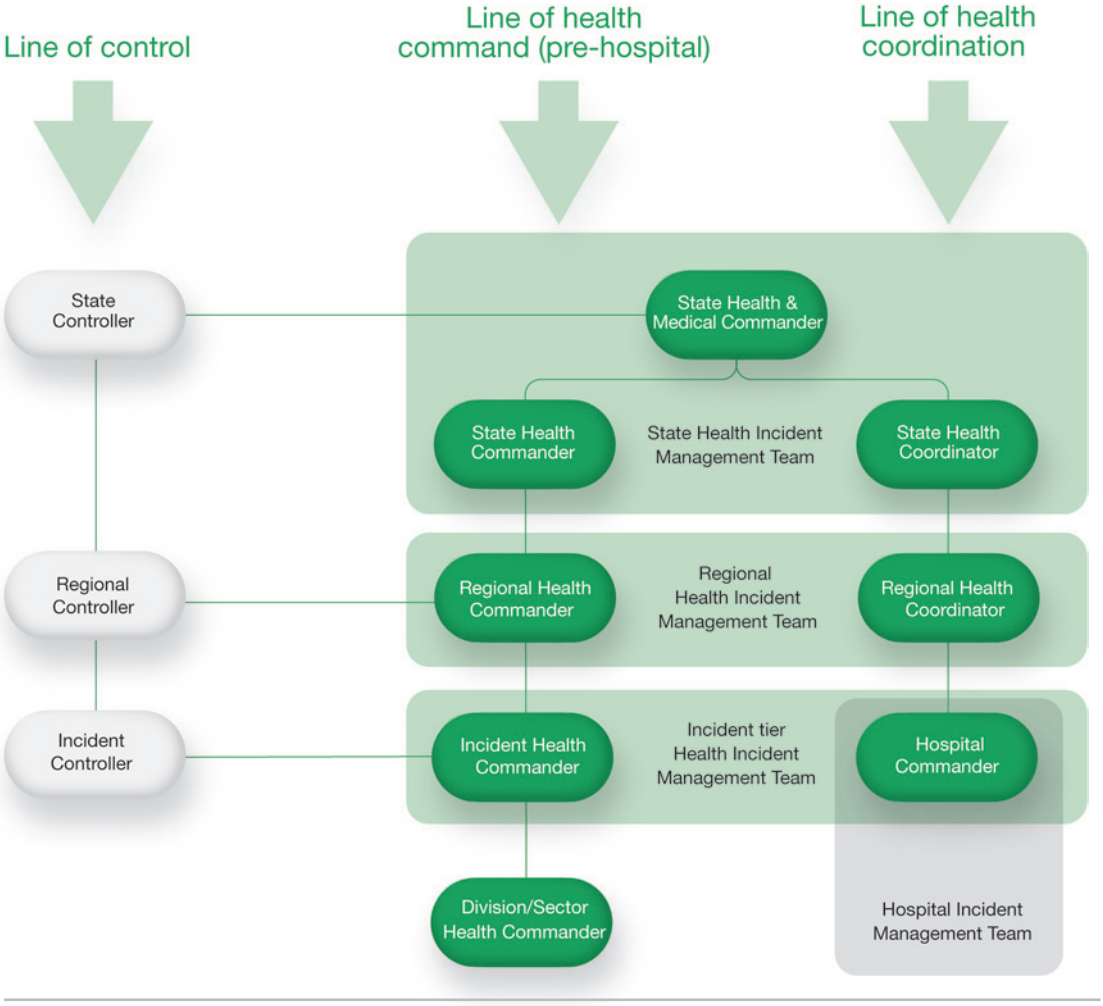
Health incident responses are structured around the three tiers of control. The tiers at which the health response operates will vary according to the impact on the health system and the tiers where control is exercised.

Within each tier, the Health Commander (or Health Coordinator where necessary) will determine the escalation level at which to manage the incident . Decisions to escalate will be based on the complexity of the incident, including factors such as size (for example, number of patients), resources (for example, field resources needed for patient care and management) or risk (for example, political sensitivities, media interest, location).

A health incident management structure may be established to enable coordination and management of the health response at the state, regional or incident tier. The management structure will be supported by an HIMT. The HIMT will provide the IMS functions of planning, operations, logistics, public information, investigation and intelligence to support the health response.

Each health incident response tier is described in the following sections, including the roles and the teams and their relationship with the Incident Controller (Figure 1).

Figure 1: Reporting relationships within the lines of incident control, health command and health coordination



4.2 Strategic relationships

At each tier an EMT is responsible for establishing a common understanding of the event, creating an understanding of the risks and consequences and developing and implementing a plan to deal with these.

At each tier the Health Commander represents all pre-hospital health agencies and the Health Coordinator represents the Department of Health as members of the EMT supporting the Controller.

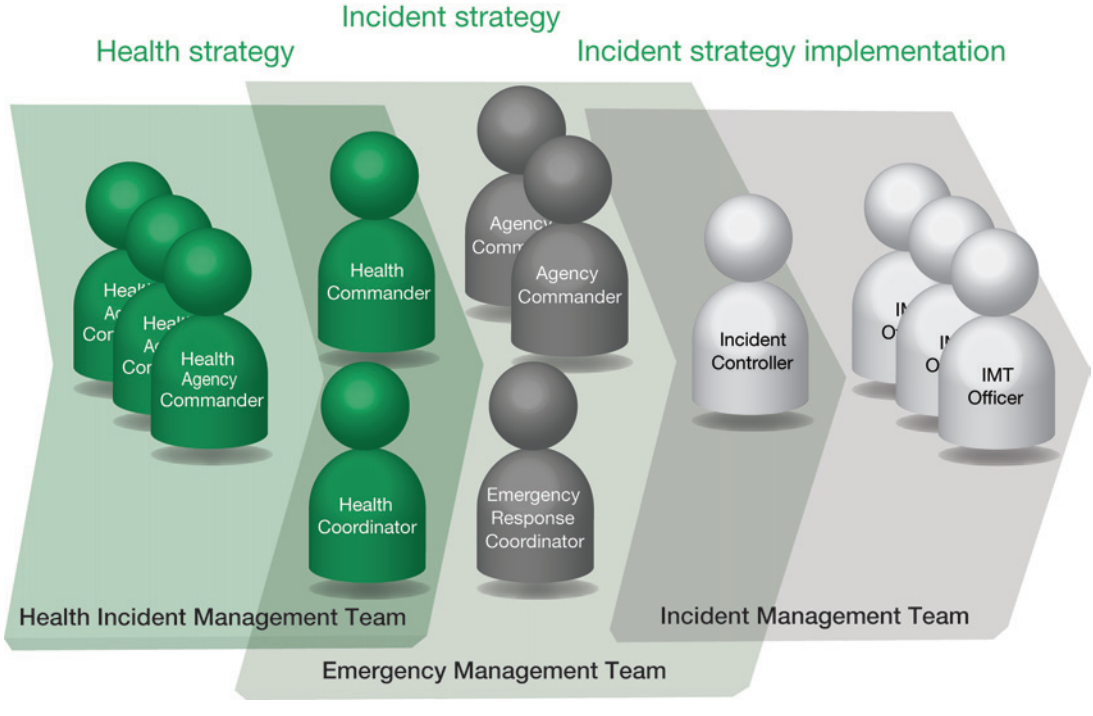
It is essential that the health representatives contribute to the development of the incident strategy and other priorities to ensure a joint approach to the management of the incident in order to minimise health consequences.

Once the incident strategy has been confirmed, the Incident Controller will also direct their IMT logistics function to liaise with the Incident tier Health Incident Management Team (I-HIMT) to ensure a joined-up approach to health delivery across the incident site.

If an EMT is not formed, the Incident Health Commander must make direct contact with the Incident Controller.

Figure 2 illustrates the relationship between the HIMT, the EMT and the IMT for each tier.

Figure 2: The relationship between the HIMT, EMT and IMT in developing incident strategy and priorities



4.3 Incident tier roles and structure

4.3.1 Incident Health Commander

The Incident Health Commander is a nominated ambulance manager (unless otherwise appointed by the State Health and Medical Commander). They report to the Regional Health Commander and are responsible for overseeing and directing the operational health response to an emergency.

The Incident Health Commander may form an I-HIMT and liaise with Hospital Commanders to coordinate a whole-of-health response to an emergency at the incident tier.

Incident Health Commanders work with the Incident Controller and the Incident Emergency Management Team to develop the health strategy and contribute to the incident strategy.

4.3.2 Hospital Commander

For the purposes of SHERP the term Hospital Commander is used to identify the chief executive officer or delegated member of staff who leads the health service or residential aged care service response under their site-specific response plan for external emergencies (known as a Code Brown plan). The Hospital Commander leads the Hospital Incident Management Team (HoIMT).

Hospital Commanders are responsible to their organisation's chief executive and board but also have a reporting relationship to the Regional Health Coordinator during an incident.

Hospital Commanders will also participate as a member of the I-HIMT and liaise directly with the Incident Health Commander.

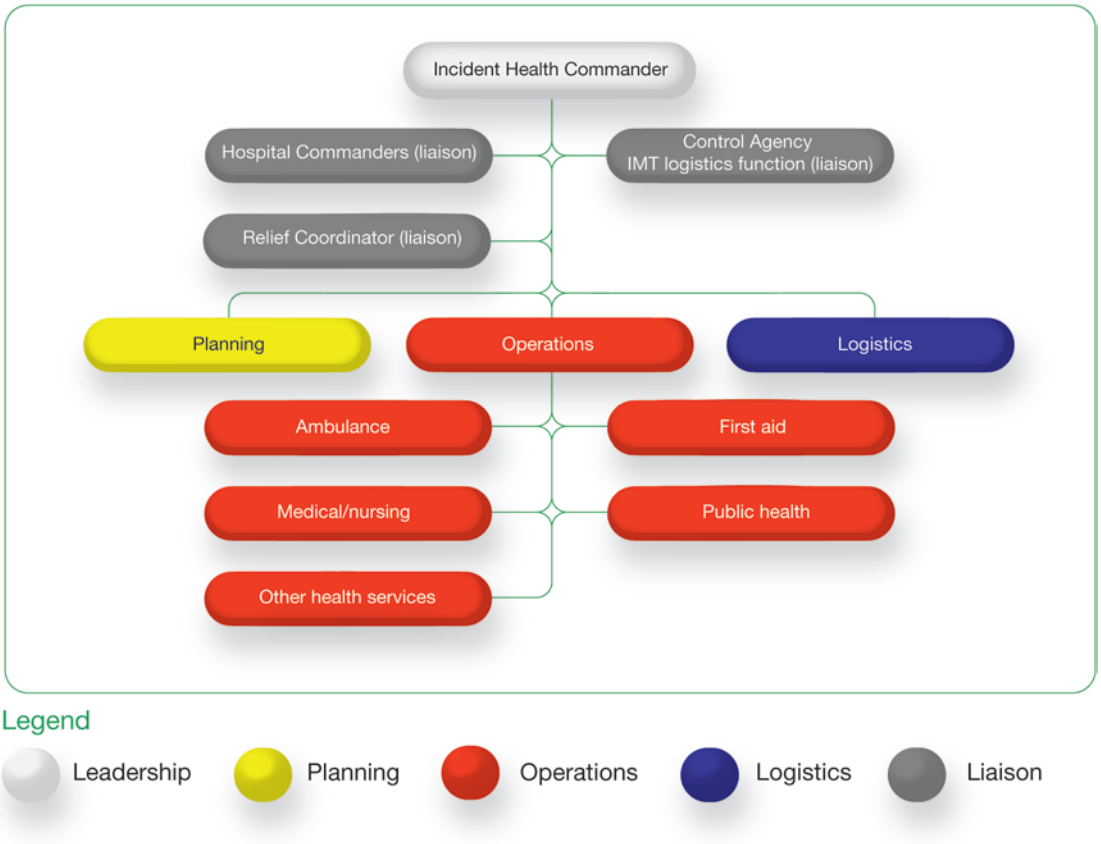
4.3.3 Incident tier Health Incident Management Team

At the incident tier, the Incident Health Commander will form an I-HIMT composed of themselves and Hospital Commanders from affected facilities.

Consistent with IMS principles, as an incident increases in size or complexity the Incident Health Commander may choose to delegate the functions of operations, planning and logistics to appropriate personnel available at the incident tier.

In the health setting, the operations function will be formed with each of the health functions required at the incident. Generally, each function will be represented by the Commander of the agency providing the function (see Figure 3).

Figure 3: I-HIMT structure



The I-HIMT may also have a liaison from the Control Agency's IMT logistics team (or medical services unit) to ensure a joined-up approach to health delivery across the incident site.

For smaller incidents, all IMS functions may be undertaken by the Incident Health Commander.

The I-HIMT may operate remotely through telecommunications, or within a facility or a mobile health command post.

4.3.4 Multiple/complex sites

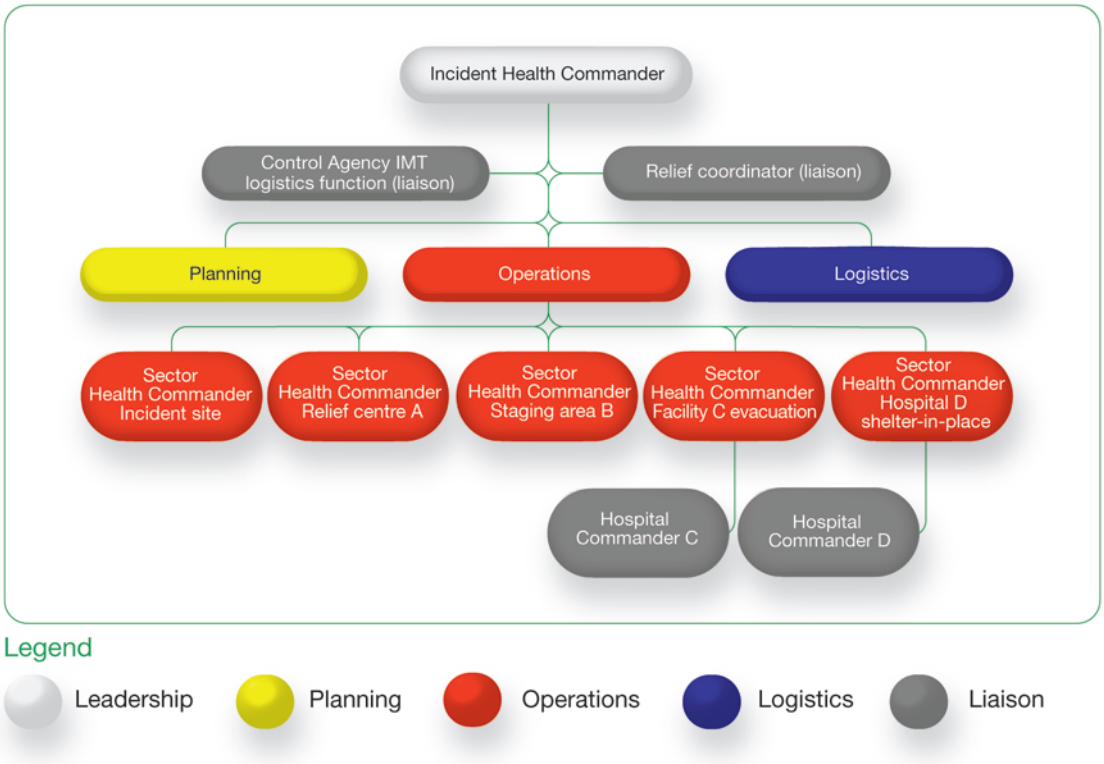
The HIMT must also consider the 'span of control' of single or multiple sites (or functions). Span of control is the practical limit of the resources and issues that one person can effectively manage.

It may be necessary to appoint Sector or Divisional Health Commanders to support the Incident Health Commander if an incident has a number of sites or a number of health functions. For example:

- a complex terrorist attack with multiple sites
- a widespread flood affecting a number of health facilities
- a mass casualty incident involving many health agencies.

In such cases the Incident Health Commander will be in close contact with the Incident Controller and the EMT. Each Sector/Divisional Health Commander will inform the Incident Health Commander of the specific requirements of each site or function, to ensure appropriate targeting of health resources (Figure 4).

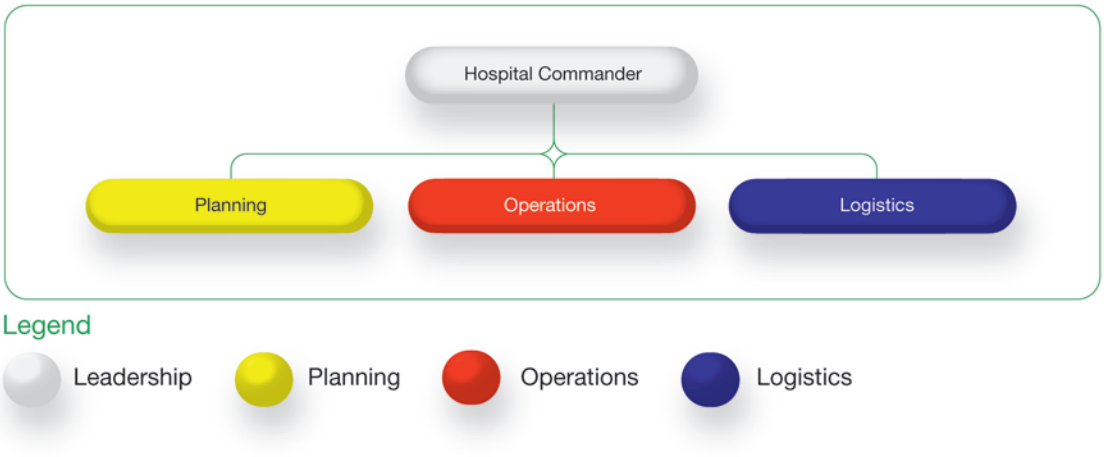
Figure 4: I-HIMT structure with multiple sectors



4.3.5 Hospital Incident Management Team

The HoIMT receives and manages all operational information related to the incident within the hospital (Figure 5). If an incident is going to extend beyond one shift change, the HoIMT will implement a roster system with a minimum of two equally capable and knowledgeable teams so rest breaks can be taken.

Figure 5: Basic HoIMT structure



Health service Code Brown plans should specify a room that can be used as an emergency operations centre (EOC) or similar. This area will be used for additional administration, coordination and communication functions. An alternative site should be identified in case the EOC is unavailable or unsuitable.

The area should be large enough to accommodate the HoIMT and equipment. This room should either be dedicated to this purpose or able to be commandeered with minimal disruption. The HoIMT should have priority access to the room in the event of an incident.

4.4 Regional tier roles and structure

4.4.1 Regional Health Coordinator

The Regional Health Coordinator is the relevant Director Health and Aged Care or their authorised delegate. They report to the State Health Coordinator and are responsible for coordinating the activities of the Department of Health in response to an emergency at a regional level.

The Regional Health Coordinator may form a Regional Health Incident Management Team (R-HIMT) to coordinate a whole-of-health response to an emergency at the regional tier and will liaise directly with the Regional Health Commander.

The Regional Health Coordinator will represent the department on the Regional Emergency Management Team and will contribute to the regional plan (risk and consequence) via the Regional Controller.

4.4.2 Regional Health Commander

The Regional Health Commander is a rostered ambulance manager (unless otherwise appointed by the State Health and Medical Commander). The Regional Health Commander reports to the State Health Commander and is responsible for directing the pre-hospital response to an emergency at the regional tier.

They will participate as a member of the R-HIMT and liaise directly with the Regional Health Coordinator.

The Regional Health Commander will represent the pre-hospital functions on the Regional Emergency Management Team and will contribute to the regional plan (risk and consequence) via the Regional Controller.

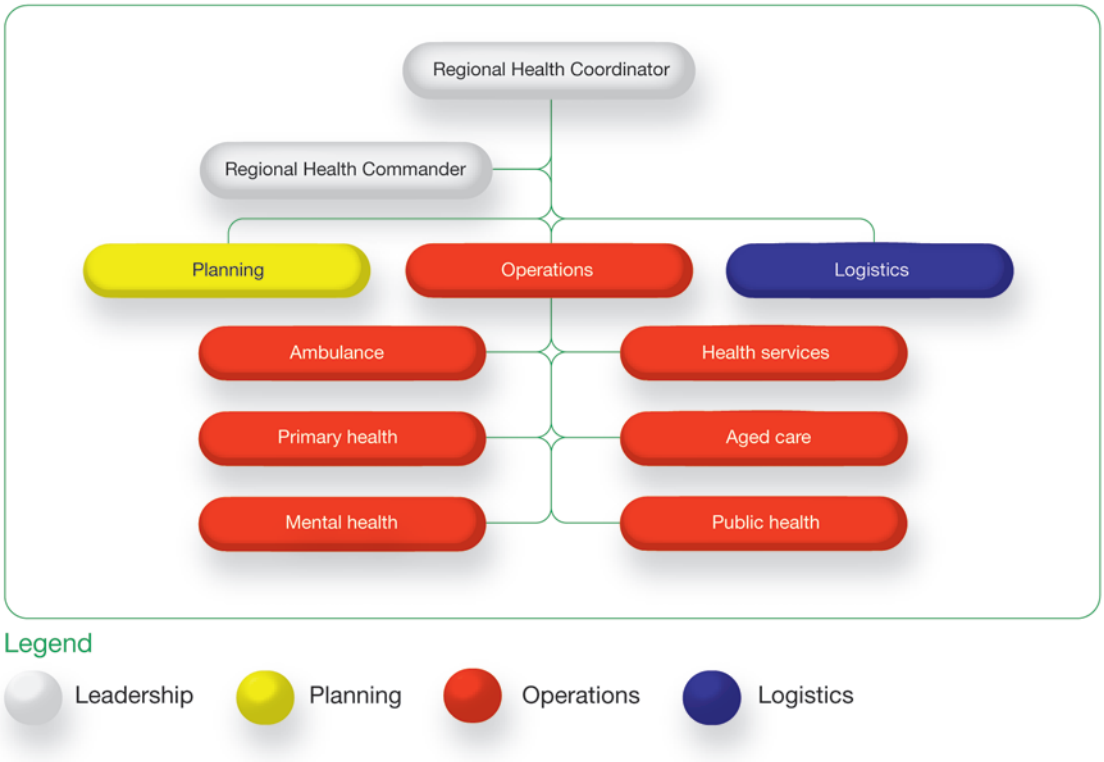
4.4.3 Regional tier HIMT

At the regional tier, the Regional Health Coordinator will form a R-HIMT on the recommendation of the Regional Health Commander. It will comprise both roles.

In line with IMS principles, as an incident increases in size or complexity the Regional Health Coordinator may choose to delegate the functions of operations, planning and logistics to appropriate personnel available at the regional tier.

In the health setting, the operations function will be formed from all the health functions that require regional coordination. Generally, each function will be represented by the Regional Commander of the agency providing the function or departmental representative (see Figure 6).

Figure 6: R-HIMT structure



For smaller incidents, all IMS functions may be undertaken by the Regional Health Commander or Regional Health Coordinator according to the consequences being managed.

The R-HIMT may operate remotely through telecommunications, or at a Department of Health facility such as the regional EOC.

Operations functional sections

The nature and duration of an emergency determines which R-HIMT operations functional sections are activated.

Ambulance

The ambulance section is activated before (based on potential) or during an emergency in a variety of circumstances. The ambulance section is responsible for maintaining situational awareness of the impact an emergency is having on the pre-hospital sector.

Primary health

The primary health section is activated during an emergency if field primary care or local medical practitioners are required. This is normally in the immediate aftermath of an emergency. The primary health section is responsible for rostering and managing health professionals for field primary care clinic (FPCC) deployments.

Aged care

The aged care section is activated during an emergency if the evacuation or relocation of residential aged care services is imminent. This normally occurs in the response phase of an emergency. The aged care section is responsible for informing the operational response, including information from the Australian Government Department of Social Services regarding alternate accommodation options.

Health services

The health services section is activated prior to (based on potential) or during an emergency in a variety of circumstances. The health services section is responsible for communicating with health services and maintaining situational awareness of the emergency's impact on them. The health services section has a key role in maintaining bed capacity, monitors demand and surge, activates medical assistance teams and works closely with the ambulance section.

Mental health

The mental health section is activated prior to (based on potential) or during an emergency. The mental health section is responsible for:

- facilitating an integrated approach to mental health and psychosocial support during an emergency
- maintaining situational awareness of the impact an emergency is having on mental health services
- providing advice on public information about trauma recovery
- providing advice on mental health issues.

Public health

The public health section is activated in accordance with responsibilities related to the control functions on behalf of the Department of Health. The Department of Health *Public health control plan* establishes the responsibilities, roles and functions required of the department under the leadership of the Chief Health Officer.

If the department is not performing a control function during an emergency or activation, the Public Health section provides support in accordance with the *State public health control plan*.

4.5 State tier roles and structure

4.5.1 State Health and Medical Commander

The State Health and Medical Commander is a nominated role of the Department of Health. In emergencies, the role of the State Health and Medical Commander is to direct health and medical resources. This includes the authority and responsibility for using departmental and associated resources to prepare for and respond to the health impacts of emergencies.

The State Health and Medical Commander may form a State Health Incident Management Team (S-HIMT) to coordinate a whole-of-health response to an emergency at a strategic level.

The State Health and Medical Commander represents the S-HIMT on the State Emergency Management Team and contributes to the state plan (risk and consequence) via the State Controller. This activity may be delegated to the State Health Coordinator (as the representative of the Department of Health) and State Health Commander (as the representative of the pre-hospital function).

The State Health and Medical Commander may delegate their responsibilities to the State Health Coordinator.

The State Health and Medical Commander is authorised to appoint or replace any health command or coordination role in connection with the operation of SHERP.

4.5.2 State Health Coordinator

The State Health Coordinator is appointed by the State Health and Medical Commander. They report to the State Health and Medical Commander and are responsible for coordinating Department of Health emergency activities at the state tier.

They participate as a member of the S-HIMT and liaise directly with the State Health Commander.

4.5.3 State Health Commander

The State Health Commander is the appointed ambulance emergency manager (unless otherwise appointed by the State Health and Medical Commander). The State Health Commander reports to the State Health and Medical Commander and is responsible for directing the pre-hospital response to an emergency at the state tier.

They participate as a member of the S-HIMT and liaise directly with the State Health Coordinator.

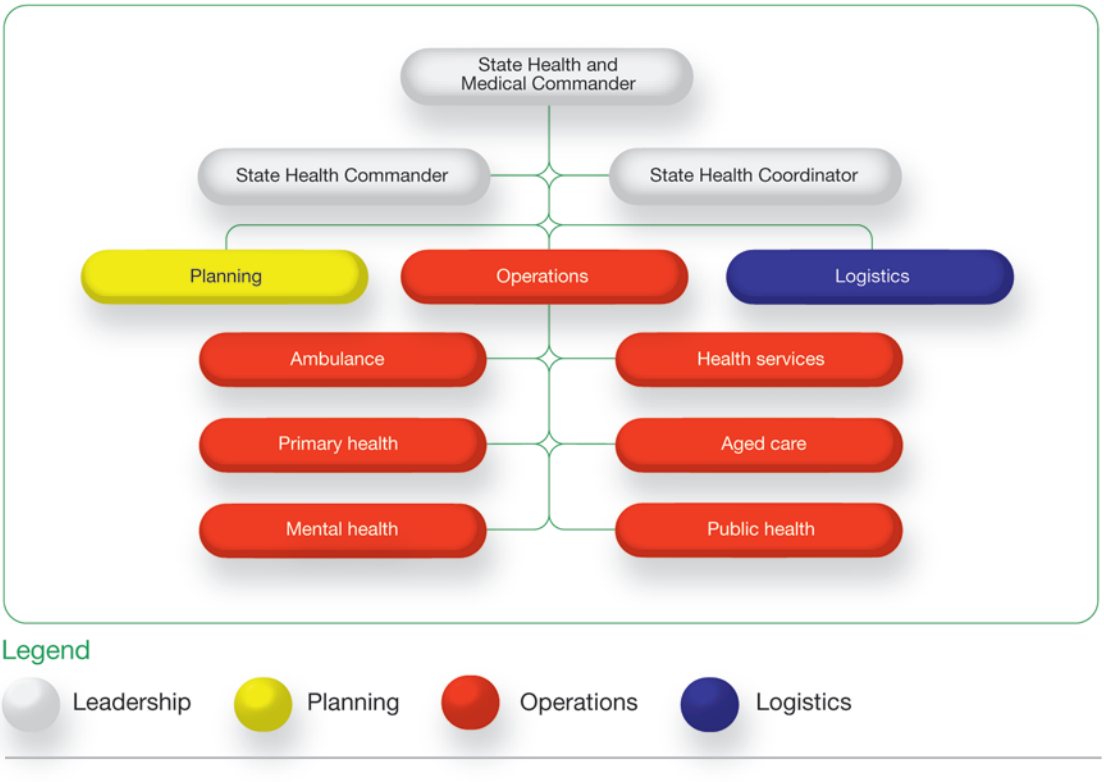
4.5.4 State tier HIMT

At the state tier, the State Health and Medical Commander forms a S-HIMT composed of themselves, the State Health Commander and the State Health Coordinator.

In line with IMS principles, as an incident increases in size or complexity the State Health and Medical Commander may delegate the functions of operations, planning and logistics to appropriate personnel available at the state tier.

In the health setting, the operations function is formed from all the health functional sections that require state coordination. Generally, each functional section is represented by the State Commander of the agency providing the functional section or departmental representative (see Figure 7).

Figure 7: S-HIMT structure



For smaller incidents, all IMS functions may be undertaken by the State Health Commander or State Health Coordinator.

The S-HIMT may operate remotely through telecommunications, or may choose to operate as a team within a Department of Health facility such as the State Emergency Management Centre.

4.6 Escalation of response level

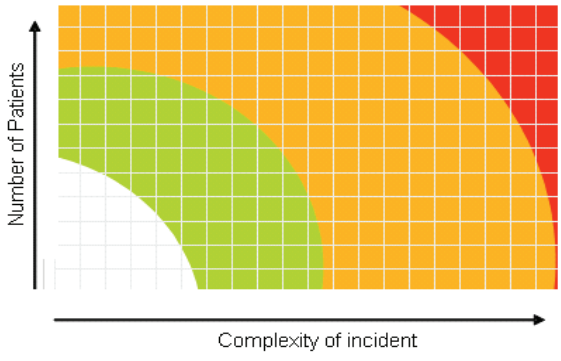
4.6.1 Triggers for escalation

The health system is always active, and most agencies with SHERP responsibilities also undertake normal operations (represented by the white section in Figure 8).

SHERP is triggered to escalate when information is received about an incident or potential incident that is likely to impact normal operations of the health system or any agency that operates within SHERP. Escalation levels apply to each tier of incident management, and each tier can operate at a different level of escalation.

Information can be received through various channels such as: triple zero calls received by Ambulance Victoria; multi-agency dispatch requests to Ambulance Victoria; warnings and advice issued by Control Agencies; information disseminated by Victoria Police Emergency Response Coordinators; or planning arrangements for major public events.

Figure 8: Complexity and escalation



The graph opposite illustrates how escalation is affected by the complexity of an incident and the number of patients involved – this has consequences for normal agency operations.

Normal operations	Level 1	Level 2	Level 3
Low impact on normal operations	Medium impact on normal operations; resolved through use of local or initial response resources	Major impact on normal operations; more complex management of emergency response in size, resources or risk	Severe impact on normal operations; complexities requiring substantial management of response

Adapted from Ambulance Victoria

4.6.2 Considerations for determining level of escalation

The complexity and size of the incident will determine which functions of SHERP are established and escalated. The level of escalation can be influenced by:

- location (for example, regional/remote, proximity to a hazardous facility)
- agency involvement
- political sensitivities/complexities
- media interest
- public awareness
- risk environment.

4.6.3 Agency escalation plans

All agencies and hospitals operating within SHERP must have a plan to escalate their preparedness response. In the case of a health service this may activate a Code Brown response to a mass casualty incident.

During the planning process, risks can be classified according to their impact on the normal operations of the agency or health service. They can be measured by a risk matrix to identify the level of response required.

The planning process for a Code Brown response should identify potential risks, the likelihood of occurrence and the appropriate treatments. Key questions are:

- What happened?
- What are the likely impacts on the facility?
- Can that impact be managed through daily operations and management practices?

Usually there is not enough initial information about an incident to easily determine the scale of response required. Preparedness arrangements need to be flexible to respond to changing situation information.

4.7 Notification

4.7.1 Format of notification

All notifications, requests for assistance and updates within SHERP should follow the format described by the mnemonic 'ETHANE':

- **E**xact location
- **T**ype of incident
- **H**azards
- **A**ccess and egress
- **N**umber of patients
- **E**mergency services at scene or required.

4.7.2 Notification for Health Commanders

When notified of an incident, Ambulance Victoria will make an assessment of the incident based on the available information and deploy an Incident Health Commander to the scene if necessary.

As part of this process the Regional Health Commander will be notified and, for significant incidents, the State Health Commander. The State Health Commander will liaise with the State Health Coordinator.

The State Health Commander will notify all relevant SHERP response agencies for level 2 and 3 incidents.

4.7.3 Notification for Health Coordinators

If a health service or residential aged care service believes there is a risk to their normal operations due to an incident, they will inform and confirm with:

- the Regional Health Coordinator (in the case of rural/regional-based services)
- the State Health Coordinator (in the case of metropolitan-based services).

A contact list is available in Appendix 1.

The Regional Health Coordinator will inform the State Health Coordinator of any significant incidents and liaise with the Regional Health Commander. The State Health Coordinator will liaise with the State Health Commander.

The State Health Coordinator will issue a 'first wave' communication for level 2 and 3 incidents. This provides a statewide communication to the Victorian public and private health and aged care sector, including:

- all public health services
- all private hospitals
- all public-sector residential aged care services
- the Australian Government Department of Social Services
- the Commonwealth Department of Veterans' Affairs.

4.8 Documentation

4.8.1 Logs

A full contemporaneous record of events, decisions and actions taken is essential for managing the incident, handover between teams, debriefing, and for inquiries after the incident. It is essential that incident logs are maintained by those managing the incident.

Logs:

- keep a record of all issues
- maintain a date and time record of all actions, requests and decisions made
- communicate key issues – outstanding and completed
- provide a record of the incident response that may be used after the incident.

4.8.2 Situation reports and action plans

Situation reports and incident action plans are used to manage information and ensure actions meet the overall incident objectives.

Health services may need to submit a situation report to the Department of Health that describes health service capacity and bed status to inform development of the state health incident strategy.

4.9 Community information

The Control Agency has the responsibility to manage community information. This information should address:

- what is known and unknown about the emergency
- what is being done
- ongoing threats
- actions required by individuals and the community to prevent further injury, death and damage to property and the environment.

The Health Commander at each tier, as the pre-hospital representative on the EMT, will give the Controller information on health and medical issues.

The State Health Coordinator will provide further information through the S-HIMT and the Chief Health Officer.

4.10 Media

Health personnel at the incident site should not speak to the media or release any information about casualties. The Controller is responsible for all media management. The chief executive officer or their delegate is responsible for coordinating media management for each health service.

If the Control Agency cannot deal directly with the media, it may request assistance from the State Health Commander, State Health Coordinator and the Emergency Management Joint Public Information Committee (EMJPIC). The EMJPIC should be briefed about issues that may impact more broadly on the community (refer to the EMMV Part 5, page 19).

4.11 Stand down

Stand down is the return to normal operations when deployment of resources and personnel is no longer required (see EMMV Part 3).

Stand down activities include:

- hospital notification of incident site stand down
- hot debrief of all agencies deployed
- peer support
- audits and reports
- review of SHERP and supporting plans and standard operating procedures.

4.12 Operational debriefs

An operational debrief is essential to assist future planning and address issues.

By Control Agency: The Control Agency is responsible for conducting a multi-agency debrief with input from participating agencies, which are responsible for conducting their own operational debriefs beforehand.

By Department of Health: The department may conduct an operational debrief of agencies involved in a health emergency response. The focus of this debrief should be on the application of SHERP. This will be used to identify areas for special recognition, continuous improvement and to inform the department's input to the multi-agency debrief.

By agency: Shortly following an incident, an operational debrief should be undertaken to examine the agency's response to the emergency. All those involved in the incident should participate, including representatives from any key external agencies.

As well as the operational debrief, 'hot' debriefs should be conducted at the end of the incident (or shift in the case of protracted incidents). This will usually be facilitated by the Health Commander or Health Coordinator and provides an opportunity for personnel to express their views and hear others' perspectives.

5. Response

5.1 Scene management

5.1.1 Safety

By their nature, incident sites may have a range of hazards. Safety is paramount.

As a general rule, all health responders are responsible for their own personal safety and, where possible, that of people under their care. Each agency or organisation is also responsible for ensuring the safety of their personnel and people under their care.

In addition the Incident Health Commander has overall responsibility for the safety of health responders and the people under their care. The Incident Health Commander will work with the Incident Controller and the EMT to ensure the safety of all those at the scene.

Of particular note to health responders is the issue of contamination and correct use of personal protective equipment. For further information on decontamination see the Department of Health's *Decontamination guidance for hospitals*.

5.1.2 People management

Incident sites can be chaotic, with numbers of dead, injured and uninjured people. Three key groups are evident:

- people with physical injuries (including the dead)
- people with little or no physical injuries but who may be affected by the event
- people electing to leave the scene prior to the arrival of emergency services or during the triage process. These people may self-present at hospitals or general practitioners' clinics, or simply return to their community.

Note that the deceased are left in situ for the coroner (or Victoria Police acting on behalf of the coroner) to process.

5.1.3 Triage

Triage ensures that limited patient management resources are directed to achieve the greatest good for the most number of people. It seeks to prioritise patients by clinical severity and optimise outcomes during times of severe resource constraints. Triage is a continuous process that needs to be repeated frequently. It also provides pre-hospital personnel with guidelines for assigning treatment and transport priorities. Initial triage by health responders will 'sieve' people into the following priorities:

Triage priority	Code	Comment
Priority 1	Red	Transport priority; move to a casualty clearing point
Priority 2	Yellow	Delayed transport; move to a casualty clearing point
Priority 3	Green	Walking wounded, potential to discharge at scene; move to a casualty clearing point
Survivor	Grey	Not injured, potential for psychological support; move to a relief centre
Dead	Black	No treatment; leave in place for the coroner

Following initial triage and movement to a casualty clearing point, a secondary triage is undertaken (when resources allow) to 'sort' patients based on a more detailed physiologic assessment.

Most triage systems result in most children being triaged higher – that is, more serious – than their physiological conditions warrant. In situations where a small number of children are affected, this will result in them being removed from the scene faster and is considered good practice. However, where scenes involve a large number of children, the triage method needs to be modified to prioritise among them.

Some people may elect to leave the scene prior to triage and it may be difficult to contact them for further follow-up, if required. Where possible, agencies should emphasise the importance of the triage and registration process for all people affected by the incident.

5.1.4 Casualty clearing point

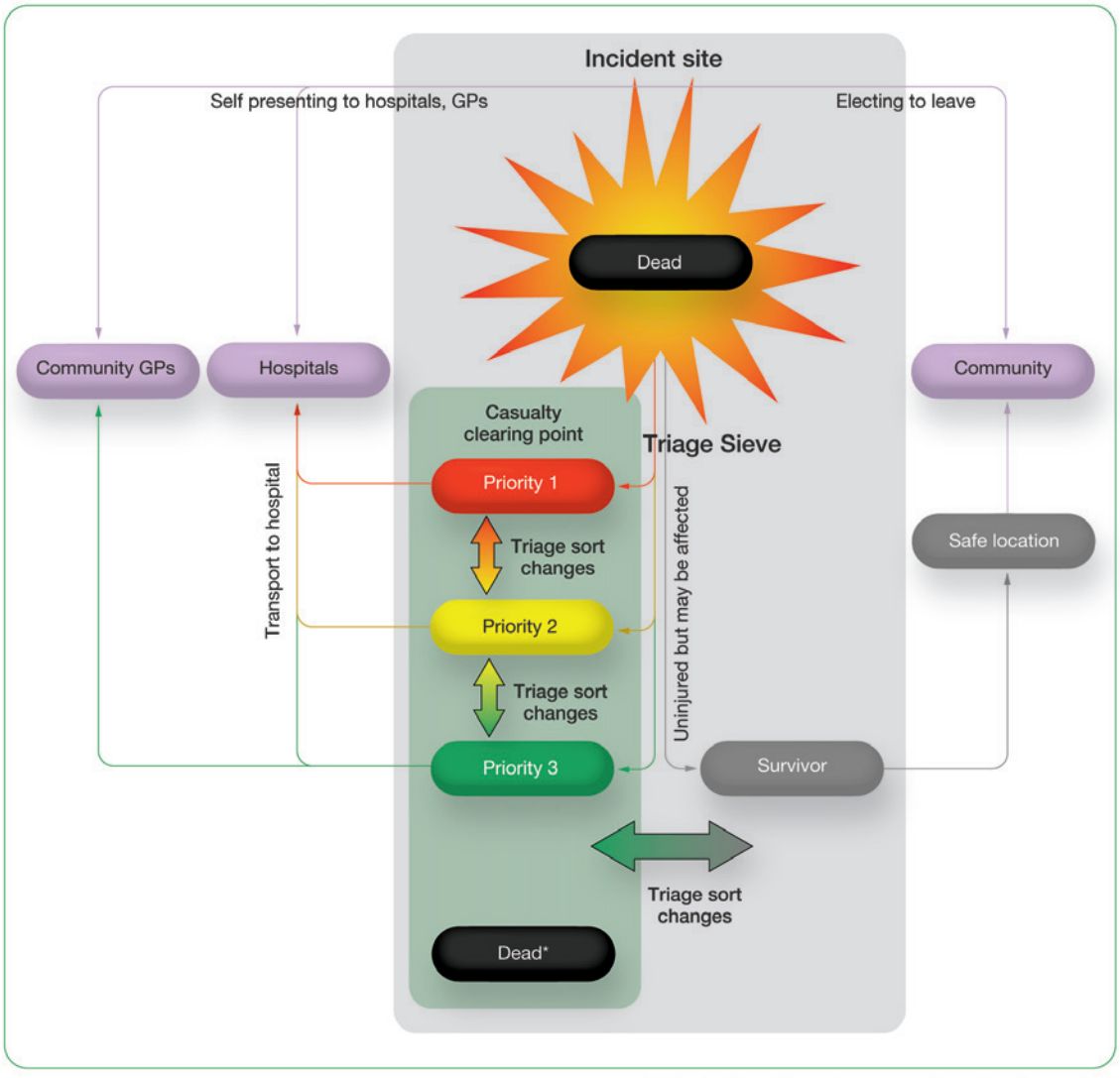
An effective way of organising a scene is to establish a casualty clearing point where patient management activities can be aggregated. For large or complex scenes, multiple casualty clearing points may be required.

Establishing casualty clearing points is the responsibility of the Incident Health Commander. Some key principles are listed below:

- Ensure the site is located safely away from the hazard.
- Provide sufficient space.
- Minimise the exposure of low-priority patients to the dead and severely injured.

Figure 9 describes the flow of people from an incident site to appropriate receiving facilities.

Figure 9: Scene management



5.1.5 Psychosocial response

Introduction

Emotional reactions are a normal response to the distress and trauma associated with an emergency. They can occur regardless of whether an individual sustains any physical injuries. The stress associated with an emergency event equally affects children and adults and any response needs to include working with children. Some people may be at risk of serious, long-term psychological disorders, and research suggests lack of post-event support may be a significant risk factor in these outcomes. The literature stresses the need for immediate psychosocial support alongside and integrated with the incident response.

Responders' role

Everyone involved in responding to an emergency can have a positive impact on helping people's emotional and physical recovery by using the proven psychological support principles, which are: ensuring people feel safe; helping people to help themselves, keeping families and groups together; being calm and hopeful; preserving privacy and dignity; and facilitating early access to physical, emotional support. Through the use of these simple actions, health and medical responders will help people positively recover and reduce the likelihood of longer-term psychological impacts.

Whenever possible, people who are not triaged for medical treatment should be directed to a safer area, away from exposure to the immediate noise and direct viewing of the incident scene. They should not be left unattended. As resources become available, personal support teams should be activated to provide psychological support and other forms of personal support. Providing psychosocial support is as important for the uninjured as it is for the injured.

Activation arrangements for personal support, including psychological support

Personal support and psychological support arrangements are documented within municipal emergency management plans as a part of the local relief and recovery arrangements. At both the regional and the state levels, these arrangements are documented in section 4 of the EMMV. Relief and recovery plans describe a range of services that can be activated in response to an event to assist with relief and recovery. Emergency relief can help to provide shelter, water, food and psychological support. The local municipal emergency management plan will detail the agencies responsible for providing personal support.

Health and medical personnel at the scene of the emergency should alert the Incident Health Commander as soon as they identify the need for personal support and psychological support. Providing early access to personal support is vital and it should be activated early if it is likely the event scene will not be quickly settled.

The Incident Health Commander should liaise with the Incident Controller, who has the primary responsibility for activating emergency relief services. The Municipal Emergency Response Coordinator (Victoria Police) will liaise with the Municipal Emergency Resource Officer or the Municipal Recovery Manager to coordinate relief services at the site if it is safe to do so, or at a nearby location.

The Emergency Response Coordinator is responsible for transporting individuals from the scene to an established emergency relief centre if this is required.

For patients who are transported to hospital it is important that hospitals recognise and plan for responding to the psychosocial support needs of the uninjured family or friends who may attend the hospital as well as attending to the health and emotional needs of the admitted patients.

Local governments will work with response agencies to ensure community relief needs are identified and recovery plans are developed to address the psychosocial support needs of individuals and communities in the short, medium and longer term.

Personal support and psychological support

A key focus of psychosocial support in the early stages of an emergency is providing personal support to affected individuals. Personal support is the provision of information, practical assistance, emotional support, assessment of immediate needs and referral to other support agencies and services as required. Relief agencies such as Red Cross and non-government organisations including the Victorian Council of Churches (VCC) have volunteers trained in psychological support who can be activated through municipal emergency management plans. Red Cross and the VCC can be deployed at short notice to relief centres or incident sites where it is safe to do so. Agency personnel undertake roles as defined in the municipal emergency management plan, which include providing psychological support and other emergency relief services.

5.1.6 Management of trauma

The Victorian state trauma system[4] facilitates the management and treatment of major trauma patients in Victoria. The system aims to:

- reduce preventable death and permanent disability
- improve patient outcomes by matching the needs of the injured patient to an appropriate level of treatment in a safe and timely manner.

The system works to have 'the right patient delivered to the right hospital in the shortest time'. Early activation of the trauma system is required to optimise response capacity.

The Victorian *Trauma triage guidelines* provide direction and criteria for all health workers involved in assessing patients against the definition of a major trauma patient, and the necessary action required.

Where resources permit, all trauma casualties at SHERP incidents should be treated according to these guidelines.

Specialist medical and nursing field responses should be used if it is likely transfer of major trauma patients will be delayed, or if specialised intervention is required. Any practitioners deployed should have appropriate qualifications, experience, training and be credentialled.

Management of burns

Optimal care for severe burn injuries is best delivered in specialist burns units. Victoria has two specialist burns units: at The Alfred (adults) and The Royal Children's Hospital (paediatric). The *Trauma triage guidelines* provide direction and criteria for all health workers involved in assessing patients with burns, and the necessary action required.

4 See <www.health.vic.gov.au/trauma>.

Incidents involving multiple burn casualties follow the underlying principles of the state trauma system and SHERP. The initial assessment and stabilisation of burns patients should follow the *Victorian state burns clinical practice guidelines*[5] in consultation with the on-call Major Trauma Service Burns Consultant.

If the incident involves multiple burn casualties, burns patients should be stabilised and transferred to specialist burns units as soon as practicable.

Specialist medical field responses should be used if it is likely that transfer of major trauma patients will be delayed, or if specialised intervention is required.

If five or more severe burn casualties are anticipated, activate the systems described in the *Guideline for multiple burn casualties* as early as possible to ensure limited burns management resources are used effectively.

All hospital Code Brown plans should consider the management of mass casualties with burns.

5.1.7 Management of children

Children have different physiological, psychological and developmental needs and the type of care they require in an emergency will depend on their stage of life. The priorities in managing children in emergencies are to protect them from further harm, treat injuries, minimise psychological trauma and where possible prevent their separation from family.

The availability of paediatric professionals, equipment and drugs, and the appropriate triaging of children, should be a priority when planning for medical emergency response. There are different approaches to triage depending on the number and proportion of injured children.

Immediate psychological support is required for children affected by an emergency. Contributing factors for psychological distress in emergencies can include: displacement; death within the immediate family and friends; house damage; and distressing sights and sounds directly or through the media.

Separation from family significantly increases the psychological impact on children. The level of vulnerability increases in children and young people if the adults who support them are also affected by the emergency. It is important to keep children with their families if possible. If children are separated from their families or guardians, they should be reunited as quickly as possible.

During mass casualty incidents involving large numbers of children, ensure the needs of children are considered and given priority within the health incident strategy. This should include improving the wellbeing of children at the incident by providing direct care and promoting the needs of children and those children with special needs.

5.1.8 Management of evacuation/relocation

Evacuation

The Incident Controller is responsible for issuing a recommendation to evacuate communities and the Evacuation Manager from Victoria Police is responsible for managing the planning and operational aspects of community evacuation during an emergency as described in the evacuation guidelines in the EMMV.

5 See <www.vicburns.org.au>.

The role of the Incident Health Commander is to work with the Incident Controller, Evacuation Manager and Hospital Commanders to:

- provide health and medical strategic advice to the Incident Controller and Evacuation Manager
- oversee health and medical support to evacuating communities
- oversee health and medical support at emergency shelters (including emergency relief centres)
- manage the withdrawal and return of identified vulnerable people from health and aged care facilities
- support the withdrawal and return of identified vulnerable people who have health-related needs.

Facility relocation, shelter in place and evacuation

The chief executive officer or person with delegated authority for health services, hospitals and residential aged care services is responsible for determining the decision to relocate, shelter in place or evacuate the facility.

These services must work with the Incident Controller, Evacuation Manager, Incident Health Commander and Regional Health Coordinator (or State Health Coordinator in metropolitan areas) to decide on the appropriate course of action for their facility. They will notify their decision to the Regional Health Coordinator (or State Health Coordinator in metropolitan areas) in accordance with section 4.7.3 of this plan.

Once the decision is made and notified, services will then work with the Incident Health Commander to implement their plan.

Health services, hospitals and residential aged care services should have an emergency management plan. They should make sure it can be activated and implemented onsite so it can inform decisions to relocate, shelter in place or evacuate. The emergency management plan should be reviewed and updated regularly with the involvement of local emergency service organisations.

Residential aged care services have a responsibility under Commonwealth legislation and are accountable to the Australian Government Department of Social Services to have emergency management plans in place, to exercise informed decision making and to take responsibility to protect the health and safety of residents and staff.

For further information please see the EMMV Part 3 and Part 8 Appendix 9, which provides details on the evacuation process and also the *Relocation, shelter in place and evacuation guidance note for public and private health services, hospitals and residential aged care services*.[6]

5.1.9 Field resources

Managing spontaneous volunteers

When health agencies arrive at an incident, spontaneous volunteers may already be actively assisting patients. Once they have handed over their care to responders, spontaneous volunteers may be able to assist in a range of activities, with or without specific qualifications. Spontaneous health and medical volunteers are not part of any agency response and will require registration and checking of credentials before assisting in the health response.

Victoria Police is responsible for volunteer registration and the Incident Health Commander (or delegate) will be responsible for checking credentials and task deployment.

Volunteers will be specifically tasked under the command of a health agency within the HIMT.

6 See <www.health.vic.gov.au/publications/emergency-relocation>.

Ambulance

Ambulance services will usually be the first health agency on the scene and provide immediate triage, treatment and transport. They will also coordinate communications between different parts of the health response.

The role of ambulance is to:

- provide appropriate skills and equipment for various health emergencies, including mass casualty and complex incidents
- triage casualties and provide first aid and advanced treatment
- provide the most effective transportation for casualties to appropriate medical care
- assist with coordinating medical teams
- provide health support to other agencies, where appropriate
- provide medical support to casualties undergoing decontamination.

A detailed description of role of Ambulance Victoria may be found in the *Agency and role statements* section of SHERP.

First aid

First aid agencies under SHERP provide trained first aid teams at incident sites, casualty clearing points and relief centres – or as otherwise directed by the Incident Health Commander. Their role is to provide initial treatment and basic care at these sites.

Services and resources provided may include:

- trained first aid officers to assist with site triage, initial treatment and resuscitation of casualties and ongoing care
- trained advanced-level first aid officers, capable of providing defibrillation, oxygen resuscitation and limited drug therapy
- portable first aid supplies and other patient care equipment that is easily transported in a vehicle, trailer and kit form, for establishing first aid posts.

A list of SHERP first aid agencies may be found in the *Agency and role statements* section.

Medical and nursing

A range of medical and nursing resources are available to be deployed to an incident site. The Incident Health Commander will assess the requirement for medical support and resources. This assessment should be based on the clinical needs of those affected and the clinical skillsets available onsite and their ability to meet the *Trauma triage guidelines*.

Medical and nursing resources are required at a scene where:

- transport will be delayed and extended care is required in the field
- a patient is unable to be moved and specialist clinical skills are required
- the Incident Health Commander requires support in undertaking patient distribution
- there are large numbers of patients who require specialist expertise (such as children)
- there are large numbers of low-acuity patients who could be discharged from the scene after medical assessment.

The options available include:

- organised, experienced emergency clinicians
- organised medical teams containing a range of medical and nursing personnel
- local medical practitioners.

A list of SHERP medical and nursing programs may be found in the *Agency and role statements* section.

Public health

Public health is concerned with maintaining the health of the population and seeking to reduce the incidence of disease, premature death and disability.

When the Department of Health is not the incident Control Agency, early involvement of this support may help protect health and contribute to risk communication strategies for the community. A public health officer may attend an incident in support of SHERP to provide public health expertise to the HIMT and EMT. The public health officer can provide technical advice and community support without attending the incident, and can advise on recovery processes.

The public health arrangements may be activated by the Regional or State Health Coordinator in liaison with the Health Commander.

The Department of Health *Public health control plan* describes the arrangements for public health for use within SHERP. Alternatively, when the department exercises its control responsibilities, SHERP may provide support if appropriate.

Emergency relief

Emergency relief may be needed at the site of the emergency to provide safety, shelter, water, food and psychological support. It may also include registering affected individuals, which is the responsibility of Victoria Police and Red Cross.

Emergency relief is time-critical and health and medical responders must consider the need for relief services at the scene and alert the Incident Health Commander when it is required. If necessary, the Incident Health Commander will activate relief arrangements through the Incident Controller.

Local governments will work with response agencies to ensure community relief needs are identified and appropriately met.[7]

The Emergency Response Coordinator is responsible for transporting individuals from the scene to an established emergency relief centre if this is required.

Registration and information collection

Two separate registration and information collection processes can be established in an emergency, each with a distinct purpose. Health agencies must be prepared to accommodate these processes. The information gained may also inform any ongoing psychosocial support programs.

7 See <www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/emergency-relief-handbook>.

Register Find Reunite

Reconnecting people with family and friends affected by an emergency is facilitated through the Register Find Reunite service (formally known as the National Registration and Inquiry System or NRIS). Victoria Police is responsible for activating the service; Red Cross manages and operates the system. Registration commences during the response phase of an emergency, continues through relief efforts, and can be used to inform recovery.

Registration can occur at an emergency relief centre, online at the Red Cross website or via a call centre (State Inquiry Centre). The service can also operate at an emergency site/staging area or, in some cases, at a hospital. Register Find Reunite collects information about an individual's home address, contact details and their intended destination.

For planning purposes, further information on this service can be obtained from the *Emergency relief handbook: a planning guide.*

Relief centre registration

When establishing an emergency relief centre, municipal councils may set up a system for recording the details of everyone who attends the relief centre. Contact details and preliminary information about the person's relocation plans will be collected. The council will use this information to develop a recovery plan including scheduling outreach visits to affected communities and for individual follow-up.

Register Find Reunite and relief centre information collection should be coordinated to reduce the need for people to repeat basic personal information to different agencies.

5.2 Receiving facilities

5.2.1 Primary healthcare

Local medical practitioners (including general practitioners) play an important support role in Victoria's overall ability to respond to emergencies. Medicare Locals may also be involved. Within clinics/practices medical practitioners:

- may assist hospitals in managing clinical surge demands as a result of an emergency
- provide clinical care for self-presenters resulting from an emergency, such as walking wounded and individuals who have no physical injuries but have psychological trauma or distress
- provide primary treatment and care for their local community
- provide clinical assistance with patients referred from hospital to home-based care.

5.2.2 Short-term clinics

Additional general practice and nursing services may be provided in affected areas to help support people affected by emergencies. These services are established by the practitioners themselves and are not necessarily linked to the government response efforts.

General practitioners and nurses providing these valuable services are urged to link in with the Incident Health Commander to ensure coordination. Clinics are also advised to link in with coordinating bodies, such as Rural Workforce Agency Victoria (RWAV), General Practice Victoria (GPV), Medicare Locals, the Royal District Nursing Service (RDNS) or the Australian Government Department of Social Services, to ensure appropriate services are provided. This coordinated effort will also form part of discussions between state and Commonwealth governments in planning appropriate responses.

5.2.3 Field primary care clinics

In major emergencies, communities may have reduced access to primary healthcare due to medical infrastructure damage, incapacity of usual medical practitioners, increased demand for medical services, loss of personal transport or limited capacity to leave the immediate vicinity.

If additional primary healthcare is needed, FPCCs can be established and staffed by registered medical practitioners, nurses and paramedics.

The State Health and Medical Commander is responsible for authorising the activation of an FPCC.

Once authorised by the Department of Health, the S-HIMT is responsible for the operational deployment of the FPCC. The ambulance section will deploy infrastructure and supporting logistical resources. The primary care section will supply health professionals.

Management of these FPCCs is the responsibility of the Incident Health Commander, who may appoint a Sector Health Commander to manage an FPCC. Clinics will operate within appropriate safety and clinical governance guidelines.

5.2.4 Hospitals and health services

Health services play a critical role in the Victorian health response to an emergency. Once notified of an incident, hospital Code Brown response plans will be activated as the whole health service prepares to manage an influx of patients.

The health service will appoint a Hospital Commander who will oversee all aspects of the incident and establish a key contact point for all incoming and outgoing communications. Hospital Code Brown plans will interface with SHERP.

Public health services may also form partnerships with private hospitals to assist in such functions as emergency decanting of patients. Additional requests for assistance from the private hospital sector will be coordinated through the Regional or State HIMT.

Managing the incident

While most health services' day-to-day management systems are very effective at what they do, they are generally not sufficient for an emergency response due to different time pressures, objectives and information management requirements. The ability to work in a structured manner is important during stressful situations.

Staff who will have a lead role in managing emergency incidents should be trained appropriately, and maintain this knowledge and skill. All other staff should know how incidents are managed and the response required from them.

The IMS system has been widely applied in Victorian emergency response agencies to provides a flexible mechanism for coordinated and collaborative incident management. It is not an emergency response plan. Rather, it is a management framework that facilitates a clear response authority, the acquisition of resources and effective management of the incident. It uses a management-by-objectives methodology.

IMS is used by many first-responder groups (fire, police, ambulance) as well as government agencies that coordinate emergency situations. It helps to improve coordination with and between health services and other emergency response agencies.

IMS recognises that many different activities must occur to successfully manage an incident response. It groups these tasks into categories with functional similarities, such as operations, logistics and planning. Additional functions may be added if needed, for example, finance and liaison. The size and scale of the response is flexible and will depend on the type of incident and the impact it has on the health service.

IMS can be used to manage both small and complex incidents, and it should be employed for every incident or scheduled event to help hone and maintain skills needed for the large-scale events.

5.2.5 Patient tracking

This section provides health services with guidelines for tracking multiple casualties in a major incident from triage to discharge. Individual hospitals will have their own policy and procedure for registering patients (known or unknown identity) and this should be used in conjunction with Code Brown arrangements.

Health services must be able to locate major-incident casualties anywhere in the facility. They must have in place a system to identify and track patients throughout the treatment process and identify patient movement.

Consideration must be given to the following:

- triaging all casualties from a major incident at a single point
- making casualties readily identifiable in the triage area (such as using armbands or triage cards)
- assigning casualties with their 'disaster' UR medical record prior to moving from the triage area
- having a designated patient registration officer
- having a process to rapidly assign UR numbers when capacity is overwhelmed (such as having a set of pre-assigned disaster UR numbers and bands)
- having a hospital identifier with the UR number (because UR numbers may be duplicated at another hospital)
- having a system for tracking patients within the health service (such as an electronic system or patient tracking template)
- making information on patient tracking available on a display (such as on an electronic screen or whiteboard).

5.2.6 Self-presenting casualties

After an emergency, affected people may leave the scene and then self-present at hospitals and medical practices. Casualty-receiving hospitals may be initially notified of the incident through Ambulance Victoria. However, if hospitals and health services become aware of an event, other than through normal communication channels, they should consider activating Code Brown plans.

General practices should develop internal procedures to manage an influx of self-presenters. In long-duration incidents, general practitioners may be asked to assist, as described within local health service arrangements.

5.2.7 Managing surge

Although responding to the incident is a priority for hospitals and health services, they must also maintain appropriate critical business services. The Code Brown response plan should identify how this will be achieved, either by using managers not involved in the incident, or giving the HoIMT responsibility for all coordination.

A surge in patients from a mass casualty incident or a long-term incident such as an influenza pandemic can place pressure on hospital services that is likely to exceed available resources. The guiding principle in these situations is to preserve essential functions that achieve the healthcare facility's goals. This means providing care and allocating scarce equipment, supplies and personnel in a way that saves the greatest number of lives.

Decisions will have to be made on operational issues such as cancelling elective admissions, non-urgent surgery and all other non-essential activities. The processes for making these decisions should be detailed in the Code Brown plan.

For details about managing a surge in intensive care services see *Surge planning guidance for Victorian public intensive care services*.

5.3 Transport

5.3.1 Patient distribution from a scene

Under normal circumstances, healthcare workers have established, autonomous methods determining appropriate definitive care and patient referral. In order to maximise the effectiveness of patient transport services and minimise the impact across the health network, patient distribution needs to be managed by the Incident Health Commander with support from the I-HIMT.

The Ambulance Victoria State Communications Centres have routine, direct communication with hospital emergency departments. For smaller level 1 and 2 incidents, they can provide the Incident Health Commander and I-HIMT with information on hospital capacity and capability for use in planning and distribution. The medical and nursing section of the I-HIMT may also be tasked with gathering information on hospital capacity and capability.

For level 3 incidents at the state tier, the *Health incident consequence tool* may be activated to support the state HIMT in determining high-level patient distribution.

It is important that there is good coordination and transition of hospital information from the Ambulance Victoria State Communications Centre to the HIMT at the incident, regional and/or state tiers.

For level 2 and 3 incidents, medical practitioners, short-term clinics and FPCCs should also be considered in patient distribution.

The following criteria are taken into account when distributing patients:

- patient numbers and complexity
- percentage occupancy at the destination hospital
- time to the destination
- transport resources
- type of injuries
- special needs patients.

5.3.2 Secondary transfer between health service

Secondary transfer occurs if a patient is admitted to a hospital from the scene but is then transferred to another hospital. The three main reasons for requiring secondary transport are:

- to increase capacity
- to provide patients with critical care facilities
- to provide patients with specialist medical expertise.

If this situation occurs, the hospital will follow its normal procedures for inter-hospital transfers. Where specialist medical expertise is required, the following agencies may be engaged:

- ARV – Adult Retrieval Victoria
- Paediatric Infant Perinatal Emergency Retrieval (PIPER), comprising –
  - PETS – Paediatric Emergency Transport Service
  - NETS – Newborn Emergency Transport Service
  - PERS – Perinatal Emergency Referral Service.

If an emergency incident is likely to impact on multiple health services and there is more than one patient for inter-hospital transfer, the decision-making process will be coordinated by S-HIMT in collaboration with the specialist services listed above. This will take into consideration the capacity and capabilities within Victoria and other jurisdictions, as well as available specialist transport.

During a mass casualty incident, there can be a range of extraordinary issues that hinder the normal modes of patient transportation and this can affect the timely discharge of patients to home or to a neighbouring facility. The extent of the issues will be determined by the nature of the incident but may include road closures, traffic congestion and lack of ambulance vehicles. Plans for transport vehicles to access and exit from the hospital should also be determined to mitigate congestion.

6. Preparedness

All organisations with roles or responsibilities under this plan are required to ensure they are adequately and appropriately prepared to respond.

6.1 Planning

6.1.1 Clinical and organisational governance

Clinical governance is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for safety and quality of care. All health services and agencies under SHERP will have a formal and effective clinical and organisational governance framework that is consistent with the *National safety and quality health service standards*[8] and *Credentialling and defining the scope of clinical practice in Victorian health services – 2011 update*.[9] The *Victorian clinical governance policy framework*[10] also provides guidance in the four domains of:

- consumer participation
- clinical effectiveness
- an effective workforce
- risk management (encompassing incident reporting and management).

Occupational health and safety

Occupational health and safety planning will ensure that, as much as possible, the physical and psychological wellbeing of staff is protected when they are involved in a health emergency response.

Peer support and psychological debriefing

Staff should have the opportunity for peer support and/or psychological debriefing. This is voluntary and should be undertaken by a professional. Emergencies may have adverse short- and long-term effects on those directly and indirectly involved. Identifying and managing adverse psychological effects is an integral part of debriefing. Early intervention minimises long-term effects.

6.1.2 Developing partnerships

It is crucial that SHERP agencies and health services realise that effective emergency preparedness and response cannot be achieved without consistent, effective and practised integration with other members of the emergency management community at the local, regional and state tiers.

A collaborative approach through partnerships can be used to develop agency plans and health service Code Brown plans. This integration should begin in the planning stage. Building relationships enables:

- insights on roles and responsibilities to be shared
- a well-crafted response plan where each party is aware of their roles and responsibilities
- sharing of available resources
- the ability to conduct joint exercises and training.

Beyond this, partnerships are valuable in creating relationships between responders that will lead to improved planning initiatives and the likelihood of a more coordinated and effective response.

8 See <www.safetyandquality.gov.au/our-work/accreditation/nsqhss/>.
9 See <www.health.vic.gov.au/clinicalengagement/credentialling/index>.
10 See <www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy>.

Potential partners can include, but not be limited to:

- neighbouring private hospitals
- rural regional health and medical emergency planning committees
- emergency services – Victoria Police, Ambulance Victoria, Victorian State Emergency Service, fire services
- Medicare Locals
- local government – councils have responsibilities for health planning and community recovery programs (participation on the Municipal Emergency Management Planning Committee promotes an integrated approach to resources between the hospital/health service and other public health matters)
- volunteer agencies.

If agencies agree, resource sharing should be formalised.

6.1.3 Organisational plans

All organisations with roles or responsibilities under this plan must have the necessary plans to allow them to respond according to SHERP, such as business continuity, workforce capability, training, exercise and communications.

Business continuity planning

Business continuity management (BCM) assists organisations to manage business and service continuity risks. For hospitals, it is a complementary process that supports Code Brown planning. BCM controls, strategies and plans ensure the uninterrupted availability of resources that support critical business processes and services.

A strategic concept in BCM is 'managed degradation'. When a hospital system is under extreme stress, priority activities should be preserved, while less critical services are allowed to degrade.

This strategy is designed to avoid catastrophic or random failure of emergency response systems when system capacity or capability is exceeded. The care of patients and safety of staff should always be priorities.

BCM may also require an integrated, multi-agency organisational response at the local, regional and national levels (inter-dependencies with other government agencies).

Workforce capability

Workforce capability and competency is developed through plans, skills training and adequately providing technical equipment and committed resources. The needs of children at a mass casualty event should be a key consideration.

Awareness: All agencies with a role or responsibilities in this plan, or emergency response plans that interface with this plan, must be familiar with this plan.

Equipment and resources: The agency plan should record how technical equipment and resources will be made available when required.

Communication planning

Communications plans link with many other aspects of the emergency plan. Reliable internal and external communications are vital to successfully managing an emergency incident. Appropriate systems, adequate training and contingencies are needed to ensure effective communication during the incident. Information must be accurate and timely.

A plan should:

- give details of communication facilities to be used
- clearly articulate how information will be communicated
- identify all stakeholders, both internal and external, and methods of contact in both business hours and after hours
- articulate the role of a switchboard or call centre and how calls will be diverted if required.

Equipment

Normal information technology systems, power supply and telephone lines cannot be relied on as the sole communication method during large-scale emergencies. An over-reliance on mobile phone networks can be particularly problematic. Contingencies must be in place and these should be regularly tested and made familiar to staff. Dedicated internal communication lines between key departments may need to be considered.

Hospital plans

Code Brown plan

Hospitals should be guided by Australian Standard (AS) 4083–2010 *Planning for emergencies – health care facilities* when developing their Code Brown plan.

Major incidents present hospital staff with challenging situations that are different from the normal business and organisation responses. It is therefore essential that hospitals provide adequate training for staff to enable an appropriate and successful incident response. A well-developed and tested plan, as well as a standardised approach to emergency planning, has many benefits that include:

- minimising preventable morbidity and mortality in an emergency situation
- minimising the impact on delivering normal operation/business during times of increased demand on services
- the ability for the Department of Health to coordinate a statewide response to a significant incident.

Hospital Code Brown plans are developed to enable hospitals to achieve a well-coordinated, entire hospital response that adequately manages resources for a surge in patients from an emergency. As most health services already work at full capacity, plans need to include systems and processes for scaling down non-critical services to deal with an unexpected influx of patients. A well-constructed plan will identify triggers for escalation and scaling down emergency response. These triggers will usually be determined by the number of patients presenting to the health service, the nature of their injuries and the resources available for effective treatments.

The following information is an extract from AS 4083-2010 and outlines essential elements of a Code Brown plan. Reference should be made to AS 4083-2010 for more detailed guidance.

- Internal response (if casualty reception is anticipated) –
  - *(i) carry out a plan for clearing the emergency department of non-urgent cases;*
  - *(ii) carry out a plan for rapid discharge of non-urgent cases from hospital beds;*
  - *(iii) carry out special procedures for labelling casualties, and medical record keeping; and*
  - *(iv) adopt security measures as follows:*
    - *(A) Supply information to the police for release to relatives and the media.*
      NOTE: Police will normally have the sole authority to release information on fatalities.
    - *(B) Restrict the entry of unauthorized persons.*
    - *(C) Provide facilities for relatives of victims.*
    - *(D) Instigate procedures for handling personal effects enabling receipt and protection of patients' valuables when many casualties arrive simultaneously.*
- Prepare for mass casualty reception –
  - *(i) recall and on-going staff management strategies;*
  - *(ii) emergency department reception area expansion capability; and medical equipment resupply system.*
- *All facility staff who may be required to perform duties during a mass casualty situation shall be made fully aware of what is required of them during the various stages of an alert. To assist in this awareness, the emergency plan should include details of staff duties, to whom they report, the area of responsibility, and a clear assembly point or location to which they should report.*

Other references that may assist hospitals to develop associated plans include:

- AS 3745–2010 *Planning for emergencies in facilities*
- AS NZS ISO 31000 *Risk management*
- AS NZS 5050–2010 *Business continuity – managing disruption-related risk*.

6.2 Training

All state, regional and local multi-agency emergency management training should include references to SHERP, its principles and its supporting guidelines where applicable.

All organisations participating in SHERP should undertake training to maintain capacity and capability to respond under the plan, in addition to maintaining their relevant clinical or other professional skills, competencies and authorities.

6.3 Exercising

All state, regional and local multi-agency exercises should include arrangements for incorporating SHERP roles and structures, including objectives to test the implementation of SHERP where applicable.

All organisations participating in SHERP should become involved in multi-agency exercises to test and rehearse their response.

7. Plan administration

7.1 Authority

This plan takes its authority from the Emergency Management Act, and is accountable to the Minister for Health, with responsibility to the Minister for Police and Emergency Services. The Victorian Government, through the Emergency Management Act, has responsibilities in planning for, and managing, the consequences of a health emergency event.

The Department of Health is responsible for coordinating all health and medical emergency responses. It therefore has the responsibility for developing, reviewing and maintaining this plan. The Health and Human Services Emergency Management Branch may undertake this work on behalf of the Department of Health through a shared service arrangement.

The State Health and Medical Subcommittee of the State Emergency Response Planning Committee acted as the reference group for the current version of SHERP. The State Emergency Response Planning Committee endorsed this plan as a subplan of the *State emergency response plan*.

7.2 Future policy and legislative change

In December 2012 a white paper on Victorian emergency management reform proposed changes to Victoria's emergency management arrangements. These include establishing Emergency Management Victoria as the overarching body for Victoria's emergency management sector and the appointment of an Emergency Management Commissioner. Revisions to SHERP may be necessary to ensure alignment and compliance with policy and legislative changes.

7.3 Plan review

The Department of Health is responsible for reviewing SHERP. It must be reviewed:

- every three years
- after any major activation of this plan or relevant subplans or specific plans, as required by the State Capability and Response Subcommittee
- after any new developments or substantial changes to the health operational context.

Outcomes of any monitoring and review activities will be overseen by the State Capability and Response Subcommittee.

7.4 Plan communication

Early implementation of SHERP (third edition) will be supported by a communication strategy that aims to ensure key stakeholders are aware of the updated SHERP and understand how it applies to them.

Key stakeholders include:

- health services
- residential aged care services
- organisations that respond under SHERP
- control agencies
- support agencies
- government departments.

Key communications strategies include:

- electronic publication of the plan and fact sheet on the Department of Health website
- email distribution of the plan to key stakeholders
- limited hard copy distribution
- face-to-face briefings to key stakeholder groups
- internet-accessible video clips
- social media announcements.

Appendix 1: Department of Health emergency management contacts

Emergency contact for immediate response

In an emergency, where the public, health services, hospitals or residential aged care services requires an immediate response from police, fire or ambulance, the number to call is triple zero (000).

Service providers seeking urgent advice during an emergency can contact regional or central office emergency management contacts, as per their emergency management plan.

Department of Health emergency management contacts

The Victorian Department of Health and Victorian Department of Human Services operate a shared services arrangement for the management of emergencies.

To contact the Victorian Department of Health during emergencies please use the contact details listed in the tables below.

Rural services

Consult and report to the relevant Regional Health Coordinator through the contact details below.

Rural regions	Phone	Email
Barwon South-Western	**0428 513 875**	Barwon.EOC@dhs.vic.gov.au
Gippsland	**1300 528 951**	Gippsland.EOC@dhs.vic.gov.au
Grampians	**03 5338 7928**	Grampians.EOC@dhs.vic.gov.au
Hume	**1300 735 231**	Hume.EOC@dhs.vic.gov.au
Loddon Mallee	**1300 165 413**	Loddon.EOC@dhs.vic.gov.au

Metropolitan services

Consult and report to the State Health Coordinator through the contact information below.

Central	Phone	Email
State Health Coordinator	**1300 790 733**	health.command@health.vic.gov.au SEMC@health.vic.gov.au

Appendix 2: Glossary

'All-hazards' approach	An 'all-hazards' approach to emergency planning is one that is adaptable to a wide range of situations.
Casualty	An injured person.
Casualty clearing point	The location established at a scene where casualties are managed in groups according to priority (triage category) and receive treatment onsite and transport according to priority.
Code Brown	Hospital-recognised code for an external emergency.
Command	Directing an agency's people and resources in the performance of its role and tasks. Authority is vertical within the agency.
Complex	Long, drawn-out emergency that cannot be ended quickly or simply. An evolving, multifaceted, multi-system event that may adversely affect many different areas of the community. Potential economic and infrastructure impacts.
Complex trauma event	An emergency involving one or more casualties with major trauma and where significant additional resources are required and often for a protracted period of time.
Control	The overall direction of response activities in an emergency situation. Control acts horizontally across agencies, as it carries the responsibility for tasking other agencies.
Control Agency	An agency nominated through the authority of the EMMV to control response activities for a specific emergency.
Coordinate/ coordination	Bringing together agencies and elements to ensure an effective response to the emergency. Involves the systematic acquisition and application of resources (agencies, personnel and equipment). Police are always the coordinators of an incident response.
Credentialling	The formal process of verifying the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners to determine their competence and suitability to provide safe, high-quality healthcare services within specific organisational environments.
Debrief	A meeting held during or at the end of an operation to assess its conduct or results.
Division	An organisational level within the IMS having responsibility for operations within a defined geographic area or with a functional responsibility.
Emergency	Definition from the *Emergency Management Act 1986*: 'An emergency due to the actual or imminent occurrence of an event which in any way endangers or threatens to endanger the safety or health of any person in Victoria or which destroys or damages, or threatens to destroy or damage, any property in Victoria, or endangers or threatens to endanger the environment or an element of the environment in Victoria including, without limiting the generality of the foregoing: (a) an earthquake, flood, wind-storm or other natural event; and (b) a fire; and (c) an explosion; and (d) a road accident or any other accident; and

Emergency (cont.)	(e) a plague or an epidemic; and (f) a warlike act, whether directed at Victoria or part of Victoria or at any other State or Territory of the Commonwealth; and (g) a hi-jack, siege or riot; and (h) a disruption to an essential service.'
Emergency management	Measures taken in response to particular hazards, incidents or disasters. Government, voluntary and private agency resources are organised and directed according to a plan that anticipates needs and coordinates efforts by assigning tasks to particular responders, organisations or field units.
Emergency management joint public information committee (EMJPIC)	Its foremost responsibility is to ensure public information is co-ordinated and distributed in a timely and accurate manner to inform and advise community members during a major emergency, as well as ensuring media needs are met, through a co-ordinated multi-agency approach.
Emergency management manual Victoria	The EMMV contains policy and planning documents for emergency management in Victoria, and provides details about the roles different organisations play in the emergency management arrangements. The EMMV is maintained by the Department of Justice.
Emergency Management Team	The EMT consists of the Incident Controller, support agency commanders (or their representatives) and the Emergency Response Coordinator (or representative). The EMT should be formed when two or more agencies combine or work cooperatively in response to an emergency. Once the Incident Controller determines the control strategy (in consultation with support agency commanders), this is implemented through their respective command structures. The Emergency Response Coordinator's role is to ensure a coordinated multi-agency response, and to provide for systematic acquisition of required resources.
Emergency operations centre	A facility from which emergency operations and functions can be carried out.
Emergency relief centre	A building or place established to provide life support and essential needs to those affected by an emergency (including evacuees). Emergency relief centres are established on a temporary basis to cope with the immediate needs of those affected during the initial response to the emergency. They do not imply any longer term use of facilities as a location for recovery services.
Emergency shelter	Shelter for people affected by an emergency, in locations such as community halls, relief centres and tents. Emergency shelter should be provided in the days following an emergency for as long as it is required until other accommodation arrangements are made.
Escalation	The act of moving to a higher level of response within a tier for appropriate management of the emergency incident. Escalation is based on the complexity of the incident, including factors such as size (for example, number of patients), resources (for example, field resources required) or risk (for example, political sensitivities, media interest, location).
Evacuation	The planned relocation of people from dangerous or potentially dangerous areas to safer areas and eventual return. The purpose of an evacuation is to use distance to separate the people from the danger created by the emergency.

Evacuation Manager	A Victoria Police emergency management role with responsibilities in the evacuation process, including managing the withdrawal, shelter and return stages of the evacuation in consultation with the Incident Controller and Health Commander.
Field primary care clinic	A FPCC is a service that can be established to provide additional primary healthcare in major emergencies where communities may have reduced access to primary healthcare due to medical infrastructure damage, incapacity of usual medical practitioners, increased demand for medical services, loss of personal transport or limited capacity to leave the immediate vicinity.
Functional command	Direction of personnel and resources of more than one agency in accordance with agreed, pre-existing arrangements.
Functional sections	Individually managed sections of personnel that can be established if required by the escalation. In SHERP, functions include ambulance, primary health, aged care, health services (hospitals), mental health and public health.
Hazard	A condition or event potentially harmful to the community or environment. *Natural hazards* are phenomena such as disease, floods, earthquakes, bushfires, severe storms and temperature extremes. *Technological hazards* include transport accidents, industrial accidents and hazardous material incidents. *Conflict hazards* include riots, civil unrest, terrorism and war.
Health agency	A health organisation or department contributing to the Victorian emergency management arrangements.
Health and medical specialists	A range of health and medical specialists provided by nominated agencies (as listed in Appendix 5) who are available to respond to an incident.
Health Commander	The person responsible for directing the pre-hospital health emergency operations. At each tier the Health Commander will be an appropriate ambulance manager. Otherwise, the appointment is made by the State Health and Medical Commander.
Health Coordinator	An emergency management role, within the regional and state tiers, responsible for representing and coordinating the activities of the Department of Health in response to an emergency at that tier.
Health Incident Management Team	The health response will be lead by the Health Commander and supported by the HIMT at each tier. The HIMT provides the Incident Management System functions of planning, operations and logistics to support the health response and is made up of the team leaders of attending health response agencies.
Hospital Commander	In SHERP the term Hospital Commander is used to identify the chief executive officer or delegated member of staff who leads the health service or residential aged care service response under their site-specific response plan for external emergencies (known as a Code Brown plan).
Hospital Incident Management Team	Led by the Hospital Commander, the Hospital (or health service) Incident Management Team (HoIMT) is responsible for receiving and managing all operational information related to an emergency incident.
Health response / health emergency response	In SHERP, health response and health emergency response means the organised management of a pre-hospital and hospital response to an emergency incident.

Health service	The term 'health service' relates to public health services, denominational hospitals, metropolitan hospitals and public hospitals, as defined by the *Health Services Act 1988*, with regard to acute and subacute services provided within a hospital or a hospital-equivalent setting.
Incident action plan	A consolidated 'road map' of action to be taken for the next period of time.
Incident Controller	The individual with overall responsibility for emergency response operations. Normally appointed by the Control Agency, but can be appointed by the Emergency Response Coordinator in circumstances where s. 16 or 16A of the Emergency Management Act apply.
Medical practitioners	In SHERP, the term 'medical practitioners' is used to mean general practitioners and other medical specialists.
Level of incident management (escalation)	See Escalation.
Mass casualty incident	An emergency involving such number and severity of casualties for which normal local resources for response may be inadequate.
Personal support	The provision of information, practical assistance, emotional support, assessment of immediate impact for the individual, assessment of immediate needs and referral to other support agencies and services as required.
Pre-hospital	A functional component of health emergency response, from response at the scene of an incident, to the receiving hospital or other healthcare facility.
Preparedness	Involves both arrangements and measures. Arrangements to ensure that, if an emergency occurs, all required resources and services can be efficiently mobilised and deployed. Measures to ensure that, if an emergency occurs, communities, resources and services are able to cope.
Primary healthcare	The care received at the first point of contact with the healthcare system, for example, when someone sees a physiotherapist because they have a sore back. It is traditionally delivered in community health centres or through private allied health providers.
Public health	What we, as a society, do collectively to assure the conditions in which people can be healthy. Public health focuses on prevention, promotion and protection rather than on treatment, on populations rather than individuals, and on the factors and behaviour that cause illness and injury.
Registration	A process that can be applied for managing spontaneous volunteers, registering affected people who may need emergency relief and reconnecting people to family and friends. Responsibility for registration is described in SHERP.
Register Find Reunite	The service used to reconnect people with family and friends affected by an emergency (previously National Registration and Inquiry System, NRIS).
Scene	The place of an incident where health response resources are required.
Sector	An organisational level within an IMS having responsibility for operations within a defined area of a division or having a specific functional responsibility.

Shelter in place	To shelter in place is to remain onsite within an existing service during an emergency. The decision to shelter in place is based on information from a variety of sources that confirms this option is safer or more appropriate than evacuation. The movement of patients or residents from one facility at risk to another safer facility within the same campus location is also considered shelter in place. The decision to shelter in place is made by the chief executive officer (or equivalent) of the service before an emergency, or as per advice from emergency services during an emergency.
Short-term clinic	A service that may be established in an affected area by general practice and nursing services to help support people affected by an emergency. These services are not necessarily linked to the government response efforts.
Situation report (SITREP)	Agency situation report of an event, outlining the background of the situation and the action taken by the agency responding.
Spontaneous health volunteers	Those volunteering their skills/knowledge who are not members of either an attending emergency service or a volunteer organisation.
Stand down	The phase when an agency's response is no longer required, and services are drawn back. Site teams are returned to base, and additional staff released from duty.
State emergency response plan	A plan that identifies the organisational arrangements for managing the response to emergencies within, or with the potential to affect, Victoria. It forms Part 3 of the EMMV and is prepared in accordance with the requirements of the Emergency Management Act.
Surge	An increase in demand for health services requiring a timely increase in capacity.
Support	The Control Agency may need assistance from support agencies. Support agencies are either primary (for example, ambulance service) or secondary (for example, a first aid organisation activated to support the ambulance service). A primary agency is designated by the EMMV as having a responsibility to provide and/or manage support tasks.
Tiers of incident control	There are three tiers of incident control for emergency response in Victoria: incident, regional and state. These tiers are reflected in the SHERP emergency management structure.
Triage	The process by which casualties are sorted, prioritised and distributed, according to their need for first aid, resuscitation, emergency transportation and appropriate care.
Trauma triage guidelines	Victorian guidelines providing direction and criteria for all health workers involved in assessing patients against the definition of a major trauma patient, and the necessary action required. Where resources permit, these guidelines should be adhered to for all trauma casualties at incidents managed under SHERP.
Victorian health system	The diverse range of providers of services that are managed and funded by the Commonwealth, state and local governments, and by private and not-for-profit organisations. Examples include ambulance, hospitals, community health services, private practices and residential aged care services.
Victorian state burns clinical practice guidelines	Guidelines for managing mass casualties with burns and the initial assessment and stabilisation of burns patients.

Appendix 3: Abbreviations

EMMV	*Emergency management manual Victoria*
EMT	Emergency Management Team
EMJPIC	Emergency Management Joint Public Information Committee
EOC	emergency operations centre
ETHANE	Exact location, Type of incident, Hazards, Access and egress, Number of patients, Emergency services at scene/required – mnemonic used for notifications
FPCC	field primary care clinic
HIMT	Health Incident Management Team
HoIMT	Hospital Incident Management Team
I-HIMT	Incident tier Health Incident Management Team
IMS	incident management system
R-HIMT	Regional Health Incident Management Team
S-HIMT	State Health Incident Management Team

Appendix 4: Public events and mass gatherings

Introduction

Every day, events conducted throughout Australia attract crowds to all types of venues. The degree of planning and preparation for associated health and safety aspects varies just as greatly.

SHERP provides a planning and management structure for public events and gatherings where there is potential for immediate mass casualties – and possibly increasing numbers of casualties over time. Involving health response agencies in pre-event planning may contribute to a safer, and therefore more successful, event. To this end it is recommended that events engage with health and medical providers that meet the requirements outlined in SHERP.

Planners should ensure that event managers have a basic understanding of the SHERP framework and the role of the Incident Health Commander and Incident tier Health Incident Management Team.

Aim

To provide a resource and checklist for planners using the SHERP model as a basis for emergency health response coordination in public events and mass gatherings.

Scope

This information applies to a wide range of mass gatherings and public events within Victoria. In situations such as visits by high-profile political figures or controversial activists, intensive security arrangements are necessary. Such procedures are outside the scope of this appendix; therefore, liaison between emergency services personnel, health professionals and security personnel is required.

Planning considerations

Take health and safety considerations into account:

- a hazard analysis of the area
- geographic location
- entry and exit for emergency vehicles
- crowd movement
- types of spectators
- time of year and weather conditions
- public health issues
- availability of food and water.

Also consider general health and medical issues:

- the physical and psychological needs of children and young people when large numbers are expected
- level and mix of onsite medical care required, for example, first aiders, paramedics, nurses, doctors, mobile medical teams, psychological support
- appropriate skilling for selected personnel
- notification of appropriate persons, such as the State Health Incident Coordinator (SHIC)
- special credentialling, to allow medical personnel and/or vehicle access to all parts of the venue and to any restricted areas

- storage and resupply of medical supplies
- suitable onsite medical facilities, such as a first aid room, tent or vehicle, which are clearly identified and easily accessible
- transporting patients within and outside the event
- communications between health and medical staff, off-site medical staff, event organisers, security and other support staff.

Events requiring special consideration

Certain types of events have inherent management issues:

- water events and power boat races
- car rallies on public roads
- air shows and displays
- fireworks and pyrotechnics, including laser light shows
- events involving pre-teens and early teens
- festivals with potential for heightened emotional states or consumption of alcohol and drugs.

Checklist for planners

Health response planners should use this as guide only. Components such as a detailed hazard analysis and communications plan should be attached.

Issue/item	Y/N	Comment/document attached
Involvement in event planning committee		
Event requires special consideration (see above)		
Hazard analysis undertaken:		
• hazard identification		
• risk assessment matrix		
• treatment options		
Level of Ambulance Victoria involvement (staffing load/mix/skill)		
Health agencies (other than Ambulance Victoria)		
Medical facilities available		
Roles and responsibilities		
Communication plan		
SHERP notifications required (for example, State Health Commander, State Health Coordinator, hospitals)		
Entry/exit security		
Links with municipal emergency management plans/ regional plans		

For more information on planning for these types of events, see the Australian Emergency Manuals Series' *Safe and healthy mass gatherings*, available through <www.ema.gov.au>.

Appendix 5: Key SHERP organisations (matrix)

Function	Organisation
State health and medical command	Department of Health
Health command	Ambulance Victoria
Health coordination	Department of Health
Ambulance	Ambulance Victoria
Medical and nursing – command	Field Emergency Medical Officer (FEMO)
Medical and nursing – teams	Victorian Medical Assistance Teams (VMAT)
Medical and nursing – other personnel	Medical practitioners and nurses as credentialled by FEMO onsite
First aid	St John Ambulance Australia Australian Red Cross Life Saving Victoria Chevra Hatzolah Metropolitan Fire Brigade – Emergency Medical Response Program
Psychological support	Department of Health Local Government Authorities
Public health	Department of Health Local government authorities
Emergency relief	Department of Human Services Local government authorities
Hospital	Public health services Private hospitals
Secondary transfer	ARV – Adult Retrieval Victoria PIPER, incorporating: • PETS – Paediatric Emergency Transport Service • NETS – Newborn Emergency Transport Service • PERS – Perinatal Emergency Referral Service

Organisation	Ambulance Victoria – Health Commander
Functional area(s)	• Health Commander
Reports to	• Higher tier Health Commander (within SHERP) • Controller (through the Emergency Management Team) • Emergency Response Coordinator (through the Emergency Management Team)
Subordinates	• Health Incident Management Team • Subordinate Health Commander(s)
Activation	• Primary response (usually via triple zero)
Resilience activity summary	• Support the Department of Health in resilience activities as required
Response summary	• Deploy a Health Commander to direct the operational health response, assemble and lead the Health Incident Management Team • Represent health as a member of the Emergency Management Team • Activate other key SHERP position holders or mobile specialist teams • Initially notify casualty-receiving hospitals • Support the Evacuation Manager in evacuating vulnerable people
Recovery summary	• Support the Controller as requested • Support other agencies tasked with recovery, where appropriate

Incident tier role

- Operates to support the Incident Controller
- Is a member of the Incident tier Emergency Management Team (IEMT) as the Functional Commander for pre-hospital response
- Provides regular situation reports to the Regional Health Commander including requests for activating health support agencies, including:
  - ambulance personnel and equipment
  - medical, nursing and first aid personnel
  - patient, personnel and equipment transport vehicles
  - notifying hospitals
- Assesses the requirement for emergency relief, including psychological support at the scene and notifies the Incident Controller through the IEMT to activate
- Assumes command of the health and medical function of the emergency at the incident tier
- Forms and provides leadership for the Incident tier Health Incident Management Team (I-HIMT)
- In consultation with the I-HIMT, develops the health strategy for inclusion in the incident strategy via the IEMT
- Oversees (with police assistance) registration and deployment of spontaneous health volunteers
- Is responsible for distribution of casualties
- Monitors practices relating to occupational health and safety of all responding health personnel involved in the emergency

Organisation	Ambulance Victoria – Health Commander (cont'd)

Regional tier role

- Operates to support the Regional Controller
- Is a member of the Regional tier Emergency Management Team (REMT) as the Functional Commander for pre-hospital response
- Provides regular situation reports to the State Health Commander including requests for activating health support agencies
- Assumes command of the pre-hospital function of the emergency at the regional tier
- Recommends the formation and provides leadership for the Regional tier Health Incident Management Team (R-HIMT)
- In consultation with the R-HIMT, develops the health plan for inclusion in the regional plan (risk and consequence) via the REMT
- Provides assistance with determining appropriate destinations for casualties

State tier role

- Operates to support the State Controller
- May be delegated to represent as a member of the State tier Emergency Management Team (SEMT) as the Functional Commander for the pre-hospital response
- Provides regular situation reports to the State Health and Medical Commander
- Assumes command of the pre-hospital function of the emergency at the state tier
- Recommends the formation and provides leadership for the State tier Health Incident Management Team (S-HIMT)
- Participates within the S-HIMT to develop the health plan for inclusion in the state plan (risk and consequence) via the SEMT
- Provides assistance with determining a strategy for distributing casualties

Organisation	Ambulance Victoria
Functional area(s)	• Ambulance
Reports to	• Health Commander
Subordinates	• Ambulance personnel
Activation	• Primary response (usually via triple zero)
Resilience activity summary	• Provide appropriate pre-hospital leadership, skills and equipment through planning for various health emergencies, including mass casualty incidents • Active participation and representation in emergency management forums and exercises to maintain a high level of preparedness for all emergencies, including mass casualty incidents • Promote community resilience through community education programs
Response summary	• Respond to requests for pre-hospital emergency care • Triage casualties and determine treatment priority • Transport casualties to appropriate medical care • Provide health support to other agencies, where appropriate • Provide health support to casualties undergoing decontamination
Recovery summary	• Support the Controller as requested • Support other agencies tasked with recovery, where appropriate

Organisation	Ambulance Victoria (cont'd)

Incident tier role

- Provides management resources to take on the health command role (see organisational statement 'Ambulance Victoria – Health Commander')
- Is a member of the Incident tier Health Incident Management Team (I-HIMT)
- Provides leadership for the ambulance function
- Provides ambulance advice to the I-HIMT
- Assesses credentials and manages spontaneous ambulance volunteers
- Provides assistance with determining an appropriate distribution of casualties
- Triages casualties and determines treatment priority
- Provides pre-hospital care
- Transports casualties to appropriate medical care
- Provides health support to other agencies, where appropriate
- Provides health support to casualties undergoing decontamination

Regional tier role

- Provides management resources to take on the health command role (see organisational statement 'Ambulance Victoria – Health Commander')
- Is a member of the Regional Health Incident Management Team (R-HIMT) reporting to the ambulance section
- Provides leadership for the ambulance function
- Provides ambulance advice to the R-HIMT
- Provides assistance with determining appropriate destinations for casualties

State tier role

- Provides management resources to take on the health command role (see organisational statement 'Ambulance Victoria – Health Commander')
- Is a member of the State Health Incident Management Team (S-HIMT) operating as the ambulance cell
- Provides leadership for the ambulance function
- Provides ambulance advice to the S-HIMT
- Provides assistance with determining a strategy for distributing casualties
- Deploys mass casualty management resources
- Deploys the field primary care clinic infrastructure

Organisation	Australian Red Cross
Functional area(s)	• First aid
Reports to	• Health Commander
Subordinates	• First aid volunteers
Activation	• State Health Incident Management Team (usually via the State Health Commander in consultation with the State Health Coordinator) • Via local arrangements with local government authorities for assistance at relief centres
Resilience activity summary	• Delivery of community information to assist people, communities, government and agencies to prepare for, respond to and recover from emergencies using resources such as REDiPlan • Ongoing training and exercising for all first aid volunteers • Skills maintenance via providing first aid services at public events • Maintenance of first aid equipment and supplies
Response summary	• Support in providing first aid services to affected people and emergency services personnel through SHERP • Provide relief services in support of health incident responses as detailed in relevant municipal, regional and state plans
Recovery summary	• Provide recovery services as detailed in relevant municipal, regional and state plans
Incident tier role	
• Is a support agency to the Incident Health Commander by providing first aid • Coordinates Red Cross local resources	
Regional tier role	
• Coordinates Red Cross regional resources to support the Regional Health Commander	
State tier role	
• Coordinates Red Cross statewide resources to support the State Health Commander	

Organisation	Chevra Hatzolah
Functional area(s)	• First aid
Reports to	• Health Commander
Subordinates	• Nil
Activation	• Primary response (via contact to the Hatzolah emergency number 9527 5111) • In support, via State Health Incident Management Team (usually via the State Health Commander in consultation with the State Health Coordinator)
Resilience activity summary	• Ensure all Hatzolah personnel are provided with the skills and expertise necessary to provide first aid services at a major incident • Promote community resilience through community education program
Response summary	• Be a support agency for providing first aid services to the public • Provide response, resources and first aid teams at incident sites, casualty collection posts and relief centres as directed by the Incident Heath Commander
Recovery summary	• Support the Incident Health Commander as requested

Incident tier role

- Provides pre-hospital care
- Provides first aid teams to assist at incident sites, casualty clearing posts and relief centres as directed by the Incident Health Commander

Regional tier role

- Supports the Regional Health Commander

State tier role

- Supports the State Health Commander

Organisation	Field Emergency Medical Officer (FEMO) program
Functional area(s)	• Medical and nursing
Reports to	• Health Commander (all tiers)
Subordinates	• Subordinate FEMOs • Medical assistance teams • Medical practitioners • Other medical and nursing personnel
Activation	• State Health Incident Management Team (usually via the State Health Commander in consultation with the State Health Coordinator)
Resilience activity summary	• Engage local medical and nursing resources in preparation and planning • Maintain awareness of local medical and nursing capacity, capability and availability • Facilitate training and exercise of local medical and nursing personnel
Response summary	• Health Incident Management Team member • Provide command role for medical and nursing function • Provide information on local medical and nursing resources (including health services) • Provide clinical advice
Recovery summary	• Support the Health Commander as requested.

Organisation	Field Emergency Medical Officer (FEMO) program (cont'd)

Incident tier role

The FEMO:

- is a member of the Incident tier Health Incident Management Team (I-HIMT), reporting to the Health Commander
- provides leadership for the medical and nursing function
- provides advanced medical and clinical advice to the I-HIMT
- assesses the need for additional medical and nursing support to the incident
- advises on local medical and nursing resource capability, capacity and availability
- assesses credentials and manages spontaneous health and medical volunteers
- provides assistance with determining an appropriate distribution of casualties
- may provide advanced medical care to patients
- may refer casualties to alternative care options.

Regional tier role

The FEMO:

- is a member of the Regional Health Incident Management Team (R-HIMT), reporting to the health services section
- provides leadership for the medical and nursing function
- provides advanced medical and clinical advice to the R-HIMT
- assesses the need for additional medical and nursing support at the regional level
- advises on regional medical and nursing resource capability, capacity and availability
- provides assistance with determining appropriate destinations for casualties.

State tier role

The FEMO:

- is a member of the State Health Incident Management Team (S-HIMT), reporting to the health services section
- provides leadership for the medical and nursing function
- provides advanced medical and clinical advice to S-HIMT
- assesses the need for additional medical and nursing support at the state level
- advises on state medical and nursing resource capability, capacity and availability
- provides assistance with determining a strategy for distributing casualties.

Organisation	Life Saving Victoria (LSV)
Functional area(s)	• First aid
Reports to	• Health Commander
Subordinates	• LSV volunteer lifesavers • LSV employed lifeguards • Westpac lifesaver rescue helicopters
Activation	• State Health Incident Management Team (usually via the State Health Commander in consultation with the State Health Coordinator) via the LSV State Duty Officer (13 7873)
Resilience activity summary	• Provide minimum and approved first aid equipment standards for all services • Provide technical and reference manuals, texts, resources and newsletters on water safety, lifesaving, life guarding, CPR and first aid • Provision of information and education displays at tradeshows and community events • Provide vocational education and training programs such as lifeguard, first aid, oxygen equipment, and specialist areas such as automatic external defibrillation (AED), pain management, and aquatic and dry spinal injury management
Response summary	• Make both paid and volunteer lifesavers and lifeguards available to support events statewide • Services proactively provided from 68 locations across Port Phillip Bay, the Victorian coastline and Mildura (Murray River) • Provide emergency evacuation centres at the lifesaving club clubrooms • Provide Westpac lifesaver rescue helicopter services statewide
Recovery summary	• Support other agencies as requested, where appropriate

Incident tier role

- Supports the Incident Health Commander in providing first aid and emergency care trained personnel, equipment and facilities

Regional tier role

- Supports the Regional Health Commander

State tier role

- Supports the State Health Commander

Organisation	Metropolitan Fire Brigade – Emergency Medical Response Program
Functional area(s)	• First aid
Reports to	• Health Commander
Subordinates	• Nil
Activation	• Primary response (usually via triple zero) • State Health Incident Management Team (usually via the State Health Commander in consultation with the State Health Coordinator)
Resilience activity summary	• Ensure all MFB first responders have the training, skills and expertise necessary to provide first aid services on a daily basis and at a major incident • Provide the necessary equipment to enable MFB first responders to provide first aid on a daily basis and at a major incident • Ensure all MFB first responders training in incident management and emergency management • Skills maintenance in place through providing continuing education sessions held by Ambulance Victoria • Promote community resilience through community education programs
Response summary	• Provide emergency medical response to life-threatening emergencies on a daily basis • Provide teams of more than 1,400 professional firefighters who are trained as first responders with skills in advanced first aid, oxygen therapy and defibrillation • Provide 105 strategically located MFB primary vehicles that are fully equipped with first aid kits, oxygen therapy kits and semi-automatic external defibrillators • Support agency for providing advanced first aid services to the public • Surge capacity to provide triage and emergency medical response in the event of a major incident
Recovery summary	• Support the Health Commander as requested • Support other agencies as requested and where appropriate

Incident tier role

- Support agency to the Incident Health Commander by providing first aid
- Provides assistance with site triage and additional shelters
- Provides assistance with people management and evacuation
- Command of MFB resources as required

Regional tier role

- Command of MFB first-responder resources to support the Regional Health Commander

State tier role

- Command of MFB first-responder resources to support the State Health Commander

Organisation	St John Ambulance Australia (Victoria)
Functional area(s)	• First aid
Reports to	• Health Commander
Subordinates	• St John Ambulance personnel
Activation	• State Health Incident Management Team (usually via the State Health Commander in consultation with the State Health Coordinator) • Via local arrangements with local government authorities
Resilience activity summary	• Promotion and provision of community first aid training through public education in schools, workplaces and to the public • Improve community readiness through marketing appropriate and cost-effective first aid kits • Provide onsite consultations with workplaces and community groups to include first aid component within first aid management plans for the prevention of minor injuries • Provide advice to event organisers with the planning of first aid and medical service delivery at local and major events • Provide first aiders, first responders and health professionals through a planned and structured response • Participate in multi-agency emergency management exercises and meetings, maintaining a high level of first aid preparedness for deployment
Response summary	• Support agency for providing first aid services to other emergency service agencies and public • Provide various levels of trained first aid support statewide • Provide response and resources within the scope of the first aid support (such as mobile first aid vehicles, first aid/first-responder trained teams)
Recovery summary	• Support the Health Commander as requested

Incident tier role

- Reports to the Incident Health Commander
- Provides assistance with site triage
- Provides first aid care
- Supports the Incident Health Commander and the community

Regional tier role

- Supports the Regional Health Commander

State tier role

- Supports the State Health Commander

Organisation	Victorian Medical Assistance Team (VMAT)
Functional area(s)	• Medical and nursing
Reports to	• Field Emergency Medical Officer (FEMO)
Subordinates	• Nil
Activation	• State Health Incident Management Team (usually via the State Health Coordinator)
Resilience activity summary	• Participation in training and exercises • Maintenance of VMAT clinical equipment • Maintenance of VMAT personal protective equipment (PPE) • Maintenance of VMAT deployment process
Response summary	• FEMO will recommend the scale of VMAT response required based on clinical requirements • Nominated health services will supply a team of up to six medical and nursing personnel with PPE and clinical equipment • VMAT may provide specialist clinical care to complex trauma patients • VMAT may provide extended duration care to mass casualties at an incident
Recovery summary	• Support the Health Commander as requested via the FEMO

Incident tier role

- Reports to the Incident tier Field Emergency Medical Officer
- May triage casualties and determine treatment priority
- Provides specialist medical care to individual patients
- Provides extended duration care to mass casualties at an incident
- May refer casualties to alternative care options

Regional tier role

- Nil

State tier role

- Nil