

### III. MEDICAL TEAM RESPONSIBILITIES

#### A. TAKING CARE OF YOUR OWN

#### INTRODUCTION

- This section and the following one cover the most important part of the Medical Team’s task: assuring the health and medical needs of the task force personnel.

#### TREATMENT PRIORITIES

- The following treatment priorities are essential for the task force to effectively carry out the mission:
  - Treatment of task force personnel, including support staff and canines
  - Treatment of victims directly encountered by the task force. This is specific to the assigned rescue operation.
  - Other victims as indicated
  
- It is not the intent for the Medical Team to serve as a free standing medical resource at the disaster site.

#### TRIAGE

- The concept of triaging your resources must be employed throughout the response period.
  
- Care of your own must be recognized as top priority in the triage process.

#### OPERATIONAL FUNCTIONS

- It is the function of the Medical Team to:
  - Minimize risks for the task force
  - Provide minor/major medical treatment
  - Provide intervention for incident stress
  - Provide limited treatment of hazardous materials/biologic exposures for task force members
  - Provide treatment to the Search Team canine

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| <p><small>FEMA US&amp;R RESPONSE SYSTEM</small></p> <p><small>TASK FORCE MEDICAL TEAM TRAINING</small></p> <p><small>04/97</small></p> <p><b>MEDICAL TEAM RESPONSIBILITIES</b></p> <p><b>INTRODUCTION</b></p> <p><small>FEMA US&amp;R RESPONSE SYSTEM</small></p> <p><b>TAKING</b></p> <p><small>TASK FORCE MEDICAL TEAM TRAINING</small></p> <p><small>04/97</small></p> <p><b>CARE OF</b></p> <p><small>MEDICAL TEAM RESPONSIBILITIES</small></p> <p><b>YOUR OWN</b></p> <p><b>TAKING CARE OF YOUR OWN</b></p> <p><small>VIEW GRAPH III A - 1</small></p> |
| <p>■ Treatment Priorities</p>   |
| <p>• Task force personnel</p>   |
| <p>• Victims</p>  |
| <p>• Others</p>   |
| <p>■ Med Team not a free-standing resource</p>  |
| <p><small>VIEW GRAPH III A - 2</small></p> <p><small>FEMA US&amp;R RESPONSE SYSTEM</small></p> <p><small>TASK FORCE MEDICAL TEAM TRAINING</small></p> <p><small>04/97</small></p> <p><small>MEDICAL TEAM RESPONSIBILITIES</small></p>   |

**III. MEDICAL TEAM RESPONSIBILITIES**  
**A. TAKING CARE OF YOUR OWN (continued)**

**CARING FOR YOUR OWN**

- May sound self-serving, but this is essential that we care for our own above all other concerns.
- It is the rescuers that have the most at risk during a collapsed structure incident response.
- The Medical Team component was designed with the concept that the task force must not place additional strain on the local resources.
- It is important that the task force members are aware that their medical needs will be cared for with modern-medicine capabilities that they have become accustomed to expecting.
- They should not have to concern themselves with “What would happen if I get injured?”
- Avoids further strain on local medical system.
- The operational functions of the Medical Team must be in accordance with the treatment priorities. For example, it is imperative that we not adversely commit our limited personnel resources during transports of regular victims.
- We must also assure that we keep intact the portion of the medical cache designed to care for task force members.
- REMEMBER OUR PRIMARY FUNCTION.

**MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN**

**Pre-Mobilization**

- Encourage task force sponsoring organizations to adopt and enforce health and fitness standards for its members. This will ensure adequacy of performance on-incident and

minimize personnel health risks.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**A. TAKING CARE OF YOUR OWN (continued)**

**MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN**

**Pre-Mobilization (continued)**

- FEMA has elected to defer this task to the sponsoring organization of each task force.
- Equipment acquisition, packaging and training to assure ability to adequately perform on a response.
  - Training should occur on a regular basis. A portion of exercises should involve Medical Team training with entire task force.
  - Medical cache management will preferably involve entire Medical Team for familiarization with specific equipment and its location within the cache.
  - Medical cache maintenance to occur on a regularly scheduled basis.
- Health input into task force cache.
  - Tents
  - Water purification systems
  - Food storage
  - Nutrition
  - Clothing/safety equipment
- Arrange resources and policies/procedures for post-incident stress debriefing for task force personnel.
- Assure task force personnel health forms are completed and reviewed by Medical Team for medical problems that would preclude disaster response.
- Assure that task force personnel are adequately immunized.
- Assure medical personnel enrollment in NDMS/FEMA (Receiving ID cards means paperwork was completed).

**III. MEDICAL TEAM RESPONSIBILITIES**  
**A. TAKING CARE OF YOUR OWN (continued)**

**MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN**

**Mobilization**

- Pre-mobilization preparation, team safety, and review of health information.
- Be prepared to provide medical care from the very beginning to end of mission. Have your packs with you at all times.
- Every deployed task force member must be cleared at Medical Check-in.
  - Rationale
  - Preferably overseen by non-deployed TF physician who makes recommendations to TFL regarding deployability of individuals.
  - Review health forms of responding task force personnel for clarity and new problems.
  - Adequate privacy must be provided for this portion of check-in.
- Screening should consist of:
  - Review of responder information sheet
  - Vital sign check
  - Questionnaire on current illness (in development)
  - Agility check
  - Weight?
- If medical issues are discovered which could prevent deployment of an individual, they should be referred to a “trouble-desk” where a physician will be stationed for case review. This will prevent slowing of the check-in process.
  - Replacements for a non-deployable member should be sought early.
  - Exclusionary criteria for deployment are currently under review by the Medical Working Group.
    - Criteria for deployment
    - Controversial — “Any medical condition that in an austere environment has the real potential to cause harm to the responder or serve as a

medical detriment to the TF.”

- Include canines in check-in process (paper work and physical).

### **III. MEDICAL TEAM RESPONSIBILITIES**

#### **A. TAKING CARE OF YOUR OWN (continued)**

#### **MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN (continued)**

##### **Transportation**

- Medical personnel should be stationed in a manner such that all task force personnel are quickly accessible during transportation to impacted area.
- Assure adequate communications between various portions of the Medical Team.
- At minimum, equipment to be carried during transport includes:
  - Physician pack
  - Medic pack
  - O<sub>2</sub> source
  - Monitor/defibrillator

##### **Arrival at the Impact Area**

- Establish medical treatment area early on.
- Do not forget your refrigerated meds - address early!
- Critical portions of medical cache should be unpacked early:
  - Pharmacy
  - Bed boxes
  - Site boxes
  - Other treatment packs
- Medical intelligence gathering. Begin gathering this ASAP (If IST has been deployed, Medical IST good source for this information). Particularly important info for task force care:\*)
  - ~~Local dangerous animals~~
  - Potential hazardous materials exposures
  - Available local medical resources
  - Evacuation routes for injured task force personnel

- (different than patient evacuation).  
Impending medical issues \*See Medical Action Plan



**III. MEDICAL TEAM RESPONSIBILITIES**  
**A. TAKING CARE OF YOUR OWN (continued)**

**MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN**

**Arrival at the Impact Area (continued)**

- Above information should be conveyed to entire task force as well as brief stress education and what to expect at the disaster site.
- Assist safety officer and logistics with environmental concerns in establishment of BOO.

**During Deployment**

- Monitoring of task force personnel throughout mission must occur for signs of physical or mental stress. Can occur in a variety of ways but should include, at minimum, daily medical contact with each individual TF member.
- "Mother Hen Role:" Reminding team members of their role in keeping healthy (i.e., sunscreen, rest, hydration, etc.)
- Safety officer role:
  - Important to be alert to safety violations during task force activities.
  - Problems should be brought to the immediate attention of the appropriate team manager or Task Force Leader.
- Briefings:
  - This will be a regular activity, especially for the Medical Team Manager, throughout the mission and has a variety of forms.
  - Attend Task Force briefings as indicated.
  - Medical Team Manager should attend all briefings for task force leadership to obtain the important medical intelligence information.
  - Brief TFLs on medical data as it becomes available.
  - Brief task force personnel on important medical/health issues including environmental concerns of disaster

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| <small>FEMA US&amp;R RESPONSE SYSTEM</small>          |  |
|   |  |
| <small>TASK FORCE MEDICAL TEAM TRAINING 04/97</small> |  |
|   |  |
| ■ Monitor personnel                                   |  |
|   |  |
| ■ "Mother Hen Role"                                   |  |
|   |  |
| ■ Safety Officer                                      |  |
|   |  |
| ■ Briefings   |  |
|   |  |

- area.
- Send pertinent medical intelligence information that is acquired back to Disaster Field Office for state/federal health officials.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**A. TAKING CARE OF YOUR OWN (continued)**

**MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN**

**During Deployment (continued)**

- Medical cache management and resupply:
  - This is a very important function that must occur throughout the mission.
  - Medical cache capabilities:
    - 10 critical cases
    - 15 moderate cases
    - 25 minor cases
  - Many more than this, or many with similar injuries requiring the same resources may tax the cache.
  - Packaging/staging for efficient on-incident availability.
  - Tracking the cache during the incident includes:
    - Monitoring controlled drugs
    - Preservation of “fixed medical assets”
    - Defibrillators, monitors, etc. (Non-disposables must be maintained on site and WILL NOT go with patient).
    - Conservation of reserve supplies for task force personnel
  - Avoid depletion of supplies that may be vital if a task force member is injured.
  - Insuring resupply as needed:
    - What, when, how....
    - Working closely with the task force Logistics Specialists
    - Requests channeled through IST Medical
  
- Care for Minor Problems — minor complaints are very common throughout the mission and it is important that they are promptly dealt with:
  - URI's
  - Backaches
  - Headaches

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  - Hemorrhoids
  - Blisters
  - Sunburn

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|---|-------|
| <b>Error!</b> FEMA US&R RESPONSE SYSTEM |       |
| TASK FORCE MEDICAL TEAM TRAINING        | 04/97 |
|   |       |
| ■ During deployment                     |       |
|   |       |
| • Cache management                      |       |
|   |       |
| • Packaging / staging                   |       |
|   |       |
| • Cache tracking                        |       |
|   |       |
| • Supply depletion                      |       |
|   |       |
| • Resupply                              |       |
|   |       |
| • Minor problems                        |       |
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- Motion Sickness

**III. MEDICAL TEAM RESPONSIBILITIES**  
**A. TAKING CARE OF YOUR OWN (continued)**

**MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN**

**During Deployment (continued)**

- Major complaints should be expediently dealt with in a manner to respect the individual's privacy:
  - Medical documentation for task force personnel:
    - All care of injuries/illness
    - All injuries and biologic/hazmat exposures
    - Gather information to support workman's compensation claims
  - Any task force member requiring medical attention must have at least the patient care form, sponsoring agency's internal reports and forms and U.S. Dept. Of Labor Forms CA-1, CA-2, and CA-16.
  - Portion of patient care form to NDMS
  - Dept of Labor Forms to IST for delivery to EST
  
- Evacuation of a task force member:
  - Pre-plan routes, communications, equipment, etc.
  - May be the exception to the rule of not sending advanced medical equipment with the patient.
  - REMEMBER, preplanned evacuation routes and considerations for task force members that become injured or ill must be known so that if needed, it may be accomplished with minimal attention. The evacuation procedure is different for task force members.
  - Through Task Force Leader, assure that information is filtering back to family of injured individual as quickly as possible.
  
- Death of a task force member:
  - This is unfortunately a real possibility with the hazards involved in this type of disaster response.
  - It is very important to assure established procedures are followed in the event of a task force member death.

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| <small>FEMA US&amp;R RESPONSE SYSTEM</small>         |  |
|  |  |
| <small>TASK FORCE MEDICAL TEAM TRAINING 0497</small> |  |
|  |  |
| ■ <small>During deployment</small>                   |  |
|  |  |
| • <small>Major complaints</small>                    |  |
|  |  |
| • <small>Evacuation of TF member</small>             |  |
|  |  |
| • <small>Death of a TF member</small>                |  |
|  |  |

**III. MEDICAL TEAM RESPONSIBILITIES**  
**A. TAKING CARE OF YOUR OWN (continued)**

**MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN**

**During Deployment (continued)**

- Death procedures:
    - Identity verification
    - Establish probable cause of death
    - Inform Task Force Leader ASAP
    - Ensure that personal items (wedding rings, watches, etc.) are secured.
    - Assure that a task force member is assigned to accompany the remains to original Point of Departure (Task Force Leader makes the assignment).
    - Transfer of the remains must be coordinated with the local incident command staff and possibly ESF-8 DMORT (Mortuary Team).
    - Also crucial to coordinate with local medical examiner.
    - Family notification
    - Media statement
    - TF briefing
  
  - The Medical Team Manager must initiate all appropriate documentation to record the details regarding the cause of death and to support the follow-up investigation.
  
  - Keep task force members apprised of injury/death of a task force member.
  
  - The Task Force Leader, in conjunction with the Medical Team, must assess the stress impact of the incident/accident on the task force personnel and determine its further operational capability.
  
  - Canine care: see UNIT V.
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**III. MEDICAL TEAM RESPONSIBILITIES**  
**A. TAKING CARE OF YOUR OWN (continued)**

**MULTI-FACETED APPROACH FOR ASSURING WE TAKE CARE OF OUR OWN**

**Demobilization**

- Assure appropriate follow up occurs for task force members with exposures or illness/injury during mission.
- Assure that task force members who have been started on medications during deployment, have enough to last them until necessary medical follow up.
- Any individual with an active medical issue should have a brief check prior to departure from demob site.
- Accountability for remaining controlled medications is vital (return with accountability log).
- All medical encounter forms and daily logs should be secured with the Medical Team Manager or his/her designee.
- Assure that formal post-incident stress debriefing occurs for all task force members.

**CONCLUSION**

- The geographical area of the response may not be able to supply the commonly accepted medical practices the task force members are accustomed to and we must therefore be able to “Care for Our Own.”
- *“WE CANNOT SAVE THE WORLD. WE CAN OFFER OUR EXPERIENCE AND EXPERTISE TO ALLOW PEOPLE TO BE SAVED. WE CAN SAVE OURSELVES.”*

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**PROVISION OF MEDICAL CARE**

- During disaster response with destroyed or damaged infrastructure, numerous problems will present that may affect the personal health and safety of the team as well as the type of medical care it can render to any victim.
- Requirements for basic human needs include common services such as:
  - Water
  - Food
  - Sanitation
  - Shelter
  - Transportation

**WATER**

- Potable:
  - Due to the extreme levels of mental and physical stress placed on TF members during a mission, any contamination of potable water may render a unit non-operational within hours.
  - Rehydration mandatory, therefore the entire TF affected.
  - Unlike contaminated food, which may spare TF members who are not eating.
  - Assume initial water supply in impact zone contaminated until tested.
  - Availability does not equal access.
  - Protect TF water supply within the cache.
- Volume:
  - 62 personnel X 72 hours.
  - Moderate heat and work load.
  - 1 pint/person each hour for 24 hours, or
  - 1 quart/person each hour for 12-hour shift.
  - 62 personnel = 31 quarts per hour.
    - = 744 quarts/day.
    - = 186 gallons/day.
    - = 558 gallons/72 hours.



buffalo

= approx. 1 US military water

= 108 cubitaners or 5-gal. cans.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**WATER (continued)**

- Additional needs:
    - Health centers - 10-15 gal/patient/day
    - Feeding centers - 5-6 gal/victim/day
    - Sanitation centers - 1 gal/user/day
  
  - Sources:
    - Municipal piped systems
    - Bottled
    - Wells and springs
    - Ground
  
  - Rehydration:
    - Small amounts throughout shift.
    - Voluntary thirst stimulus inadequate.
    - Insensible losses especially in the cold.
    - Enforced rehydration breaks every 20-30 minutes.
    - Increase in dirt and concrete dust environments.
    - Increase in protective gear and respiratory work.
    - Personal canteens and water bottles.
    - Dilute juices and energy drinks for palatability.
    - Coffee and soda not adequate substitutes.
  
  - Cleaning 5-gallon potable containers:
    - Requires 100 PPM chlorine.
    - Fill container with five gallons of water.
    - Add five tablespoons of liquid bleach.
    - Cap can and let stand for one hour.
    - Discard and rinse twice with clean, potable water.
    - Invert can and air dry.
    - Recap can for storage.
  
  - Potable container guidelines:
    - Black plastic preferred over tan or clear due to slower bacterial growth.
    - Initial fill should be from clean domestic water system outside the impact zone.
    - Test residual chlorine levels from source before and after fill if in doubt.
- 
- Minimum chlorine residual should be 2-3 PPM.
  - All personnel handling containers must wash hands.
  - Clean container mouth with 10% solution prior to filling.

- If using hose for filling, use RV-type.
- Protect fill hose from contamination, clean regularly.
- Contaminated water containers need treatment with 10% solution for 8 hours then have residual chlorine tested.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**WATER (continued)**

- Testing equipment:
  - Test for pH and residual chlorine.
  - Commerical swimming pool test kits adequate.
  - 30-minute residual chlorine test:
    - pH 6.5 to 7.5
    - temperture above 68° F
    - should test at 5 PPM chlorine
    - 10 PPM chlorine if pH higher or temp lower.
  
- Test frequency based on threat level:

|                       |                            |
|-----------------------|----------------------------|
| • <u>Threat level</u> | <u>Test frequency</u>      |
| none known            | weekly                     |
| slight                | daily                      |
| medium                | twice daily                |
| severe                | four times daily           |
| imminent              | hourly                     |
| known                 | hourly/each issue of water |
  
- Polluted water:
  - Fecal colliform greater than 10/100 ml.
  - Viruses.
  - Protozoa.
  - Organic contaminants.
  - Heavy metals.
  - Other toxics.

**DISINFECTING POTABLE WATER**

- Heat:
    - Time-honored means but energy-consuming.
    - Rolling boil, adding 1 min/2000 ft. elevation.
    - Rolling boil for 10 min: kills heat-resistant spores.
    - Waterborne enteric pathogens killed at lower temp and longer times.
- 
- Pasteurization: 160° F for 20-30 minutes.
  - When cooled, no residual disinfection.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**DISINFECTING POTABLE WATER (continued)**

- Halogenation:
  - Affected by pH, temperature, turbidity.
  - Greater treatment required for higher pH, lower temp, higher turbidity.
  
- Chlorine:
  - Household bleach = 5% sodium hypochloride.
  - Use one drop/quart of non-turbid water.
  - Let stand for 30 minutes.
  - Tap water 0.5 PPM.
  - Swimming pools 2-3 PPM.
  - Field water techniques 5 PPM.
  
- Iodine:
  - Bottle of 50 tabs should be issued to each TF member.
  - One to two tabs per full canteen.
  - Cap and carry on belt for 30 minutes.
  - Test residual chlorine: should be 5 PPM.
  - If inadequate, add add'l tab and repeat sequence.
  
- Palatability:
  - Try powdered drink mixes after water is treated.
  - Do not halogenate preflavored drinks.
  - Decrease halogen concentration and increase contact time.
  - Charcoal filters.
  
- Mechanical filtration:
  - Removes Giardia and bacteria but not viruses.
  - Need pore size less than 0.45 microns.
  - Need prefilter and ability to clean or replace.
  - Slow: one pint/minute.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**NONPOTABLE WATER**

- Uses:
  - Handwashing and personal cleanliness: one gallon.
  - Laundry and utensil cleaning: two gallons.
  - Showers and decontamination: two gallons.
  - Five gallons/day/person in non contaminated environment.
  - 300 gals/day for task force.
  - 900 gals for first 72 hours.

**FOOD**

- Handling:
  - Failure to maintain safe food handling is leading cause of food borne disease outbreaks.
  - Do not accept any food or water from unapproved or unknown sources.
  - Odor, taste, and smell not adequate monitors.
  - Average daily requirement: 2500-3000 Kcalorie.
  - Do not allow eating at work sites.
  - Encourage team or shift eating together.
  - Always place handwashing, food service, and garbage disposal together.
  - Place food service at least 100 feet from unsanitary places if possible.
- Sources:
  - MREs.
  - Canned and boxed.
  - Local acquisition.
  - Palatability and variety.
  - Avoid raw meats, fish, vegetables, thin skinned fruits.
  - No refrigeration = no fresh foods.
  - Protect from environment and vectors.

FEMA US&R RESPONSE SYSTEM  
TASK FORCE MEDICAL TEAM TRAINING 04/97

|                |
|----------------|
| ■ Food         |
| • Handling     |
| • Sources      |
| • Preparation  |
| • Food service |

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**FOOD (continued)**

- Preparation:
  - Food handlers must practice good hygiene.
  - Always provide handwashing stations and garbage disposal at all feeding areas.
  - Four sinks:
    - handwashing
    - cleaning dishes
    - sanitizing utensils
  - Keep hand contact to minimum during preparation.
  - Prepare only sufficient food for immediate consumption.
  - Avoid storage of leftovers.
  - Keep food preparation surfaces clean.
  - Avoid contact between raw and cooked foods.
  - Food storage in rodent and insect proof containers.
  - Limit perishable foods, especially ground meat, potato salad, eggs, fish.
  
- Food service:
  - Avoid self-service food lines.
  - Use single-service or disposable eating and drinking utensils.
  - Observe temperature limits:
    - hot foods, above 140° F
    - cold foods: below 45° F
    - DANGER ZONE: 46-139° F: maximum time food can be left out: 3 hours.
  - Use insulated food containers.
  - Boiling water preparation for hot food containers.
  - Ice water preparation for cold food containers.
  - Avoid galvanized containers for acidic foods and beverages due to zinc poisoning.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**CLEANING AND SANITIZING**

- Cleaning utensils:
  - Prescrape.
  - Detergent wash in hot (120-150F) soapy water.
  - Rinse in hot water.
  - Sanitizing rinse with 100 PPM residual chlorine.
  - Air dry.
  - Store in dry, clean container.
- Substitute chlorine solution at 250 PPM if hot water not available. 7 oz. Chlorine in 5 gallons water.
- Limit dust, insects, rodents.
- Properly dispose of solid and liquid waste.
- Control insects and rodents.
- Establish quality control inspection.
- Vehicles used to transport food should be clean and enclosed.
- Avoid any cross contamination with trash, hazardous materials, diesel.

**SANITATION**

- Total liquid and solid waste production, including showers, 100 lbs/person/day.
- Waste disposal options:
  - Burial pits
  - Incineration
  - Soakage pits
  - Evaporation beds
  - Latrines
  - Trenches
  - Chemical toilets



**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**SANITATION (continued)**

- Latrines: 4% of male, 6% of female population:
  - 4 unisex latrines for each TF.
  - Consider separation of sexes.
  - 20 feet from shelter.
  - 100 feet downwind from food and medical if possible.
  - 100 feet downhill from water supplies.
  - Consider privacy, night lighting, vector control.
  
- Personal hygiene:
  - Self washing facilities.
  - Buckets or jerry cans and soap.
  - Watch runoff.
  - No slip floors.
  - Foot protection.
  
- Garbage: waste which decays:
  - Separate health waste.
  - Removal: difficult in disaster impact zone.
  - Properly labeled containers throughout area.
  - Spray with insecticide.
  - Collect daily in plastic bags.
  - Burial: 100 feet from ground water.
    - flies, odors, rodents.
    - 2 feet wide trench, 4 feet deep.
    - dirt covered layers.
  - Incineration: environmental limitations.
  
- Kitchen waste:
  - 1-5 gals/person/day.
  - 300 gals/TF/day.
  - Two soakage pits: 4 feet square, 4 feet deep.
  - Each pit: 200 gals/day, alternate use.
  
- Rubbish: waste which does not decay:
  - Collect in plastic bags.
  - Remove.

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  - Recycle.
  - Incinerate.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**SANITATION (continued)**

- Biologic and medical waste:
  - Separate.
  - Incinerate if possible.
- Stagnant surface water:
  - Drain potential pond areas.
  - Prepare for runoff in rain.
- Dust control
- Vector control

**SHELTER**

- Coordinate with TFL and logistics concerning placement of BOO in regards to:
  - all weather protection
  - day and night conditions of heat, cold, rain, mud
  - accessibility to water and sanitation
  - noise and light effects on night shift workers
  - environmental hazards:
    - wind, rain, mud, heat, cold, lightning
    - local populace
  - Proximity to rescue site.
  - Accessibility to transportation.
  - Privacy, security, and relaxation.
  - Adequate space of 100 square feet per person.
  - Drainage, elevation, and windage.
- TF cache has prefabricated shelters designed for portability and ease of set up:
  - Unsuitable in high winds.
  - Not grounded for lightning.
  - Not secure or lockable.
  - Heat retention in summer.
  - No elevated floor.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**SHELTER (continued)**

- Considerations for sleeping quarters:
  - Remote from noise.
  - Provision for dirty outer gear and boots to be left out.
  - Proximity to kennels for handlers.
  
- Considerations for medical tent within BoO:
  - Climate controllability.
  - Handwashing stations.
  - Privacy or quarantine areas.
  - Elevated cots for patient care.
  - Support for supplies in packs.
  - Accessibility to all supplies.
  - Workstation for documentation.
  - Daily sick call area.
  
- Forward rehab shelter at rescue site:
  - Walking distance to rescue site.
  - Protection from elements.
  - Provision for rehydration, snacks, rest while on site.
  - Handwashing station.
  
- Rescue site tent or equivalent (vehicle, protected room):
  - Weather and security protection of medical supplies on site.
  - Temporary victim protection awaiting transportation.
  
- Vector control:
  - Consultation with environmental protection units: local, state, military.
  - Good sanitation protocols and precautions.
  - Insect repellants, netting, lights.
  - Rodent repellants, traps.

Refer to Fairfax County USAR BOO Set Up Procedures 10/93  
Refer to FEMA USAR Medical Cache Management Handbook, pgs 10 and 12

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**III. MEDICAL TEAM RESPONSIBILITIES**  
**B. PUBLIC HEALTH / ENVIRONMENT ISSUES**

**MEDICAL EVACUATION**

- Establish evacuation priority and protocol.
- Maintain separate team pharmacy and individual medications.
- On-site coordination with local resources.
- Communication with DOD, Federal, State resources.
- May be separate chain from disaster victims.
- Coordination through TFL, logistics, and IST.
- Consider loss of critical medical equipment.
- Know medical capabilities enroute.
- Thorough medical documentation and follow through.

■ Medical Evacuation

• Priority

• Pharmacy

• On-site coordination

• Communications

• Documentation

**III. MEDICAL TEAM RESPONSIBILITIES**  
**C. OTHER ROLES OF THE MEDICAL TEAM**

**INTRODUCTION**

- Much of this course thus far has covered the roles of the Medical Team in caring for task force personnel and covered much about victim care. In order for the Medical Team to adequately perform its stated functions, there are multiple other tasks it must perform during the response.
- This section will detail many of those tasks.

**PRE-MOBILIZATION**

- Equipment acquisition.
- Encourage health and fitness in selecting task force personnel.
- Health input into task force cache.
- Review Responder Information Forms.
- Regular Training.
- Personnel enrollment in NDMS/FEMA. (Receiving ID cards assures paperwork was completed.)
- Most of this has been covered extensively in earlier sections, but must be re-emphasized as critical tasks to allow timely and effective Medical Team mobilization.

**OTHER RESPONSE ROLES**

- Mobilization — equipment to Point of Departure.
- Medical equipment:
  - Medical equipment/supply cache acquired.
  - Organized and moved to point of departure.
  - Med packs distributed to each Medical Team member.
  - Team member assigned as cache manager.

|                                       |
|---------------------------------------|
| ■ Mobilization — Equipment to the     |
| Point of Departure:                   |
| • Equipment/supplies acquired         |
| • Organized in packaging              |
| • Med packs distributed to each       |
| Medical Team member                   |
| • Team member assigned as             |
| cache manager                         |
| TASK FORCE MEDICAL TEAM TRAINING 0497 |
| ■ Pre-Mobilization                    |
| • Equipment acquisition               |
| • Health and fitness                  |
| • Task force cache                    |
| - Personnel support                   |
| • Health forms                        |
| - Responder Info Sheet                |
| • Regular training                    |
| TASK FORCE MEDICAL TEAM TRAINING 0497 |
| • Personnel enrollment                |
| - FEMA                                |
| - NDMS                                |

# FEMA US&R RESPONSE SYSTEM

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### III. MEDICAL TEAM RESPONSIBILITIES

#### C. OTHER ROLES OF THE MEDICAL TEAM (continued)

#### OTHER RESPONSE ROLES (continued)

- NDMS forms and IDs
  - NDMS federal appointment forms completed and faxed:
    - FAX # (301) 443-5140
    - ATTN: NDMS Personnel
- There are two forms that must be faxed and hard copies sent via regular mail:
  - Oath of Office (SF-61). Requires the signature of the:
    - person appointed.
    - person authorized to administer oath (If the authorized official is not available, the oath must be signed and notarized by a Notary Public).
  - Declaration of Appointee (SF-61B).
- These Forms should be completed at the same time on or before the official activation date and **BEFORE** services are rendered, including travel to the disaster site.

#### MEDICAL INTELLIGENCE GATHERING

- This is a very important function throughout the deployment.
- Should start at initial notification by gathering information about the area of the disaster (weather, terrain, insect vectors, etc.).
- Task Force Medical Team Intelligence Sheet:
  - This is a form to help the Medical Team Manager remember the important information that must be obtained during the mission.
  - It is currently under development.
- Environmental/haz mat threats.
  - Environmental/haz mat threats in the disaster area (including contaminated drinking water sources, etc.).

#### ■ Mobilization

#### • NDMS forms completed

#### • Forms faxed

- (301) 443-5140
- ATTN: Personnel

#### • Identification cards

- FEMA
- NDMS
  - Form SF-612
  - Form SF-61B

**III. MEDICAL TEAM RESPONSIBILITIES**  
**C. OTHER ROLES OF THE MEDICAL TEAM (continued)**

**MEDICAL INTELLIGENCE GATHERING (continued)**

- Victims:
    - Potential numbers.
    - Types of injuries.
    - Ages.
    - Etc.
  
  - Type/function of structures:
    - Types of collapsed structures to predict type of patients/injuries and resultant medical needs (nursing home vs. newborn nursery, chemical factory, etc.).
  
  - Surviving medical system and its condition:
    - Important to develop a back-up resource list and a sense of where patients may be transferred to after extrication.
  
  - Other available medical resources:
    - Incoming regional/state/NDMS medical resources.
    - Military medical personnel on-site.
  
  - Transfer of patients:
    - To whom/procedures/communications with them, etc.
    - Required triage tags and other documentation.
  
  - Processing of deceased:
    - Procedures for processing extricated deceased victims (coroner notification, transfer of remains, required forms, etc.).
  
  - Evacuation process for task force members:
    - To assure prompt access to intact definitive medical care in the event of a life-threatening illness/injury.
    - Very likely will be different from the patient transport system.
    - Assure reliable communications with the resource.
    - Since DoD is responsible for US&R, very likely that they will be providing the evac if needed.
-

# FEMA US&R RESPONSE SYSTEM

## TASK FORCE MEDICAL TEAM TRAINING MANUAL

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### III. MEDICAL TEAM RESPONSIBILITIES

#### C. OTHER ROLES OF THE MEDICAL TEAM (continued)

#### MEDICAL INTELLIGENCE GATHERING (continued)

- Medical intelligence gathering: a dynamic process.
  - Must continue to occur throughout the deployment, since needs, resources, threats, etc., will change continuously.

#### BRIEFINGS

- This will be a regular activity, especially for the Medical Team Manager, throughout the mission and has a variety of forms.
- Attend Task Force briefings as indicated.
- Medical Team Manager should attend all briefings for task force leadership to obtain the important medical intelligence information.
- Brief Task Force Leaders on medical data as it becomes available.
- Brief task force personnel on important medical/health issues, including environmental concerns of the disaster area.
- Send pertinent medical intelligence information that is acquired back to Disaster Field Office for state/federal health officials.

#### MEDICAL CACHE MANAGEMENT

- This is a very important function that must occur throughout the mission.
- Medical cache capabilities:
  - 10 critical cases.
  - 15 moderate cases.
  - 25 minor cases.
- Many more than this, or many with similar injuries requiring the same resources may tax the cache.

#### ■ Briefings

- Attend task force briefings

as indicated

- Brief Task Force Leaders on

medical data

- Brief task force personnel

on medical/health issues

- Send pertinent/important

medical intelligence info to

Disaster Field Office



**III. MEDICAL TEAM RESPONSIBILITIES**  
**C. OTHER ROLES OF THE MEDICAL TEAM (continued)**

**MEDICAL CACHE MANAGEMENT (continued)**

- Packaging/staging for efficient on-incident availability.
- Tracking the cache during the incident includes:
  - Monitoring controlled drugs.
  - Preservation of "fixed medical assets."
  - Defibrillators, monitors, etc. (non-disposables must be maintained on site and WILL NOT go with a patient).
  - Conservation of reserve supplies for task force personnel.
- Avoid complete depletion of supplies that may be vital if a task force member is injured.
- Insuring resupply as needed :
  - What, when, how...
  - Working closely with task force Logistics Specialists.

**INTERACTING WITH OTHER RESCUE TEAMS/HEALTH CARE RESOURCES**

- Occur through the Incident Management System routes.
- Tactful assessment of resource's true medical capability.
- Explain to them your Medical Team's capabilities/limitations (Medical Team Fact Sheet).
- Arrange communications with resources as indicated.
- Assure that the other rescuers on-site understand the importance of prompt "in-rubble" medical care for victims.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**C. OTHER ROLES OF THE MEDICAL TEAM (continued)**

**INTERACTING WITH THE LOCAL POPULATION**

- Must understand that the Medical Team is not a free-standing medical facility for all injured.
- Provide medical support for other on-site rescuers and for task force support personnel.
- "In-rubble" medical evaluation and care for rescued victims.
- Ensure that communications are established as needed:
  - Within rubble.
  - With Task Force Leader(s).
  - With medical resources.

**NON-MEDICAL RESPONSIBILITIES**

- Due to the limited cadre of task force personnel, each Medical Team member accepts multiple areas of responsibilities.
- Safety Officer role:
  - Important to be alert to safety violations during task force activities.
  - Problems should be brought to the immediate attention of the appropriate team manager or Task Force Leader.
- Body recovery:
  - To occur **ONLY** if body is in the way of a rescue operation. We are not a body recovery resource.
  - If a body needs removed, the Medical Team should be involved.
  - Appropriate documentation of information for coroner (how/where found, apparent injuries or cause of death, etc.).
- Protect from body fluids by wearing appropriate clothing/protective gear is very important.

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■ **Multiple non-medical responsibilities**

established as needed

- Safety Officer role

- Within rubble

- Body recovery

• Only done if impeding a rescue

- use protective gear

- With medical resources

- Sanitation conditions of

Base of Operations

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■ **Interacting with the local population**

- Not a free-standing

medical facility

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**III. MEDICAL TEAM RESPONSIBILITIES  
C. OTHER ROLES OF THE MEDICAL TEAM (continued)**

**NON-MEDICAL RESPONSIBILITIES (continued)**

- Assessment of sanitation conditions of the Base of Operations:  
This includes:
  - Food.
  - Water.
  - Task force public health concerns.
  - Sleeping quarters.
  - Overall vector control.
  
- Other tasks as assigned by Task Force Leader:

**PATIENT DOCUMENTATION**

- Patient Care Form and documentation requirements covered earlier.
  
- Mechanics of doing the documentation may be difficult:
  - Documentation must occur outside the "hole".
  - One team member "in the hole" may need to maintain brief notes to be transcribed outside the hole to the standard patient care form.
  - Task Force Leader kept informed of all patient transports.
  - When possible capture patient care/ rescue operation on film for future evaluation/education.

**FEMA US&R RESPONSE SYSTEM APPENDIX J, TASK FORCE MEDICAL PROCEDURES**

- This document covers much of this information and is a good reference for future education and for review upon notification of an incident.

|   |
|---|
| <ul style="list-style-type: none"> <li>■ Sanitation conditions at the Base of Operations</li> </ul> |
| <ul style="list-style-type: none"> <li>• Food</li> </ul>  |
| <ul style="list-style-type: none"> <li>• Water</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Task force public health</li> </ul>                        |
| <ul style="list-style-type: none"> <li>• Sleeping quarters</li> </ul>                               |
| <ul style="list-style-type: none"> <li>• Vector control</li> </ul>                                  |

**III. MEDICAL TEAM RESPONSIBILITIES**  
**C. OTHER ROLES OF THE MEDICAL TEAM (continued)**

**MEDIA RELATIONS**

- All formal releases are through the Task Force Leader.
- It is not the Medical Team's role to be responsible for media information.
- If sought out by the media for information:
  - Be positive and congenial.
  - Answer questions specific to your functions and refer others to appropriate task force personnel.
  - Don't speculate.
  - Refer all policy/plans questions to Task Force Leader.

**TASKS DURING DEMOBILIZATION**

- Prompt return of the medical cache to a readiness state is important.
- Complete all inventory forms. Replace expended supplies.
- Notify Task Force Leader of any unaccounted or malfunctioning equipment so replacement can be accomplished.
- Necessary cleaning of equipment. Batteries checked/placed on charge if necessary.
- Equipment and supplies are left behind for the local population ONLY IF directed by the Task Force Leader.
- Assist in cleaning up Base of Ops and other task force sites.

**FORMAL DEBRIEFING**

- Includes review of:
  - Overall operation successes/failures.
  - Review of other teams' activities and outcomes.
  - FEMA review.

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■ Media Relations

- All formal releases through

Task Force Leader

- When sought out:
  - Be positive
  - Answer questions specific

to your function-refer the others

- Don't speculate
- Refer all policy/plans questions

to Task Force Leader

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**OBJECTIVES**

At the end of this section, the participant will:

- Be prepared to define Extended Incident Stress and its distinction from the Critical Incident Stress concept.
- Identify incident stressors inherent in collapsed structure response.
- Understand the Medical Team's role in mitigating incident stress.
- Define with examples
  - Stress recognition
  - Stress intervention:
    - personal
    - IST
    - TF management
    - TF medical team

**STRESS REACTION/MONITORING/INTERVENTION**

**Disaster Stress Factors**

- Inherent in collapsed-structure response
- Common issues:
  - Sudden & prolonged deployment
  - New & unfamiliar experience for most responders
  - Possibility of "intentional" disaster
  - Infant & child innocent victims
  - Possibly no "live" finds
  - Start & stop nature of the work, with other ICS imposed frustrations
  - Very dangerous environment
  - Drudgery of much of search & rescue work
  - Other

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION (continued)**

**Extended Incident Stress**

- Definition: Psychological effects caused by unusual and extended disaster event involving human casualty. It is normal people reacting normally to severe stress; not "post-traumatic stress disorder" or other psychiatric disorder; We are talking about NORMAL reactions. Mental HEALTH, not disease.
- Stress effects are not necessarily negative. Properly executed stress management during an incident may lead to very positive changes ("growth") in responders. E.g.: re-examination of personal priorities, development of appreciation for life's "blessings", enhanced interpersonal relationships between TF responders or between responder and his/her family, etc.
- Reasons for on-incident stress intervention:
  - Prevent stress effects from causing bad decisions and/or performance.
  - Minimize post-event sequelae
  - Stress causes a "re-organization" phenomenon in individuals during a response. This period is when the responder is the most vulnerable and it also provides the most influential "window" to assure that the stress effects are a net "positive".
- An "extended incident" differs from a "critical Incident" in that it "exceeds a single work shift and therefore has periods of "off-time" and periods of slow activity or with staging areas and rehab areas where responders have little activity. These incidents often involve major aberration in the usual local emergency management structure, with assignment of personnel to roles that differ markedly from the usual (and often not as close to the "action" and decision-making roles). A "critical incident" has been considered a stressful experience of high activity without opportunity for stress intervention during the incident.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION**

**Extended Incident Stress (continued)**

- Extended Incident Stress monitoring and intervention by the medical component of collapse team is an important aspect of Caring for Your Own.
- This course does not permit sufficient time to completely educate the medical team members on all of the components relevant to monitoring or intervening in incident stress. Further education and training is highly recommended.
- Extensive stress management training of at least one Medical Team member is recommended.
- Important for the administrators of the sponsoring organizations to understand the cost-effectiveness of addressing incident stress to prevent responder drop-out and adverse effects on organization's performance during and post- incident.

**Who Gets Stressed**

- On-site:
  - First responders
  - Secondary direct responders (Including FEMA US&R Task Forces)
  - Organizational personnel (Local and Federal)
- Others:
  - Workers left behind (often with increased workloads)
  - Families of those who go (leave on short notice, uncertain of safety, etc.)

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION (continued)**

**Prevention of Severe Stress in Families of Responders**

- Preplanning will significantly help keep family stress at a controlled level by:
  - Pre-event education: US&R mission, methods and function, minimization of risks, uncertainty of information during response, “rumor mill” phenomenon, press dramatization and possible harassment, interview guidelines, preparation of family and responder for response, family support system during the response, post-deployment expectations, etc.
  - Pre-event meetings: become familiar with each other and the sponsoring agency personnel who will interact with families during a response.
  
- During Response:
  - Establishing a phone tree or other method so everyone is kept informed: real-time information sharing.
  - Planned meetings for family members of those that were mobilized.
  - Attempt to keep everyone as informed as possible to the T.F. activities, “saves”, the T.F.’s positive impact for victims, etc.
  - Support structure for families: stress assistance, advice for home repair problems, etc. “Resource bank” to assist families with problems during deployments (child-care, home repair, financial advice, stress management, health advice, etc.).
  - Explaining press reports and other controversial facts or rumors to families.
  - Arrange appropriate welcome home event for T.F. personnel to reunion with families. Assure privacy and protection from press as required.
  
- Post- Response:
  - Post-incident family meeting if indicated. Obtain feedback from families to improve family support system.



**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION (continued)**

**Prevention of Severe Stress in T.F. Personnel Left Behind**

- These personnel may have special “needs” depending on their level of involvement with the T.F. prior to deployment and the reason why they couldn’t respond (more likely to have psychologic impact if they are heavily invested in the T.F. and response was prevented by circumstances beyond their control such as illness or family emergency). Effects may be decreased with intervention:
  - Keep informed as to T.F. performance.
  - Recruit to assist with T.F. support activities as needed.
  - Recruit to assist with family support activities (may require special training for this).
  - Participation in homecoming activities may be beneficial.
  - Acknowledgment of their value to the T.F. despite their inability to respond for this incident.

**Prevention of Severe Stress in Responders: Systems Approach**

- Traditional stress management approach
  - Monitor individuals for signs of stress and intervene individually as indicated.
- Systems approach
  - Acknowledges importance of individual monitoring and intervention.
  - Recognizes that the individual T.F. personnel’s stress reactions must be considered indicators for systemic stress, which should be mitigated at a “systems level” using interventions that will positively impact all T.F. personnel (and possibly other responders as well).
  - Three systems-level approaches: decrease stressors and their effects on personnel; improve responders’ abilities to resist the stressors; positive actions that help personnel cope with or recover from stressors.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION**

**Prevention of Severe Stress in Responders: Systems Approach  
(continued)**

- Medical Team stress monitoring strategies:
  - Daily evaluation of T.F. members during medical check.
  - Formal observation during meals and breaks.
  - Arrangement for safety officers or other personnel to be formally monitoring medical team personnel.
  - "Buddy" system for medical team members to check each other.
  - Analyze findings, devise intervention strategies and work closely with T.F. management to implement interventions.

**Stress Identifiers (Individuals)**

- Physiologic signs (how one physically reacts)
- Cognitive/intellectual signs (how one thinks)
- Emotional signs (how one feels)
- Behavioral signs (how one acts)

**Stress Assessment: Personnel**

- Normal Behavioral Signs of Stress
    - Must get to know the responding personnel's baseline: (i.e. does the person always walk with a "pressured gait" or always have a "slumped over" posture or is this new?)
    - Response team members should be assigned to stay together in the same rest/rehab area and eating areas.
- 
- **IMPORTANT** for Med Team to directly evaluate members through observation during these periods.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION**

**Stress Assessment: Personnel (continued)**

- Recognition of Severe Stress in Individuals
  - Changes in usual behavior (withdrawing, overworking, etc.)
  - Withdrawal is a common response: should be obvious since most responders are action oriented & "doers." If this changes, don't necessarily stop it, since it may be helpful, but recognize & monitor it & maybe modify it.
  - Changes in thought (distracted, difficulty concentrating, etc.)
  - Changes in emotions (loss of sense of humor, identifying with victims, short-tempered, etc.)
  - Physical complaints or signs (undue fatigue, anxiety, somatic complaints, etc.)
  - Watch for rescuer seemingly without a purpose or with a negative change in their behavior.
  - Look for markers such as change in affect, someone disinvolving himself, staying in hotel room or a change from usual behavior during rest and meal periods.

**Stress Prevention: Systems Approach**

- Pre-response
  - Educate prior to stressor: mission and activities of T.F., exposure to human tragedy, risks during response, personal and family impact of the quick "get-away" time and two week duration, importance of personal preparation, media training, medical examiner issues, etc. Make information on response stress a part of the individual's orientation to the T.F..
  - Pre-response Preparation: Will, Power-of-attorney, Life insurance and disability insurance review for adequacy, Checklist (childcare, money information, mail stop form, newspaper stop, pet care arrangements, repairman list, notification list, other

special needs, etc.).

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION**

**Stress Prevention: Systems Approach (continued)**

- During response
  - Stress education during initial and daily briefings.
  - Visible competency of medical team (health maintenance activities, medical surveillance, etc. will be very reassuring to T.F. personnel.
  - T.F. leader attitude: briefings start with reviewing past interval's goals and successes before concentrating on problems. Important for T.F. personnel to be reminded that in a disaster, the yardstick to measure their performance is different from that used in every-day practice (event is overwhelming, Incident Command regimentation can be frustrating, being a "guest" of the local jurisdiction may be inhibiting, etc.) Must use a "disaster response yardstick" to unconsciously measure your performance in order to avoid frustration and stress.
  - Family communications: maximize as allowed by deployment circumstances; stress importance to T.F. personnel to maintain family contact; monitor compliance.
  - Adequate rest & eating habits
  - Avoid coffee, donuts, baloney sandwiches, junk food, fats, alcohol.
  - Complete removal from scene during breaks.
  - Discussion of mission encouraged during rest periods to allow "venting."
  - Physical exercise
  - Briefings: KEEP INFORMATION FLOWING, especially with serious incidents; e.g.: If responder sustains severe injury or death, team members must be kept informed.
  - Allow humor

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION (continued)**

**Intervention during response: Applied at both individual and systems levels:**

- Stress intervention can be a two-edged sword: "First, DO NO HARM!" (Incorrect actions can lead to secondary injury)
  - Avoid concept of "mental illness"
  - Educate response personnel to expect stress during the response (cover in initial and daily briefings).
  - Emphasize that stress response is normal.
  - "Get them to talk": facilitate re-telling.
  - Avoid classifying person's response as "Post-traumatic stress", etc.
  - Focus on support structure
  - Reinforce "Good Job" performance rating by peers and respected superiors.
  - Reinforce the T.F. is "doing all that is possible."
  - Much of the stress will come from seeing so much destruction and being able to have only a limited impact: discuss this openly. Re-defining the self-assessment "yardstick".
  - Assume competence of the person: be direct and honest with them.
  - Deal directly with T.F. member initially, not his/her superior.
  - Treat with respect.
- 
- Emphasize your confidence in member's professional competence.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION**

**Intervention during response: Applied at both individual and systems levels: (continued)**

- Recognize and understand the importance of rituals.
- Give active/directive care:
  - Direct into useful activity
  - Suggest re-assignment to a less stressful role (positive approach).
  - Direct into rest/leaving the scene if indicated
- Innovate!
  - School visits
  - Task Force rituals
- Promote humor
  - Helps depersonalize tragedy.
  - Recognize as a sign of stress (evaluate stressors for reduction).
  - Allow as a relief valve but control offensiveness.
  - Be discrete, keep within group & avoid public places.
  - "Gallows Humor": Morbid, racist, sexist, expense of others, offensive, etc.); must be recognized as sign of excessive stress and controlled.
- Arrange "treats"
- Promote positive feedback from dignitaries, respected professionals and superiors, etc.

**Stress Management During Demobilization**

- Remember that the demobilization period may continue to be a very stressful time for T.F. personnel and that major stress manifestations may not be expressed until the pressure of incident response has begun to fade. Continued monitoring vigilance by the medical team must be maintained.

**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION**

**Stress Management During Demobilization (continued)**

- An “Incident Review” is an important aspect of extended incident stress management and must be conducted during the demobilization phase. It should take place after the final operational period and cache breakdown, but before going out to celebrate or other activities. It must not appear to interfere with family re-unification. The Review should be conducted by T.F. personnel and be an objective review of the response events: non-pejorative, no personal accusations. The objective is to have all members understand the events and important but obscure details; the rationale behind events and controversial decisions; an explanation and chance for “airing out” by T.F. members of any controversies that arose during the deployment; etc. This is not a CISD program and doesn’t focus on “feelings”. It also does not replace a technical critique of the deployment which should take place at a separate time.
  
- Review of homecoming re-unification issues: Reminder to T.F. personnel that their families experienced stress; that homecoming may be different from expectations; that personal and family fatigue must be recognized and addressed; that lack of concentration and other physical and psychologic effects from the deployment are expected and that they are normal.



**III. MEDICAL TEAM RESPONSIBILITIES**  
**D. EXTENDED INCIDENT STRESS**

**STRESS REACTION/MONITORING/INTERVENTION (continued)**

**Stress Management Post-Disaster**

- Post- Incident Debriefing Concepts:
  - Session occurs two to four weeks post-event (allows physical recuperation, time to catch up on professional and personal responsibilities, “settling out” of thoughts and emotions from response.
  - Mandatory that session occurs, \; should be financially supported by sponsoring organization.
  - T.F. responders should be strongly encouraged to attend.
  - Focus on the event, not on “feelings”. Strict CISD model is not recommended. One format could be to ask T.F. personnel to submit their favorite, most poignant and/or controversial pictures for a slide review. Compile and allow brief presentation by T.F. members with facilitated discussion.
  - Separate from critique.
  - Atmosphere of emotional support.
  - Facilitated by true “peers”, possibly best done by unaffected non-deployed T.F. members.
  - Identify any group actions to be taken.
- Potential actions
  - Memorial service, esp. for the death of a worker.
  - Fund raising activity, return to the site for later service, group communication of thanks to personnel from the disaster location, etc.
  - Formal stress evaluation or defusing sessions.
- Post-incident stress surveillance should be incorporated into the health surveillance activity for the T.F. personnel.

**CONCLUSION**