CLINICAL PRACTICE STANDARD – Aeromedical Operations
AO.CLI.17 – Major Incident

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Contents	**Clinical Practice Standard**: AO.CLI.17 – Major Incident
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Associated Policy Directive/s and/or Operating Procedures/s	This work instruction details the implementation requirements for Command and Control, EMPLAN, AMPLAN, MEDPLAN, HEALTHPLAN
Directorate	Aeromedical Operations
Author Branch	
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Summary	Re-written to reflect changes to Command and Control, plus NSW key plans EMPLAN, AMPLAN, MEDPLAN, HealthPlan. Also updated to provide clarity around the role, actions and Command / Control of NSW Ambulance Medical Teams.
Applies to	NSW Ambulance aeromedical clinical crew.
Review Date	September 2022
Previous Reference	Nil
Status	Active
Approved by	Executive Director, Aeromedical Operations
Related Legislation	Nil
Related Documents	Nil

Compliance with this operating procedure is **mandatory**

CLINICAL PRACTICE STANDARD – Aeromedical Operations
AO.CLI.17 – Major Incident

1. Purpose

This procedure directs the use of NSW Ambulance medical teams as part of a broader ambulance response to major incidents.

Medical Teams are staffed by Critical Care Doctors and Critical Care Paramedics (with specialist access skills), specifically equipped and trained to operate in the pre-hospital environment.

Multiple teams are available at any given time through a range of dedicated land-based and aeromedical retrieval assets located across NSW helicopter bases. Medical teams assist the broader response by ensuring patients involved in a major incident receive the highest level of care as early as possible in accordance with the principle of utility; *"Greatest good for the greatest number"*.

This procedure should be read in conjunction with; *Command and Control Policy*, *NSW State Emergency Plan (EMPLAN), NSW Health Plan (HEALTHPLAN)*, *NSW Ambulance Plan (AMPLAN),* and the *NSW Major Incident Medical Services Supporting Plan (MEDPLAN).*

2. Procedure

2.1 Activation, Command and Control

Medical teams can be activated by the Aeromedical Control Centre (ACC) according to existing day-to-day tasking procedures. This is considered to be 'Ops Normal'.

In the event of a major incident, the State Health Emergency Operations Centre (SHEOC) may be activated by the State Health Services Functional Area Coordinator (State HSFAC). The SHEOC will incorporate strategic level management and the NSW Health Controllers (Medical, Mental Health, Public Health, Ambulance, Health Communications and Health System Support).

Three plans that directly relate to NSW Ambulance Medical Teams may be used:

- **NSW HEALTHPLAN:**

  The State HSFAC can activate HEALTHPLAN, which dictates the specific use and management of health resources, including medical teams. In this situation, NSW Ambulance medical teams will initially be tasked by the ACC and handed over to a Medical Commander to form Emergency Medical Teams (EMT). Other medical personnel may also be called on to create additional EMTs as dictated by the nature of the incident.

- **NSW AMPLAN (supporting plan to NSW HEALTHPLAN):**

  Does not need to be “formally activated” but only the State Ambulance Controller (normally the Chief Executive) can escalate AMPLAN (which can escalate into HEALTHPLAN). In practice, AMPLAN involves normal day-to-day tasking and command and control arrangements, with some additional roles. Medical teams will form part of this normal response.

- **NSW MEDPLAN (supporting plan to NSW HEALTHPLAN):**

  When MEDPLAN is activated, the State HSFAC may assign the State Medical Services Controller the responsibility for centrally coordinating the management and definitive care of multiple casualties from a major incident. This may involve deployment of health resources to an incident. EMTs will initially be formed by medical retrieval personnel but may also be drawn from Local Health Districts (LHD).

  Depending on the location and nature of the incident, the responding team(s) will usually be the duty crews operating out of NSW Ambulance helicopter bases. Self response to the scene by crews, or individuals not on duty, is not to occur (per Ambulance Standard Operating Procedures).

Specialist roles during a Major Incident:

Aeromedical staff may be required to fill one of a number of roles at a major incident. Appointment will be via the Ambulance Controller or the State HSFAC or their delegates (if no specific appointment is announced, normal Command and Control arrangements apply). These may include:

- **Medical Commander or Forward Medical Commander** - Senior Doctor (Staff Specialist) – see Appendix 1 Action card
- **Ambulance Commander or Forward Ambulance Commander** - most Senior Paramedic
- **Triage / Medical Triage Officer** - Paramedic or Doctor
- **Treatment Officer / Casualty Clearing Station (CCS) Medical Supervisor** - Paramedic or Doctor – see Appendix 2 and 3 Action cards

Medical Commander roles

Medical Commander:

Once appointed is responsible for providing expert determination of the medical services requirements for the scene and liaising with the Ambulance Commander. The Medical Commander will also:

- Determine the priorities of treatment and transport for casualties
- Coordinate medical resources on site
- Be responsible for the clinical management of casualties in the Casualty Clearing Station
- Appoint a Casualty Clearing Station Medical Supervisor who will be responsible for clinical coordination of the CCS including secondary triage, deciding priority and destination of transport and clinical supervision of treating medical teams
- Provide accurate medical information to the Ambulance Commander and State Medical Services Controller

Forward Medical Commander:

Once appointed is to support the Medical Commander, or act on their behalf if the Medical Commander cannot reach the scene (or particular parts of the scene) or there are multiple scenes.

2.2 Planning

If an incident is anticipated to require a prolonged response, the local Helicopter Zone Manager will be in charge of liaising with broader Ambulance (and / or Health) via the chain-of-command. Each zone will establish an **Incident Planning Team** (IPT) (see ***Appendix 5 Action card***) consisting of:

- **Zone Manager** - team leader, plus communications with contractors, ACC and external stakeholders
- **Medical Manager (or delegate)** - primary responsibility for doctor communications and gear
- **Duty Operations Manager (DOM) (or Helicopter Duty Supervisor (HDS)** - primary responsibility for Helicopter Station Officer (SO) and paramedic communications and gear
- **Southern Zone Equipment Officer** - medical gear capacity and consumables
- **Bankstown Executive Assistant** - scribe for Zone Manager and responsible for keeping an Incident log book.

The **Aeromedical Zone IPTs** will:

- Maintain regular contact with each other (via the team leaders).

- Liaise with broader Ambulance and / or Health via the chain-of-command, about available and required resources in the event of prolonged operations (including early embedding of medical teams with forward deployed Ambulance teams).
- Consider staff movements / call-ins and pre-positioning, rostering / rotation for fatigue, aircraft availability / maintenance, medical consumable stock levels, etc for incident deployment and maintenance of normal operations.
- Maintain an up to date log of staff deployed.
- Communicate with broader aeromedical staff.

2.3 Safety

All staff responding to a major incident must have adequate Personal Protective Equipment (PPE). In addition to one's flight suit (or operational uniform), this will include:

- helmet
- eye and ear protection
- gloves (disposable latex gloves as well as heavy duty riggers' gloves if responding to an Urban Search And Rescue (USAR) incident)
- tabard / vest identifying the person's role.

If arriving by helicopter the opportunity should be taken to establish an **aerial reconnaissance** of the scene and its hazards. Should time allow and it is safe to do so, an overhead diagram (or photograph) noting important features such as the hot zone, access routes, potential locations for CCS, ambulance loading zones and services present is useful to assist planning.

Responding staff should approach the scene with caution and should not enter the hot zone without specific advice from the Combat agency through the Ambulance Commander or Ambulance Safety Officer that the scene is safe to enter and that no additional PPE is required.

2.4 Communications

Communications are one of the most important links in successful major incident management but are a common failure mode. Multiple redundant systems are necessary. Communications need to be "3-dimensional" (up, down and across the command structure).

- Duty helicopter crews carry radios for communication with each other and for communication with the ACC and local control centres.
- Responding teams should switch to the local channel or to the channel allocated to the incident as soon as possible. If communications are unable to be established, the team should switch back to the last channel where communications were obtained.

- Mobile phone coverage may be limited at the scene of major incidents but may be a useful backup if radio communications with the ACC fail. Satellite phones are also available to helicopter crews. (ALL phone comms MUST go via the ACC to be recorded.)
- If necessary, verbal and written information can be conveyed on scene using runners.
- A Medical Commander, if appointed will preferably carry a Government Radio Network (GRN) radio which can access the digital Medical Incident channel 17 if this channel is being utilised.

2.5 Access

Depending on the nature and location of the incident, transportation to the scene may be by road, rotary wing or fixed wing vehicles. Vehicles and teams remain at the disposal of the Ambulance Controller, in consultation with the State HSFAC on the advice of the Ambulance and Medical Commanders present on scene and will be tasked by the ACC.

Aviation resources may be utilised for the transport of medical teams to the site, for transporting casualties to hospital or for reprovisioning the major incident site with essential equipment or pharmaceuticals.

2.6 Triage

Primary triage is the responsibility of the initial crews on scene. Emergency Medical Teams (EMT) (see Appendix 4 Action card) may be asked to perform secondary triage as well as identify patient clinical requirements, to assist in the appropriate destination of patients.

2.7 Treatment

It is important that those filling Commander roles at a major incident avoid involvement in patient care and ensure regular contact with the Commanders of the other Emergency Services present. The Medical Commander will work closely with the Ambulance Commander and all health resources arriving at the scene will report to them for allocation of roles. The Ambulance and Medical Commanders will be located near the Ambulance Control Vehicle.

2.8 Documentation

Documentation must be performed for any patient receiving clinical treatment. In the event of mass casualty incidents, this will be limited by time and casualty constraints however any treatment administered (in particular the administration of drugs or any medical intervention) must be noted on the patient's triage tag (SmartTag Triage Card) to ensure continuity of care.

A log of patients treated must be kept by teams.

Following the recovery phase of a major incident there will be a detailed examination of decision-making and contemporaneous note keeping is essential. A dictaphone is provided in the Medical Commander Pack and the use of a scribe is recommended if personnel numbers allow.

2.9 Equipment

Equipment required and brought to the scene of a major incident by aeromedical staff should complement that of standard ambulance crews. Resupply of basic equipment is the responsibility of NSW Ambulance and will be sourced from responding ambulance vehicles in the first instance.

Requests for additional equipment specific to aeromedical operations will go via the Ambulance or Medical Commander through the SHEOC who will liaise with the local Helicopter Zone Manager.

In the event of a prolonged incident, the NSW Medical Cache may be deployed. If additional equipment or resupply is unable to occur, the State HSFAC may arrange supply from a nearby hospital.

2.10 Transport

The State Medical Services Controller and State HSFAC are responsible for directing the appropriate distribution of patients, as they have an overview of the overall system capacity and resources that is not available to those at the scene in the early stages of a major incident.

The Loading Officer in conjunction with the Casualty Clearing Officer should distribute priority 1 and priority 2 patients across major trauma centres, so as not to overload any one hospital. Patient demographics, clinical and transportation details must be recorded in a log, such as the NSW Health Arrivals and Movement Register – Disaster Patients (Appendix 6). It is reasonable to send two priority 1 (red) patients to a trauma centre simultaneously. If possible, those requiring subspecialty care (eg burns, spinal) should be sent directly to the specialty hospital.

The Medical Team may utilise the helicopter to transport patients to destinations further afield at the discretion of the Ambulance or Medical Commander, in consultation with the State Medical Services Controller. The aim of treatment is to stabilise the patient to ensure that they will reach hospital safely, bearing in mind the aim of major incident management is to do the greatest good for the greatest number.

Although priority for transport should be given to those with more serious injuries, it is advisable to transfer those less seriously injured to a hospital as soon as practicable using alternatives to ambulances such as bus transport. NSW Ambulance is responsible for prehospital patient transport, however they may source transport assistance through the Transport Functional Area Coordinator (where possible, such patients should be accompanied by an attendant trained in Basic Life Support as a minimum.)

REFERENCES

1. PD2014_012 New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN)
2. Major Incident Response Plan (NSW AMPLAN) Version 1.0 131218
3. GL2018_017 Major Incident Medical Services Supporting Plan (NSW MEDPLAN)

APPENDICES

1. Action card – Scene Medical Commander (from GL2018_017, page 17-18)
2. Action card – Treatment Officer (from NSW AMPLAN, page 42-43)
3. Action card – Casualty Clearing Station Medical Supervisor (from GL2018_017, page 18)
4. Action card – Emergency Medical Team (from GL2018_017, page 19-20)
5. Action card – Helicopter Zone Incident Planning Team (IPT)
6. NSW Health Arrivals and Movement Register – Disaster Patients

REVISION HISTORY

Version (Document #)	Amendment notes
4.0 WI2020-111 Issued 15 October 2020	Reflects changes to MEDPLAN with the inclusion of Action cards for key roles Transition and naming convention to the new format. Approved by A/Executive Director, Aeromedical Operations.
3.0 March 2016	Re-written to reflect changes to Command and Control, plus NSW key plans EMPLAN, AMPLAN, HealthPlan. Also updated to provide clarity around the role, actions and Command/Control of NSW Ambulance Medical Teams Approved by Executive Director, Health Emergency & Aeromedical Services
2.0 July 2013	Reviewed with updates to include contacts Approved by Director, State-wide Services Division
1.0 April 2012	Original Approved by Director Aeromedical and Medical Retrieval Services

Appendix 1 – Action Card – Scene Medical Commander

SCENE MEDICAL COMMANDER
The role of the Scene Medical Commander is to command all clinical aspects of secondary triage, treatment, transport priority and transport destination from the scene and liaise regularly with the State Medical Controller.

The Scene Medical Commander will:

Proceed to the Scene when notified, establishing communications as soon as possible with the State Medical Controller at State Health Emergency Operations Centre (SHEOC).

On arrival at the Scene :
• Don appropriate PPE and tabard
• Make contact with the Health Commander to obtain a briefing (Ambulance Commander assumes role of Health Commander).
• Confirm the best choice to optimise patient treatment and transport opportunities has been made for:
  ◦ Ambulance Staging Area
  ◦ Loading Point
  ◦ Casualty Clearing Station
• Appoint the CCS Medical Supervisor. This will be the most experienced clinician available. They will be responsible for the clinical coordination of the CCS, including secondary triage, deciding priority and destination of transport, and clinical supervision of treating medical teams
• Review the incident and report regularly (approximately every 30mins) to the State Medical Controller detailing:
  ◦ Number of casualties and respective triage categories (both known and estimated) at the scene
  ◦ Number of casualties and respective triage categories (both known and estimated) transported to hospitals
  ◦ Type of injuries (eg penetrating trauma, blunt trauma, burns)
  ◦ Breakdown of patients between adults and children
  ◦ Requirement for further Medical Teams and/or special equipment
• Liaise regularly with the CCS Medical Supervisor regarding preferred destination hospitals as advised by State Medical Controller.

Keep contemporaneous log of: • Important decisions made • Hospital assignments and tracking of patients - information from CCS Medical Supervisor.
Brief and allocate Emergency Medical Teams (EMT) as they arrive on site.
Conduct welfare checks and maintain logs of medical team duration within incident. Liaise with State Medical Controller regarding ongoing medical team shifts for relief of teams within protracted events.
Provide appropriate handover at the end of the shift.

On completion of the incident, advise the State Medical Controller, advise all EMTs and contribute to “Hot” debrief.

Appendix 2 – Action Card – Treatment Officer

TREATMENT OFFICER

The Treatment Officer will be appointed by the Forward Commander and will be the most experienced person available, not necessarily the most senior as they have key responsibilities for the early clinical management of patients until relieved by a Medical Commander.

The Treatment Officer will (in the absence of a Medical Commander):

- ☐ Put on high visibility safety vest, safety helmet and appropriate personal protective equipment (PPE).
- ☐ Ensure that all patients have undergone an initial Triage Sieve prior to proceeding to the Casualty Clearing Station
- ☐ Establish the Triage Sort point adjacent to the entry to the Casualty Clearing Station.
- ☐ Ensure the Triage Sort using the current algorithm to prioritise casualties and directing casualties to the appropriate treatment sector.
- ☐ Clinical status will be classified by the appropriate SMART Triage Tag.
- ☐ Provide advice to the Loading Point Supervisor on the number and clinical priority for the transport of patients (in the absence of a Medical Commander).
- ☐ Ensure appropriate numbers of paramedics are available for treatment and movement to the loading point.
- ☐ Update the Forward Commander on number and clinical priority for the transport of patients in the Casualty Clearing Station as required.

Colour	Priority	Description
RED	Priority 1 (Immediate)	Casualties who require immediate lifesaving procedures/transport.
YELLOW	Priority 2 (Urgent)	Casualties who require definitive treatment within four to six hours.
GREEN	Priority 3 (Delayed)	Less serious casualties who do not require treatment within the above times.
BLACK	Deceased	Victims and/or body parts are labelled and left undisturbed, in situ for Disaster Victim Identification (DVI) and forensic investigation.

TREATMENT OFFICER

Once a Medical Commander arrives on scene, the Treatment Officer will:

- ☐ Provide the Medical Commander with a comprehensive briefing on the numbers, clinical profiles, existing treatment regimens and transport priorities based on the Triage Sort for those casualties currently contained within the CCS.
- ☐ At the completion of the briefing, handover responsibility for ongoing Triage Sort, clinical treatment and transport priorities to the Medical Commander
- ☐ Provide oversight and management of all activities, paramedic resources and patient flow through the CCS to ensure that it is operating at maximum efficiency to move patients from onward to the Loading Point
- ☐ Maintain continual liaison with the Medical Commander.

Appendix 3 – Action Card – Casualty Clearing Station Medical Supervisor

CASUALTY CLEARING STATION (CCS) MEDICAL SUPERVISOR
The CCS Medical Supervisor may be deployed to the scene at the request of the State Medical Controller to lead the clinical aspects of secondary triage, treatment, transport priority and transport destination in the CCS.

The CCS Medical Supervisor will:

On arrival at the site, report to the Scene Medical Commander in the Medical Forward Command Post for a briefing.
Briefly review location and internal setup of CCS for best suitability.
Allocate Medical Teams to treatment areas.
Establish liaison with Ambulance Triage (SORT).
Perform (alone or by utilising another doctor) secondary triage (sort) on patients arriving into the CCS. Document on SMART tag the decision re both • Triage colour (red, yellow, green) and • Destination hospital (Major Trauma Services (MTS), Burns MTS, Paediatric MTS, Regional Trauma Service/other).
Communicate clearly (directly or delegate) with the Ambulance Loading Point Officer to determine transport priorities and destination hospitals of individual patients, and keep a log of same. Note: In a major incident situation, the transfer of patients will not necessarily be influenced by hospital status.
Regularly update (30mins at least) Scene Medical Commander with information re injuries, categories and destinations of patients.
Receive regular updates from Scene Medical Commander re preferred destination hospitals using feedback from the Medical Controller/SHEOC.
Conduct welfare checks and maintain logs of medical team duration within incident. Advise Medical Commander of requirements for further medical teams and/or equipment.
Identify and correct any issues affecting patient triage, treatment and flow.
Provide appropriate handover at the end of the shift.
On Stand Down of Incident attend hot debrief.

Appendix 4 – Action Card - Emergency Medical Team

EMERGENCY MEDICAL TEAM(s)
Emergency Medical Team(s) (EMTs) may be deployed to the scene at the request of the State Medical Services Controller where they have the necessary resources to function effectively. Team members are responsible when on scene to the Scene Medical Commander or, if appointed, to the CCS Medical Supervisor. They will provide necessary treatment to casualties at the incident site prior to their transport to hospitals for definitive care and/or medical discharge direct from the scene. Initial deployment of EMTs to an incident scene will generally be from duty aeromedical retrieval personnel. They will be attired in standard medical retrieval uniform and PPE (blue/navy flight suit) with appropriate qualifications, identification and medical equipment. If there are multiple teams, an EMT leader will be appointed from within each team.

The Team(s) will:

On arrival at the site, report to the Scene Medical Commander in the Forward Command Post.
Receive a briefing and allocation of tasks from the Scene Medical Commander.
Under supervision provide necessary treatment to casualties at the CCS prior to their transport to hospitals for definitive care or medical discharge direct from the CCS. The CCS will generally be subdivided by triage category, and EMTs may be assigned to be responsible for one or more categories of patients. Medical treatment at the scene should not delay transport to definitive care unless absolutely necessary to save life or limb. In general any interventions should be minimised to the simplest Airway/Breathing/Circulation interventions required to maintain oxygenation and perfusion to vital organs during transport to definitive care. If scene times are prolonged due to transport delays or for other reasons, further interventions may be advisable – the CCS Medical Supervisor and Scene Medical Commander should be involved in these decisions to enable feedback to the SHEOC. Review all Green patients to determine if injuries can be dealt with at an alternate location to a public hospital.
Maintain up-to-date clinical documentation of triage, vital signs and treatment by updating the SMART Triage tags.
Complete documentation as required, including the Disaster Patient Record Form.

Provide appropriate handover to relieving medical team members at the end of the shift.
On Stand Down of Incident: • Attend hot debrief • Collect all medical equipment and resources.

The EMT Leader will:

Provide leadership and support to EMT members in medical services provision.
Report to CCS Medical Supervisor.
Ensure all EMT members are appropriately attired.
Ensure accuracy and collection of all documentation.
Conduct welfare checks and maintain logs of medical team duration within incident. Request if required further equipment/consumables for further medical teams.
Provide appropriate handover at the end of the shift.
On Stand Down of Incident attend hot debrief.

Appendix 5 – Action Card – Helicopter Zone Incident Planning Team

MAJOR INCIDENT ACTION CARD *(FRONT)*
Helicopter Zone Incident Planning Team (IPT) - Leader

Actions to be taken in the event of a major incident being DECLARED or the zone being placed on STANDBY by ACC

The Zone IPT consists of (until relieved):

1. Zone Manager - leader, plus communications with contractors, ACC and external stakeholders
2. Medical Manager (or delegate) - primary responsibility for doctor communications and gear
3. DOM (or HDS) - primary responsibility for helicopter SO and paramedic communications and gear
4. Southern Zone Equipment Officer - medical gear capacity and consumables
5. Bankstown EA - scribe for Zone Manager (using incident log book)

1

Group text to be sent out via Whispir to the HEMS Incident Planning Team (IPT) by ACC:
MESSAGE: "HEMS Standby for Major Incident. Phone 9553 2233 within the next 10 minutes to confirm receipt and await further details of teleconference"

This teleconference may also include:

- Director, Aeromedical Operations
- Helicopter Station Officers
- State Retrieval Consultant (SRC) of the day
- Duty Retrieval Consultant (DRC) of the day

2

Following IPT teleconference, a group text is to be sent out via Whispir to all Aeromedical paramedics, consultants and registrars by Zone IPT:
MESSAGE: "HEMS Standby for Major Incident. Please send SMS to [*insert mobile phone number*] ASAP with your Name and ETA to reach [*insert location*] Base ONLY if able to respond. Please await further instructions"

Contacts can be found in Distribution lists in Whispir:

Doctors *(Greater Sydney Area HEMS list)*	**Paramedics *(Helicopter Duty Supervisor list)***
• Consultants NSWA • Consultants Westmead • Retrieval Registrars (year)	• Bankstown Helo Paras - Permanent • Bankstown Road Retrieval - Permanent • Orange Helo Paras - Permanent • Wollongong Helo Paras - Permanent

3 EA to start Log sheet of Actions / Reports

4

Confirm current crew availability at all bases:

- Staff on shift
- Helicopters operational
- Road vehicles operational
- Equipment and consumables available

5

Zone Managers to contact ACC on 9553 2233. Report for their zone:

- Current vehicle availability
- Current crew availability
- Group call made

6 Liaise with stakeholders regarding need for additional teams and the early embedding of Medical Teams with any forward deployed Ambulance teams.

MAJOR INCIDENT ACTION CARD *(BACK)*

Additional Points:

1. ACC should contact the helicopter support paramedic, ops support doctor and Duty Retrieval Consultant (DRC) if not already at the base requesting them to attend their base.

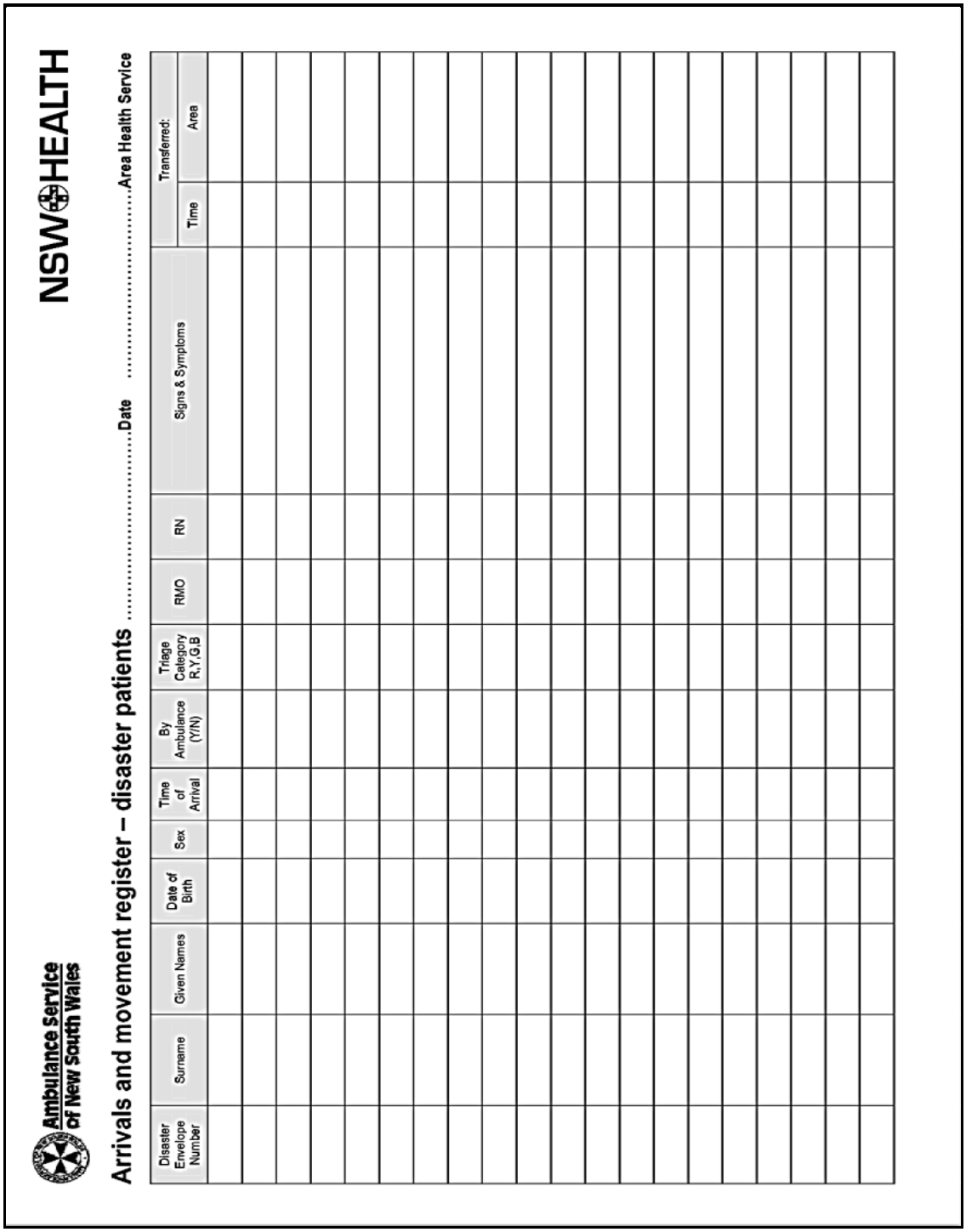
2. Duty crews to ensure that they are ready and equipped to respond. Each responding crew should have a set of drug and pre-hospital packs between them. (If the Sydney DRC is anticipated to fill a Medical Commander role, they will not need to bring drug or pre-hospital packs.)

3. Teams are to wait at their base until further instructions are obtained and tasking is confirmed by the ACC. If it is anticipated that the incident will be prolonged, available staff on the next shift should also present to the base if their shift start is within two hours of notification, otherwise staff on the next shift should arrive at the usual shift start time.

4. Details of medical team members being shuttled to the scene must be announced to ACC and recorded when departing base.

5. Other available staff should contact the number given and await further instructions.

Appendix 6 – Action Card – NSW Health Arrivals and Movement Register – Disaster Patients



NSW HEALTH

Ambulance Service of New South Wales

Arrivals and movement register – disaster patients .....Date .....Area Health Service

Disaster Envelope Number	Surname	Given Names	Date of Birth	Sex	Time of Arrival	By Ambulance (Y/N)	Triage Category R,Y,G,B	RMO	RN	Signs & Symptoms	Transferred: Time	Transferred: Area