Medical Intervention Plan (MIP)

Contents

General principles 3
1. Introduction 3
2 Context 3
3 Glossary of terms and abbreviations used within discipline 2 5
Medical Intervention Plan - MIP 10
1 Objective 10
2 Operation and structure 10
2.1 Alerting 10
Who is authorised to alert 11
Levels of alerting 11
2.2 Scaling-up and reinforcement 12
The 'EXTENDED MIP' 13
The 'MAXI MIP' 13
Inter-provincial support 14
2.3 Takeover (relieving of staff) 14
2.4 Scaling-down and conclusion 15
2.5 Follow-up 15
2.6 Summary overview 16
3 Coordination 17
3.1 Operational coordination 17
3.2 Strategic coordination 17
4 Organisation of the disaster site 18
4.1 Zoning 18
Red zone 18
Orange zone 19
Yellow zone 19
4.2 Tasks discipline 2 19
4.3 Medical chain 20
Takeover point 20
Pre-triage 20

Minor noria 21
Advanced Medical Post 21
Major noria 23
Ambulance fleet 23
First destination point/rendezvous point 23
Reception structures 24
5 Staff and resources 24
5.1 Coordinating functions 24
5.2 Additional functions 25
5.3 Intervening resources 28
5.4 Organisational chart and deployment of staff and resources 28
5.5 Communication chart 29
5.6 Functional recognisability 30
6 Conclusion of the MIP 31
7 Link with the PSIP 31
8 Action cards 32
9 Training and exercise 32
10 Legislation 33

General principles

1. Introduction

The mono-disciplinary intervention plan governs the intervention to be provided by a single discipline, in accordance with existing emergency and intervention plans (RD of 16 February 2006 on emergency and intervention plans, art 4).

For discipline 2, it contains the measures taken in implementation of the law of 8 July 1964 on emergency medical assistance, for the organisation of assistance in the event of disaster incidents, catastrophes or loss events in a multi-disciplinary context.

The following text is intended:

- to facilitate the drafting of municipal, provincial and federal general emergency and intervention plans, adapted to the identified risks (cf. NPU2 and NPU4);
- to avoid the typical errors which occur when the assistance action is not coordinated via a medical intervention plan in advance.

With this in mind, the legislator published the Royal Decrees of 16 February 2006 on emergency and intervention plans, and of 2 February 2007 determining the function of the director of medical care and the scope thereof, implementing the law of 8 July 1964.

2 Context

A collective emergency situation can result in severe loss for a large number of people, resources or the living environment. Consequently, the initial need for medical assistance, in the broadest sense of the term, can exceed the day-to-day capacity of emergency medical assistance.

The specific organisation of medical and psycho-social care as a result of collective emergency situations demonstrates the need for strengthening resources. In addition to the vital mobilisation of resources, deployed during individual day-to-day assistance, this implies the mobilisation of exceptional resources.

This is why it is necessary to define the modalities for the coordination and organisation structure of the chain for emergency medical and psychosocial assistance, in order to confront:

- a (significant) influx of victims,
- a situation with particular health risks, or a threat to public health.

Moreover, the preservation of the organisation and structure of day-to-day emergency medical assistance must be guaranteed, so that it is not compromised.

The same applies for events presenting a (large) risk and/or wherever large numbers of people gather together (cf. ministerial circular letter OOP 41 of 31 March 2014).

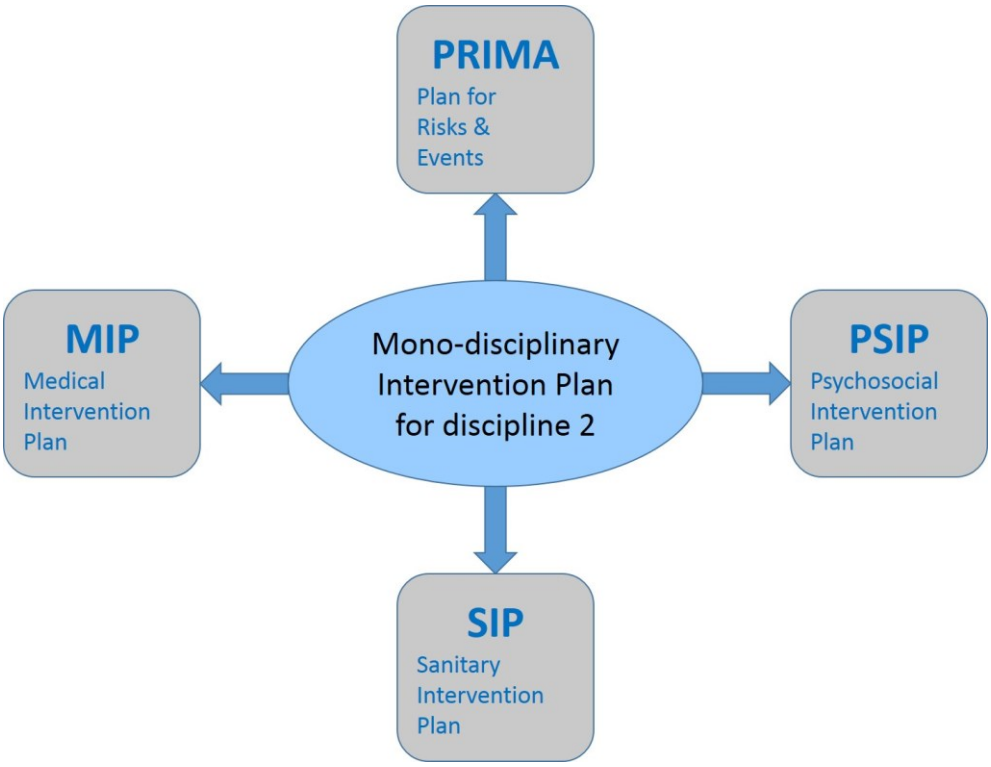
It is essential to have a good inventory of all available resources, at all times and in every situation (staff, material and services), which can be deployed.

This all falls within the federal government's risk prevention policy, and has resulted in the Mono-disciplinary Intervention Plan for discipline 2 (D2), in which the specific risks each make up a separate component:

- the Medical Intervention Plan (MIP),
- the Psychosocial Intervention Plan (PSIP),
- the Plan for Risks and Events (PRIMA) which targets risk assessment for events,
- the Sanitary Intervention Plan (SIP)

The Sanitary Intervention Plan (SIP) and the Plan for Risks and Events (PRIMA) will be published at a later date.

Schematic overview of the make-up of the Mono-disciplinary Intervention Plan for discipline 2:



3 Glossary of terms and abbreviations used within discipline 2

Concept	***Description***
Adjunct director of medical assistance (ADJ DIR-MED)	*Adjunct to the DIR-MED who assists in the implementation of the DIR-MED functions.*
Adjunct federal health inspector (ADJ HI)	*Adjunct to the federal health inspector who assists in the implementation of the functions of the federal health inspector.*
Adjunct regulation coordinator (ADJ COORD REG)	*The person who supports the responsible person for regulation.*
Adjunct triage (ADJ TRI)	*MEG Nurse who supports the doctor responsible for triage (MED TRI)*
Advanced Medical Post (AMP)	*Transitional structure before admission to a hospital which makes it possible to carry out triage and stabilisation of the victims, their conditioning, the registration and identification of the victims, and their controlled evacuation to hospitals (in accordance with RD Dir-Med of 2 February 2007).*
Affected person	*Any person directly confronted with an emergency situation who is present at the time of the event (deceased, injured, uninjured, eye witness).*
Aid-Ambulance officers (AA-O)	*A function recognised by the Minister for Public Health and included in the provision of Emergency Medical Assistance. The AA-O has followed a training course at a provincial EMA school and has passed all theoretical and practical exams.* *For the sake of clarity in this text, no distinction is made between aid-ambulance officer and nurse-ambulance officer.*
Ambulance fleet coordinator (COORD AMB)	*The person responsible for the ambulance fleet who ensures the orderly preparation of ambulances so that they can be quickly deployed to intervention sites. He or she is appointed on the basis of experience or knowledge of the MIP.*
Ambulance service	*Ambulance service organised by the public authorities, pursuant to article 5, first paragraph, of the law of 8 July 1964. Ambulance service organised by private operators who, pursuant to article 5, third paragraph of the same law, have agreed with the State to cooperate in Emergency Medical Assistance (in accordance with the RD of 2 April 1965 on EMA modalities, art 1, 6°).*
AMP Coordinator (COORD VMP-PMA)	*The person responsible for the Advanced Medical Post (AMP) for all non-medical aspects. The person who ensures that the AMP is set up accordingly and the logistics supply of the AMP is guaranteed.*
Assembly point	*Area where uninjured people are assembled before being escorted from the disaster site.*
Belgian association for burns injuries plan (BABI Plan)	*National plan which governs the number of beds for severe burns injuries, with the coordination of the various burns injury centres.*
Command post operations (CP-Ops)	*The consultation between the operational responsible persons of the various disciplines under the leadership of the director of command post operations (DIR CP-OPS)*

Commission for Emergency Medical Assistance (CEMA)	*The Commission for Emergency Medical Assistance is an advisory body for the provincial and municipal authorities. The Commissions bring together all stakeholders active in Emergency Medical Assistance at the provincial level and the Brussels-Capital Region administrative level, under the presidency of the federal health inspector (in accordance with the RD of 10 August 1998).*
Conditioning	*Preparing a victim for transportation with the aim of a controlled evacuation.*
Director of medical assistance (DIR-MED)	*A doctor that has the operational leadership over all medical, sanitary and psychosocial assistance on-site, used for the medical care chain, regardless of the department from where the assistance originates. The DIR-MED works under the administrative authority of the federal health inspector who sits in the Coordination Committee (in accordance with the RD Dir-Med of 2 February 2007).* *In this text, DIR-MED (written in capitals) refers to the function, while Dir-Med (written in lower-case) refers to a doctor designated by Ministerial Decree.*
Emergency Medical Assistance (EMA)	*The immediate provision of appropriate assistance to all persons whose health condition following an accident, sudden episode, or sudden onset of an illness requires urgent intervention, following a call to the uniform call system. Medical assistance, transportation and accommodation to an appropriate hospital department is ensured (in accordance with the law on Emergency Medical Assistance of 8 July 1964).*
Emergency Social Intervention (ESI)	*A service of the Red Cross which supports discipline 2 as a supralocal psychosocial actor concerning the psychosocial reception of people involved in collective emergency situations. The service is an operational unit within the implementation of the PSIP.*
Federal health inspector (HI)	*Doctor, official of the FPS Health, Food Chain Safety and Environment, member of the municipal or provincial Coordination Committee as the representative of discipline 2, with administrative authority on behalf of the Minister and liaison officer for the departmental crisis unit of the FPS Health, Food Chain Safety and Environment.*
Federal Public Service Health, Food Chain Safety and Environment (FPS HFCSE)	*The Federal Public Service which is competent for public health, the safety of the food chain, and the environment.*
First destination point (FDP)	*This is a location situated away from the hazard zone where all (transport) resources are gathered and itemised. Based on the needs on-site, the most appropriate resources are sent to the location where they can be deployed.*
Help centre 112/100 (HC 112/100)	*The organisation of Emergency Medical Assistance which consists of a uniform call number and staff who take the emergency calls in accordance with the rules imposed by the FPS Health.*
Hospital emergency plan (MASH)	*A plan for 'alerting hospital departments'. Every hospital needs to develop an action plan consisting of an 'internal section' which deals with a problem in the hospital, and an 'external section' which handles the reception capacity for victims of a collective emergency situation (in accordance with the RD of 23 October 1964, whereby Art. N1, Annex A, III, 14° was amended via the RD of 17/10/1991). This can be considered as a Specific Emergency Response plan, but is approved by the provincial governor.*

Hospital with 'specialist emergency care' function	*A hospital which has a recognised 'specialist emergency care' function in accordance with the RD of 27 April 1998 establishing the standards which a 'specialist emergency care' function must meet in order to be recognised as such.*
Logistics Coordinator (COORD LOG)	*The person responsible for the logistical support of the medical actions at the disaster site.*
Logistics Rapid Intervention Team (RIT LOG)	*A component of RDR: a vehicle with logistical material for the organisation and operation of an AMP and the assistance chain of D2 (stretchers, beds, tents, gensets, lighting, etc.)*
Major noria	*Controlled evacuation of victims from the Advanced Medical Post (AMP) to the appropriate structures for reception and/or treatment.*
Medical assistance chains	*The resources and staff which can be requisitioned pursuant to the law of 8 July 1964 on emergency medical assistance (in accordance with the RD Dir-Med of 2 February 2007).*
Medical Emergency field Triage Tag (METTAG™)	*International concept for a tag with a universal code which indicates the evolution of the severity of the injuries, and facilitates the registration of the victim.*
Medical Intervention Plan (MIP)	*Component of the mono-disciplinary intervention plan for discipline 2 (D2). It contains every measure taken in implementation of the law of 8 July 1964 on Emergency Medical Assistance, to organise appropriate assistance and care and administer it to victims during collective medical emergency situations.*
Medical logistical resources	*Resources for installing and equipping Advanced Medical Posts. These resources, along with staff, are supplied using vehicles set aside for this purpose.*
Medical Rapid Intervention Team (RIT MED)	*A component of RDR: a vehicle with medical material to equip and make operational an AMP in the assistance chain of D2 (oxygen, bandages, blankets, extra medication, etc.)*
Minor noria	*Evacuation of victims from the takeover point to the entrance (triage area) of the Advanced Medical Post (AMP).*
MIP alert	*The initiation of the medical assistance chain when the criteria for initiating the medical intervention plan are met.*
MIP pre-alert	*Partial alerting of the medical intervention plan whereby only the coordinating structure of the medical intervention plan is alerted, for the purpose of properly assessing the medical consequences of the emergency situation.*
Mobile Emergency Group (MEG)	*A 'mobile emergency group' function recognised by the Minister for Public Health and included in the provision of Emergency Medical Assistance. The MEG is deployed to an indicated location at the request of staff at the uniform call system (in accordance with RD of 10 August 1998).*
Municipal Coordination Committee (MCC)	*The consultative body between the policymakers of the various disciplines under the leadership of the mayor.*
Paramedical intervention team (PIT)	*Recognised 112 ambulance, staffed with a nurse with the special professional title emergencies/intensive care, and extra material.*

Preliminary triage (pre-tri)	*An initial, rapid, clinical assessment usually carried out at the boundary between the red and orange zones, and in specific cases possibly already in the red zone. Victims are divided into groups according to the level of urgency with which they need to be evacuated to the next link in the medical assistance chain.*
Preventive medical provisions	*All of the medical-sanitary measures taken before planned events which could pose risks to participants and/or the general public, in consultation with the organisers and the competent authorities (in accordance with the RD Dir-Med of 2 February 2007).*
Provincial Coordination Committee (PCC)	*The consultative body between the policymakers of the various disciplines under the leadership of the governor.*
Psychosocial Assistance Network (PAN)	*The psychosocial assistance network (PAN) is a group of collaborator responsible for the initial psychosocial reception of affected persons in an emergency situation in a city or municipality. This group is comprised of local collaborators, meaning that it is possible to organise short-term initial reception.*
Psychosocial Intervention Plan (PSIP)	*Component of the mono-disciplinary intervention plan of discipline 2 which activates and coordinates psychosocial assistance in collective emergency situations for all affected persons, both during the acute phase and when transferred to the later phase.*
Psychosocial manager (PSM)	*The psychosocial manager (PSM) ensures the operation and coordination of the PSIP and falls under the administrative authority of the Health Inspector for this mission.*
Rapidly Deployable Resources (RDR)	*Set of the resources (staff and vehicles) of D2 which in the event of an emergency, can be brought to the site by a partner.*
Reception centre (RC)	*A centre where the initial psychosocial reception is provided to affected persons. If necessary, measures are taken for a long-term stay. The location and organisation of the RC are determined in the municipal emergency plan (in accordance with the PSIP).*
Regulation Coordinator (COORD REG)	*The person responsible for regulation on-site in a collective emergency situation, in accordance with the rules of the medical intervention plan.*
Responsible person psychosocial assistance (R-PSA)	*The R-PSA is responsible for the local PSA staff and acts as the direct link between the municipality and the PSIP. If the PSIP is activated, this function becomes a component of D2 whereby assignments are carried out under the responsibility of the DIR-MED, the HI (or the adjunct) and the PSM, and in terms of subordinates, the responsibility of the structures.*
Stabilising	*Set of medical treatments used to optimise the condition of the patient, so that their chances of adequate treatment are increased.*
Triage	*A medical and clinical assessment, carried out at the entrance to the Advanced Medical Post, whereby victims are split up according to the severity and urgency of their injuries.*
Triage card	*A standard registration method for personal and medical data which remain with the victim throughout the entire medical care chain, from the site of the incident right up to the hospital.*
Triage doctor (MED TRI)	*MEG doctor who carries out triage*
Uninjured	*Any person present at a collective emergency situation who does not appear to have any physical injuries.*
Victim	*Any person present at a collective emergency situation who appears to have physical injuries.*

This page has been intentionally left blank to maintain compliance with the other language versions.

Medical Intervention Plan - MIP

1 Objective

The objective of the plan is to define the specific procedures for the medical management of a large-scale collective incident, in order to provide every victim with appropriate care.

The mono-disciplinary intervention plan for discipline 2 has the following objectives:

- to set up an assistance model which aims to optimise the available aid workers and resources,
- to apply the principles which are used for individual assistance to a vision of collective assistance, whereby the latter cannot itself be the sum of individual cases of assistance, but must involve a coordinated approach so that the efficient deployment of a large number of resources is achieved,
- to avoid as much as possible that the standard medical-sanitary infrastructure is overloaded by an (uncontrolled) influx of victims,
- to ensure that the continuation of day-to-day emergency medical assistance can be maintained, with or without temporary reorganisation,
- to bring the plans and actions of discipline 2 into alignment with the plans and actions of other disciplines to assist victims in collective emergency situations,
- to optimise the management of the medical assistance chain so as to assist victims in the best possible manner, with respect for medical confidentiality.

2 Operation and structure

The present plan outlines the organisation, operational development and the coordination.

The plan should be seen as a (conceptual) basis which can be adapted to the circumstances, in accordance with the needs, demands and available resources. The adaptations are made following consultation between the coordinating responsible persons and can occur at the level of staff and/or resources and/or logistics deployment. It may therefore be the case that some structures are fully developed, only partially developed, or not developed at all.

2.1 Alerting

Alerting describes the staff and resources which the operator of the HC 112/100 or the medical dispatching needs to inform when the various levels of the MIP are initiated. The operator will alert the resources to be deployed in accordance with procedures and principles which have been determined in advance.

Who is authorised to alert

The first assistance teams to arrive at the scene (members of D1, D2, D3) are authorised to request that the MIP is declared.

The following actors are authorised to declare an MIP:

- Dir-Med or the adjunct,
- the first MEG to arrive at the scene which (temporarily) takes over the DIR-MED function,
- HI or the adjunct,
- the department head for emergency assistance (FPS HFCSE), or his or her adjunct,
- at the request of the Coordination and Crisis Centre of the Government (CGCCR) or of the on-duty doctor of the Public Health Emergency service of the FPS HFCSE via the HI or the department head for emergency assistance or their respective adjunct.

The territorially competent HC 112/100 or the medical dispatching will formally declare the MIP.

Levels of alerting

PRE-ALERT

The pre-alert is raised in situations which could be potentially dangerous for public health and/or the living environment.

The 'Pre-alert' level is designed to inform the *coordinating responsible persons*, in other words the federal health inspector and the adjunct, the on-duty Dir-Med and adjunct, and the Psychosocial Manager (PSM). The coordinating responsible persons may go to the scene if they wish.

They will be requested to make an assessment of the situation, and to ensure the follow-up. To this end, they can request to place the rapidly deployable resources (RDR) on pre-alert.

Within the pre-alert, notification will also be provided to these actors, who need to be alerted to mobilise themselves.

The alerting is the communication of the relevant details from the HC 112/100, or the medical dispatching to the coordinating responsible persons (and any additional actors at their request). This will at least involve the communication of the details by telephone, and may be supplemented by a text message (by paging, tetraradio, mobile phone, etc.).

ALERT

The alert acts as the standard response to a situation in which an effective and efficient deployment of the medical resources is required. It includes the notifying of the *coordinating responsible persons* but also the immediate *mobilisation of the operational services*.

***Please note**: there is no automatic declaration of the MIP during the initiation of a (municipal, provincial or federal) phase in the emergency and intervention planning.*

The alerting of the coordinating responsible persons, the actors and the operational services takes place via a telephone call whereby HC 112/100, or the medical dispatching, communicates the necessary details. The telephone call can be supplemented by a text message (via paging, tetraradio, mobile phone, etc.).

The MIP can be automatically declared if at least one of the following quantitative criteria is fulfilled when the questioning is carried out during the call:

- 5 seriously injured people,
- 10 injured people for which the nature/severity of the injuries is unknown,
- more than 20 people potentially in danger, whether or not following an evacuation which was not due to law enforcement.

The MIP can be declared according to qualitative criteria whereby account is taken of the pathology of the victim(s), or of unique and specific situations (for example terror and/or NRBC incidents). The declaration based on qualitative criteria only takes place after consultation between the operator of the HC 112/100, or the medical dispatching, and one of the coordinating responsible persons.

In the event of an MIP alarm and initiation, the following resources will be alerted at the least by the HC 112/100, or the medical dispatching:

- the federal health inspector and the adjunct,
- Dir-Med and the adjunct(s),
- the PSM,
- 3 MEG teams,
- 5 ambulances (EMA),
- Rapidly Deployable Resources (RDR).

In the event of an evacuation, the rapidly deployable resources (RDR) are only alerted following consultation with one of the coordinating responsible persons.

2.2 Scaling-up and reinforcement

Scaling-up entails increasing the number of deployed resources, and reinforcing staff, material and/or logistical resources for the assistance chain of discipline 2.

Scaling-up occurs:

- via the HC 112/100 or the medical dispatching on the basis of the received information,
- at the request of the first MEG doctor to arrive at the scene (temporary DIR-MED),
- on the instructions of the DIR-MED or the adjunct,
- on the instructions of the HI or the adjunct,
- on the instructions of the department head for emergency assistance (FPS HFCSE), or the adjunct,
- at the request of the Coordination and Crisis Centre of the Government (CGCCR) or of the on-duty doctor of the Public Health Emergency service (FPS HFCSE) via the HI or the department head for emergency assistance or their respective adjunct.

The 'EXTENDED MIP'

The 'EXTENDED MIP' can be automatically declared if at least one of the following quantitative criteria is fulfilled when the questioning is carried out during the call:

- 20 seriously injured people,
- 40 injured people for which the nature/severity of the injuries is unknown,

In the event of an 'EXTENDED MIP' alarm, the following resources will be alerted at the least by the HC 112/100, or the medical dispatching:

- the federal health inspector and the adjunct,
- Dir-Med and the adjunct(s),
- the PSM,
- 10 MEG teams,
- 20 ambulances (EMA) & Red Cross,
- Rapidly Deployable Resources (RDR).

If the resources which fall under the authority of the assistance centre or the medical dispatching are insufficient to cover the deployment of an 'EXTENDED MIP', bearing in mind that the standard emergency medical care service provision must remain guaranteed, then back-up will be requested from resources of neighbouring provinces.

The HC 112/100 or the medical dispatching of the affected province contacts the HC 112/100 or the medical dispatching of the neighbouring province and requests additional resources in the context of an 'EXTENDED MIP'. The HC 112/100 or the medical dispatching of the neighbouring province will immediately communicate which resources it can send, and in what quantities.

The HC 112/100 or medical dispatching from provinces who will provide support must also take into account that they must continue to guarantee minimum service provision in the context of emergency medical assistance.

The 'MAXI MIP'

The 'MAXI MIP' can be automatically declared if at least one of the following quantitative criteria is fulfilled when the questioning is carried out during the call:

- 50 seriously injured people,
- 100 injured people for which the nature/severity of the injuries is unknown.

On initiation of a 'MAXI MIP', the following resources will be alerted at the least by the HC 112/100, or the medical dispatching:

- the federal health inspector and the adjunct,
- Dir-Med and the adjunct(s),
- all PSMs,
- 20 MEG teams,
- 40 ambulances (EMA) & Red Cross,
- Rapidly Deployable Resources (RDR).

If the resources which fall under the authority of the assistance centre or the medical dispatching are insufficient to cover the deployment of a 'MAXI MIP', bearing in mind that the standard emergency medical care service provision must remain guaranteed, then back-up will be requested from resources of neighbouring provinces.

The HC 112/100 or the medical dispatching of the affected province contacts the HC 112/100 or the medical dispatching of the neighbouring province and requests additional resources in the context of a 'MAXI MIP'. The HC 112/100 or the medical dispatching of the neighbouring province will immediately communicate which resources it can send, and in what quantities.

The HC 112/100 or medical dispatching from provinces who will provide support must also take into account that they must continue to guarantee minimum service provision in the context of emergency medical assistance.

Inter-provincial support

When a MIP is scaled up, the affected province can call on the resources of neighbouring provinces. This request occurs as follows:

- the HC 112/100 or the medical dispatching of the affected province requests the HC 112/100 or the medical dispatching of the supporting province,
- the resources from a supporting province will assemble at a pre-determined assembly point within their own province,
- the HC 112/100 or the medical dispatching from the supporting province will indicate a 'leader of the convoy' who is responsible for:
    - the contact between the HC 112/100 or the medical dispatching and the convoy,
    - keeping the convoy together,
    - travelling to the FDP of the affected province,
    - notifying the DIR-MED of the resources in the convoy,
- as soon as the convoy is formed, the HC 112/100 or the medical dispatching of the supporting province will contact the HC 112/100 or the medical dispatching of the affected province, in order to:
    - inform that the convoy is ready for deployment,
    - enquire about the FDP for the convoy,
    - notify the deployment of the convoy,
- once arrived at the FDP and the notification has been given by the leader of the convoy to the DIR-MED, all resources deploy to the indicated discussion group (the resources are therefore individually deployable on behalf of the assistance).

2.3 Takeover (relieving of staff)

During the development of a MIP, when it appears likely that it might last a fair number of hours, various elements need to be taken into account:

- opportunities for rest (areas and time) for staff and the resources deployed,
- sanitary provisions for the staff and victims,
- food/drink for the staff of the deployed resources.

If the duration of the development of the MIP takes more than 8 hours, regular relieving of staff from the deployed resources needs to be organised, as well as the framework of the MIP (HI, DIR-MED, adjuncts, etc.)

It is the task of the coordinating responsible persons to bear this in mind and take responsibility for the smooth relieving of staff and the necessary provisions.

2.4 Scaling-down and conclusion

Scaling-down involves reducing the number of deployed resources, and therefore reducing the number of staff, material and/or logistical resources for the care chain of discipline 2.

Scaling-down takes place, after consultation, at the request of:

- the DIR-MED and the adjunct(s),
- the HI or the adjunct
- the department head for emergency assistance (FPS HFCSE), or the adjunct.

The conclusion of the MIP will be formally communicated to the parties involved by the HC 112/100 or the medical dispatching, at the request of the coordinating responsible persons.

After every MIP, the representatives of the activated services must send a report to the competent Health Inspector as quickly as possible and at the latest 1 month after the incident, containing the following details:

- the resources deployed,
- the actions taken,
- the timing,
- the number of victims tended,
- the destination of the victims.

The responsible persons of the activated services are responsible for re-organising the deployed resources as quickly as possible, with the aim of ensuring that they are available again in the EMA system within a short deadline.

2.5 Follow-up

In the aftermath of a MIP, it must not be forgotten that staff need (psychosocial) monitoring, either at the time or afterwards. In the first instance, the responsible person within the service is responsible for the initial reception and follow-up of his or her staff after an intervention. Additionally, within the context of the PSIP, support and assistance can be arranged, for example by organising a psychological debriefing with other actors who were active within the MIP, or a discussion with an expert.

2.6 Summary overview

In the table below, an overview is provided of the criteria and deployment for the various levels with the 'alert'.

level	***quantitative start-up criteria***	***alerting/deployment***
MIP	• 5 seriously injured people, • 10 injured people for which the nature/severity of the injuries is unknown, • more than 20 people potentially in danger, whether or not following an evacuation which was not due to law enforcement.	• HI and the adjunct, • Dir-Med and the adjunct(s), • PSM, • 3 MEG teams, • 5 ambulances (EMA), • Rapidly Deployable Resources (RDR).
EXTENDED MIP	• 20 seriously injured people, • 40 injured people for which the nature/severity of the injuries is unknown.	• HI and the adjunct, • Dir-Med and the adjunct(s), • PSM, • 10 MEG teams, • 20 ambulances (EMA) & Red Cross, • Rapidly Deployable Resources (RDR).
MAXI MIP	• 50 seriously injured people, • 100 injured people for which the nature/severity of the injuries is unknown.	• HI and the adjunct, • Dir-Med and the adjunct(s), • all PSMs, • 20 MEG teams, • 40 ambulances (EMA) & Red Cross, • Rapidly Deployable Resources (RDR).

For the 'EXTENDED MIP' and the 'MAXI MIP', inter-provincial support can be requested so that the standard provincial EMA operations are not compromised.

The inter-provincial resources are sent via a first destination point (FDP), and are subsequently divided up across the disaster site(s).

Account should be taken of the fact that the intervening resources must be relieved if the duration of the deployment exceeds 8 hours.

The scaling-down and termination of a MIP occurs on the instructions of the DIR-MED, HI, the department head for emergency assistance (FPS HFCSE) or one of the respective adjuncts.

3 Coordination

3.1 Operational coordination

The operational command post (CP-Ops), which remains in the vicinity of the intervention site and in a safe location, ensures the operational coordination. The CP-Ops is also responsible for policy coordination pending the opening of the Coordination Committee, which carries out policy coordination.

The DIR-MED is in charge of the medical discipline (D2) and actively participates in the activities of CP-Ops. For the implementation of his assignments, the DIR-MED can be supported by one or more adjunct DIR-MEDs, by the responsible PAN, and by the representative from the Red Cross.

If an MIP is deployed simultaneously at different sites, a DIR-MED can be appointed for each site. If one single CP-Ops is activated for all sites, the Dir-Med in the CP-Ops can rely on the active contribution of the various DIR-MEDs relating to the activities in their respective sites. If multiple CP-Ops are activated, each DIR-MED actively participates in the CP-Ops of its own site.

The HC 112/100 or the medical dispatching is responsible for alerting the deployed resources, but also for ensuring communication between the different deployed resources. Additionally, the HC 112/100 or the medical dispatching also have the task of alerting the hospital departments involved, so that they can make the necessary internal arrangements to be able to handle the influx of victims.

In order to fully carry out its role as coordinator of the resource deployment, and ensure a clear flow of information, an operator from the HC 112/100 or the medical dispatching can be made available to the CP-Ops. He is under the leadership of the DIR-MED and is responsible for seamless communication and information exchange between the CP-Ops, DIR-MED and the HC 112/100 or the medical dispatching.

If required, the responsible coordinator can request the HC 112/100 or the medical dispatching to support the regulation assignment of the regulation coordinator (COORD REG), or even to completely take over.

Moreover, the HC 112/100 or the medical dispatching remains responsible at all times for the day-to-day operation of the emergency medical assistance. The HC 112/100 or the medical dispatching will ensure that emergency medical assistance remains guaranteed for every citizen.

3.2 Strategic coordination

The competent authority (at the federal level, the Minister; at the provincial level, the governor; and at the municipal level, the mayor) is responsible for the strategic coordination, to support the operational actions on the ground.

The HI (or the adjunct) actively participates in the activities of the Committee, and can be supported in the execution of his or her assignment by his or her adjunct and the PSM.

In order to carry out the strategic coordination in an effective manner, the development of a 'D2 work cell' can be implemented, especially for large scale incidents. This work cell is intended to function as a back office for the Coordination Committee (CC) for the tasks where discipline 2 is responsible and competent. In the D2 work cell, (experienced) representatives from the medical and psycho-social actors are involved, so that there is assurance that the coordinating tasks are devised appropriately with and based on the most recent and available information.

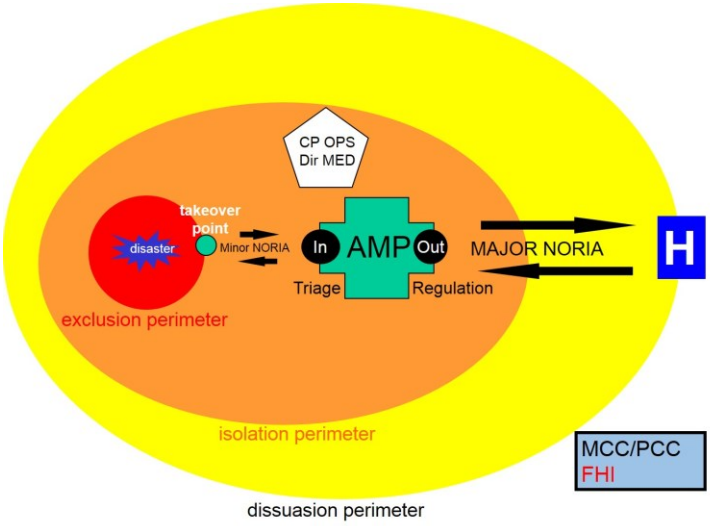
4 Organisation of the disaster site

4.1 Zoning

The organisation of the intervention site is based on the concept of 'zoning' and contains 3 zones:

- red zone,
- orange zone,
- yellow zone.

The resources of discipline 2 are rolled out in the orange zone.



Red zone

The red zone is demarcated by the exclusion perimeter.

The rescue and freeing tasks are carried out by members of the 'assistance operations' discipline (D1), unless there are specific risks for which another discipline is more appropriate to be active within the red zone (e.g. there is an active gunman). They move the victims outside this red zone, in other words outside the exclusion perimeter. They are then assembled at the takeover point, where they are transferred to discipline 2 in a safe environment.

The presence of discipline 2 in the red zone is only possible with the agreement of the DIR-CP-Ops after consultation with directors from the respective disciplines D1, D2 and D3.

This exceptional presence may be intended to stabilise one or more people with potentially life-threatening injuries and/or to carry out a pre-triage if this cannot be performed at the takeover point.

Orange zone

The orange zone is demarcated by the isolation perimeter.

This zone includes the necessary space to enable the emergency services to carry out their work. The CP-Ops and the AMP are also situated in this zone where victims are assembled, stabilised, conditioned and evacuated. At the takeover point, the orange zone adjoins the red zone.

Yellow zone

The yellow zone is demarcated by the dissuasion perimeter.

This zone must be kept clear to ensure that the emergency services have access to the affected zone at all times.

4.2 Tasks discipline 2

Article 11§1 of the RD of 16 February 2006 on emergency and intervention plans specifies the minimum tasks for discipline 2 as follows:

- setting up the medical chain,
- providing medical and psycho-social care to victims and other persons affected by the emergency situation,
- carrying out the transportation of victims,
- taking all measures to protect public health.

Additionally, discipline 2 also has the following responsibilities:

1. assessing the overall medical-sanitary situation,
2. assessing the measures taken and adjusting them where necessary.
3. keeping HC 112/100 continually informed via situational reports (SITREP).

Every affected person, both injured and uninjured, must pass through the care chain in order to undergo triage and identification. If necessary, each person will receive the necessary care for medical stabilisation and conditioning. Subsequently, each person will be regulated and evacuated in the most efficient manner to the most appropriate reception centre for his or her condition.

The specific and detailed tasks of all actors within discipline 2 must be included in action cards which are an integral part of the mono-disciplinary emergency plan of discipline 2.

4.3 Medical chain

Takeover point

A theoretical point at the boundary between the red zone and the orange zone (exclusion perimeter) where the transfer takes place of victims to the staff from D2.

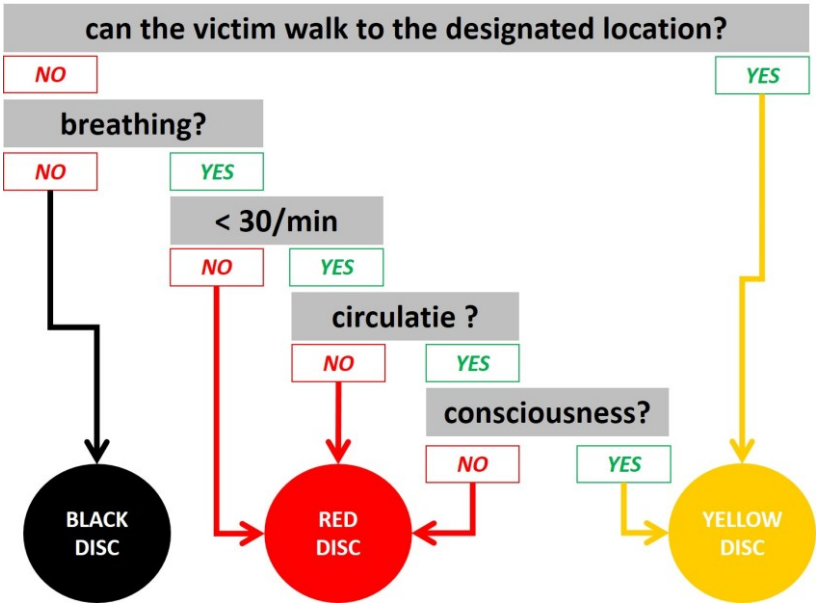
This point is not always specified, in particular when there is no red zone.

Pre-triage

The pre-triage (PRE-TRI) is an initial rapid medical assessment of the condition of the victims, with the aim of ascertaining the priority for transfer to the next link in the medical chain. During pre-triage, no medical treatment is administered, except for the freeing of airways and life-saving treatments (staunching bleeding wounds, etc.).

Victims are provided with a red or yellow disc which indicates their priority for being evacuated from the disaster site to the next link in the medical chain. Victims with a red pre-triage disc have priority over victims with a yellow disc.

The amended START principle is used for carrying out the pre-triage on victims of physical trauma, as illustrated below.



In principle, fatal victims cannot be evacuated from the disaster site. The doctor must confirm the death of a person at the scene, before the body of the deceased is placed under the responsibility of discipline 3.

Minor noria

The minor noria includes the transfer from the takeover point, or if there is no red zone, from the intervention site, to the triage point (TRI) of the advanced medical post (AMP).

Depending on the distance to be travelled and the condition of the site, this transport can be organised in various ways (on foot with a stretcher, by ambulance, etc.)

The medicalisation of the victims during transportation from PRE-TRI to TRI only takes place with the consent of the DIR-MED, with the resources which are made available for this purpose.
In certain cases and provided the DIR-MED agrees, an immediate and direct evacuation can take place from the location of the preliminary triage to an adequate care facility (e.g. victims with injuries which require urgent surgery).

Advanced Medical Post

The following tasks are carried out in the AMP:

- registration of the victims,
- triage,
- stabilisation and conditioning,
- further referral in the medical chain depending on the reception and treatment availability (hospital or reception centre).

The AMP concept is set up in the orange zone, in a safe area (taking into account the wind direction and an assessment of the evolutive risk, in consultation with the CP-Ops) and in proximity to an access route which allows the transit and parking of ambulances.

The AMP can be set up in various areas/ways:

- in an existing building,
- in one or more tents,
- in an open area.

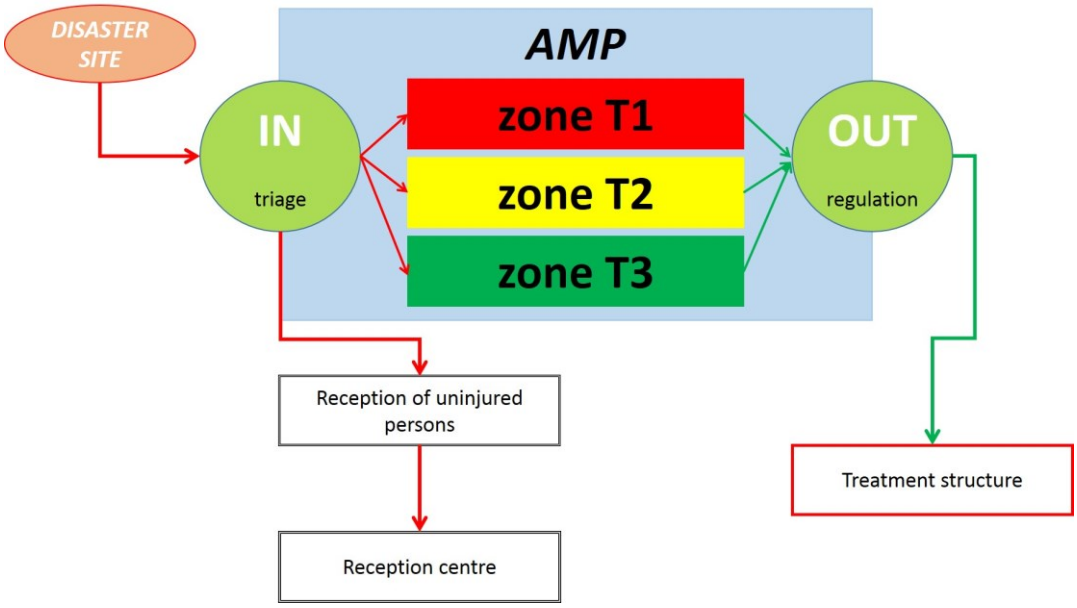
The COORD-VMP is in charge of the AMP. He or she assures the functioning of the entire unit, with the exception of medical assessments and treatments. Support is provided by the logistics coordinator (COORD-LOG) concerning the logistical-technical aspects and the provisioning of the AMP.

The organisation and arrangement of an AMP includes:

- A triage zone with an "IN" secretariat, which has the following tasks:
  - the triage of victims in categories T1, T2 and T3:
    - T1: immediate medical treatment required:
      a life-threatening situation and/or risk of losing a limb (e.g. a hand) or an organ (e.g. an eye). Urgent transfer to a hospital is indicated.
      This corresponds to a hare on the METTAG™
    - T2: no life-threatening situation but the situation requires medical care. Transportation to the hospital can only be delayed by a few hours at the most.
      This corresponds to a tortoise on the METTAG™
    - T3: medical treatment can be delayed or is not absolutely necessary (contusions, minor or slight injuries, emotional shock, etc.). Transportation by ambulance is not necessary, but acknowledgement and identification is required.
  - triage is carried out by a doctor (MED TRI), supported by a nurse (ADJ TRI),
  - registration of the victims who enter the AMP:
    - every affected person receives a registration sheet,
    - the METTAG™ is currently used for this purpose,
    - the sheet also makes it possible to ensure a minimum of medical information and monitoring, which can also serve as a basis for the transfer,
    - a general list of affected persons (whether injured or not) is retained.

- A care zone for:
  - the medical stabilisation of victims,
  - conditioning or preparing the patient for transport, depending on the transportation to the most appropriate structure,
  - medical supervision of patients pending transportation,
  - the medical assessment and treatment is coordinated under the leadership of a MEG doctor or MEG nurse.

- The regulation zone with an "OUT" secretariat, which has the following tasks:
  - regulation and evacuation,
  - directing the victims to the appropriate services,
  - choosing the means of transportation and taking a decision on any medicalisation,
  - registering the patients who leave the AMP,
  - regulation is carried out by the COORD REG, supported by an ADJ COORD REG



Major noria

The major noria includes the discharge of affected persons from the AMP to the reception structures identified by the regulation. This means that victims will be transferred to appropriate treatment structures, while uninjured persons will be transferred to a reception centre, as described in the psychosocial intervention plan (PSIP).

Ambulance fleet

To ensure that the ambulances or other vehicles do not obstruct the efficient flow of discharges, they are summoned from an assembly point. This assembly point, where medical resources are stationed in an orderly manner, is referred to as the ambulance fleet.

The positioning of the ambulance fleet is determined after multi-disciplinary consultation within the CP-Ops and is situated in the yellow zone, in the vicinity of the AMP. A free area (e.g. a football field) can be used as a heliport.

The management of the ambulance fleet is assigned to the ambulance fleet coordinator (COORD AMBU). At the request of the (ADJ) COORD REG and after the consent of the CP-Ops, the COORD AMBU will dispatch the necessary resources to the scene.

First destination point/rendezvous point

The location of the first destination point (FDP), also referred to as the rendezvous point, is designated after multi-disciplinary consultation (consultation with all other emergency services or CP-Ops). the FDP is in the yellow zone, at a reasonable distance away from the emergency situation, and upwind from it. This FDP is preferentially managed by the police or fire brigade.

The FDP must be sufficiently large to receive the resources of all disciplines (including trucks from D1 and D4). A large existing parking area or large street is usually used for this purpose.

The ambulance fleet can be a component of the FDP.

Reception structures

In principle, the reception structures are situated outside the previously-mentioned intervention zones.

These possible services are:

- hospital departments used for the reception and possible uptake of victims.

  The potential activation of the hospital emergency plan should take place in accordance with the applicable criteria as specified in the RD of 23/10/1964 establishing the standards which must be met by hospitals and their departments (Art. N1, Annex A, III, 14° amended via the RD of 17/10/1991). The number of patients which the hospital can receive in this context must be set out in this action plan, and validated by the CEMA.

  The hospital informs the HC 112/100 of the activation of its plan and communicates the reception and treatment capacity according to the identified care needs of the victims. This information is communicated by the (ADJ) DIR-MED to the HC 112/100.

  Using regulation, patients are spread across the various hospitals, depending on the available places, so as to avoid the hospitals becoming overloaded.

- reception structures for sheltering the affected persons, as anticipated in the PSIP.

5 Staff and resources

5.1 Coordinating functions

Federal health inspector (HI)

The doctor, official of the FPS Health, Food Chain Safety and Environment, and member of the municipal or provincial Coordination Committee who acts as the representative of discipline 2. The HI takes the administrative measures on behalf of the Minister for Public Health, and liaison officer for the federal departmental crisis unit of the FPS HFCSE.

Adjunct federal health inspector (ADJ HI)

The adjunct federal health inspector assists in the implementation of the functions of the federal health inspector. Depending on the circumstances, the ADJ HI will sit in the CC, support the DIR-MED at the emergency site, or be part of the work cell D2.

Psychosocial manager (PSM)

The Psychosocial Manager is a federal official who coordinates the psychosocial assistance within discipline 2, and supervises the operation of the psychosocial plan (in accordance with the PSIP). The actions of the PSM and the relationship with the MIP are comprehensively detailed within the PSIP. The PSM reports the psychosocial operation to the HI.

Director medical care (DIR-MED)

The doctor who has operational leadership over the medical, sanitary and psycho-social care on-site, used for the medical assistance chain at the disaster site, regardless of the service from where the care originates. The DIR-MED works under the administrative authority of the (adjunct) federal health inspector.

The task of DIR-MED is carried out by the MEG doctor from the 1st MEG to arrive at the scene, until the moment that the Dir-Med arrives, or a more experienced MEG doctor takes over.

Adjunct DIR-MED (ADJ DIR-MED)

The ADJ DIR-MED assists in the implementation of DIR-MED functions. The DIR-MED and/or the ADJ DIR-MED sits as representative of discipline 2 in the CP-Ops.

5.2 Additional functions

The functions described below are carried out depending on the scale of the disaster or incident, the needs on-site and staff availability.

Triage doctor (MED TRI) and his or her adjunct (ADJ TRI)

This function is preferably taken over by the emergency doctor from the first MEG, if the MEG should not (temporarily) take over the DIR-MED function. The MED TRI must examine all patients, and perform a triage of the victims. The MED TRI reports to the (ADJ) DIR-MED and communicates the relevant information to the staff in the AMP via the COORD VMP.

The ADJ TRI is the MEG nurse who supports the MED TRI in the carrying out of his or her function.

Advanced Medical Post Coordinator (COORD AMP)

The person who assures the functioning of the entire AMP, with the exception of medical assessments and treatments. He or she ensures:

- an appropriate allocation of tasks within the AMP,
- the setting up of the various triage zones in the AMP,
- the efficient carrying out of the stabilisation and conditioning of the victims by other staff (doctors, nurses, care workers-ambulance officers, RDR staff, etc.),
- the follow-up of the tasks of the DIR-MED,
- supervision of the smooth running of the activities.

He reports to the (ADJ) DIR-MED and coordinates with the (ADJ) COORD REG.

Regulation coordinator (COORD REG) and his adjunct (ADJ COORD REG)

The person responsible for the regulation of the victims to the treatment structures. He will determine, based on the condition of the victim and the available treatment capacity, which is the most appropriate treatment structure destination. He will instruct the ambulance fleet coordinator to obtain adequate transport, and coordinates with the HC 112/100 (possibly via the staff member at the scene) concerning departure and the transport destination.

The (ADJ) COORD REG reports to the (ADJ) DIR-MED.

The choice of the COORD REG (doctor or nurse) and whether to deploy an ADJ COORD REG or not depends on the scale of the disaster, the specificity of the pathology provided in the AMP, the medical stabilisation possibilities and staff availability.

Secretariat Coordinator (COORD SECR)

The person who organises the administrative tasks at the disaster site in general, and specifically in the AMP. This is usually a member of the rapidly deployable resources (RDR) of the Red Cross. He or she will be responsible for the administrative registration of victims, as well as other affected persons, and the destination of these persons, etc.

These details are only made available to third parties on the instructions of the responsible official of the FPS HFCSE.

Logistics coordinator (COORD LOG)

The person, usually a member of the RDR, who works on behalf of the COORD AMP and under the leadership of the (ADJ) DIR-MED. The COORD LOG is responsible for the supply, organisation and optimal use of the logistical resources which are necessary for the total medical assistance chain.

The COORD LOG is responsible both for medical resources (bandages, medication, oxygen) and the technical logistical resources (stretchers, tents, lighting, heating, catering).

The vehicle fleet of the medical sanitary assistance chain does not fall under the responsibility of the COORD LOG, but under that of the COORD AMB.

Where necessary, he will consult and coordinate with the responsible person for technical logistical resources from discipline 4.

Ambulance fleet coordinator (COORD AMB)

The person who manages the vehicle fleet which is available to the medical sanitary assistance chain. He is under the authority of the (ADJ) DIR-MED but is directly instructed by the (ADJ) COORD REG.

He ensures the smooth operational and technical execution of the discharge of patients, in accordance with the instructions (destination and means of conditioning for transport) of the (ADJ) COORD REG.

Liaison coordinator HC 112/100 or medical dispatching (COORD MED DISP)

Whenever a staff member from the HC 112/100 or the medical dispatching is required on-site, the liaison coordinator will be added to the operational staff of the CP-Ops, with the consent of the DIR-CP Ops. He is responsible for seamless communication and information exchange between the CP-Ops, the (ADJ) DIR-MED and the HC 112/100 or the medical dispatching (coordination of ASTRID discussion groups, active group allocation, keeping a log book).

Staff (STAFF)

Given the multitude of functions, the administrative technical framework for the (ADJ) DIR-MED and the need for the HI and/or the adjunct to continually provide the required and correct information, extra staff can be provided. Staff members can receive tasks such as:

- maintaining the list of victims,
- keeping the list of discharged persons updated,
- managing the list of staff occupation and material deployment
- …

Federal Coordination (FEDERAL COORDINATION)

Staff of the Emergency Assistance Service of the FPS HFCSE. He is responsible for the coordination of the deployment of the medical discipline in situations of a multi-provincial/federal activation of resources. He can also be requested to be present at major provincial events to support the provincial coordinating functions.

5.3 Intervening resources

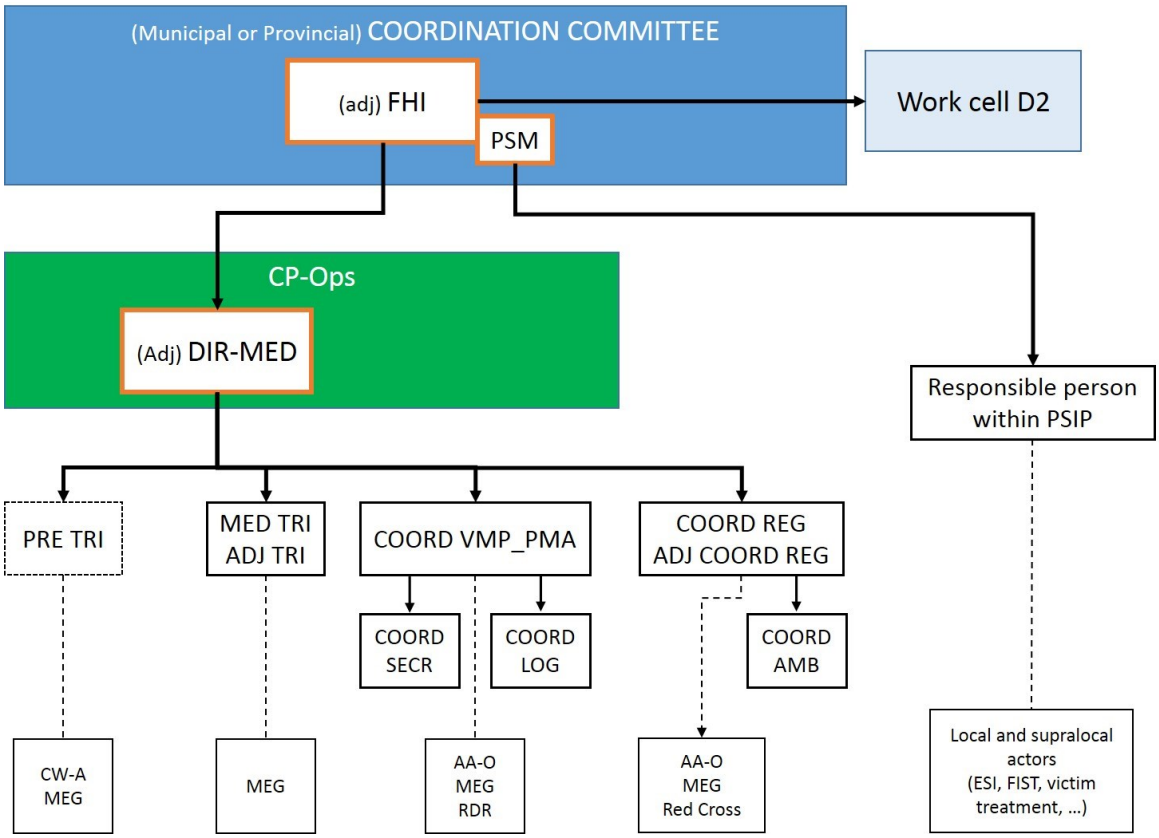
Staff and resources which are deployed in the first instance (not necessarily limited to their own province):

- MEG teams,
- aid-ambulance officers,
- PIT teams,
- the RDR,
- the Red Cross.

This staff acts in accordance with his or her action card.

Everyone (doctors, nurses, ambulance officers and others) who are available to go to the disaster site, either on request, or spontaneously, can be deployed following the approval of the (ADJ) HI or (ADJ) DIR-MED. All of these persons must act in accordance with the action card which they receive from the (ADJ) DIR-MED.

5.4 Organisational chart and deployment of staff and resources



5.5 Communication chart

The purpose of a communication chart is to ensure that everyone knows immediately via which channel another function can be reached (regardless of the location of the incident). The aim is to limit the number of different discussion groups as a whole, but also to limit the number of discussion groups to be followed by a given function.

The coordinators and the responsible functions of the medical deployment can reach each other via the discussion group xxx DIRMED (the red arrows in the chart), whereby xxx is the indication of the province:

- ANT Antwerp
- BRU Brussels
- BRW Walloon Brabant
- HAI Hainaut
- LIE Liege
- LIM Limburg
- LUX Luxemburg
- NAM Namur
- OVL East Flanders
- VBR Flemish Brabant
- WVL West Flanders

The functions and resources which are deployed in the major noria communicate among themselves via the discussion group xxx RAMP yy (purple arrows in the chart). In the event that there are multiple sites whereby the major norias do not overlap, a separate discussion group (per site) can be used.

The contact between the HC 112/100 and the treatment structures takes place via telephone or via the routine discussion group xxx Zy 01, whereby 'y' is a serial number (blue arrow in the chart).

The discussion group xxx PSY (brown arrow in the chart) is used by the psycho-social manager (PSM) for the coordination of the 'Psychosocial Intervention Plan' (PSIP) section. Depending on the development of the PSIP, the representatives of the staff within the PSIP will take part in this discussion group. The staff within the psychosocial network communicate via their own radio and/or telephone network (pink arrow in the chart).

The communication between the logistical functions and staff takes place via the discussion group M xxx LOGyy, whereby the competent HC 112/100 will determine the serial number yy (black arrow in the chart).

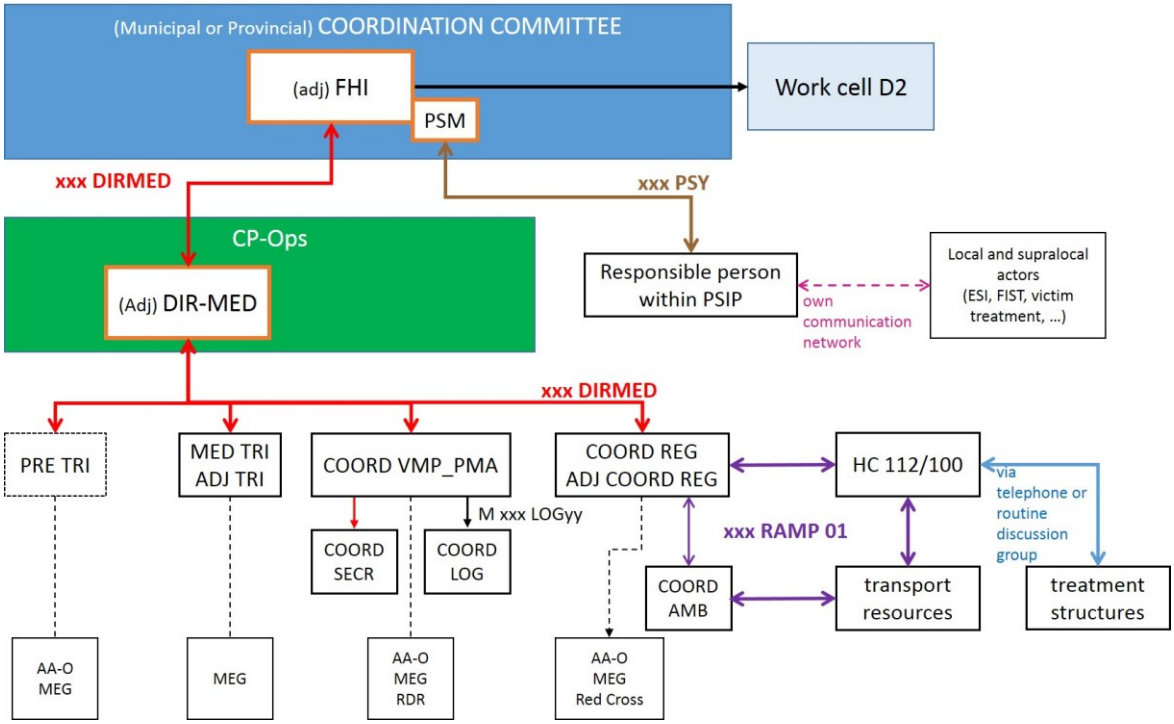
If necessary, the (ADJ) DIR-MED can make radio contact with the other members of the CP-Ops via the discussion group M XXX CPOPSyy.

If necessary, the (ADJ) HI can make radio contact with the other members of the municipal or provincial Coordination Committee (MCC or PCC) via the discussion group M xxx CCyy.

The communication between the (ADJ) HI and the work cell D2 takes place via telephone and/or orally

Summarised

Discussion group	***Users***
xxx DIRMED	(ADJ) HI, (ADJ) DIR-MED, MED TRI, ADJ TRI, COORD VMP_PMA, COORD SECR, (ADJ) COORD REG
xxx RAMP yy	(ADJ) COORD REG, COORD AMB, HC 112/100, transportation resources major noria
M xxx LOGyy	COORD VMP_PMA, COORD LOG
xxx PSY	PSM, R-PSA, coordinators of PSIP structures
M xxx CCyy	*optional – (ADJ) HI with other members of MCC/PCC*
M xxx CPOPSyy	*optional – (ADJ) DIR-MED with other members of CP-Ops*



5.6 Functional recognisability

The persons who exercise a specific function in the (medical) assistance chain are recognisable by their yellow vests, which indicate their function in a fluorescent rectangle surrounded by a double row of alternate reflective grey and green squares. A wide reflective grey strip runs vertically across the shoulders, except for the HI and DIR-MED whose shoulder strip is green (respectively policy-related and operational manager).

6 Conclusion of the MIP

Before the actual conclusion of the medical intervention plan, the (ADJ) HI and the (ADJ) DIR-MED need to ascertain what the current requirements for resources and staff are. If possible, the deployment will be scaled down.

The conclusion of the MIP will be communicated from the competent HC 112/100 to staff in the context of the medical intervention plan, at the request of the (ADJ) HI or the (ADJ) DIR-MED.

Please note, the MIP and the PSIP can be terminated simultaneously, but they can also be terminated separately.

Following every deployment as part of a medical intervention plan, regardless of the duration, location, or scale, etc., the responsible persons from the activated services will send a report to the competent federal health inspector, containing at the least an indication of the resources deployed by the service, the actions taken, the timing of the actions taken, the number of victims treated/discharged by the service, and the destination of the discharged victims.

Other relevant information may also be included in the report which is submitted to the federal health inspector.

The report should be sent to the federal health inspector at the latest 1 month after the conclusion of the medical intervention plan.

7 Link with the PSIP

Psychosocial care workers who arrive at the disaster site register with the (ADJ) DIR-MED. This person can give the necessary instructions, in consultation with the PSM or (ADJ) HI. As such, via the (ADJ) DIR-MED and/or the R-PSA, psychosocial care workers can provide support during the assembling, reception and transportation of uninjured persons to the reception centre.

The actions which are carried out (in the acute phase) on behalf of the psychosocial care workers to affected persons are comprehensively described in the PSIP. In addition to assembling and transporting uninjured persons away from the disaster site, these workers are also responsible for:

- the reception of uninjured persons and/or their relatives in the reception centre,
- the (definitive) registration of all persons who were directly involved in the disaster,
- the operation of the telephone information centre for concerned relatives,
- the operation of the central information point for processing details.

Whenever medical support is required in the reception centre, this is organised via the (ADJ) DIR-MED. Preferably, a GP will be provided in the reception centre (possibly requested via the Circles of General Practitioners).

In general, the PSIP remains active for longer than the duration of the MIP, in order to go over the actions, as comprehensively described in the PSIP. The operations are under the leadership of the PSM.

8 Action cards

The action cards describe all the actions to be taken, as well as the competence of the various staff for discipline 2. Everyone's place within the organisation chart is also specified, so that it is clear whose authority staff are under, whom they have authority over, and to whom they need to report.

The action cards are drawn up so that they correspond to the regulation outlined above, but also sufficiently cover the provincial particularities.

They are intended for the intervening parties or functions summarised below:

- the HC 112/100 or the medical dispatching,
- the federal health inspector (HI),
- the adjunct federal health inspector (ADJ HI),
- the psychosocial manager (PSM),
- the director of medical care (DIR-MED),
- the adjunct director of medical care (ADJ DIR-MED),
- the aid-ambulance officers,
- the first MEG at the scene,
- the triage doctor and nurse (MED TRI, ADJ TRI),
- the AMP coordinator (COORD VMP_PMA),
- the regulator doctor and/or nurse (COORD REG, ADJ COORD REG),
- the secretariat coordinator (COORD SECR)
- the logistics coordinator (COORD LOG)
- the vehicle fleet coordinator (COORD AMB),
- the GP(s) on duty,
- the rapidly deployable resources (RDR),
    - the medical rapid intervention team (RIT MED),
    - the logistics rapid intervention team (RIT LOG).

All the staff referred to above must have the complete MIP filled in with action cards per function.

These action cards must be approved by the provincially competent CEMA.

9 Training and exercise

The concepts, actions, cooperation, communication, etc., which are described above in the medical intervention plan can be applied in real situations if the various staff have a thorough (theoretical) knowledge and have practised the medical intervention plan sufficiently.

The setting up of pedagogically responsible, educational and well-organised exercises should also take place on a regular basis. The purpose of every exercise should at least be the training of the various staff within their own discipline. The exercise policy must also give sufficient attention to the collaboration between the various departments and the various disciplines.

Regular participation in exercises in which multi-disciplinary deployment is required, is encouraged. Frequent joint exercises are the first step towards successfully counteracting disaster incidents in a multi-disciplinary setting.

10 Legislation

Legislation	**Article**	
Law 8/7/1964	Art 1	Determination of the general deployment in EMA
RD 23/10/1964 amended by RD 17/10/1991	Art N1, Annex A, III, 14°	Establishing the standards which must be met by the hospitals and their departments, in particular action plans to cope with major accidents
RD 2/4/1965	Art 7, 3rd paragraph, 1°	Deployment of MEG in collective incidents
RD 10/08/1998	Art 4, 3°	Drafting and approval of MIP
RD 02/02/2007		Definition of the Dir-Med
RD 16/02/2006	Art 11	Definition and tasks of discipline 2
NPU-1 16/02/2016		Additional description of discipline 2 tasks (explanatory circular letter with the RD of 16/02/06)
NPU-2 30/03/2009		Ministerial circular letter concerning the general provincial emergency and intervention plan
NPU-4 30/03/2009		Ministerial circular letter concerning disciplines
MCL 27/06/2016		Ministerial circular letter PSIP

The legislation specified above is the basis legislation. Any amendments should always be taken into account, and the consolidated legislation should be assumed to ensure a complete picture of the current legislation in force.