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DEPARTMENT OF HEALTH

Medical Support & Preparedness at Mass Gatherings and Events Standard

● PUBLIC / عـــــــام

Document Title:	Medical Support & Preparedness at Mass Gatherings and Events Standard		
Document Ref. Number:	DOH/CEPAR/MSPMGE/ST/V1/2024	Version:	V1
New / Revised:	New		
Publication Date:	January, 2024		
Effective Date:	January, 2024		
Document Control:	DoH Strategy Sector		
Applies To:	- DoH licensed Healthcare Providers. - DoH authorized Health Payers. - All Health Insurance products and schemes, as applicable.		
Owner:	CEPAR Healthcare Facilities		
Revision Date:	January, 2025		
Revision Period:	One Year from publication date		
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1. Standard Scope

This Standard serves as a comprehensive approach for governance, planning and execution of medical coverage to mass gatherings and events within the Emirate of Abu Dhabi. This document is designed to ensure the highest level of patient care, crew & public safety, and operational efficiency in the field of emergency medical services (EMS). This standard applies to all mass gatherings in the Emirate of Abu Dhabi.

2. Definitions and Abbreviations

No.	Term / Abbreviation	Definition
2.1	ALS	Advanced Life Support
2.2	Abu Dhabi Civil Defence Authority (ADCDA)	• A government entity in the Emirate of Abu Dhabi that provides emergency services including (Rescue, Firefighting, Public Ambulance services and other supporting specialties such as search and rescue and CBRN). • ADCDA is responsible for operational EMS response in the Emirate of Abu Dhabi. ADCDA works with DOH to set Ambulance services licenses and operation requirements and standards.
2.3	NCEMA	National Emergency Crisis and Disasters Management Authority
2.4	ADCMC	Emergencies Crisis and Disasters Management Center Abu Dhabi
2.5	ICS	Incident Command System
2.6	ADPHC	Abu Dhabi Public Health Centre
2.7	Ambulance	Any mode of transport operated by a licensed/authorized pre-hospital care service (PHCS), or agency utilized and equipped for clinical treatment of a person requiring medical monitoring, assessment, or treatment outside of a hospital setting.
2.8	Ambulance Service	The business of transporting and/or providing emergency and non-emergency medical care to the sick or injured by ambulance. Ambulance service is inclusive of emergency response, interfacility transfer, and standby.
2.9	Ambulance Service Provider	A healthcare provider engaged in the business of transporting and/or providing emergency and non-emergency medical care to injured or sick by ambulance, including but not limited to transport to or from healthcare facilities, from non-health institutions to healthcare facility, from home or roadside, or as a standby service.
2.10	BLS	Basic Life Support
2.11	CASMEET	CASMEET is acronym used by EMS to communicate the important details of a patient over to an emergency control center, receiving hospital, or other definitive care provider. A CASMEET message can be sent to pre-alert a receiving emergency department that a critically ill patient is being brought in.
2.12	CEPAR (Center of Emergency Preparedness and Response)	CEPAR maintains independent authority over healthcare emergencies, and shares authority with the appropriate DOH sectors including Healthcare Facilities, Workforce, Payers, and Legal. It is the combination of all these authorities that delineate the medical direction system. The regulatory authorities reside with CEPAR and each of the sectors and shall be enforced through them.
2.13	CDD	Communicable Disease Department
2.14	Disaster	Disasters are serious disruptions to the functioning of a community that exceed its capacity to cope using its own resources. Disasters can be caused by natural, man-made and technological hazards, as well as various factors that influence the exposure and vulnerability of a community.
2.15	DOH	Department of Health
2.16	Emergency	A situation or state characterized by a clear and marked reduction in the abilities of people to sustain their normal living conditions, with resulting damage or risks to health, life, and livelihoods.
2.17	ED	Emergency Department
2.18	EMS	Emergency Medical Services

2.19	Estijabah System	Estijabah system is a web-based Emergency management system that provides a multiple user access to a common site for the collection, coordination, and dissemination of emergency or event-related information.
2.20	Event Organizers	Entity that has overall responsibility in case of regular or permanent mass gatherings and healthcare providers at site.
2.21	Event Medical Director	A senior healthcare provider (Physician), licensed with DOH, who has formal training in medical management of Major Incidents and prehospital emergency medicine; onsite operational direction can be provided by the most senior clinician present.
2.22	Hazard	A hazard is a dangerous phenomenon, substance, human activity, or condition. It may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage.
2.23	HCF	Health Care Facility
2.24	JLOC	Joint Local Operations Centre
2.25	Major Incident	A critical event that requires a coordinated response from multiple organizations to ensure the safety of the public and minimize harm.
2.26	Mass Casualty Incident	MCI stands for "Mass Casualty Incident". It refers to a situation where many people are injured or become sick at the same time, typically because of a disaster, accident, or other sudden event. In such cases, the incident may overwhelm the available resources of the local emergency response system, leading to the need for a coordinated and systematic response from multiple agencies and organizations.
2.27	Mass Gathering Event	A mass gathering event is defined as a large-scale gathering of people in a single location for a specific purpose, such as a concert, festival, sporting event, political rally, or religious gathering. The exact definition of a mass gathering event can vary depending on the context and the governing authorities, but it generally refers to an event that requires coordination and planning to ensure public safety and manage potential risks.
2.28	Medical Action Plan	An outline of the specific details of the organization and delivery plan for emergency medical care at a mass gathering event. It is based on experience of previous events of a similar nature, duration, and venue.
2.29	Medical Emergency	Injury or illness that occurs suddenly or unexpectedly and poses an immediate risk/threat to a person`s life, limb, body function or long-term health
2.30	MOC	Medical Operations Command a combination of operational technicians and information management systems used to monitor and manage integrated systems, operations, events, and incidents
2.31	Paramedic	A qualified and licensed pre-hospital health care professional whose primary role is to provide basic and/or advanced medical care for patients outside of a hospital setting. The license of paramedic is defined by the Abu Dhabi PQR for healthcare professionals.
2.32	EMT	Emergency Medical Technician is a qualified and licensed pre-hospital health care professional whose primary role is to provide basic and intermediate care for patients outside of a hospital setting. The license of EMT is defined by the Abu Dhabi PQR for healthcare professionals.
2.33	Public health emergency preparedness	The capability of the public health and health care systems, communities, and individuals to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing or unpredictability threatens to overwhelm routine capabilities.
2.34	Preparedness	a coordinated and continuous process of planning and implementation that relies on measuring performance and taking corrective action.
2.35	Pre-Hospital Care Service	A licensed and integrated medical care delivery organization provides emergency and non-emergency medical care in a pre-hospital setting. Inclusive of EMS and other ambulance services.
2.36	Risk Assessment	A step in a risk management process; the determination of quantitative or qualitative value of risk related to a concrete situation and a recognized threat (also called hazard).

2.37	SOP	Standard Operating Procedure, an organizationally defined series of tasks for conducting a process with specific controls identified.
2.38	MDS (Medical Direction System)	A system of physician-directed leadership, quality assurance, administrative and medical oversight that provides professional and public accountability for medical care provided in the pre-hospital setting.
2.39	HLO's (Health Liaison Officers)	Health liaison officers (HLO) are persons selected to ensure information flows between the emergency operations centers or coordination center at a local, district or state level, on Health agency operational capabilities and issues as they arise.
2.40	On-line (Concurrent) Medical Direction	Direction provided directly to out-of-hospital providers by the medical director or designee, generally in an emergency, either on-scene or by direct voice communication by radio, telephone, or other means as technology develops, and including person-to-person communication of patient status, and orders to be carried out
2.41	Off-line (Prospective and Retrospective) Medical Direction	Direction including the administrative promulgation and enforcement of accepted standards for out-of-hospital care accomplished through both prospective (e.g., training, testing and certification of providers, protocol development, operational policy and procedures development, and legislative activities), and retrospective methods (e.g., medical audit and review of care/ process improvement, direction of remedial education, and limitation of patient care functions)
2.42	PHCS (Pre-Hospital Care Service)	A licensed and integrated medical care delivery organization provides emergency and non-emergency medical care in a pre-hospital setting. Interchangeable with Emergency Medical Service (EMS)
2.43	SPP (Special Program Pathways)	The Special Program Pathways are defined by the potential clinical path patients take as part of their healthcare, the criteria that establish requirements for meeting minimum standards for treatment, and ongoing review processes to ensure further development and improvement of the specific Pathway System and hospital Pathway Programs. Each potential step along the way is captured separately with specific criteria, actions, and tasks that should occur.

3. Standard Requirements and Specifications

3.1. Information Gathering Phase:

3.1.1. In collaboration with relevant entities, event organizers shall collect sufficient information about the event to enable a viable Medical Action Plan to be created and tested. Such information should include, but is not limited to the following:

3.1.2. Entity and staff responsible for planning and provision of medical care for the mass gathering.

3.1.3. Expected number of attendees. This should include specifics on vulnerable populations, such as children or the elderly, and those with mental or physical handicaps.

3.1.4. Type of event (indoor or outdoor, religious gathering, music festival, political rally, etc.)

3.1.5. Any potential health risks (Appendix 3 can be used as a guide).

3.1.6. Exact dates and timings of the event, including when workers should be on site and when they will be expected to leave site.

3.1.7. Policies for patient transport and treat and release plans.

3.1.8. Plan for MCI response at the mass gathering event.

3.2. Event Planning Phase:

3.2.1. In collaboration with the event organizer, the organization providing medical coverage to mass gatherings should determine a detailed and suitable Medical Action Plan that will then be submitted to DOH for approval, along with a completed mass gathering or event comprehensive risk assessment and business continuity plan in case of disruption to vital services.

3.2.2. The risk assessment completed by healthcare providers must use a risk management system, processes, and an assessment matrix such as that in Section 6 below to assess the risks for each mass gathering event, identifying any population-related, visitor-related, site related, and environmental risk factors. It should include:

3.2.2.1. Potential hazards and risks specific to the event, including crowd dynamics, weather conditions, access to emergency medical services, and any unique aspects of the event venue must be considered.

3.2.2.2. Analysis of potential consequences and impacts of identified risks, including potential injuries, illnesses, public health implications, and reputational damage.

3.2.2.3. Development of risk mitigation strategies and measures to minimize the identified risks and their impacts.

3.2.2.4. Risk assessment is an iterative process. The risk assessment document is a working document that is continually referred to, updated, and revised as the planning progresses and the event unfolds. For example, as the event gets closer, forecasting for the type of weather conditions expected during the event might influence patient presentation to Medical Centres or Medical Aid Posts with weather-related illness. Refining the risk assessment as the event progresses is valuable in assessing, monitoring specific incidents as they develop, and essential in ensuring appropriate responses.

3.2.3. The Medical Action Plan should outline specific details about the organization and delivery of emergency medical care at a mass gathering event. It should form the basis for contractual agreements between the Healthcare provider and the event organizers and / or other parties as appropriate and could include but not limited the following:

3.2.3.1. The medical action plan must meet or exceed all local, regional and / or federal guidelines for mass gathering event EMS planning, as well as meet the level of out-of-hospital emergency medical practice in the surrounding community.

3.2.3.2. The medical action plan must be designed or reviewed and approved by the event medical director or the medical director of the EMS agency primarily responsible for delivery of emergency medical care in the jurisdiction of the event.

3.2.3.3. Scope and responsibility for emergency medical care must be clarified, agreed upon, and then documented.

3.2.3.4. Previous Event Research of demand for and provision of medical care in previous similar or recurring events and Venue Medical Reconnaissance of the event venue elements affecting need for and access to medical care.

3.2.3.5. An organizational chart consisting of the reporting structure regarding medical oversight responsibilities must be included in the plan.

3.2.3.6. Liability, workmen's compensation, medical malpractice insurance or other types of insurance for medical personnel specific to the mass gathering / event should be in-place prior to the start of the event in-line with local regulations.

3.2.3.7. Proximity and exact location of Command-and-Control Centre, ensuring representatives from each organization are present throughout the duration of the event (EMS, Civil Defense, Police, Security etc.).

3.2.3.8. Access and egress routes for emergency services, including identified hazards as well as potential evacuation points.

3.2.3.9. Accurate and detailed site plan (CAD drawings for buildings, maps) and safety cordons.

3.2.3.10. Capacity and proximity of medical assessment and treatment areas.

3.2.3.11. Proximity, location and number of first aid stations / medical centers, including locations of placed AED's (if relevant).

3.2.3.12. Number of responders and standby locations (medical volunteers, first responders, EMT's, Nurses, Paramedics, Doctors). Placement should be planned to allow casualties to receive care in the shortest time possible. Mobile or roving teams should be used to facilitate timely patient access.

3.2.3.12.1. Appendix 1 should be used as a guide to assist in determining the number and level of healthcare professionals required in order to safely cater to a mass gathering event.

3.2.3.12.2. A clear declaration of intent to employ basic life support (BLS) personnel versus advanced life support (ALS) personnel and the unique capabilities associated with the chosen level of care that justify this choice must be included in the Medical Action Plan.

3.2.3.12.3. Plans should address how assets and personnel will be deployed to achieve early defibrillation capability for anyone within the venue to meet a collapse- to-shock goal of 5 minutes or less. In some situations, or environments this may not be achievable, so the fastest possible response will be addressed.

3.2.3.12.4. For large scale and longer mass gatherings / events, staffing plans should additionally take into consideration:

3.2.3.12.4.1. Work cycles (shift rotation)

3.2.3.12.4.2. Shift-related check-in and out procedures

3.2.3.12.4.3. Credentialing procedures

3.2.3.12.4.4. Hydration and alimentation need.

3.2.3.12.4.5. Rest and/or sleep needs

3.2.3.12.4.6. Back-up scheduling

3.2.3.13. Access and availability of medical equipment at the site, including the restocking of vital equipment should the need arise.

3.2.3.14. Capabilities to perform effective Triage and patient management during MCI situations, following an accredited MCI standard.

3.2.3.15. Plans for additional resources considering the expected type of injuries due to the location, type, crowd, or risks associated with the gathering. E.g., risk of CBRNE Incident (Chemical, Biological, and Radiation & Nuclear and Explosion Incident) in accordance with the risk analysis approach shown in Section 6 below.

3.2.3.16. Communication channels to be used during the mass gathering, including plans for resilience systems.

3.2.3.17. Implementation of Standard Operating Procedures (SOPs) that define a chain of command and communication strategy (public and media) and should be routinely used and tested.

3.2.3.18. The coordination of government entities surveillance plans to assist in ensuring the safety of healthcare providers and medical wellness of patrons of the event.

3.2.3.19. Consideration should be given to utilizing surveillance equipment, including drones (and obtaining approvals when required) in place to help monitor potential patients and confirm locations. Crowd dynamics, medical emergencies, and potential crush situations should also be actively monitored for in coordination with event security and management staff.

3.2.3.20. Pathways to appropriate and definitive care at healthcare facilities within proximity of the mass gathering / event location within appropriate timeframes.

3.2.3.21. Where appropriate, communication and involvement of local healthcare facilities should be considered and consulted to determine capacity levels to deal with patients and assistance during MCI situations if required.

3.2.3.22. Event organizers and healthcare providers where appropriate based on size and scale of event should develop and implement strategies to disseminate public information regarding health promotion, injury prevention, and emergency preparedness at mass gatherings. This information should be easily accessible to attendees and should address topics such as heat exhaustion, crush injury or traumatic injuries, alcohol and substance abuse, evacuation criteria, and emergency contact details.

3.2.3.23. Healthcare providers should have a system in place to monitor, track, and report on injuries / illnesses that occurred during the event. This should be in line with relevant data protection and privacy laws and regulations in place.

3.2.3.24. Significant attention should be given to ensuring staff working at the event are adequately and appropriately trained, including, but not limited to:

3.2.3.24.1. DOH requirements to practice at licensed level.

3.2.3.24.2. Qualified event medical director.

3.2.3.24.3. Accredited MCI training.

3.2.3.24.4. Knowledge and familiarity surrounding the contents of the risk assessment specific to the Mass Gathering event.

3.2.3.24.5. Training on communication systems utilized for Mass Gathering event, as well as escalation procedures.

3.2.3.24.6. Training on all equipment and consumables in use.

3.2.3.24.7. Specialized training specific to the event / mass gatherings needs.

3.2.3.25. Event Plan should take into consideration patrons who may belong to special population groups (children, elderly, or those with physical or mental handicaps). specific requirements need to be included to ensure their safety, which may include, but is not limited to the following:

3.2.3.26. Prioritization of inclusivity and accessibility for all visitors, regardless of age or disability.

3.2.3.26.1. Access and egress routes, barriers, funnels, and potential crush and entrapment zones, appropriate handrails or ramps, along with designated seating areas where necessary.

3.2.3.26.2. Any special facilities they require (wheelchair ramps, special access toilets, trained personnel to assist them).

3.2.3.26.3. Management of these groups should an emergency occur and how they will be assisted (minor or major incident) should be specifically addressed.

3.2.3.26.4. Allocating specific medical resources / staff to cater for their needs.

3.2.3.26.5. Ensure appropriate facilities and resources to accommodate the needs of families or caregivers accompanying vulnerable population groups.

3.2.3.26.6. Staff, volunteers, and security personnel should have training to raise awareness and enhance their understanding of the specific needs for vulnerable population groups.

3.2.3.27. Medical planning for mass gathering events should include consideration towards environmental sustainability initiatives, in compliance with environmental regulations. Sustainable practices may include proper waste management, energy consumption, plastic reduction or other eco-friendly measures as appropriate.

3.2.3.28. This plan should include the potential impact for existing patients in their care at the time of any Major Incidents, Disaster or Large-Scale Public Health Emergency. The medical planners shall work with event organizer or sponsor to assess risks for event types that they do not have prior experience in.

3.2.3.29. The medical action plan should detail the key members of staff working the event (Event commander, stakeholder relations, JLOC member etc.), as well as the contact number for the on-site medical command personnel. An event medical director shall be present on site (or their designee who is suitably qualified) during the event.

3.3. Testing and Refinement of Plan:

3.3.1. Once the event Action Plan (including the medical plan) has been completed, where appropriate it is imperative that the plan is tested and discussed in collaboration with other concerned stakeholders. This will help to ensure that the plan is sufficient to deal with the realities of the live mass gathering / event.

3.3.1.1. Where appropriate based on size and scope of event a basic medical reconnaissance visit must take place for mass gathering event in order to identify key facts, such as:

3.3.1.1.1. Venue location and characteristics, expected attendance, available medical resources.

3.3.1.1.2. Regional traffic flow time patterns and impact upon EMS transport times must be evaluated.

3.3.1.2. Such a visit should address mitigation strategies to handle an increase in patient volume which may be due to one of more of the following factors:

3.3.1.2.1. Crowd composition, volume, density, mood, control, and mobility.

3.3.1.2.2. Physical barriers to crowd / patient access, aisle space, time to access patients in different areas of the venue, entrance and exit locations, wet or slippery vs dry ground conditions.

3.3.1.2.3. Availability and / or use of alcohol or illicit drugs, availability of food, water, shelter.

3.3.1.2.4. Temperature and other weather hazards.

3.3.1.2.5. Law enforcement and/or security presence, threats against the event or other security concerns, VIPs in attendance, potential for violent group behavior.

3.3.2. In conjunction with event organizations and other organization representatives as appropriate, the medical action plan for the mass gathering event should be tested through table-top exercises as well as live simulations on-site incorporating potential emergency situations designed to uncover gaps within the mass gathering plan. These exercises should include scenarios that assess the effectiveness of response procedures, communication, and coordination among stakeholders. Such scenarios may include, but are not limited to:

3.3.2.1. Collapse of building or stands.

3.3.2.2. Explosions (intentional or unintentional)

3.3.2.3. Active shooter situation

3.3.2.4. Large hostile crowds

3.3.2.5. MCI Situations

3.3.2.6. Stampede or crush

3.3.2.7. Extreme weather events

3.3.2.8. Care for vulnerable population groups during adverse events

3.3.3. The findings from these exercises should be documented and used to further improve the mass gathering medical plan and the response to potential situations.

3.3.4. This documentation should be kept as part of the overall event plan and made available for auditing purposes when requested.

3.3.5. In the event of permanent or routine sites of mass gathering events, these plans should be tested bi-annually.

3.3.6. The final version of the Medical Action Plan, when appropriate based on size and scope of the event, along with the complete risk assessment, must be shared with DOH for approval recommendation, who will then act according to Appendix 4.

3.3.7. When planning for the event, it is important to submit for DOH approval well ahead of time (4 weeks at least) for any alterations to the Medical Action Plan to still be done. Without DOH approval, the event will not be able to proceed.

3.4. Event Execution:

3.4.1. The Medical Action Plan should form the framework and guidelines for the medical organizations approach to the event.

3.4.2. The plan should be readily available on-site for reference and referred to as and when necessary.

3.4.3. The Event Medical Director, or a designated person of authority on site from the healthcare organization must update DOH Medical Operation Center when they arrive / depart from the mass gathering or event using the following emails: moc@doh.gov.ae.

3.4.3.1. Deployment of emergency medical personnel and equipment must occur before the event begins when the gates open to spectators.

3.4.3.2. Dismissal of emergency medical personnel and pack up of equipment must not occur before the event ends and all spectators have left the event.

3.4.4. Continuous assessment of the event and the environment in which it is occurring should be carefully monitored throughout the duration of the event in reference to the risk assessment.

3.4.4.1. The risk assessment should be continuously updated throughout the duration of the event should situations change, or new information is received (e.g., Severe weather warning, threats made against the event etc.).

3.4.5. Maintain patient records and decision logs as appropriate for audit purposes and secured as required.

3.4.6. Log records must be entered during the event, be protected from tamper and archived for five years.

3.4.6.1. They should contain the following as minimum content:

3.4.6.1.1. Event logging pages.

3.4.6.1.2. Decision log

3.4.6.1.3. Patient & ambulance movement record

3.4.6.1.4. Triage details, transport, and destination details with reference number to patient care record where applicable.

3.4.6.1.5. Major Incident documentation or reference to other system or records that would be used to capture above information in such conditions.

3.4.7. Potential situations that may result in MCI scenarios should be communicated early via the proper channels and DOH should be informed of such situations as a priority.

3.4.8. The event organizer should consider regular short meetings throughout the duration of the event between all on-site medical service providers where appropriate to ensure smooth functioning of all parties and discussion of any issues found or experienced that are having an impact on event execution.

3.5. Post-Event Debrief:

3.5.1. Debrief sessions should be conducted as soon as possible following a mass gathering event as per the approved definition (within a maximum of 3 weeks).

3.5.1.1. By conducting debriefings promptly, organizers and participants can better recall the details and experiences of the event, leading to more accurate and productive discussions.

3.5.2. The purpose of these sessions is to reflect on the event, identify successes and areas for improvement, and address any issues or concerns that may have arisen.

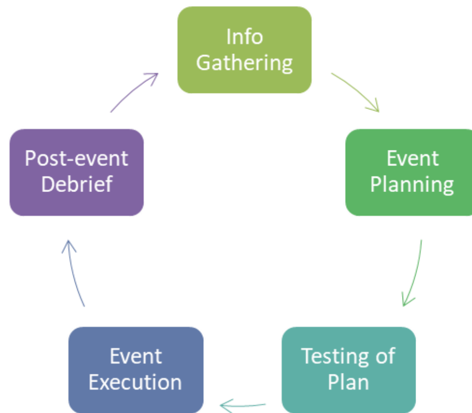
3.5.3. All organizations involved in the event where appropriate or when requested by government agency should attend the debriefing session.

3.5.4. A record of identified successes and areas for improvement should be well detailed and included in the overall project plan for the mass gathering event. These should be made available for presentation and auditing purposes when required.

3.5.5. When planning a repeat of similar mass gatherings, these records should be consulted with the aim of improving future mass gathering plans.

3.6. Framework and Process for Planning and Executing the Medical Plan for Mass Gatherings and Events.

Figure 1: Event Planning Cycle



3.7. Using the Risk Assessment Matrix:

3.7.1. When assessing a risk for the first time, assume there are no controls already in place. The subsequent two assessments are completed with 1) the initial controls already in place and 2) with any additional controls needed to reduce the risk further. The assessor should assign values for the identified 'likelihood' of occurrence (A) and the severity of the 'Impact' (B). By multiplying 'A' and 'B' together you get the rating score, which gives an indication of how important the risk is. The thick black line is the "line of tolerance".

3.7.2. Those risks that have all possible controls in place and yet are still plotted above the line (score 10 – 25) are "out of tolerance" and the event should only proceed with extreme caution.

3.7.3. The figure below can be referenced for risk assessment.

3.7.4. Risks should be expressly highlighted when submitting the Healthcare Plan and Risk assessment to DOH.

Subject Area	Hazard and Effect	To whom does the risk apply?	Severity of Impact Rating x Likelihood = Primary risk based on no controls B x A = R	Existing Control Measure	Severity Impact Rating with control x Likelihood =residual Risk Bc x A=R	Action Required Where Risks are Not Adequately Controlled	Any other Comments or notes to be highlighted

LIKELIHOOD (A)						
	Very Likely 5	5	10	15	20	25
	Likely 4	4	8	12	16	20
	Feasible 3	3	6	9	12	15
	Slight 2	2	4	6	8	10
	Very unlikely 1	1	2	3	4	5
		Insignificant 1	Minor 2	Significant 3	Major 4	Critical 5
	IMPACT (B)					

Green = Low risk, Amber 9 = Medium risk, Amber 10 –12 high risk, Red = High risk

Likelihood of Occurrence (A)	Severity of Impact (B)
1 - Very unlikely (hasn't occurred before)	1 - Insignificant (have no effect)
2 - Slight (rarely occurs)	2 - Minor (little effect)
3 - Feasible (possible, but not common)	3 - Significant (may pose a problem)
4 - Likely (has before, will again)	4 - Major (Will pose a problem)
5 - Very Likely (occurs frequently)	5 - Critical (Immediate action required)

3.7.5. In conjunction with the risk matrix, the above risk register should be utilized to record identified risks, their ratings, and their ratings after control measures have been put in place. The register should be included with the risk assessment for submission to DOH and record purposes. (Add additional roles as appropriate to accommodate all identified risks)

4. Key stakeholder Roles and Responsibilities

4.1. Department of Health (DOH) is responsible for:

4.1.1. Regulating the healthcare sector in Abu Dhabi. Health service operations and patient/ public clinical care and treatment are the responsibility of the healthcare providers licensed by DOH.

4.1.2. Directing, leading, planning and coordinating the healthcare management of major incidents, disasters, and large-scale public health emergencies across government agencies in the emirate of Abu Dhabi, including those arising during Mass Gathering events as per DOH Standard on Pre-Hospital Mass Casualty Incidents (MCI) for the Emirate of Abu Dhabi the Health Protection Policy, Part C. Public Health Emergencies, and Chapter VII of the Healthcare Regulator Policy Manual. An overwhelming or threat of overwhelming of medical resources at a mass gathering event will be considered as a Major Incident by the DOH.

4.1.3. Ensuring that mass gathering events do not adversely affect the medical and emergency capabilities of the local healthcare facilities and EMS system, and that participants at mass gathering events are afforded the same access to emergency care as compared to the local community.

4.1.4. Liaising and working closely with Emergencies crisis and disasters management center Abu Dhabi and other related agencies.

4.1.5. Monitoring, reviewing, and approving measures undertaken by healthcare providers and organizers of mass gatherings to ensure the DOH applicable standards are complied with. This will require the development and approval of a medical action plan by the event medical director, approved by the DOH prior to any event. (A detailed document pertaining to the creation of a Medical Action Plan can be found in reference no. 21). This may also involve measures such as random and regular audits of event plans, event execution, and pre & post-event debriefs to ensure compliance and best practices are being followed. The DOH and the event organizer will further ensure any first aid posts or clinics are properly set up according to the DOH licensing regulations.

This can be done in concordance with measures undertaken by NCEMA and does not supersede any NCEMA authorities.

4.1.6. Ensuring public health and safety, health promotion information and activities for primary prevention purposes are available as required at mass gathering sites.

4.1.7. Alerting and warning healthcare providers and event organizers if an external incident threatens to affect the health of the public or emergency services at mass gatherings or if there is a threat of disruption in the provision of healthcare service provision in the area.

4.1.8. Regular revision and updates of Standards and relevant legislation to ensure international best practice is being advocated and followed.

4.1.9. Ensuring the availability of unique care requirements for vulnerable population groups (such as people of determination, children, elderly, etc.) are undertaken by event and healthcare organizations which are sufficient for use.

4.1.10. Ensuring a coordinated plan for mass casualty incidents occurring at the mass gathering and its approval by all relevant stakeholders.

4.1.11. Ensuring all health care providers are properly licensed, trained and proficient in incident command (i.e. ICS, MIMMS).

4.1.12. Maintaining a database of national experts for advice on specific problems, protocols, and formal arrangements for coordinated efforts with other countries, or between provincial / state governments within the country.

4.2. Event Organizers and Responsible Organizations should:

4.2.1. Establish clear emergency communication policies and processes with all involved parties, including DOH regarding the coordination of healthcare response in case of Major Incident. Information should include:

4.2.1.1. The mechanism and trigger point for alerting DOH to coordinate medical response (Standby or activation)

4.2.1.2. Major incident management plan.

4.2.1.3. Risk Assessment activities including collaborative assessments with all involved parties. Ensure risk details and accepted residual risks are appropriately communicated to emergency services (e.g., Ambulance, Fire, Police), DOH, other government agencies and healthcare providers contracted for the event.

4.2.2. Ensure that all healthcare providers contracted to provide services for mass gatherings and events have the Pre-Hospital Care capability and resources to fulfill the criteria as detailed in this standard.

4.2.3. Ensure Ambulances contracted for the event are following Clinical Practice Protocols approved in the emirates of Abu Dhabi.

4.2.4. Ensure Ambulances contracted for the event are following DOH Clinical Practice Protocols.

4.2.5. Ensure, and hold responsibility for coordinating and aligning all medical provision plans and major incident plans with those of other agencies, organizations and Emergency Services involved with the event. Ensure necessary support, access and updated information is available to the medical services to enable safe and timely provision of services. Failure to do so may lead to imposing sanctions by the respective Abu Dhabi regulatory authority.

4.2.6. Provide information to DOH and to healthcare providers contracted for the Mass Gathering or event to ensure safe and quality service planning and provision including:

4.2.6.1. Expected number of attendees, timings, and schedules.

4.2.6.2. Site plan, key locations including clinic and ambulance locations, and safety cordons (if possible, using CAD drawings of buildings and maps).

4.2.6.3. Access and availability of medical resources and equipment at the site.

4.2.6.4. Operational Plans, plans for joint incident command / control center on-site, with appropriate services including but not limited to Fire, Police, Ambulance and Security Forces.

4.2.6.5. Medical Action Plan developed in coordination with the respective contracted medical service (Further details provided in the 'Event Planning' Phase below.)

4.2.7. Test all plans and capabilities prior to the event (and periodically if the site is an area of permanent or routine site of mass gathering).

4.2.8. Communicate to DOH the outcomes and revision of activities resulting from the testing of plans.

4.2.9. Comply with DOH directions that may be issued through other regulatory authorities e.g. EAD - ADEHS (Environment Agency Abu Dhabi - Abu Dhabi Environment, Health and Safety), to improve the quality and safety of preparedness for mass gatherings and the provision of medical care including, but not limited to, public information and health promotion information and activity; and communication of information to attendees using a range of means appropriate to the type of event and audience; organizers may consider using, for

example physical signposts; announcements using a sound system; verbal communication from staff employed as marshals / stewards; and written information on a program or flyer.

4.2.10. Conduct post-event debriefs to discuss challenges that may have arisen during the event, as well as practices that worked well. The aim of these debriefs should be to improve future event delivery. Discussions during the debriefs should be well documented and include a log of lessons learnt.

4.2.11. Maintain records necessary to provide an after-action report, to include number and type of patient encounters, number of patients transported, any critical patient encounters or deaths, and summary of post event debriefs, and improvement plans for future events. The DOH shall provide a mechanism to obtain these reports and records.

4.3. Healthcare Organizations must:

4.3.1. Develop and communicate to DOH:

4.3.1.1. A Medical Action Plan that includes a major incident medical plan and comprehensive risk assessment of the mass gathering or event.

4.3.1.2. The plan should include the capability for supplies, human resources, co-ordination activity, response times, command, and communication to DOH prior to the event, considering requirements for mass casualty incident (MCI) capabilities; that is:

4.3.1.2.1. At least 6 weeks prior to the mass gathering for one-off events.

4.3.1.2.2. Ongoing coordination with regular updates - for recurring events and areas of permanent or regular/ routine mass gatherings.

4.3.1.2.3. As soon as possible - for events and gatherings that may be requested at short notice or for an unplanned mass gathering.

4.3.2. Create and maintain event logs in the form of documented evidence.

4.3.3. Ensure only DOH licensed healthcare professionals are employed to provide services at mass gatherings; healthcare professionals must have:

4.3.3.1. Internationally recognized Pre-Hospital Care training, in line with the requirements needed to gain DOH licensure at the specific clinician level, as well as an accredited MCI training appropriate to their anticipated role in an MCI (e.g bronze, silver, gold or similar).

4.3.3.2. The appropriate Pre-Hospital Care Personal Protective Equipment (Appendix 2).

4.3.3.3. Appropriate and sufficient medical equipment, considering potential risks identified in the risk assessment.

4.3.4. Ensure that:

4.3.4.1. The service is supervised on-site, throughout the duration of the event by a DOH licensed event medical director who has formal training in medical management of Major Incidents and prehospital emergency medicine.

4.3.4.2. All healthcare professionals practice within the specified scope of services, and the job duties assigned to them by their employing facility and comply with the requirements of the DOH Standard for Privileging Framework.

4.3.4.3. Staff, equipment, level of skills and capability reflects the scope of services and scope of practice as per Clinical Practice Protocols.

4.3.4.4. Maintain an adequate supply of medical resources, equipment, and medications at mass gathering sites. This includes maintaining appropriate stock levels, ensuring timely resupply, and regularly checking and maintaining equipment functionality. Ensure provisions are made for Major Incident response and establishment of command and control.

4.3.4.5. Medical resources provided for the mass gatherings are compatible with and able to function in alignment with and complement additional medical resources that are likely to be mobilized to the site in case of Major Incidents.

4.3.4.6. Medical procedures undertaken in the Pre-Hospital Care environment conform to internationally acceptable clinical practices in prehospital care and are undertaken by staff with appropriate level of skill, knowledge, and experience in the medical specialty, as per the latest DOH Clinical Practice Protocols (CPPs).

4.3.4.7. Ambulance personnel are a minimum crew of two, both of whom must have prehospital training, qualifications, and accreditation at the Emergency Medical Technician – Basic level or higher. The mix of provider skill levels must be addressed in the Medical Action Plan and provide a level of emergency care that would be comparable to that available outside of the event.

4.3.4.8. They comply with the business continuity requirements as set by the Health Protection Policy, Part C. Public Health Emergencies, Chapter VII of the Healthcare Regulator Policy Manual Version 1.0 and the DOH Standard for Major Incident and Disaster Preparedness in Healthcare, including conducting Business Impact Analysis to determine potential detrimental impacts likely to arise in responding to major incidents and large-scale public health emergencies.

4.3.4.9. They comply with the DOH Standard for Patient Transfer.

4.3.4.10. In providing medical cover for events, efforts must be undertaken by healthcare providers to prevent depletion of critical resources from healthcare facilities that may be called upon to receive patients in case of Major Incident at the site of the Mass Gathering or Event (DOH designated facilities).

4.3.4.11. They comply with this standard, considering any time constraints including when:

4.3.4.11.1. The organizer does not provide adequate time or information needed by the healthcare / medical cover provider to prepare in accordance with this standard.

4.3.4.11.2. Directed by higher authorities at short notice to provide medical cover for unplanned mass gathering or mass gatherings occurring as result of sudden unexpected events or unforeseen circumstances.

4.3.4.12. In the circumstances ensure that comprehensive and complete documentation is retained, and copies are preserved by the healthcare provider and made available as requested by DOH to demonstrate adequate levels of compliance with this standard.

4.3.5. Participate in the risk assessment activities conducted by event organizers and provide necessary input regarding medical resources and emergency response capabilities to mass gathering event, considering the identified risks and hazards. Regularly review and update these plans based on lessons learned, changes in risks, and any updates from DOH or relevant authorities.

4.3.6. Collaborate with event organizers, emergency response agencies, and relevant government bodies to ensure effective communication, coordination, and cooperation in responding to medical emergencies at mass gatherings.

4.3.7. Provide appropriate accommodations to cater medical care and support to vulnerable populations, including children, elderly individuals, and individuals with disabilities, in line with current international best practices.

4.3.8. Provide material to enhance public education and health promotion initiatives to reduce injuries and mitigate risks of spreading communicable diseases. Such initiatives may include frequent hand-washing posters, flyers about pre-cautions to avoid spreading diseases etc.

4.3.9. Ensure EMS providers have appropriate medical and operational supervision and/or guidance from a medical command/control authority to safeguard delivery of appropriate standardized emergency medical care.

4.4. Medical Healthcare workers must:

4.4.1. Provide healthcare at the mass gathering or event site to the minimum standards required by the DOH.

4.4.2. Ensure familiarity with equipment, procedures, communication channels, and medical interventions they may have to undertake on-site as per DOH licensed level of care.

4.4.3. All healthcare professionals practice within the specified scope of practice, and the job duties assigned to them by their employer; and comply with the requirements of the DOH Standard for Privileging Framework.

4.4.4. Undertake and record results of pre-event checks, including all equipment on site, vehicles, and communication equipment.

4.4.5. Assist in the dissemination of public education material and health promotion initiatives.

4.4.6. Ensure any issues or potential large-scale situations are escalated early and clearly to the relevant personal, as per the event escalation matrix contained in the Medical Action Plan.

4.4.7. Ensure they are familiar with the event layout and can navigate around the event with ease, have knowledge of exits, medical tents and equipment, mobile units, and ambulances when relevant.

4.4.8. Understand the event MCI protocols and their roles and responsibilities in potential MCI situations.

5. Monitoring and Evaluation

5.1. DOH will monitor and review the compliance of healthcare providers and event organizers with this standard through regular inspections and audits. Such monitoring and reviews may include: Number of ambulances detailed in plan are live at the event, as recorded by telemetries outlined in DOH related standard; on site auditing which may include number of staff in attendance, qualification levels, valid DOH licenses, event knowledge, accredited MCI training, key on-site locations, equipment checks etc. are in line with the DOH standard and are the same as detailed in the Medical Action Plan; reviewing of documents, such as risk assessments, event plans, and debrief meetings.

5.2 Event organizers and healthcare providers should maintain accurate records and reports related to their medical emergency preparedness and response activities at mass gatherings. These records should be made available to DOH upon request.

6. Enforcement and Sanctions

6.1. Healthcare providers must comply with the requirements of this Standard, the DOH Information and Cyber Security Standard, and the DOH Data Standards and Procedures. DOH may impose sanctions in relation to any breach of requirements under this standard in accordance with the healthcare sector disciplinary regulation. The DOH may deny approval of event medical plan should be participating parties fail to comply with this standard.

7. Relevant Reference Documents

S. No.	Reference Date	Reference Name	Relation Explanation / Coding / Publication Links
1	16 June 2023	The WHO guidelines on communicable disease alert and response during mass gatherings	Ahmed QA, Barbeschi M, Memish ZA. (2009). 'The quest for public health security at Hajj: The WHO guidelines on communicable disease alert and response during mass gatherings', Travel Medicine & Infectious Disease; 7,4: pp. 226-230. Available at: https://www.sciencedirect.com/science/article/abs/pii/S1477893909000052
2	18 June 2023	ASPR/TRACIE Topic Collection: Mass Gathering/Special Events	Alberts E, et al. (2020), 'ASPR/TRACIE Topic Collection: Mass Gathering/Special Events', Available at: https://asprtracie.hhs.gov/technical-resources/85/mass-gatherings-special-events/0#agencies-and-organizations
3	17 June 2023	Medical management of mass gatherings	Brown, J.F., Smith, J.G., Tataris, K.L. (2021), 'Medical management of mass gatherings, Chapter 96', in Cone, D. et al, (eds), Emergency Medical Services: Clinical Practice and Systems Oversight, Third Edition, pp.273-283, Portico. Available at: https://doi.org/10.1002/9781119756279.ch96
4	16 June 2023	Emergency Planning	Canadian Centre for Occupational Health and Safety, (2022), 'Emergency Planning', Available at: https://www.ccohs.ca/oshanswers/hsprograms/planning.html
5	20 June 2023	Regulations relating to Emergency Care at Mass Gathering Events	Department of Health, South Africa (2017), National Health Act, 2003, Regulations relating to Emergency Care at Mass Gathering Events. Available at: https://www.gov.za/sites/default/files/gcis_document/201706/40919gon566s.pdf

6	21 June 2023	Guidelines for concerts, events and organised gatherings	Department of Health, Government of Western Australia (2022), 'Guidelines for concerts, events and organised gatherings'. Available at: https://www.health.wa.gov.au/Articles/F_I/Guideline-for-concerts-events-and-organised-gatherings
7	17 June 2023	Framework for Major Emergency Management	Department of Housing, Local Government and Heritage (2021), 'Framework for Major Emergency Management'. Available at: http://www.gov.ie/en/collection/ca182-a-framework-for-major-emergency-management/
8	17 June 2023	Preparedness for mass gatherings: rescue and emergency medical services' workload during mass gathering events	Koski A., Pappinen, J. Kouvonen, A. Nordquist H.: (2022), 'Preparedness for mass gatherings: rescue and emergency medical services' workload during mass gathering events', Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine; 30:15, Available at: https://doi.org/10.1186/s13049-022-01003-7
9	22 June 2023	Medical care at mass gatherings: emergency medical services at large-scale rave events	Krul J, Sanou B, Swart EL, Girbes ARJ., (2012), Medical care at mass gatherings: emergency medical services at large-scale rave events. Prehospital Disaster Medicine.;27(1):71–4. https://www.cambridge.org/core/journals/prehospital-and-disaster-medicine/article/abs/medical-care-at-mass-gatherings-emergency-medical-services-at-large-scale-rave-events/4CD0306C2BE06CC7991FFC2B23805A6D
10	20 June 2023	Mass casualty triage: An evaluation of the data and development of a proposed national guideline	Lerner EB, Schwartz RB, Coule PL, et al. (2008), 'Mass casualty triage: An evaluation of the data and development of a proposed national guideline', Disaster Medicine Public Health Prep; 2:S1, pp.S25-34. Available at: https://www.cambridge.org/core/journals/disaster-medicine-and-public-health-preparedness/article/mass-casualty-triage-an-evaluation-of-the-data-and-development-of-a-proposed-national-guideline/1F46780F3780F6C0DE330B5302C0A33F
11	21 June 2023	Mass Gathering Medical Care	Milsten, A., Jaslow, D., and Yancy, A. (2000), 'Mass Gathering Medical Care', NAEMSP Standards and Clinical Practice Committee. Available at: https://www.tandfonline.com/doi/abs/10.1080/10903120090941119
12	18 June 2023	Public Health Guidelines: Major Planned Events'	Ministry of Health, British Columbia, (2017), 'Public Health Guidelines: Major Planned Events'. Available at: https://www2.gov.bc.ca/assets/gov/health/keeping-bc-healthy-safe/major-planned-events/bc-major-planned-events-guidelines_2017_final.pdf
13	23 June 2023	Safe Work	Safe Work Australia, Available at: https://www.safeworkaustralia.gov.au/

14	21 June 2023	Validation of a modified medical resource model for mass gatherings	Smith WP, Tuffin H, Stratton SJ, Wallis LA. (2013), 'Validation of a modified medical resource model for mass gatherings', Prehospital Disaster Medicine;28; 01:1–7. Available at: https://www.cambridge.org/core/journals/prehospital-and-disaster-medicine/article/abs/validation-of-a-modified-medical-resource-model-for-mass-gatherings/7D6B6B85F46D82F2CD2F2E8D16A67C10
15	21 June 2023	The development of PRIMA-a Belgian prediction model for patient encounters at mass gatherings	Spaepen K, Haenen WAP, Hubloue I. (2020), 'The development of PRIMA-a Belgian prediction model for patient encounters at mass gatherings', Prehospital Disaster Medicine;35; 5:1–7. Available at: https://www.cambridge.org/core/journals/prehospital-and-disaster-medicine/article/abs/development-of-prima-a-belgian-prediction-model-for-patient-encounters-at-mass-gatherings/8E1AC0AD5D4D5FDC124D0B538B264D0A
16	24 June 2023	Critical Illness at mass gatherings is uncommon	Varon J, Fromm RE, Chanin K, Fillbin M, Vutpakd K.(2003). 'Critical Illness at mass gatherings is uncommon', Journal of Emergency Medicine; 25:4, pp.409–413. Available at: https://www.sciencedirect.com/science/article/abs/pii/S073646790300249X
17	15 June 2023	World Association of Disaster and Emergency Medicine—about mass gatherings'	WADEM, (2022), 'World Association of Disaster and Emergency Medicine—about mass gatherings'. Available at: https://wadem.org/sigs/mass- gathering/
18	22 June 2023	Community Emergency Preparedness: A Manual for Managers and Policy Makers	WHO, (1999), 'Community Emergency Preparedness: A Manual for Managers and Policy Makers', Available at: https://apps.who.int/iris/bitstream/handle/10665/42083/9241545194.pdf;sequence=1
19	19 June 2023	Public health for mass gatherings: key considerations	WHO, (2015), 'Public health for mass gatherings: key considerations', Available at: https://www.who.int/publications/i/item/public-health-for-mass-gatherings-key-considerations
20	19 June 2023	The generic all-hazards risk assessment and planning tool for mass gathering events'	WHO, (2023), 'The generic all-hazards risk assessment and planning tool for mass gathering events', Available at: https://www.who.int/publications/i/item/WHO-2023-Generic-Mass-gatherings-All-Hazards-RAtool-2023-1
21	6 July 2023	Mass Gathering Medical Care Planning	Yancey, A., Luk, J., Milsten, A., Nafziger, S., 'Mass Gathering Medical Care Planning: The Medical Sector Checklist', Available at: NAEMSP_MassGatheringsChecklist-D1-.pdf (ncw-herc.org)
22	06 March 2013	HAAD Standard for Medical Emergency Preparedness at Mass Gatherings	Health Protection Policy, Part C. Public Health Emergencies, and Chapter VII of the Healthcare Regulator Policy Manual Version 1.0.

9. Appendices

Appendix 1 - Guidance for Event Planner to assist with needs analysis for resource requirements based on the nature of the event, intelligence on the event and the likelihood of other factors. (**If there are more than 1 Healthcare Organizations providing medical coverage to different area's / zones of the event or mass gathering, a combined event Risk Assessment and Event Planner should be done to encompass the entirety of the event's needs, not the individual Healthcare Organizations area / zone of responsibility).**

Table 1 Event Nature:

Item	Details	Score
(A) **Nature of Event**	Classical Performance Public Exhibition Pop/ Rock Concert Dance Event Agricultural/ Country Show Marine Motorcycle Display Air Show Motor Sport / Sporting Events State Occasions VIPVisits/ Summit Music Festival Bonfire/ Pyrotechnic Display New Year Celebrations Demonstrations/ Marches/ Political events Low Riskof Disorder Medium Riskof Disorder High Riskof Disorder Opposing Factions	2 3 5 8 2 3 3 3 4 2 3 3 4 7 2 5 7 9
(B) **Venue**	Indoor Stadium Outdoor in Confined Location (park) Other Outdoor (festival) Widespread Public Location in Streets Temporary Outdoor Structures Includesovernight camping	1 2 2 3 4 4
(C) **Standing/ Seated**	Seated Mixed Standing	1 2 3
(D) **Audience Profile**	Full Mix, in family groups Full Mix, not in family groups Predominately young adults Predominately children and teenagers Predominately elderly Full Mix rival factions	2 3 3 4 4 5
Add A+B+C+D	***Total score for table 1***	

Table 2 Event Intelligence

Item	Details	Score
(E) **Past History**	Good Data, low casualty rate previously <1%. Good Data, medium casualty rate previously 1-2% Good Data, high casualty rate previously >2% First Event, no data	-1 1 2 3
(F) **Expected Numbers** (it should done indiviualy for each area/location in cases of multiple locations)	<1000 <3000 <5000 <10,000 <20,000 <30,000 <40,000 <60,000 <80,000 <100,000 <200,000 <300,000	1 2 8 12 16 20 24 28 34 42 50 58
(G) **Profile of event**	Includes any high-profile event such as international sporting events, visiting political dignitories, A-list artist performances, internationally televised events / gatherings etc. in which the reputation of the UAE or its leaders is on display. (Mandatory DOH in-person meeting to discuss the event, proposed medical plan, and risk assessment). This shall be done in alignment with existing event planning through NCEMA and [illegible]	62
Add E+F+G	**Total Score for Table 2**	

:

Table 3 Sample of additional considerations - Add the total for Tables1+2+3 above to give an overall score for the event.

Item	Details	Score
(H) **Expected Queuing**	< 4 Hours > 4 Hours > 12 Hours	1 2 3
(I) **Time of Year** **(outside events)**	Summer Autumn Winter Spring Ramadan	2 1 1 1 3
(J) **Proximity to definitive care** **(nearest suitable A&EDept.)**	< 30 minutes by road > 30 minutes by road	0 2
(K) **Profile of definitive care**	Choice of A&EDept. Large A&EDept. Small A&EDept.	1 2 3
(L) **Additional Hazards**	Carnival Helicopters Motor Sport Parachute Display Street Theatre	1 1 1 1 1
(M) **Additional on-site facilities**	Suturing X- ray Minor Surgery Plastering Psychiatric/ GPfacilities	-2 -2 -2 -2 -2
Add G+H+I+J+K+L **Subtract M**	***Total score for table 3***	

event.

Table 4 A guide to what resources may be required based on best practise from the scoring of the previous tables*

Score	Ambulance	First Aiders	Ambulance Personnel**	Doctor	Nurse	Ambulance Officer	Incident Support Unit Vehicle
<20	0	4	0	0	0	0	0
21-25	1	6	2	0	0	Visit	0
26-30	1	8	2	0	0	Visit	0
31-35	2	12	8	1	2	1	0
36-40	3	20	10	2	4	1	0
41-50	4	40	12	3	6	2	1
51-60	4	60	12	4	8	2	1
61-65	5	80	14	5	10	3	1
66-70	6	100	16	6	12	4	2
71-75	10	150	24	9	18	6	3
>75	15+	200+	35+	12+	24+	8+	3

t cannot take in to account all situations. Good pre planning and organisation will eliminate some of the risk factors involved with large events. The figures in this table are the total amount of resources at any one time and not a cumulative number over the whole

**Ambulance personnel denote a crew of two, both of whom must have pre-hospital training, qualifications, and accreditation in line with DOH requirements, valid DOH license, MCI training, and the designated driver to have a valid EVOC course. The decision to staff the ambulance with EMTs, Paramedics, Advanced Paramedics, or Critical Care Paramedics, nurses, or physicians is at the discretion of the Healthcare Provider who is responsible for justifying the decision in the Medical Action Plan for the Mass Gathering or Event, ensuring that sufficient and appropriate healthcare providers are on-site to deal with possible scenarios identified in the risk assessment and information gathering phases.

Appendix 2 – Pre-Hospital Care Minimum PPE requirements (additional PPE may be required over and above the below depending on event scope and risks and in line with other relevant DOH standards or current local legislations).

1) Safety Helmet conforming to international safety standards (NFPA1951:2007 /AS/NZS1801:1997 or EN443 standards)
2) Reflective Safety Jacket / Vest.
3) Safety Footwear
4) Appropriate Uniform designating they are a Healthcare worker.

   a) Name and Designation must be clearly visible.
5) Safety Glasses
6) Clinical gloves
7) Personal hand sanitizer

Medical face masks to protect from droplet or aerosolized diseases (such as surgical face masks)

Appendix 3 – Potential Health Risks:

Factor	Considerations
Weather	Heat exposure Cold exposure Lightning Precipitation
Attendance	Crowd size Staffing (paid and volunteer)
Duration of event	Extended exposure Increased exhaustion
Type of event	Outdoor vs. indoor Seated vs. mobile
Crowd mood	Music type (such as rock vs. classical concert) Team rivalry Confrontation (such as protests, political rallies)
Crowd type	Behavior and judgment Frailty/vulnerability Large numbers of people with a specific health condition (such as cancer walks) International visitors
Crowd density	Increased exposure to microbes Effects on mood Decreased access to patients Decreased access to water, bathrooms
Alcohol and drugs	Physiologic effects Decreased judgment Increased violence Binge drinking at the gate

Appendix 4 – Pre-Event / Mass Gathering DOH Escalation.

Event Planner Score	Event Categorization	Action Required
< 31	C3	Log event with DOH – continue as per event medical plan.
31 – 60	C2	Log event with DOH. DOH will review medical plan and risk assessment and 1) Approve the event; 2) Approved Pending certain changes; 3) Reject the event and require an in-person meeting to remedy medical plan and / or risk assessment.
> 60	C1	Send formal request to DOH to have in-person meeting to discuss the event, proposed medical plan, and risk assessment.

***This is a guide to be used in accordance with regulations from NCEMA and/or ADCMC.**