MCI Plan

Record of Change

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Contained within this manual are recommendations for the response to and proper handling of multi casualty incidents (MCI) within the Seven Mountains EMS Council region. Successful outcome of such responses is dependent upon situational preplanning, immediate institution of an ICS system, appropriate patient triage and treatment, and organized/documented patient transport to appropriate medical facilities.

The recommendations within are field proven to be effective in handling large numbers of patients in the most efficient and effective manor – having the greatest patient survivability outcome. Job sheets are provided for each major EMS function to assist providers, who don't handle mass casualty incidents on a daily basis, in successfully completing all the tasks needed to accomplish that job function.

These recommendations are consistent with current Incident Command System (ISC) teachings and follow National Incident Management System (NIMS) directives as contained in Homeland Security Presidential Directive #5. This manual outlines the activities within the EMS Branch within the incident command structure of a multi casualty incident. Unified command is recommended whenever multi-jurisdictional incidents are encountered.

Three levels of MCI are outlined: Multi Casualty Incident, Multi Casualty Disaster, and Catastrophic Casualty Disaster. Patient totals increase as disaster type increases; but, each are handled basically the same: Good scene size-up, Immediate institution of the incident command system, Timely request for additional assistance, Triage of all individuals involved, Proper treatment prior to transport, and Timely transport to the appropriate medical facility based on the patients injury severity.

These are only guidelines based on current "best practice". Providers have the flexibility to modify and/or alter procedures as needed based on the specific incident encountered.

Seven Mountains EMS Council would like to thank A.J. Heightman, Montgomery County Department of Public Safety, Eastern PA EMS Council, and EMMCO-West EMS Council for sharing information and references within this manual.

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Seven Mountains EMS Council
Mass Casualty Incident Plan

1.   Purpose

To maintain a functional all-hazard plan that outlines planning, emergency response, and recovery phases to guide and support emergency medical service organizations and providers within Seven Mountains EMS Council region in providing pre-hospital EMS care in a Mass Casualty Incident (MCI).

2.   Goal

To reduce morbidity, mortality and permanent disability through the delivery of critical manpower and material resources to the disaster-impacted area efficiently.

3.   Objectives

a.   Define roles and responsibilities of the regional EMS council.
b.   Identify services available from non-government organizations during an MCI event.
c.   Set guidelines and objectives for the EMS community in preparation for an MCI event within our region.

4.   Scope

Determine the manner in which EMS manpower and material resources available within the region will be utilized to meet the special needs during an MCI event. This plan is intended to address techniques in field operations that should be employed during an MCI Event when the number of patients exceeds immediately available resources. In addition, this plan may also serve as the basis for routine operations and pre-planning for mass-gathering events and other EMS special operations.

5.   Legal Authorities

a.   Federal:
        i.   Robert T. Stafford Disaster Relief and Emergency Assistance Act 42 of 1988 U.S.C. 5121 et seq.
        ii. The Federal Response Plan (for Public Health Law 93-288, as amended) April 1992.
        iii. P.L. 93-288, The Disaster Relief Act of 1974; 88 Stat. 143-164, as amended.
b.   State:

        The Bureau of EMS has the authority to maintain and coordinate a program for planning, developing, maintaining,

expanding, improving, and upgrading EMS systems within the Commonwealth.

6.   Plan Organization

This plan consists of three main sections: 1) introduction, 2) concept of operations, and 3) appendices. The introduction provides the structure and premises under which the plan will operate. The concept of operations outlines the roles and responsibilities of the EMS Council and regional EMS agencies for the planning, response, and recovery phases of an MCI. The appendices include support documents and emergency resource lists.

7.   Introduction

a. The emergency responders of today need to have a different outlook at their position in the emergency services than those of the past. With the increased threat of terrorism both international and domestic, every emergency responder must be aware of his or her surroundings. "We must always act, regardless of the chaos which is presented, based upon our knowledge and good judgment, taking whatever action will most impact the welfare of our patients." (A.J. Heightman, 1996)

b. The Seven Mountains region is at risk not only from terrorist threats but natural, technological and man-made disasters as well. History has proved that the greatest loss of life and/or property has come from floods, fires, winter and tropical storms, tornadoes and windstorms, earthquakes, landslides, nuclear industry incidents, dam failures, transportation, HAZMAT incidents, and riots. In most communities motor vehicle crashes are the most frequent event involving multiple, critically injured casualties requiring response by emergency medical services.

c. We must continually train and enhance our awareness of possible threats not only to those already injured, but also to ourselves. This document will address the EMS component within the Seven Mountains region for response to the emergency medical needs of a mass casualty incident (MCI).

8.   EMS Organizational Structure

a. The EMS agencies within the Seven Mountains EMS Council region are comprised of urban and rural quick response services (QRS), basic life support (BLS), advanced life support (ALS) and air ambulance services. The boroughs and townships within the nine county region is covered by EMS agencies staffed by career and volunteer emergency medical responders (EMR), emergency medical technicians (EMT), advanced emergency medical

technicians (AEMT), paramedics (P), pre-hospital registered nurses (PHRN), pre-hospital physician extenders (Extender) and pre-hospital physicians (HP).

    b.   The Seven Mountains EMS Council will receive guidance and direction from the Commonwealth of Pennsylvania, Bureau of EMS staff at the State level.

    c.   Voluntary mutual aid agreements have been created between neighboring municipalities and counties, as well as adjoining regions, and states bordering Pennsylvania at the state level. These agreements have been established for the purpose of securing additional resources following a disaster.

9.   Policies

    a.   This plan is the response plan for the Seven Mountains EMS Council. It supports the Health and Medical Annex (Annex J) of the State Emergency Operations Plan (SEOP).

    b.   Upon request, the regional council will provide support and logistics to the affected area. During activation of this plan, Seven Mountains EMS Council will assist with EMS authority, unless the regional EMS council or Bureau of EMS determine otherwise.

10.   Situations

    a.   This plan can be activated and implemented by any PSAP having information that leads them to believe that an MCI is occurring, or by any on scene or responding responder.

    b.   The following are situations that may trigger activation of the plan:

        a.   Partial or complete destruction of the medical infrastructure causing the interruption of access to emergency health services to a large population of residents.

        b.   Sudden onset of a large concentration of injured or killed sufficient to overwhelm the resources of the local medical response system.

        c.   Request from regional EMS agency engaged in a MCD or CCD, who have determined that the number of casualties exceed their capacity to respond.

        d.   Response to a mutual aid request by authorities of a neighboring region(s) or state(s) affected by MCD or CCD.

        e.   Request by federal authority, through PEMA, in accordance with the Federal Response Plan, Emergency Support Function #8 (ESF#8).

        f.   Request by federal authority, through PEMA, in support of the National Disaster Medical System (NDMS) during a foreign military contingency.

11.   Assumptions

    a.   This plan addresses the management of victims of MCI's.

    b.   Within the Commonwealth exists five geo-political levels of authority that may be involved during an EMS response to an MCI. They consist of:

municipal, county, regional EMS council, regional task force, and Bureau of EMS.

    c.   This plan assumes three categories of medical incident severity: MCI, MCD, and CCD.

    d.   MCI's are divided into three levels:

            I.   **Level I** – Involves less than 10 surviving victims.

          II.   **Level II** – Involves 11-25 surviving victims.

       III.   **Level III** – Involves 26-50 surviving victims.

    e.   With the varying capabilities and access to material and personnel resources, need for and/or specific needs at the municipal, county, regional, and state level will vary.

    f.   In most cases, local EMS and county emergency management agency (EMA) resources will be sufficient to manage MCI's.

    g.   MCD's involved 51-100 surviving victims and may require regional or state assistance.

    h.   CCD's involving 101 or more surviving victims will require state and possibly federal assistance.

    i.   All municipalities and counties have an MCI plan and those plans are consistent with this regional plan.

    j.   Overall management and responsibility for the MCI, MCD, and CCD remains at the local level unless otherwise explicitly transferred as dictated by local protocol.

    k.   By request, regional EMS councils may facilitate assistance to the affected area by mobilizing personnel and material resources from within the region.

    l.   Under the direction of the Secretary of Health, the Bureau of EMS can facilitate assistance to the affected area by mobilizing personnel and material resources from unaffected regions.

    m.   All requests for additional Commonwealth and federal assistance to support emergency medical needs will be requested through PEMA.

    n.   Every MCI, MCD and CCD incident will require someone to assume responsibility for EMS activities. This individual is identified in this document as "EMS Official". Under ICS and NIMS, this individual may be the "EMS representative of Unified Incident Command", "Operations Chief", "EMS Branch Director" or another functional position depending upon incident type and size.

12.   <u>Concepts of Operations</u>

    a.   Following is a sequence of desired events at an MCI, MCD, or CCD:

        i.   Upon notification of a possible MCI, MCD, or CCD a concise response system is implemented. First arriving police, fire, EMS Agency initiate an incident command system (ICS) and establish a Command Post near the incident scene. Command responsibilities are 'assumed' and any additional equipment and manpower necessary are requested.

ii.   Notification of extent and approximate number of casualties is relayed to the communications center by EMS Official. (See b.) Communications center then notifies, or assists in the notification of, all agencies involved or expected to be involved in the response – including medical facilities. (Consider Knowledge Center activation). Seven Mountains should be notified of any Level II or higher incident.

iii.   Upon notification of an incident the EMS Council regional director, or designee, will activate the regional council staff by informing them of the nature and circumstances of the event and will continue to provide regular updates as the incident/disaster response progresses. (Appendix XII). This individual will determine the need for staffing of the regional office or monitoring the situation from another location (home, County EOC, regional MCE).

iv.   The Regional Director or designee will confer with on-scene EMS operations to coordinate, in cooperation with EMA, requests for additional equipment/supplies/personnel when local assets have been exhausted.

v.   Hospitals should activate their disaster plans for external disasters according to level of disaster that has been reported and number of patients each facility may receive. (Consider Knowledge Center usage)

vi.   On-scene EMS personnel will initiate a rapid initial survey and initiate critical life-saving treatment as appropriate to the situation.

vii.   Patients are tagged according to appropriate priorities (TRIAGE) by assigned Triage Team(s).

viii.   Casualty Collection Stations are designated and set up in well-marked areas by Transportation Supervisor.

ix.   Patients are delivered (by priority if possible) to Casualty Collection Stations. Movement of patients is done as rapidly as safely possible and with appropriate patient care measures instituted.

x.   Incoming emergency units report to Equipment Staging Area to drop off personnel and supplies/equipment; then goes to Vehicle Staging Area (may be located contiguous with equipment staging) where the driver remains with the vehicle, awaiting further assignment. Or Incoming emergency unit reports to Vehicle Staging Area; personnel off-load EMS supplies, taking them to the Equipment Staging Area; driver remains with the vehicle, awaiting further assignment.

xi.   Patient treatment is implemented at Casualty Collection Stations consistent with patient needs and equipment availability.

xii.   Pre-hospital advanced life support personnel and/or designated Physician Disaster Response Teams treat patients most in need of advanced care at Casualty Collection Stations.

xiii.   Patients are transported in priority sequence, if possible, to designated hospitals as assigned by Transportation Supervisor.

xiv.   Detailed reports are maintained throughout the incident relevant to each responder's actions/responsibilities.

xv.   EMS personnel should consider using the Patient Tracking App & Knowledge Center to assist in incident accountability & control.

xvi.   EMS operations are terminated by incident command after confirmation with EMS Official that all EMS objectives have been successfully accomplished.

xvii.   Equipment and supplies are returned to appropriate agencies and readied for next incident.

xviii.   Critique of disaster scene operations conducted by all agencies involved, shortly after the disaster incident. This critique is usually coordinated through county EMA. Supervisors from responding agencies should consider the need for CISM and initiate as appropriate.

b.   Scene Reports;

i.   View as much of the scene as possible within 30 seconds of your arrival.

ii.   Process your thoughts into a logical order (CAN report – Conditions, Actions, Needs).

iii.   Present your report in a concise manner, usually 45 seconds or less, that paints a quick picture for the person to whom you are communicating.

iv.   Announce the MCI with the appropriate "Level", so all responding agencies and personnel know the appropriate patient volume with which they will be dealing.

c.   Six stages of an MCI
It is important to understand the various stages of an MCI. Responders cannot focus on the needs of a single patient, but rather the accomplishment of providing the greatest good for the greatest numbers.

i.   Preplanning and Training-*Pre-planning and training of rescuers who respond to an MCI will determine the effectiveness of the scene operation.* Plans and procedures need to be developed jointly by all the agencies likely to respond. They include fire, EMS, law enforcement, dispatch, hospitals, public works etc.
Pre-incident agreements should be developed to define the roles and responsibilities of all agencies and their resources. Use and application of the ICS must be part of the agreements. Frequent and ongoing training in MCI operations should occur. This also includes training on the application of ICS. Regular "field" exercises or drills also will sharpen skills.

ii. <u>Initial Response</u> – *Reacting to information received from callers to 911.* Consider early confirmation of the incident and the activation of a predefined response matrix. Responders should be reviewing the MCI response protocol. Dispatch center will be gathering more information on the incident, activating the MCI response action plan and relaying any pertinent information, relative to the incident, to the responding units. This stage will conclude when the first unit arrives on the scene of the incident.

iii. <u>Operations</u> – *Commences with the arrival of the first unit on the scene.* During this stage the incident is confirmed, a Command Post and Incident Command is established, and a suitable staging area is identified. Incident Command will announce, over the radio, establishment of command and location of the command post. <u>All units/personnel involved in the incident are expected to function under the Unified Incident Command Structure</u> (UICS). Incident command will provide a preliminary report to dispatch with all pertinent available information; the 5-S's (Scene Safety, Scene Size-up, Send Information, Set-up scene for causality management, Start Triage) regarding the incident. Additional EMS related updates/requests will be made by the EMS Official in coordination with Incident Command. The dispatch center will be relaying information to responding units relative to incident conditions that have been confirmed, the command post and staging area locations, and other pertinent information. It is during this stage that most of the command organization positions are activated. This stage concludes when Incident Command (IC) determines that no further response of units is required to manage the incident effectively.

iv. <u>Stabilization</u> – *At this stage the Incident Command continues to manage the incident through the Unified Command System (UICS) structure using the specified resources determined during the operations stage.* Continual progress reporting from the scene is occurring with information exchange via Knowledge Center regarding the availability of hospital beds and equipment, as well as incident operations (i.e., progress has been made, patient care has been initiated, and the incident is smoothly progressing towards de-escalation and termination).

v. <u>Demobilization</u> – *The IC commences the release of units back into service from the incident.* This release of resources can be from the scene, from the hospital after transport of patients, units still en-route can be cancelled, etc. This reduction should be as aggressive as was the initial response. It is incumbent upon the IC to ensure an appropriate level of resources on the scene to complete management of the incident.

v. <u>Termination</u> – *EMS MCI operations at an incident are terminated when the IC has determined that all patients requiring assistance*

or all potential for patients requiring assistance no longer exists. The IC will give a final progress report with recap of patient totals and unit status, stating at the conclusion of the report that the scene/incident has been secured.

13. <u>Roles and Responsibilities</u>

    a.   <u>Incident Command</u>

        i. This official is responsible for overall management of the entire operation and is identified by wearing a designated "Command" vest.

        ii. Initiates a plan and identifies strategies for the handling of all current and potential patients.

        iii. Ensures the life safety of responders and citizens.

        iv. Determines/approves tactical objectives for incident management.

        v. Implements the ICS structure as required by the demands of the incident.

        vi. Ensures that adequate resources are deployed to the incident and that those resources are handled effectively to manage the incident.

        vii. Facilitates intra- and interagency coordination under unified command as appropriate.

        viii. Authorizes and controls media access.

        ix. Delegates tasks for completion to functional area officers, who in turn will report back to the IC.

        x. Assigns a Public Information Officer (PIO)

    b.   <u>EMS Official</u> – This individual has overall responsibility for EMS operations during an MCI event and may be the "EMS representative of Unified Incident Command", "Operations Section Chief", "EMS Branch Director" or another functional position within the ICS chart depending upon incident type and size.

        i. First arriving EMS unit at the scene shall designate a member of that crew to immediately assume this responsibility.

        ii. Serves as the coordinator for all emergency medical services carried out at the disaster scene.

        i. Designates a "Triage Group Supervisor/ Unit Leader", "Treatment Group Supervisor/ Unit Leader", "Transportation Group Supervisor/ Unit Leader" and when needed "Staging Area Manager", and "EMS Communications Group Supervisor/ Unit Leader".

        ii. EMS functional positions which aren't assigned by the EMS Official are the responsibility of that position.

        iii. Assumes overall EMS responsibility to ensure proper patient care; triage and tagging of victims; transportation of victims;

appropriate hospital distribution; and control of all EMS personnel and vehicles.

    iv.   Provides visual identification of him/herself by wearing an appropriate disaster scene identification article.

    v.   Assesses the scope of the disaster incident and approximate number of survivors.

    vi.   Ensures that the communications center is provided with up-to-date information.

    vii.   Provides frequent EMS sector updates to Incident Command.

    viii.   Requests sufficient manpower and EMS units to the scene and instruct them to report to the designated Vehicle Staging Area in conjunction with the Transportation Group Supervisor/ Unit Leader.

    ix.   Works in conjunction with the Fire/Rescue Official(s) for the assignment of sufficient manpower to carry/transfer patients to the appropriate Casualty Collection Station in a safe, efficient manner.

    x.   Assigns incoming advanced level medical personnel (physicians, nurses, HPs, PHRNs, EMT-Ps) to assist the Triage and/or Treatment Unit Leader(s) based on patient needs.

    xi.   Insures that an Equipment Stockpile Area, near the Casualty Collection Stations, is established and that incoming EMS units are advised to drop off needed equipment and supplies prior to reporting to the Vehicle Staging Area.

    xii.   Informs the communications center of the total number of victims and approximate number of victims in each triage category. This information will then be forwarded to all local medical facilities as determined most effective/efficient. This task can also be accomplished thru the use of Knowledge Center.

    xiii.   If needed, establishes a temporary morgue area.

  c.   EMS Triage Group Supervisor/ Unit Leader

    i.   Possesses basic medical skills (EMT minimum) to make appropriate triage decisions.

    ii.   Provides visual identification of him/herself by wearing an appropriate disaster scene identification article.

    iii.   Determines whether triage and primary treatment will be conducted on site or at a combined Triage/Treatment Area.

    iv.   Assumes responsibility for the triage and tagging of all patients at the incident in accordance with appropriate triage protocols. This can occur where the patient is found or at the entry to the Treatment Area.

    v.   Develops and establishes the Triage Area organization.

     vi.   Determines resources required to conduct Triage Area operations:
- a.   Communications
- b.   Personnel
- c.   Equipment & Supplies
- d.   Relief Units & Personnel

    vii.   Obtains and reports to the EMS Official an approximate (and when available actual) count of patients for each triage priority category.

    viii.   Communicates all resource requirements to The EMS Official.

    ix.   Ensures safety of all members operating in the area.

    x.   Provides frequent progress reports on area activity to the EMS Official.

    xi.   Coordinates movement of patients to Treatment Area.

    xii.   Maintains incident documentation relative to his/her duties.

d.   <u>EMS Treatment Group Supervisor/ Unit Leader</u>

    i.   Establishes an area(s) where patients can be collected and treated. If possible, central treatment areas maximize the limited resources of rescuers in incidents that involve large numbers of patients. Here extensive treatment and advanced life support care are conducted. Things to remember:
- a.   Upwind and uphill.
- b.   Sufficient space for expanded operations.
- c.   Unimpeded access and egress for units.

    ii.   Provides visual identification of him/herself by wearing an appropriate disaster scene identification article.

    iii.   Identifies and requests, within ICS structure, additional personnel and equipment as needed.

    iv.   Accepts transfer of patient care responsibilities as victims are delivered to Casualty Collection Stations (care areas).

    v.   Assists with the movement of patients from the Triage Area, if requested.

    vi.   Ensures patients received into the Treatment Area are:
- a.   Separated by triage category.
- b.   Reassessed and re-triaged as appropriate.
- c.   Receive prompt and efficient treatment in accordance with established Statewide ALS/BLS protocols.

    vii.   Establishes communications and coordinates activities with Transportation Unit Leader.

    viii.   Assigns, supervises, and coordinates personnel within Treatment Area.

    ix.   Communicates resource requirement to The EMS Official.

    x.   Ensures safety of all members operating in area.

    xi.   Directs movement of patients to Transportation Loading Area.

      xii.   Provides frequent progress reports on area activity to the EMS Official.

      xiii.   Maintains incident documentation concerning his/her operational activities throughout the incident.

      xiv.   If large scale incident, the Treatment Supervisor/Unit Leader may need to assign additional support positions within this area:

          1.   Treatment Area Manager: (one for each treatment area) their role is to ensure that patients are treated and packaged for transport as soon as possible. Activating these positions is primarily a "span of control" need.

          2.   Treatment Dispatcher: This is also a "span of control" position. The dispatcher ensures that the patient is ready for transportation and coordinates with the Transportation Supervisor.

e.   <u>EMS Transportation Group Supervisor/ Unit Leader</u>

      i.   Establishes an adequately sized, easily identifiable patient loading area in coordination with the Treatment area Supervisor/ Unit Leader

      ii.   Provides visual identification of him/herself by wearing an appropriate disaster scene identification article.

      iii.   Establishes communication capabilities with hospital(s).

      iv.   Designates an EMS staging area manager in collaboration with Incident Command, EMS Treatment Group Supervisor/ Unit Leader and the EMS Official.

      v.   Directs the transportation of patients as directed by the Treatment Group Supervisor/ Unit Leader.

      vi.   Establishes communications capabilities with subordinates.

      vii.   Requests additional transportation resources using ICS structure as established.

      viii. Requests ambulances from staging area as needed.

      ix.   Coordinates use of air ambulances for patient transport.

      x.   Establishes landing zone(s) as needed.

      xi.   Maintains current inventory of available hospital beds and equipment/supplies.

      xii.   Maintains patient tracking records and other incident documentation as required by his/her position.

      xiii. Logs all ETA's, departure times, and destinations of departing ambulances.

f.   <u>EMS Communications Unit Leader</u> - These responsibilities may be handled by a Joint Communications Unit Leader and/or be under the

control of a "Communications Branch Director" depending on incident needs.

  i. Establishes and maintains EMS Communications capabilities at the command post.
  ii. Selects appropriate frequency or frequencies, in conjunction with communications center, to be used for all EMS communications concerning the incident.
  iii. Establishes a working arrangement with the Police and Fire/ Rescue Communications Unit Leader(s).
  iv. Establishes and maintains assigned frequencies for each receiving hospital. Consider State 800Mhz radio system.
  v. Establishes and maintains assigned frequencies for medical command.

g. EMS Safety Officer – These responsibilities may be handled by a Joint Safety Officer and/or be under the control of an "Incident Safety Officer" depending on incident needs and complexity.

  i. Assigned by, and reports to, the EMS Officer, Unless they are the Incident Safety Officer, then they are assigned by, and reports to the Incident Commander at all scenes.
  ii. Responsible for making sure:
      1. Proper protective clothing is being worn.
      2. Restricted or "Hot" zones are established and policed.
      3. Tired personnel are sent to "Rehab".
      4. Safe operations are utilized by all personnel on scene.
      5. Will insure that any operations deemed "unsafe" are ceased or modified in such a way as to provide maximum safety to the victims and rescuers.
      6. EMS personnel do not enter hazardous areas unprotected or alone.
      7. Patients are properly protected during extrication and movement.
      8. Ground hazards are removed, marked, or neutralized.
      9. Adequate lighting (and heating/cooling for patients) is available.
  iii. EMS Safety Officer has the authority (Just as the Incident Safety Officer does) to temporarily halt any activity which is deemed "unsafe". Operations will not resume until the operation/situation has been reevaluated and deemed as "being done safely".

14. Key Areas within the Incident

a.   Equipment Stockpile Area
    i.   Used for rapid deployment of equipment.
    ii.   Essential in expediting the treatment and transport of victims.
    iii. The Transportation Supervisor/ Unit Leader will specify to incoming units what specific items are needed and where the Equipment Stockpile area is located.
    iv.   Should have an assigned person to organize and manage the area. This individual is titled the Equipment Stockpile Manager.

b.   Casualty Collection Area
    i.   Temporary place of shelter and "processing" of patients until transported to hospital facility – must be large enough to provide adequate space based on the number of patients involved and/or expected.
    ii.   Employs 'color-coded' patient priority sections for quick identification of patient care and needs. This can be accomplished by:
        1. Colored flags or colored traffic cones.
        2. Colored floor-wash style signs OR white signs with reflective numbers.
        3. Color-coded cyalume light-sticks. (30 minute high intensity sticks work best).
        4. Color-coded salvage covers or canopies. These offer a dry protected area to place and treat victims and are one of the best means of visually separating patient treatment areas.
    iii. Creates a "Cattle Chute" to easily group and control the income of patients. They force personnel to travel where you want them. Difficult to "sneak through" the system if established and utilized early in the incident.

c.   Vehicle Staging
    i.   Should not be "too close" to the incident.
    ii.   Staging Area Manager communicates with Communications Center to alert incoming units about blocked access routes and offer alternative routes.
    iii. Non-essential apparatus are staged to prevent blocking access to in-coming or essential on-scene units.
    iv.   Position vehicles so they never need to back up.
    v.   Identify to drivers that there are "secured" entry and exit routes, so they feel confident of their destination and assured that they will not be "trapped".

       vi.   Use vehicle numbering to allow on-scene personnel to identify the units from all sides and from a distance.

      vii.   Instruct drivers to remain with their unit for easy and quick response to patient collection area.

     viii.   Most appropriate method for staging and deployment of units should be utilized (see Appendix X).

15.   <u>Transfer of Command</u>

   a.   The fact that a higher-ranking officer has arrived on scene does not mean that he/she is prepared to or should assume command of the incident. The arriving officer may or may not have a full knowledge of previous orders or current activities. Without a thorough briefing of the situation status, the officer will compromise the operations. Remember: Organizational 'rank' is not necessarily the determinant for designation of "Incident Command" and/or staffing within the ICS structure.

   b.   A standardized approach to the transfer of command is essential.

   c.   The actual transfer of command should be regulated by the following:

      1.   Officer assuming command should communicate with the present officer at the command post.

      2.   The briefing should consist of:

         a.   Incident action plan

         b.   Progress towards achieving objective

         c.   Safety considerations & concerns

         d.   Deployment and assignment of units and personnel assigned to the incident.

         e.   Appraisal of the need for additional resources

      3.   Both officers should review the tactical worksheet or command board to handle any questions that may arise.

      4.   Person being relieved of command can be re-assigned, by incoming Incident Commander, to another position within the ICS structure or processed for "end-of-shift" leaving the scene.

      5.   Upon change of Incident Command, dispatch should be advised of such.

      6.   Transfer of other command staff/ICS positions should follow the same guidelines as described above for Incident Command with the exception of step #5. Shift change transfers are recommended as incoming staff can be jointly briefed prior to assuming their duties.

16.   <u>Emergency Incident Rehabilitation</u>

   a.   The physical and mental demands associated with EMS and other emergency operations, coupled with the environmental dangers of extreme heat and humidity or extreme cold, create conditions that can have an adverse impact upon safety and health of the individual emergency responder(s).

b. Members who are not provided adequate rest and re-hydration during emergency operations or training exercises are at risk of illness and/or injury.

c. When responders become fatigued, their ability to operate safely is impaired. Their reaction time is reduced and their ability to make critical decisions diminished.

d. Rehabilitation is an essential element on the incident scene.

e. A successful rehabilitation program will improve the morale of the department and increase the level of productivity.

f. The United States Fire Administration, in an effort to reduce the incidence of emergency responders injury or death, has developed a sample Emergency Incident Rehabilitation Standard Operating Procedure. (Appendix XI)

Mass Casualty Levels

In an effort to pre-plan appropriate response to mass casualty incidents, Seven Mountains EMS Council recognizes five levels of mass casualty event. These levels are as follows:

- **Multiple Casualty Incident** are divided into four levels:
  - **Level I** – Involves less than 10 surviving victims.
  - **Level II** – Involves 11-25 surviving victims.
  - **Level III** – Involves 26-50 surviving victims.
  - **Mass Casualty Disaster (MCD**
    - **Level IV** - involves 51-100 surviving victims.
- **Mass Casualty Incident**
  - **Level V –** involving 101 or more surviving victims.

Regional use of this classification allow EMS field responders (Incident Command) to quickly apprise the communications center of the scope of involvement and needed resources (i.e. "Send me a level III EMS response" vs. "Send me 12 ambulances, 2 QRS units, and 2 ALS Squads)

The Seven Mountains EMS Council suggests that the county communications centers – working in cooperation with the county EMS agencies and with assistance from Seven Mountains – develop local EMS boxes, for at least the first four levels of incident, for all coverage areas. These 'boxes' will change as vehicles are added or removed from service and should be reviewed on an annual basis. Each defined MCI Level provides the Incident Commander with a **suggested minimum number and type** of resources that should be requested as part of the initial response package. Ultimately, the type and number of resources requested is dependent on the nature and location of the incident.

Level I - Six (6) ambulances (2 should be ALS if available)
One (1) ALS Squad
Two (2) QRS Unit

Level II- Ten (10) ambulances (3 should be ALS if available)
Two (2) ALS Squads
Four (4) QRS Units
Consider Two (2) Air Ambulances
Consider One (1) MCI Trailer

Level III- Fifteen (15) ambulances (5 should be ALS if available)
Three (3) ALS Squads
Six (6) QRS Units
Three (3) Air Ambulances
Consider Two (2) MCI Trailers
Consider other resources (Public Transportation, etc.)

Level IV- Twenty (20) ambulances (8 should be ALS if available)
Four (4) ALS Squads
Eight (8) QRS Units
Four (4) Air Ambulances
Consider Three (3) MCI Trailers

Consider other resources (Public Transportation, etc.)
Level V- Twenty-five (25) ambulances (14 should be ALS if available)
Five (5) ALS Squads
Five QRS Units
Two (2) Air Ambulances
Consider other resources (Public Transportation, etc.)
Consider "PA Strike Teams" for extended events.

When developing these "box" assignments, consideration needs to be taken to provide for "Move-up" assignments to cover other calls for assistance which may occur in the coverage area. These assignments should be one (1) BLS unit, at minimum, for any incident over a Level I response.

The Seven Mountains EMS Council has equipment and supplies, to supplement what is available during mass casualty events, and can provide technical assistance as needed. The EMS Official should consider requesting (through Incident Command) Council assets at any incident where they could be utilized. Activation is handled through the county communications center(s) and/or county EMA.

Requests for Commonwealth EMS Strike Team assets and other Commonwealth Mobile Surge System assets are handled through notification of county EMA through PEMA and the Commonwealth EOC. Remember, Strike Team assets are for events lasting days and/or weeks – not hours.

Hospital Phone Number
(Some are main switch board, some emergency department)

Hospital Name	Address	Phone Number	LAT	LON
Berwick Hospital Center	701E. 16th Street Berwick, Pa 18603	(570) 759-5031	41.07048	-76.23104
Bucktail Medical Center Renovo	1001 Pine Street Renovo, PA 177654	(570) 923-1000	41.32683	-77.738064
Carlisle Regional Medical Center	361 Alexander Spring Rd. Carlisle, Pa 17015	(717) 960-1695	40.18529	-77.21747
Chambersburg Hospital	112 N. Seventh St. Chambersburg, PA 17201	(717) 267-3000	39.93474	-77.64741
Charles Cole (Coudersport)	1001 E. Second St. Coudersport , PA 16915	(814) 274-9300	41.7732	-77.999
Children's Hospital of Philadelphia **	3401 Civic Center Blvd. Philadelphia , Pa 19104	(215) 590-3488	39.949062	-75.193362
Children's Hospital of Pittsburgh **	4401 Penn Ave. Pittsburgh, Pa 15201	(412) 692-5159	6232430	-79.95304
Clearfield Hospital	809 Turnpike Ave. Clearfield, Pa 16830	(814) 768-2388	41.0322	-78.4493
Conemaugh Memorial Medical Center(Johnstown) *	1086 Franklin St. Johnstown, Pa 15905	(814) 534-9063	41.304951	-78.91883
Crozer-Chester Medical Center ***	1 Medical Center Blvd. Upland, Pa 19013	(610) 477-2051	39.857076	-75.366162
Dubois Regional Medical Center	100 Hospital Ave. DuBois, Pa 15801	(814) 371-2200	41.11437	-78.77501
Evangelical Community Hospital (Lewisburg)	1 Hospital Drive Lewisburg, Pa 17837	(570) 522-4434	40.979947	-76.885331
Geisinger Bloomsburg Hospital	549 E. Fair Streeet Bloomsburg, Pa 17815	(570) 387-2100	41.00871	-76.45326

Geisinger Medical Center (Danville) */**	100 N. Academy Ave. Danville, Pa 17822	(570) 271-6217	40.96795	-76.60668
Geisinger-Lewistown Hospital	400 Highland Ave. Lewistown, Pa 17044	(717) 242-7180	40.61795	-77.56741
Geisinger Shamokin Area Community Hospital	4200 Hospital Rd. Coal Township, Pa 17866	(570) 644-4222		
Geisinger Wyoming Valley Medical Center	1000 E. Mountain Dr. Wilkes-Barre, Pa 18711	(570) 826-7762	41.25688	-75.8117
Holy Spirit (Camp Hill)	503 N. 21st St. Camp Hill, Pa 17011	(717) 972-4300	40.25407	-76.92428
J.C. Blair Memorial Hospital (Huntingdon)	1225 Warm Springs Ave. Huntingdon, Pa 16652	(814) 643-2290	40.493578	-78.013898
Jersey Shore Hospital	1020 Thompson St. Jersey Shore, Pa 17740	(570) 398-5130	41.201694	-77.26795
Lehigh Valley Hospital 17th & Chew	17th & Chew Streets Allentown, Pa 18105	(610) 402-6115	40.600521	-75.494054
Lehigh Valley Hospital-Cedar Crest ***	1200 S. Cedar Crest Blvd. Allentown, Pa 18105	(610) 402-6115	40.567642	-75.518647
Lehigh Valley Hospital-Hazleton	700 E. Broad St. Hazleton, Pa 18201	(570) 501-4365	40.95008	-75.96329
Lehigh Valley Hospital-Tilghman	4815 Tilghman St. Allentown, Pa 18104	(610) 402-8220	40.58927	-75.56341
Lehigh Valley-Muhlenberg	2545 Schoenersville Rd. Bethleham, Pa 18017	(610) 402-6115	40.64635	-75.40665
Lock Haven Hospital	24 Cree Dr. Lock Haven, Pa 17745	(570) 893-5040	41.13321	-77.468
Milton S Hershey Medical Center */**	500 University Dr. Hershey, Pa 17033	(717) 531-8955	40.265695	-76.674223
Mount Nittany Medical Center	1800 E. Park Ave. State	(814) 234-6110	40.81828	-77.85039

	College, Pa 16803			
Muncy Valley (Williamsport)	215 E. Water St. Muncy , PA 17756	(570) 546-4201	41.20903	-76.77565
PinnacleHealth-Community Hospital(Harrisburg)	4300 Londonderry Rd. Harrisburg, Pa 17109	(717)-657-7295	40.282754	-76.81579
Pinnacle Health-Harrisburg Hospital	111 N. Front Street Harrisburg, Pa 17105	717-255-6127	40.259417	-76.884326
Sunbury Community Hospital	350 N. Eleventh St. Sunbury, PA 17801	(570) 286-3333	40.86206	-76.77848
Tyrone Hospital	187 Hospital Dr. Tyrone, Pa 16686	(814) 684-1255	40.67595	-78.25272
UPMC-Altoona Hosp. *	620 Howard Ave. Altoona, Pa 16601	(814) 889-2153	40.52159	-78.39798
West Penn Hospital ***	4800 Friendship Ave. Pittsburgh, Pa 152245	(412) 578-5000		
Williamsport Hospital	700 High St. Williamsport Hospital	(570) 321-1000	41.24556	-77.01442

*	Regional Trauma Center
**	Pediatric referral Facility
***	Burn referral center

Helicopter Phone Numbers

|	
Allegheny General Life Flight (Pittsburgh)	(800) 244-5433
Geisinger Life Flight (Danville)	(800) 852-7828
Guthrie Air-Life Net of New York (Sayre)	(800) 435-3822
Life Lion (Hershey)	(800) 225-4837
STAT MedEvac 17 (Life Star Erie)	(800) 437-4378
Med Star (Johnstown)	(800) 633-7827
STAT MedEvac 11 (Altoona/Clearfield)	(800) 633-7827
University Medevac (Allentown)	(800) 322-9599

Communication Center Phone Numbers

Name	Address	Phone Number	Fax Number
Blair County 911	615 4th St. Altoona, Pa 16602	(814) 940-5900	(814) 940-5907
Cambria County 911	401 Candlelight Drive, Suite 100 Ebensburg, Pa 15931	(800) 281-1680	(814) 472-1439
Cameron County 911 **Covered Through Elk County**	15854 Boot Jack Rd. Ridgeway, Pa 15853	(814) 772-0000	(814) 772-0083
Centre County Department of Public Safety/911	Willowbank Building-Room131 420 Holmes St. Bellefonte, Pa 16823	800-479-0050	(814) 355-6776
Clearfield County Emergency Services	911 Leonard St. Clearfield, Pa 16830	(814) 765-1533	(814) 768-9920
Clinton County 911	22 Cree Dr. Lock Haven, Pa 17745	(570) 748-2936	(570) 896-4044
Dauphin County 911	9-1-1 Gibson Blvd. Steelton, PA 17113	(717) 558-6900	(717) 558-6950
Franklin County 911	157 Lincolin Way East, Courthouse Chambersburg, Pa 17201	(717) 264-1633	(717) 264-4246
Fulton County 911	Court House Annex No.1 214 N. Second St. McConnellsburg, PA 17233	(717) 485-0503	(717) 485-3767
Huntington County 911	530 Washington St. Huntingdon, Pa. 16652	800-373-0209	(814) 643-2644
Juniata County 911	11 N. Third St. Mifflintown, Pa. 17059	(717) 436-7770	(717) 436-7779
Lycoming County Department of Emergency Services	542 County Farm Rd. Mountoursville, PA 17754	(570) 433-3166 or (570) 433-4360	(570) 433-4435
Mifflin County Office of Public Safety	20 N. Wayne St. Lewistown, Pa 17044	(717) 248-9607	(717) 248-0300
Northumberland County Department of Public Safety	911 Greenough St. Suite 2, Sunbury, Pa 17801	(570) 988-4539	(570) 988-4546
Perry County 911	PO Box 37 Center Square New Bloomfield, Pa 17068	(717) 582-4311	(717) 582-5165
Potter County (Handled Through Tioga County)	Court House 118 Main St. Wellsboro, Pa 16901	800-622-2100	(570) 724-5963
Snyder County Department of Emergency Services	RR#1 Box 130K Selinsgrove, Pa 17870	(570) 372-0826	(570) 374-5151
Tioga County Emergency Services	Court House 118 Main St. Wellsboro, Pa 16901	800-622-2100	(570) 724-5963
Union County Department of Emergency Services	103 S. Second St. Lewisburg, Pa 17837	(570) 523-1113	(570) 524-2820

Supporting Agencies

The following supporting agencies are available to provide assistance and services Commonwealth-wide following a disaster. Activation of one or more of these agencies may be done at the discretion of county EMA or MCE.

i.	American Radio Relay League, Inc.
ii.	American Red Cross
iii.	Civil Air Patrol
iv.	Department of Military and Veterans Affairs
v.	Military Amateur Radio
vi.	Municipal/County Emergency Management Agency
vii.	National Association of Social Workers
viii.	National Disaster Medical Assistance Team (DMAT)
ix.	PEMA – Search and Rescue
x.	PA Critical Incident Stress Management Teams
xi.	PA Department of Transportation (Penn DOT)
xii.	PA Department of Health, Bureau of EMS
xiii.	PA Medical Society
xiv.	PA Nurses Association
xv.	PA Psychological Association
xvi.	PA Search and Rescue Council
xvii.	PA Trauma Systems Foundation
xviii.	Poison Centers
xix.	Regional EMS/EHS Councils
xx.	Religious Organizations
xxi.	Turnpike Commission

Sample Unified Incident Command Structure
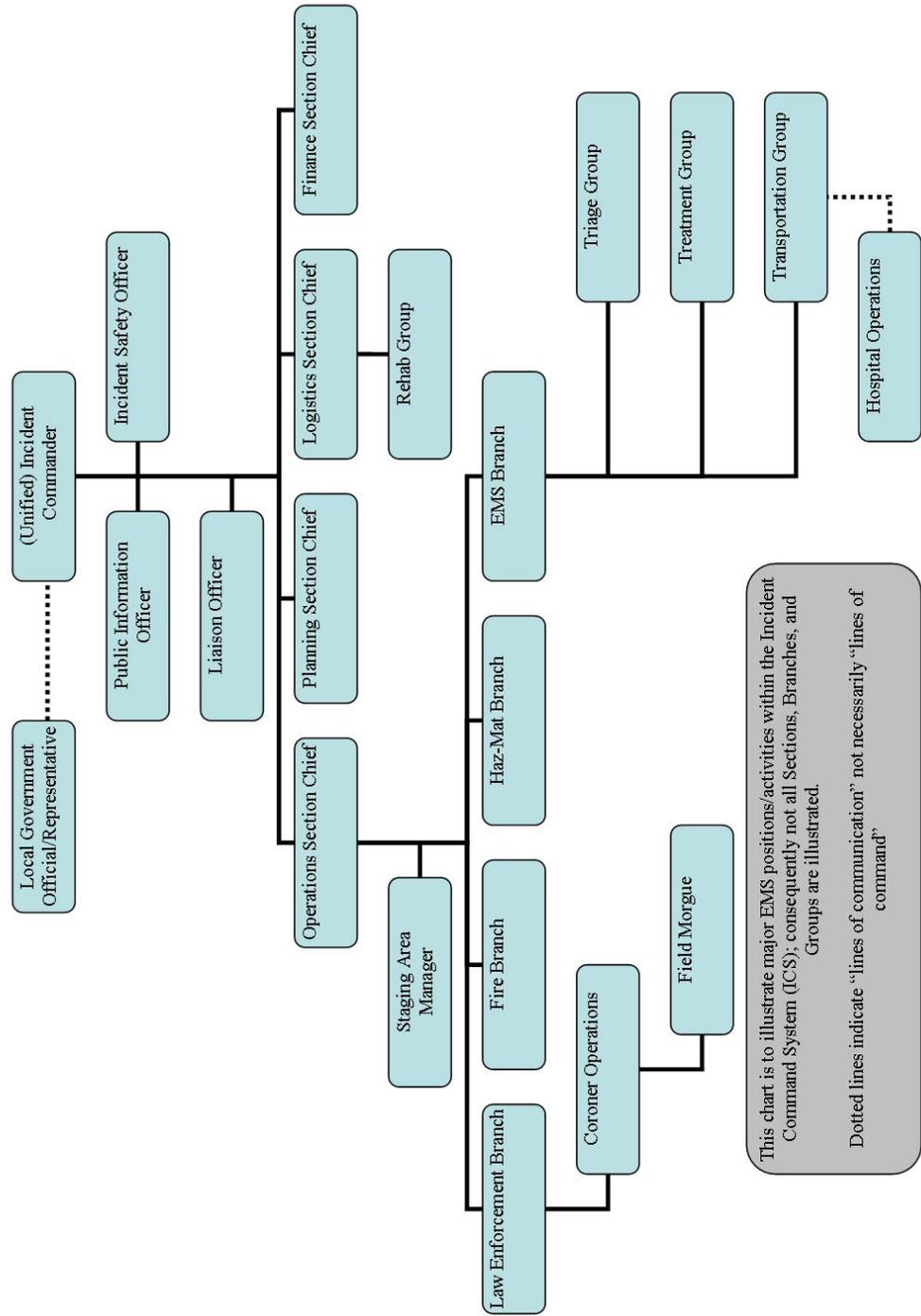
This chart is to illustrate major EMS positions/activities within the Incident Command System (ICS); consequently not all Sections, Branches, and Groups are illustrated.

Dotted lines indicate "lines of communication" not necessarily "lines of command"

(Unified) Incident Commander

Local Government Official/Representative

Incident Safety Officer

Public Information Officer

Liaison Officer

Finance Section Chief

Logistics Section Chief

Rehab Group

Planning Section Chief

Operations Section Chief

EMS Branch

Haz-Mat Branch

Staging Area Manager

Fire Branch

Field Morgue

Coroner Operations

Law Enforcement Branch

Triage Group

Treatment Group

Transportation Group

Hospital Operations

Unified Incident Command

Roles & Responsibilities

EMS Branch	The organizational level having functional responsibility for all aspects of emergency medical service (EMS) delivery within incident operations. It is organizationally situated between the section and division or group within the Operations Section. The branch leader has the title of EMS Branch Director.
Incident Action Plan (IAP)	A plan that contains objectives that reflects the incident strategy and specific control actions for the current or next operational period.
Incident Commander	The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.
Finance Section	This section is directly responsible to the IC for all costs and financial considerations of the incident. This section is also responsible for legal issues related to the incident. The section leader is a member of the General Staff and has the title of Finance Section Chief
Liaison Officer	A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies.
Local Govt. Official	Representative from the local municipality (may be municipal EMA or elected official) who has the authority to act on behalf of that municipality in mitigation of, preparation for, response to, or recovery from a natural/man-made disaster and/or MCI incident.
Logistics Section	This section is responsible for providing facilities, services, and material support for the incident. The section leader is a member of the General Staff and has the title Logistics Section Chief.
Operations Section	This section is responsible for all tactical incident operations. In ICS, it normally includes subordinate branches, divisions, and/or groups. The section leader is a member of the General Staff and has the title of Operations Section Chief

Planning Section	Responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the IAP. This section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident. The section leader is a member of the General Staff and has the title of Planning Section Chief
Public Information Officer	A member of the Command Staff responsible for interfacing with the public and media or with other agencies with incident-related information requirements.
Safety Officer	A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring personnel safety.
Staging Area Manager	The individual responsible for the coordination, support, and distribution of incoming resources. Coordinates resource movement with the transportation supervisor.
Transportation Supervisor	The individual responsible for operations within the transportation area. Is responsible for communicating with the treatment area supervisor and participating hospitals to manage transport of patients from the disaster scene.
Treatment Supervisor	The individual responsible for operations within the treatment area. Is responsible for patient treatment, from Triage through delivery to the transportation section.
Triage Supervisor	The individual responsible for the overall coordination of triage activities at a disaster scene. Coordinates the movement of patients from the scene to the treatment area(s).

EMS Official / Branch Director

Purpose: To ensure the proper command and organization of all EMS personnel functioning in response to the MCI incident and to ensure the efficient and effective triage, treatment, and transportation of all injured persons.

Scope: This guideline applies to, and should be followed by, ALL emergency medical services personnel operating on an MCI scene within the Seven Mountains EMS Council region. The EMS official should be placed in service when: a significant event has occurred that has required multi-agency operation and/or multi-level response to a specific incident. The EMS Official is usually the first arriving EMS officer on scene or the senior, highest trained attendant present at the beginning of the operation.

Section 1 – ESTABLISHING THE EMS OFFICIAL

The EMS Official is directly responsible to the Incident Commander for the overall conduct of EMS operations, to include:
1. Providing visual identification of him/herself by wearing an appropriate Major Incident Scene Identification Article, **Blue Vest**, properly labeled.
2. Assigning EMS personnel, to assist in carrying out other integral EMS roles (i.e. Triage, Treatment, and Transport) and responsibilities.

Section 2 – RESPONSIBILITIES

1. The EMS Official will appoint supervisors for TRIAGE, TREATMENT, and TRANSPORTATION – and if not already appointed: REHABILITATION & SAFETY – as soon as personnel are available.
2. The EMS Official should immediately establish a Command Post (if not already established) and start the process of Unified Command in conjunction with local fire and police officials.
3. The EMS Official will then notify the emergency dispatch center of the exact location and identification of the command post (if not already done).
4. The EMS Official will assume overall EMS responsibility to ensure proper patient care; triage and tagging of victims, transportation of victims to hospitals taking proper distribution into consideration; and control of all EMS personnel and EMS vehicles.
5. The EMS Official will establish (or assign someone to establish) radio communications and request specific communications needs (Med channels, local channels).

Section 3 – EMS Official Operational Guidelines

The EMS Official's duties at the major incident scene should be to:

1. Immediate assessment of the scope of the incident and approximate number of surviving victims. The EMS Official ensures that the emergency dispatch center is provided with this information.
2. Declare "Level" of MCI when that information is available.
3. Obtain a "Tactical-Channel" or other appropriate radio channel for operations.
4. Instruct responding EMS vehicles to report to the designated Vehicle staging Area, which has been designated in conjunction with the Transportation Group Supervisor/ Unit Leader and Staging Area Manager.
5. Assign a Triage Unit Leader and sufficient manpower to the overall task of surveying the scene for survivors and triaging these victims.
6. Assign a Treatment and a Transportation Unit Leader to establish Casualty Collection Area and have victims removed to appropriate medical facilities in an orderly, expeditious manner.
7. As appropriate, assign medical teams to report to the Treatment Group Supervisor/ Unit Leader, at the Casualty Collection Area(s), to render care to victims prior to their removal from the scene.
8. Work in conjunction with the Fire/Rescue Branch Director to assign crews to carry and transfer patients to the Casualty Collection Area in a safe, efficient manner.
9. Assign incoming advanced level medical personnel to assist the Treatment Group Supervisor/ Unit Leader at the Casualty Collection Area.
10. Designate an Equipment Stockpile Area near the Casualty Collection Area and advise incoming emergency units so they can drop off needed equipment and supplies prior to reporting to the Vehicle Staging Area.
11. Inform the emergency dispatch center of the total number of victims and approximate number of victims in each triage priority category. (This information is then to be forwarded to all local medical facilities).
12. If required & not already done, establish and identify a temporary morgue area. Request emergency dispatch center to notify coroner to respond to scene.
13. Have an assistant(s) that can handle communications, documentation and logistical requests.
14. Request additional resources, as needed, through Incident Command structure. Request notification of Seven Mountains EMS Council for logistics & equipment support as needed.
15. Receive updates, verbally and in writing, from all area operations supervisors and ensure that the information flow continues through the incident.
16. Report all updates to the incident command as available to keep him/her aware of how the incident is progressing.

EMS Official - CHECKLIST

Completed	
	Put on BLUE EMS Official vest or identifier
	Assess Situation and Notify Communications Center of. . . .

		TYPE of incident and LEVEL Designation
			Is the incident contained (cause ceased) and/or continuing (danger continues)?
			Are victims accessible or do they need extrication/rescue?
		NUMBER of Victims (approximate) and Request Appropriate Response
			Level I – MCI involving 3-10 surviving victims
			Level II – MCI involving 11-25 surviving victims
			Level III – MCI involving 26-50 surviving victims
			Level IV – MCD involving 51-100 surviving victims
			Level V – CCD involving > 101 surviving victims
		Request that the MAJOR INCIDENT PLAN be initiated by 9-1-1

	If not already completed, Identify a Unified Command Post (Announce yourself as IC and remain in the Command Post)
	Assign the following supervisors based on the extent of the incident

		TRIAGE Group Supervisor/Unit Leader
		Treatment Group Supervisor/ Unit Leader
		Transportation Group Supervisor/Unit Leader → who assigns a **Staging Area** Manager
		Incident Safety Officer
		Rehabilitation Group Supervisor

	Request an EMS Assistant for paperwork and area operations.
	Verify Communications with Public Safety Answering Point & operational areas.

Ch._____		EMS communications to Incident Command
Ch._____		EMS communications to Hospitals for notifications
Ch._____		Operational frequencies (to Treatment & Transportation supervisors)

	Identify Vehicle/Equipment Staging Area (if not already done)
	Request additional resources as needed – through Planning Sector

		Notification of Seven Mountains EMS Council & requested support

	Assign manpower resources to EMS area(s) as needed.
	Notify Coroner – if needed and not yet done
	Determine accurate victim count and notify Incident Command
	Request updates from EMS branch supervisors -10-15/min. basis
	Provide regular updates and reports to Incident Command
	Terminate Operations w/consensus of Incident Command

		Crews reassigned duty as needed
		Crews directed to Rehab. sector for rehabilitation
		Crews directed to CISM as needed

	Documentation and Inventory sent to Logistics Section

Triage Group Supervisor/ Unit Leader

Purpose: To ensure the proper triage of victims on the scene of a Mass Casualty Incident and ensure efficient transport of victims to the casualty collection area(s).

Scope: The guideline applies to ALL Emergency Services Personnel who are operating on incidents, under the jurisdiction of Seven Mountains EMS Council and/or any other agencies, who choose to adopt these guidelines. A TRIAGE GROUP/UNIT should be established when multiple victims have been identified as being injured and declaring a Mass Casualty Incident. A TRIAGE GROUP SUPERVISOR/UNIT LEADER should be established at all incidents involving multiple victims who are injured.

Definition: Triage: To sort by priority or life-threatening nature of injury.

Section 1 – ESTABLISHING THE TRIAGE AREA AND GROUP/ UNIT

The TRIAGEGROUP SUPERVISOR/ UNIT LEADER is directly responsible to the EMS OFFICIAL for the overall conduct of triage operations, to include:
1. Providing visual identification of him/her by wearing an appropriate Major Incident Scene Identification Article, usually RED VEST properly labeled.

2. Assigning EMS personnel, Triage Teams, to assist in carrying out primary surveys (ABCs) and tagging of victims.
    A. Tagging normally occurs at the immediate site of the incident.
    B. Safety concerns must be considered for patients and medical personnel and may force triage to occur in an alternate location.
    C. Coordination with Treatment Sector is imperative in these situations.

Work in the Triage Area should be completed by the Triage Team Members. The Triage Group Supervisor/ Unit Leader should establish a secured area to preserve patient and provider safety. Triage Area development includes:

1. Establish the affected area in which victims are located and make efforts to preserve the scene.
2. Obtain an actual victim count and approximate victim count for each triage priority category. (Immediately provide to EMS Official). Utilize appropriate checklists to achieve this accurate count.
3. Determine if a need exists for Gross Decontamination of mass numbers of victims. Coordinate decontamination through the EMS Official, with advice from Medial Command, and the Fire Official.

4. Coordinating with Treatment Area Supervisor to assure medical personnel are assigned to patient care responsibilities for tagging victims in patient collection stations according to urgency of need.

5. Ensuring that all victims are properly triaged and have disaster tag affixed, unless injury precludes, around the **left ankle area**. The major incident tag must show the appropriate triage classification. (Ideally, a victim could be triaged several times prior to transportation from the scene, to re-evaluate the patient's condition and reprioritize him/her if necessary). Once the Treatment and Transportation Supervisors establish a Casualty Collection Area, the Triage Group Supervisor/ Unit Leader will stay in this area to carry out his/her responsibilities.

6. Establishing the location of victims and/or bodies. (This information is helpful in determining the cause of the incident, particularly in the case of aircraft accidents). Place a marker, or flag, at any spot where a casualty was moved. Document the location on a drawing utilizing as much detail as possible.

7. Assisting the Transportation Group Supervisor/ Unit Leader in maintaining patient counts and the patient triage categories of those patients transferred from the scene.

Section 2 – RESPONSIBILITIES

Direct the Triage (Sorting) of victims and transfer to the Treatment Group.

A. Determine if a hazardous materials incident or CBRNE incident exists and the medical consequences that such an incident may have on patients and rescuers. Communicate this information to the EMS Official. Determine whether triage may be completed on-site or at an alternate location.

B. If technical decontamination is necessary, notify the EMS Official and other appropriate personnel.

C. Make sure that only critical "ABC" care is rendered during initial triage. **Opening/Control of Airway and Control of Bleeding are the only care to be initiated at this stage.**
CPR becomes a judgment call – based upon the number of patients and severity of injuries.

D. Continually assign available personnel to manage patient removal from the incident scene to the casualty collection area(s).

E. Ensure that patients with serious traumatic injuries are removed from the incident scene and transported to casualty collection areas as rapidly as safely possible.

F. Ensure that Treatment Group personnel are kept informed of the status of the incident and the priorities for on-scene emergency medical care.

G. Ensure that re-triage of all tagged patients occurs, as time permits, prior to removal to the casualty collection area.

H. Discuss utilization of additional resource needs and communicate needs to EMS Official. (Additional backboards, triage tags, etc.)

I. As needed, assign a Morgue Unit Leader to supervise a temporary morgue area, in the proximity of, but not in direct view of, the casualty collection area. Suggest EMS Official request a DMORT Team if necessary.

J. Assist Treatment Group Supervisor/ Unit Leader with prioritization and re-prioritization of their patients for transport. Coordinate this activity with the Transportation Supervisor.

Section 3 – TRIAGE GROUP OPERATIONAL GUIDELINES

Direct the utilization and organization of emergency medical personnel in the Triage Group.

A. Perform a **Safety Assessment** and observe for hazards.
   a. Fire
   b. Weather issues (Flood, Ice, Wind, etc.)
   c. Weapons of Mass Destruction (CBRNE)
   d. Electrical
   e. Flammable Liquids
   f. Hazardous Materials
   g. Secondary Devices and other life-threats

B. **Survey the Scene** (How many & extent of injuries)
   a. Type and/or cause of incident
   b. Approximate number of patients.
   c. Severity of injuries (major and minor)

C. Send Information and Request Assistance / resources
   a. Contact EMS Official with survey information
   b. Begin to establish Triage Groups
   c. Request resources & assistance as needed
      i. Request Treatment Group establishment
      ii. Request Casualty Collection Area establishment
      iii. Begin 'S.T.A.R.T.' triage and rapid transport.
   Remember: Safety, Survey, Send, Set-up and S.T.A.R.T.

D.   S.T.A.R.T.

Quick and **rapid** triage of victims should begin right where the victims lay. The Triage team members should begin to triage victims where they enter the scene and progress in a deliberate and methodical pattern to ensure all victims are triaged.

    a. Move, or allow to self move, all ambulatory patients to MINOR or NON-INJURED Treatment Area(s). Will be tagged within treatment area. It is appropriate to provide these victims with self-care kits, if available, so they may begin self-care while awaiting the arrival of additional EMS personnel.

    b. Tag and assign triage group personnel to all MODERATE and IMMEDIATE victims. Move to appropriate treatment area(s) as rapidly as safely possible.

E.   TRIAGE TAG Color Code Priorities

  a. **RED – Immediate**

    1. Serious but salvageable, with life-threatening injuries. Severe burns, bleeding, impaired breathing and internal injuries.

    2. Red tagged patients are transported first from casualty collection area.

    3. Examples of Injuries:
       i. Witnessed Cardiac Arrest (depending on incident)
      ii. Uncorrected Respiratory Problems (not minor distress)
     iii. Severe Bleeding and Shock
     iv. Open Chest and/or Abdominal Injuries.
     v. Major Fractures and Burns (Full Thickness/Airway)
     vi. Unconscious Patients
    vii. Severe Medical Problems (Heart Attack, Poisoning)
   viii. Injured Co-worker
     ix. Severe Emotional Disorders

  b. **YELLOW – Moderate**

    1. Moderate to serious injuries. Victims with potentially serious injuries such as long bone fractures and moderate bleeding are assigned here.

    2. Yellow tagged patients are transported immediately after Red Tag and may be transported with a green tag patient.

    3. Examples of Injuries:
      i. Severe Burns not affecting the airway.
     ii. Spinal Injuries
    iii. Moderate blood loss
    iv. Head Injuries

   **c. GREEN – Minor**
        1.   "Walking Wounded" and minor injuries.
        2.   Green tagged patients are delayed treatment and transport.
        3.   Examples of Injuries:
          i.   Minor Injuries – Cuts and Abrasions
         ii.   Minor Fractures
        iii.   Mortal Injuries where death appears imminent

    d. BLACK – Deceased
        1.   Victims who are found to be obviously deceased with no vital signs or obviously fatal injuries.
        2.   Transportation arrangements are made with the Coroner.
        3.   Patients should not be unnecessarily moved until approved by the Coroner.

    e. WHITE – Non-Injured
        1.   For patient accountability.
        2.   Person was involved in the incident but is not injured.
        3.   Transportation will occur when available and, probably, by mass transit capabilities.

JumpSTART Triage
age 8 years and less

- **Alert** - Eyes are open, talking spontaneously
- **Verbal** - Respond appropriately to verbal commands
- **Pain** - Respond to painful stimuli
- **Unconscious** - Do not respond
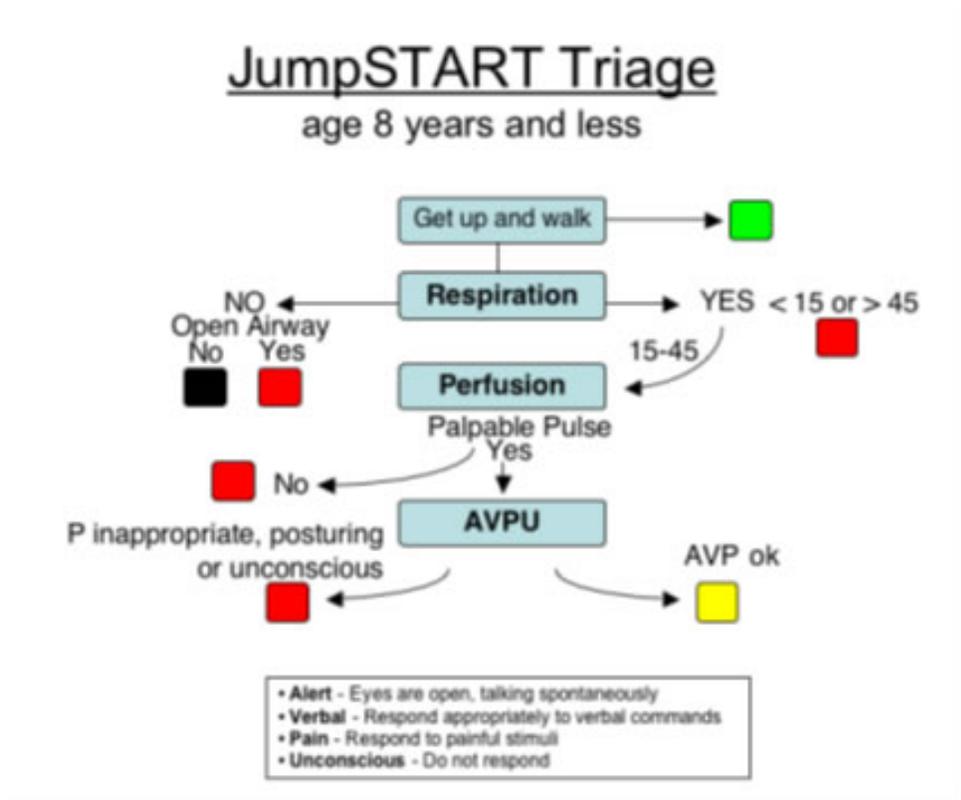
"START" TRIAGE

All Walking Wounded

MINOR

RESPIRATONS

NO → POSITION AIRWAY
- NO → **DECEASED**
- YES → **IMMEDIATE**

YES
- Under 30/min. → PERFUSION
- Over 30/min. → **IMMEDIATE**

Radial Pulse Present

Radial Pulse Absent OR Capillary Refill
- Over 2 Seconds → Control Bleeding → **IMMEDIATE**
- Under 2 Seconds

MENTAL STATUS
- Can't follow Simple Commands → **IMMEDIATE**
- CAN follow Simple Commands → **DELAYED**
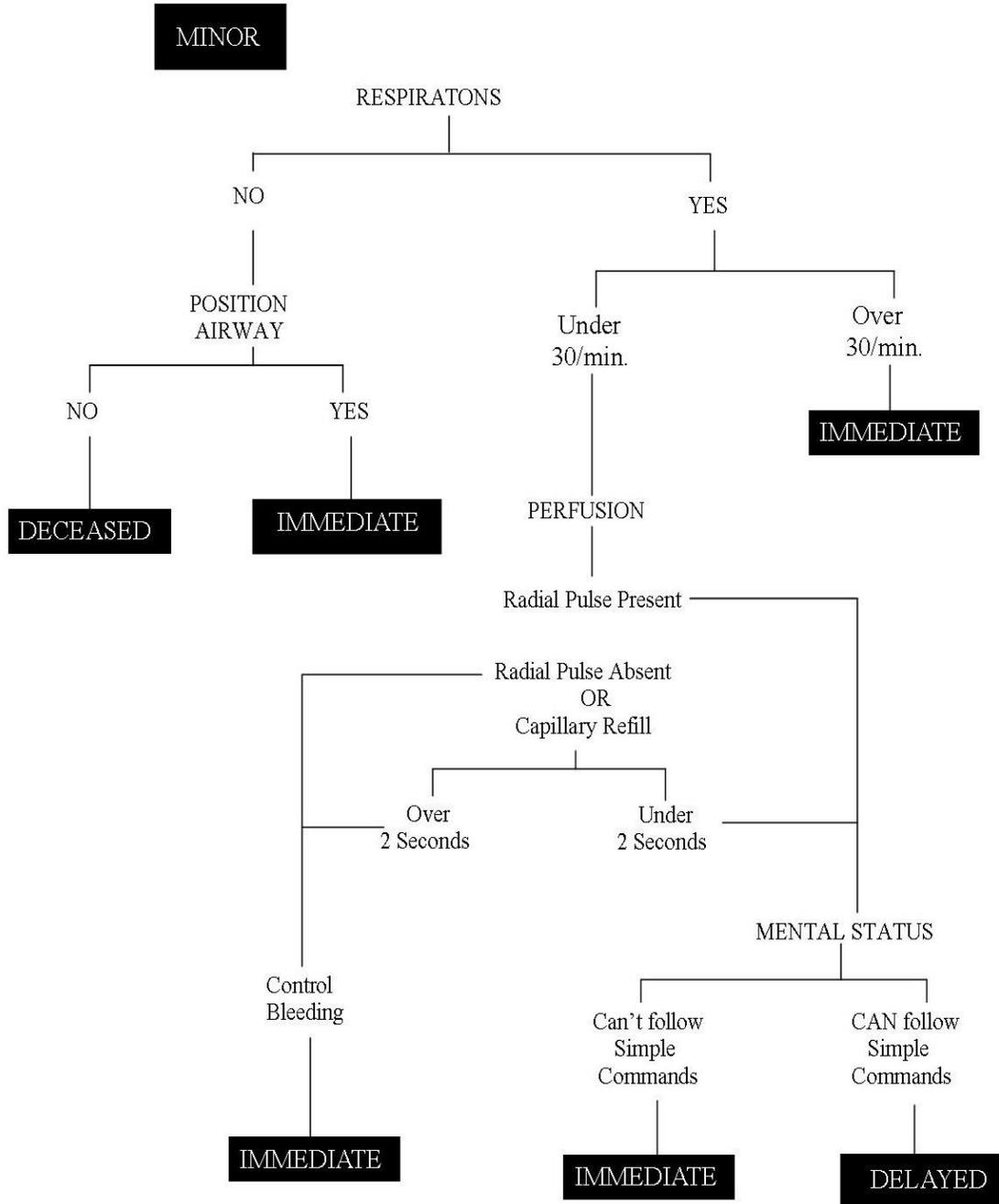
Section 4 – **Triage Tag Information**
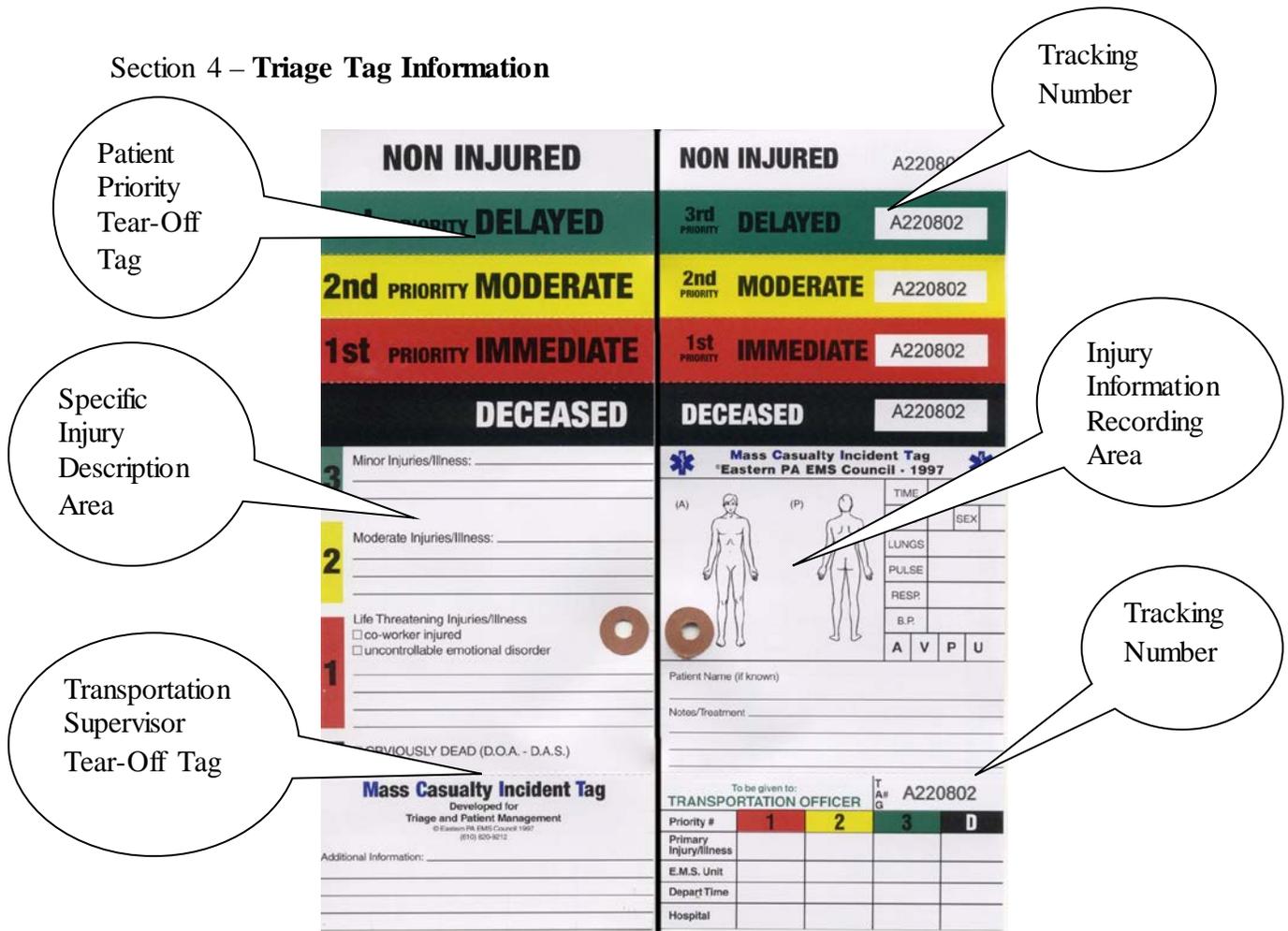
Patient Priority Tear-Off Tags - Labeled "Non-Injured", "Delayed", "Moderate", "Immediate", and "Deceased". Triage team will determine severity of injuries of patient and prioritize patient status by tearing off to appropriate tag.

Tracking Number – Unique number assigned to each tag that will be used to track patient through to the hospital.

Injury Information Area – Contains anterior and posterior anatomical views for marking of injured areas. Also, basic information should be recorded here including vital signs and other treatment notes.

Transportation Supervisor Tear-Off Tag – This section is to be collected by the Transportation Supervisor (or designee) at the time of patient departure from the scene. Information should be completed as to patient status, EMS unit transporting, Time of departure, and Hospital destination. Note patient tracking number on Tear-off to coincide with main tag.

Injury Description Area – Located on the opposite side of the tag. Specific patient information should be completed here if time permits. This may be completed in the Treatment Area. NOTE: injured co-workers and uncontrolled emotional disorders should be triaged "Immediate" and removed from the scene as soon as possible.

Triage Group Supervisor/ Unit Leader - Checklist

Completed	
	Put on RED Triage Supervisor vest or other identifier
	Perform Safety Assessment & Observe Hazards
	Survey the Scene
	Provide initial report to EMS Official & request assistance
	Hazards Identified
	Approximate number of Patients
	Additional resources/assistance needed
	Perform Initial Victim Triage (ABCs, 30 second survey)
	May use tape, marker, band, or tags
	Advise EMS Official of estimated number of patients
	Assign personnel as necessary to "Tag" ALL victims
	Provide Triage Tags & needed supplies
	Review Triage Group duties sheet (as needed)
	After reporting back, compile number & severity of patients:
	Not Injured: _____ (White Tag)
	Immediate: _____ (Red Tag)
	Moderate: _____ (Yellow Tag)
	Delayed: _____ (Green Tag)
	Deceased: _____ (Black Tag)
	TOTAL VICTIMS: _____
	Provide updated report to EMS Official
	Assign personnel to move victims to appropriate collection area
	Coordinate patient movement with Treatment Supervisor
	Request Coroner, through EMS Official, & establish temporary morgue (if needed).
	Keep EMS Official informed of group operations (10-15 min.)
	Request additional supplies & equipment as needed
	Request other resources as needed
	Update concerning ongoing operations as appropriate
	Document/Sketch the triage area for future reference
	Verify with Treatment/Transport the total number of victims
	Terminate operations w/consensus of EMS Official & Command
	Verify that ALL victims are found & accounted for
	Crews reassigned duty as needed
	Crews directed to Rehab. Area for rehabilitation
	Crews directed to CISM as needed
	Documentation and Inventory sent to Logistics Section

Triage Task Force Worksheet

Directions:	To be completed by EMT / EMT-P / PHRN / HP to aid in the initial triage of Patients and assigning a priority designation for each victim.

Completed	
	Report to Triage Supervisor for assignment to a Triage Task Force
	Secure sufficient number of Triage Tags & string
	Secure proper pen/pencil to mark major injuries on Triage Tags
	Provide only Basic Care during Triage to correct life threats
	i.e. Airway Compromise, Severe Bleeding
	Secure Triage Tag firmly around patient's LEFT ANKLE area
	Report total number of triaged victims and their priority category

	TF #1	TF #2	TF#3	TF #4	TF#5	TF #6	Totals
Red							
Yellow							
Green							
Black							
White							
Total							

	Report any problems or special situations to Triage Supervisor
	Report to Triage Supervisor when assignment is complete
	If needed, report to re-triage area of Patient Collection Area
	Patients entering Casualty Collection Area should be re-triaged
	Verify Patient Priority is same as what is on the tag
	Assist Treatment Group with patient monitoring within collection area
	Terminate operations with consensus of EMS Official and Incident Command
	Return all documentation to Triage Supervisor upon completion of assignment and termination of Task Force

Treatment Group Supervisor/ Unit Leader

Purpose: To ensure proper treatment of victims at Casualty Collection Area and ensure quick and efficient notification of victim's injuries to an appropriate hospital facility.

Scope: The guideline applies to ALL Emergency Services Personnel who are operating on incidents, under the jurisdiction of Seven Mountains EMS Council and/or any other agencies, who choose to adopt these guidelines. A TREATMENT GROUP/ UNIT should be established when multiple victims are being triaged and moved to a central casualty collection area. A TREATMENT GROUP SUPERVISOR/ UNIT LEADER should be established at all incidents involving the triaging of victims.

Section 1 – ESTABLISHING THE TREATMENT GROUP/UNIT

The **Treatment Group Supervisor/ Unit Leader** is directly responsible to the EMS Official for the overall conduct of the Treatment Group/unit, to include:

1. Provide visual identification of him/herself by wearing an appropriate Major Incident Scene Identification Article, ORANGE VEST, properly labeled.

2. Assign appropriately trained and credentialed EMS personnel to develop, staff and coordinate all activities within the Treatment Group.

Develop the Treatment Area or Casualty Collection Area(s), if this task has not already been accomplished. Treatment Group development includes:

A. Planning an appropriate location for the Treatment/Casualty Collection Area.
   i. Area should be appropriately marked with color-coded flags, cones and/or tarps to match triage tag color codes.
   ii. If Gross Decontamination is necessary, the Treatment and collection area should be established after the decontamination line.
   iii. Maintain an area for non-injured victims as an accountability area.
B. Determination of how large a sector needs to be (in terms of how complex and for what period of time pre-hospital care will need to be rendered).
C. Determination of what human and logistical resources are necessary for efficient and effective Treatment Group operations

> > i. Ensure adequate ALS/BLS personnel are assigned to Treatment Group at casualty collection areas for appropriate treatment of all patients.
> > ii. Request equipment and supplies that will be appropriate for the proper treatment of victims.
>
> D. Maintain command and control of the Treatment Group/Unit by not engaging in direct patient care activities unless a life-threatening condition exists and there are no immediately available EMS personnel to address the issue.
>
> > i. Treatment group supervisor/unit leader should be at a minimum trained to the EMT or EMT-P level.
> > ii. Ensure that all patients arriving at the Treatment Area have been triaged and direct the victims to the appropriate section area.
> > iii. Ensure all victims are being treated according to appropriate Statewide ALS/BLS protocols based on their injuries and when necessary, begin re-triaging of patients within the area.
>
> E. Obtain a designated scribe/assistant as soon as possible to record notes and document Treatment Group decisions. (This concept should parallel that of a Battalion Chief's aide).

Obtain and maintain an actual victim count for each triage priority category. Victim counts should be updated and reported to the EMS Official and Transportation Group Supervisor/ Unit Leader every 15 minutes for the duration of the incident or until Treatment Group operations are concluded. Ensure that all victims are properly identified with the appropriate disaster triage tag.

> A. Maintain documentation of the operation within the Casualty Collection Area.
> B. Keep a log of patient tracking numbers, from the Triage Tag, as it is written on the tag.

Section 2 – RESPONSIBILITIES

Direct the delivery of emergency medical care in the casualty collection area.

> A. Determine the etiology of injuries and/or illness associated with the incident. Consult with whatever resources may be available, including on-scene EMS Physicians, Regional EMS administrative staff, Regional EMS Medical Director, State Health Department, Incident support Teams, etc.
> B. Determine if hazardous materials or WMD incident exists and the medical consequences that such an incident may have on patients and rescuers. Communicate this information to the EMS Official.
> C. If technical decontamination is necessary, including mass decontamination of large numbers of casualties under the advice of a medical command physician, coordinate the implementation of this activity with the EMS

Official and other appropriate personnel to include the Haz-Mat and Fire Officials.

D. Establish and briefly review standard EMS treatment protocols for those EMS providers unfamiliar with MCI/Disaster operations.

E. Set forth and enforce treatment priorities in the Casualty Collection Area. Avoid unnecessary delays in patient care and/or transportation for interventions of unproved value in their effect on morbidity/mortality.

F. Ensure that patients with serious traumatic injuries are removed from the Casualty Collection Area and transported to hospitals as rapidly as possible. (Certain patients with unstable medical conditions may benefit from stabilization on-scene prior to transport).

G. Determine the need to invoke special disaster-related EMS treatment protocols. This includes the potential for utilization of Mark-1 and Cyanide kits as well as Field Amputation and Standing Order protocols. **Any deviation from approved statewide ALS/BLS protocols requires specific authorization from Regional Medical Director.**

H. Ensure that Treatment Group personnel are kept informed of the status of the incident and the priorities for on-scene emergency medical care.

I. Ensure the re-triage of patients in the "immediate" and "delayed" categories occurs upon patient arrival and every 15 minutes thereafter. Re-triaging of patients in the "minor" sector should occur every 30 minutes.

J. Ensure appropriate utilization of Air Medical EMS transport resources.

K. Discuss utilization of alternative transport resources for patients in the "minor" sector with Transportation Group Supervisor/ Unit Leader.

L. Assist Treatment Group personnel with prioritization of their patients for transport. Coordinate this activity with the Transportation Group Supervisor/ Unit Leader.

Section 3 – TREATMENT GROUP OPERATIONAL GUIDELINES

Direct the utilization of emergency medical personnel within the Treatment Group. This includes:

A. Organize and direct the proper distribution of EMTs. EMT-Ps, PHRNs, HPs and other ancillary personnel throughout the Treatment Group according to their availability and the types of injuries/illnesses identified. In general, critically ill or injured patients will require 1 ALS level and 1 BLS level practitioner per patient. A single EMS practitioner can likely care for up to ten (10) other patients. A higher concentration of ALS practitioners should be present in the "immediate" and "delayed" sectors whereas mostly BLS level practitioners should be adequate to staff the "minor" sector.

B. Request additional Treatment Group personnel as necessary.
   i. Coordinate with Transportation Group Supervisor/ Unit Leader for any equipment and manpower cache.

C.   Forward requests for special medical resources, such as the EMS Incident Support Team and emergency department field response teams, to the EMS Official.

D.   Monitor and coordinate the efforts of volunteers and civilians to assist in patient care. Avoid involvement of untrained rescuers and "Good Samaritans" unless a true disaster exists and they have been processed and credentialed into the scene through the Resource Unit.

E.   If an on-scene physician is present, monitor the activities of the individual(s). Discuss treatment priorities and how the physician(s) can best assist in patient care and medical decision-making.

F.   Ensure communications of pertinent medical information to receiving hospitals, including unusual medical conditions encountered.

G.   Anticipate supply shortages, including gloves, IV solutions and administration sets, airway equipment and critical medications. Through the Logistics Section request additional medical equipment and supplies before they are actually depleted.

H.   Review and approve all critical decision-making, including field termination of resuscitation, initiation of advanced medical procedures and treatment protocols and both patient and EMS-initiated refusals of care.

I.   Monitor all personnel for signs/symptoms of critical incident stress. Remove from duty anyone who is not physically or mentally fit and refer them to the Rehabilitation Group. Consider critical incident stress management (CISM) operations by qualified individuals/teams. CISM services are available through the Regional EMS Council. The services are confidential and free to the emergency services community. The team(s) provides stress defusing/debriefings. Services can be requested by contacting the Mifflin County Office of Emergency Services by any chief officer or on-site Incident Commander.

Treatment Group Supervisor/ UNIT LEADER - Checklist

Completed	
	Put on ORANGE Treatment Supervisor vest or identifier

	Notify EMS Official that the Treatment Group/Unit is "In Service"

	Select a Casualty Collection Area near the main action area (Select area large enough for anticipated victim count)

	Notify the EMS Official of your location

	Obtain Equipment & Supplies to operate the Treatment Group/Unit

	Verify communications with the EMS Official	
Ch._____		EMS communications with IC/UC and EMS Official
Ch._____		EMS communications to Hospital(s) for notifications
Ch._____		EMS communications to Triage & Transportation Supervisors

	Establish Casualty Collection Areas	
		IMMEDIATE -- Marked with a RED tarp or flag
		MODERATE -- Marked with a YELLOW tarp or flag
		DELAYED -- Marked with a GREEN tarp or flag
		DECEASED -- Marked with a BLACK tarp or flag
		NON-INJURED -- Marked area close to but not in view of Treatment Sectors

	Assign BLS/ALS personnel for appropriate patient care

	Ensure adequate equipment is available (communicate needs)

	Ensure all patients arriving at the Treatment Area are triaged & tagged

	Coordinate w/Transportation Group Supervisor/Unit Leader the movement of patients to hospitals

	Provide Updates of patient flow/treatment to EMS Official

	Assign assistant and document treatment group operations

	Terminate Operations w/consensus of EMS Official & Command	
		Crews reassigned duty as needed
		Crews directed to Rehab. sector for rehabilitation
		Crews directed to CISM as needed

	Documentation and Inventory sent to Logistics Section

Treatment Group - Worksheet

Directions: To be completed by EMT / EMT-P / PHRN / HP to aid in documenting patient flow through the Treatment Area, as designated by the Treatment Supervisor.

Completed

	Provide treatment consistent with Statewide ALS/BLS protocols and appropriate to your level of training. (Request standing order protocol, as needed, through Treatment Supervisor)

	Provide the following information for documentation purposes:

TAG #	TIME	B/P	PULSE	RESP.	LUNG SOUNDS	AVPU SCALE	TRANS-PORT

	Record, on the triage tag, the following information as time allows

	Patient Name, if known	Patient's Injuries
	Patient Age, if known	Primary Injury
	Sex of Patient	Vital Signs (AVPU)
	Treatment Provided	Other Information

	Re-triage as necessary and report results to Treatment Supervisor

	Return documentation to Treatment Group Supervisor/ Unit Leader after termination of group activities.

Transportation Group Supervisor/ Unit Leader

Purpose: To ensure the proper Transportation of victims from the casualty Collection Areas to Receiving Facilities and ensure serious patients are transported according to their injuries and priorities.

Scope: The guideline applies to ALL Emergency Services Personnel who are operating on incidents, under the jurisdiction of Seven Mountains EMS Council and/or any other agencies, who choose to adopt these guidelines. A TRANSPORATION GROUP/ UNIT should be established when multiple victims are being triaged and transported to medical facilities. A TRANSPORATION GROUP SUPERVISOR/ UNIT LEADER should be established at all incidents involving the transport of multiple victims.

Section 1 – ESTABLISHMENT OF TRANSPORTATION GROUP/UNIT

The **Transportation Group Supervisor/Unit Leader** is directly responsible to the **EMS Official** for coordinating the transportation of victims to appropriate medical facilities in an expeditious manner to include:

1. Providing visual identification of him/herself by wearing an appropriate Major Incident Identification Article, **Green Vest,** properly labeled.

2. Assist the EMS Official in selecting an equipment stockpile area and Vehicle Staging Area (if not already established).

Develop the **Transportation Group/Unit** and assist in the development of the **Casualty Collection Area(s)**. Transportation group/unit development includes:

A. Assist with the establishment of properly identified casualty collection area(s) were all survivors will be delivered for treatment and later transport to a medical facility. (The casualty collection area(s) should be large enough to allow for easy treatment and removal by emergency personnel. The casualty collection area(s) should be marked by flags or markers, which are **color coded to match the patient triage tags**).

B. Plan an appropriate area for the Transportation Group operations:
    i.   Area should be appropriately marked by cones in a "cattle chute" fashion based on vehicle approach. Ambulances should remain at least ten feet (10') from the casualty collection area and should approach from an area that will not require backing after receiving a casualty.
    ii.   Assist in the maintenance of the Non-Injured Patient Area.

C. **Assign patients to emergency care vehicles** from the vehicle staging area and specify to which medical facility each crew is to proceed with their patient(s). (Transportation Group Supervisor/Unit Leader will provide basic directions to drivers if they are unfamiliar with how to reach the assigned hospital).

D. Establish a vehicle staging area with assistance from the **Staging Area Manager.**

E. Determination of what logistical/ human resources are needed for efficient and effective transportation group operations:

    i. Assign a Staging Area Manager as necessary.

    ii. Designate an official Equipment Stockpile Area.

    iii. Assign an assistant/scribe for triage tag documentation and basic communication reporting of patient information to receiving facilities.

Obtain and maintain an actual victim count for each triage priority category. Victim counts should be updated and reported to the **EMS Official** and **Treatment Group Supervisor/Unit Leader** every 15 minutes for the duration of the incident or until transportation group operations are concluded. Ensure that all victims are properly identified with disaster tags.

Maintain documentation of operations within the TRANSPORTATION GROUP/UNIT.

Sector 2 – RESPONSIBILITIES

Direct the delivery of victims to appropriate medical receiving facilities from the transportation area.

A. Receive an exact patient count from the Triage Supervisor.

B. Request, through appropriate channels, additional ambulances/mass transportation as necessary and with consultation of the Treatment Group Supervisor/Unit Leader.

C. Determine if Hazardous Materials or WMD exists and ensure decontamination procedures are in place at both the Triage Area and the receiving medical facility. Casualties should not leave the scene without being decontaminated first or without first consulting with Medical Command.

D. Request, through EMS Official, transportation of stable ALS patients in a BLS ambulance.

E. Ensure that patients with serious traumatic injuries are removed from the casualty collection area and transported to area hospitals as rapidly as possible.

F. Ensure that staged units are kept informed of incident status and the on-scene patient care priorities as established. This will aid in reducing "Freelancing" and/or abandoning of vehicles.

G. Ensure the proper establishment of **Helicopter Landing Zones**.

H.   Assist the Treatment Group with prioritization of their patients for transport. Coordinate this activity with the Treatment Group Supervisor/Unit Leader.

I.   Maintain a written record of each patient's priority, primary injury, disaster tag number, emergency vehicle assigned to transport the patient, medical facility to which the patient was sent, and time the patient left the scene. Remove 'Transportation Group' section of the triage tag for your records and fill in appropriate information.

J.   Report each ambulance's ETA, number of patients, primary injuries, triage tag number(s) and the priority of each patient, to the receiving medical facility, in order to keep use of hospital notifications to a minimum by field units.

K.   Verify that final number of patients transported with Triage Supervisor and EMS Official to accurately determine that all patients were removed from the scene. (Stubs from the bottom of the triage tags will aid in this verification).

Section 3 – TRANSPORTATION GROUP OPERATIONAL GUIDELINES

Direct the utilization of Emergency Medical Services Ground and Air Transportation Units. This includes:

A.   Working in conjunction with the EMS Official to make sure incoming EMS crews are clearly aware of the following:
  i.   Vehicle approach routes to follow.
  ii.   Staging area manager contact.
  iii. Roadways or travel routes that are blocked or impeded by the incident.
  iv.   Vehicle staging area and casualty collection point(s)
  v.   Location of equipment stockpile area.
  vi.   Key equipment needed from the EMS unit upon their arrival.
  vii. The need for drivers to remain with their vehicles.

B.   Patrol the Patient Treatment Area looking for critical "Red Tag" patients that should be transported immediately.

C.   Request, through proper channels with consultation of the Treatment Group Supervisor/Unit Leader, the usage of Mass Transportation for "Minor Injuries".

D.   Ensure communication of basic patient information to the ambulance crew at the patient loading area. Verify that the patient information has been forwarded to the receiving hospital facility.

E.   Anticipate supply shortages by keeping an inventory of the equipment stockpile area and request additional equipment as necessary through established channels.

F.   Responsible for the implementation of a system for the constant distribution/charting/tracking of patients (Patient distribution/Record maintenance)

i. Ensure the **Triage Tags and Stubs** are completed for all patients.
ii. Designates staff to assign patients to ambulance and designate to where the patient is to be transported.
iii. Make sure that the 'Tracer Stub' is being given to the Transport Supervisor or designee.
iv. Ensure only one person within Treatment and/or Transportation Group/Unit is notifying hospital receiving facilities.
v. Assign an assistant to chart all incoming information.
vi. Request periodic updates from all hospitals concerning bed availability and patient acceptance status. Consider Knowledge Center Usage.
vii. Request hospitals notify Communication Center of "walk-in" patients involved in the incident. (For Proper Patient Count)

G. Monitor all personnel for signs/symptoms of Critical Incident Stress and/or exhaustion. Remove from duty anyone who is not physically or mentally fit and refer them to the **Rehabilitation Group** or **CISM Team** as appropriate

Transportation Supervisor - Checklist

Completed	
	Put on GREEN Transportation Supervisor vest or identifier
	Notify EMS Official that Transportation Group is "In Service"
	Assign **Staging Area Manager** and determine vehicle approach route(s)
	Determine Casualty Collection Areas with **Treatment Group Supervisor**
	Designate an **Equipment Staging Area** (if not already established)
	Set-up Patient Collection Area(s) – using tarps, cones, signs, etc. (Make sure they are not too close together)
	Verify Communications
Ch. _____	EMS communications to Incident Command & EMS Official
Ch. _____	EMS communications to Hospitals for notifications
Ch. _____	Operational Frequency (to Treatment Supervisor & Staging Manager)
	Request Mass Transportation services for low priority patients, when needed.
	Use appropriate resource call-up channels to request:
	Buses – Municipal, School, Private
	Vans – Municipal (public & senior transport), School, Church, Private
	Consider Helicopters and Landing Zones
	If being utilized, appoint **Air Transportation Manager** to coordinate activities
	Assign victims (High Priority First) to staged EMS units.
	Tell the EMS unit to what hospital facility they are transporting
	Tear off Trans. Stub from patient's triage tag prior to loading
	Complete bottom portion (stub) of Triage Tag
	Use Transportation Stub to report patient information to receiving hospital
	Distribute patients evenly to local and specialty hospitals
	Chart all patients on Transportation Group Worksheet
	Keep a running tally of the number of patients sent to each hospital
	Use Transportation Group and/or Hospital Availability Worksheet
	Terminate Operations w/consensus of EMS Official
	Crews reassigned duty as needed
	Crews directed to Rehab. sector for rehabilitation
	Crews directed to CISM as needed
	Documentation and Inventory sent to Logistics Section

Transportation Group - Worksheet

# of Victims Reported by Triage Priority				
RED	YELLOW	GREEN	BLACK	WHITE

Emergency Units Responding			

Hospital						
Can Handle						
# Sent						

Patient #	Priority	Primary Injuries	Tag Number	Emergency Unit Transporting	Receiving Hospital	Time of Departure
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Page _____ of _____

Notes:

Hospital Availability Worksheet

Incident Name: _____   Date: _____

EMS Official: _____

Hospital		Priority Red	Priority Yellow	Priority Green	Priority White	DECON Established
	A					
	U					
	A					
	U					
	A					
	U					
	A					
	U					
	A					
	U					
	A					
	U					
	A					
	U					
	A					
	U					
	A					
	U					
	A					
	U					

A = Patients that can be handled   **U = Number utilized (patients sent)**

Staging Area Manager Guidelines

Purpose: To ensure proper staging of vehicles at vehicle and equipment collection area and ensure quick and efficient entrance and egress of vehicles to Treatment and/or Transport Area.

Scope: The guideline applies to ALL Emergency Services Personnel who are operating on incidents, under the jurisdiction of Seven Mountains EMS Council and/or any other agencies, who choose to adopt these guidelines. A VEHICLE STAGING AREA should be established to keep vehicles and equipment in a central location, available for immediate use for transport. A STAGING AREA MANAGER should be established at all incidents where multiple vehicles are responding to a scene.

Section 1 – ESTABLISHING THE STAGING AREA

The **Staging Area Manager** is responsible to the **Transportation Group Supervisor/Unit Leader** for the overall staging of EMS units at the incident, to include:

1. Provide visual identification of him/herself by wearing appropriate Major Incident Scene Identification Article, **Green Vest**, and properly labeled.

2. Identify and establish an appropriate staging area for ambulances that is easily accessible from the Casualty Collection Area.

Develop a Staging Group and vehicle staging area, if this task has not already been accomplished. Staging Group development includes:

A. Establishing an area that is free of "Grid-lock", but is near the scene (improves speed, flow, and efficiency).
B. Determine how large an area will be needed based on the number of injuries and classes of victims.
    i. Have traffic control shut down an area that is only open to staging traffic.
    ii. In the event of an MCD or CCD, staging area manager should consider a peripheral central staging area for out of county EMS response.
        a. Specific directions should be given to Incident Staging Area from the peripheral staging area.
C. Establish a personnel and equipment staging area near the Casualty Collection Area.
    i. Notify incoming ambulances what equipment and personnel should report to the staging area.
    ii. Maintain a driver with each vehicle AT ALL TIMES.

D. Select a staging area that offers proper ENTERANCE/EGRESS without making the vehicles back into or out of a location.
Methods of Staging:
    1. Direct/Straight Line
    2. "Horseshoe" Staging
    3. Lateral Staging
    4. Cattle Chute Staging
    5. Off-Site Staging
E. Maintain command and control of the staging area by keeping a free-flowing area for EMS traffic and keeping a driver with each vehicle.
F. Correct all problems (vehicle/parking) immediately.
    i. Continually monitor flow of traffic
    ii. Position vehicles so that they never have to back up.
    iii. Do not allow vehicles to park "nose-to-nose".
    iv. Vehicles should park farther than ten feet (10') from the Casualty Collection Area to reduce exhaust fumes to patient.

Section 2 – STAGING AREA MANAGER RESPONSIBILITIES

Direct the delivery of ambulances to the Patient Loading Area:

A. Determine a location that will keep vehicle exhaust fumes away from casualty collection and treatment areas.
B. Determine how to stage ambulances in an area of proximity to patient loading area.
C. Choose a method of staging that best fits the area of the incident.
D. Establish direct communications with the Transportation Group Supervisor/Unit Leader.
E. Notify EMS Official and Incident Command of staging area location and that the area is in service, with directions for incoming units.
F. If decontamination is needed or hazardous materials exist, ensure patients have been properly decontaminated prior to beginning transport. Consider removing unnecessary equipment from ambulance prior to transporting based on PA DOH equipment removal recommendations.
G. Ensure Transportation Group Supervisor/Unit Leader is aware of ambulance census.
H. Keep a LOG of all ambulances in the staging area including, at minimum, their unit number, their arrival time, their departure to patient loading area time.
I. Assist Transportation Group Supervisor/Unit Leader with flow of ambulances through the Patient Loading Area and to the Hospital.

Direct / Straight-Line Staging

One behind the other…………

Amb #3   Amb #2   Amb #1

Loading Area

Priority 1 Patients   Priority 2 Patients   Priority 3 Patients
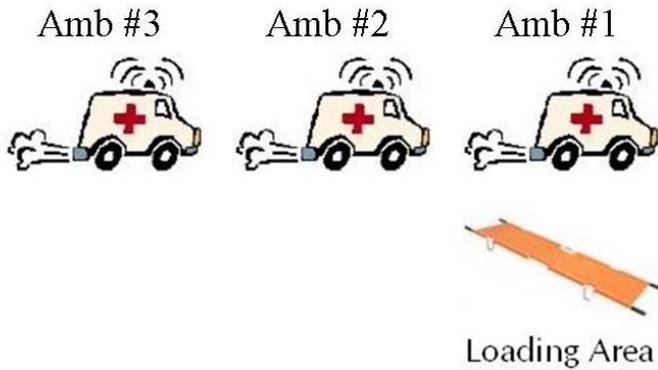
Horseshoe Staging

Vehicles approach the scene and are positioned in a 'horseshoe' pattern to expedite entry into, and exit from, the patient collection area.

Amb. #5   Amb. #6   Amb. #7

Amb. #4

Amb. #3   Amb. #2   Amb. #1

Loading Area

Priority 1 Patients   Priority 2 Patients   Priority 3 Patients
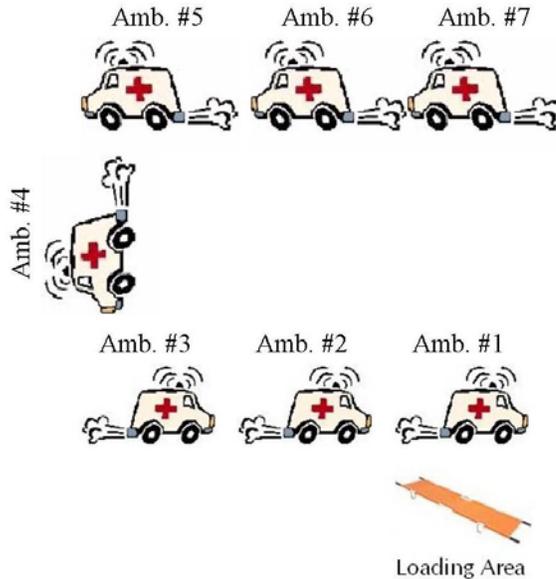
Lateral Staging

Ambulances are directed into a side-by-side parking pattern.

Advantages:

1. This pattern allows crews to be assigned patients and return directly to their own ambulance to transport the patient(s) to a medical facility. They are therefore familiar with equipment location and can function more comfortably in their own ambulance vehicle.

2. Ambulances are never blocked in by any other vehicle. Whenever a crew returns to their ambulance vehicle, they can leave immediately and not have to wait for any other vehicle to leave prior to them being able to do so.

Amb. #4

Amb. #3

Amb. #2

Amb. #1

Loading Area

Priority 1 Patients

Priority 2 Patients

Priority 3 Patients
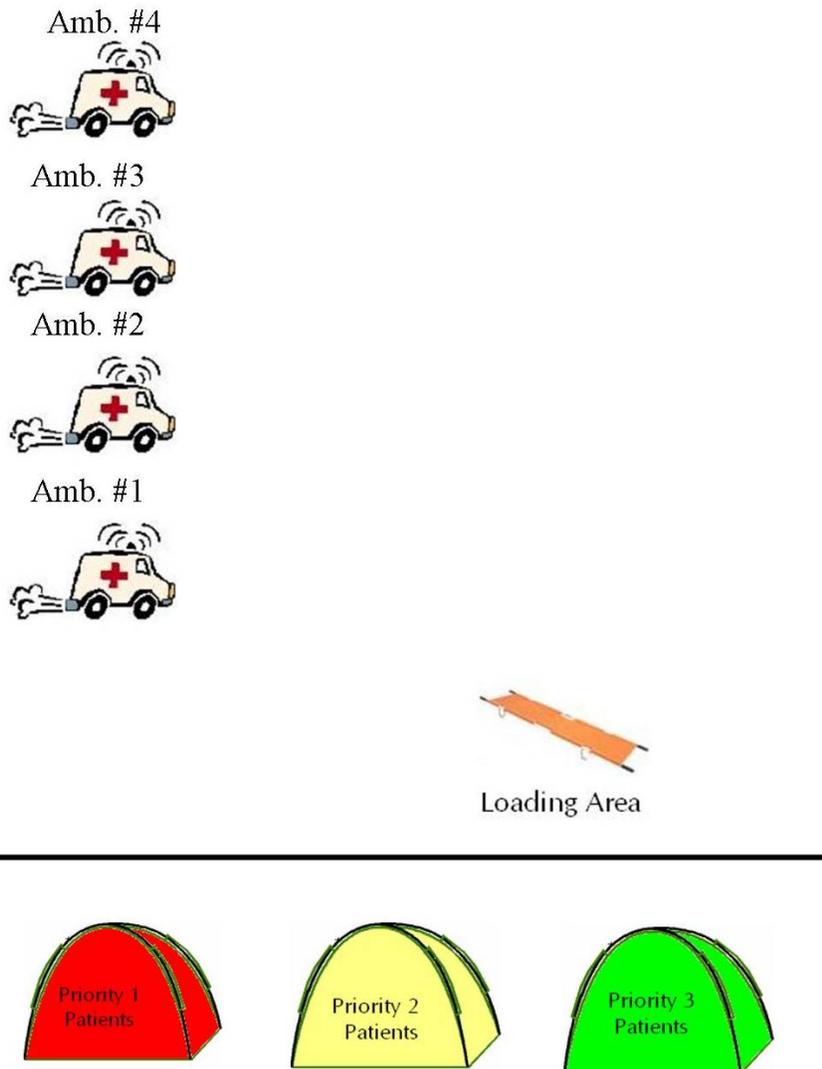
"Cattle-Chute" Staging

Multiple approach areas feed into one (1) single file pattern.
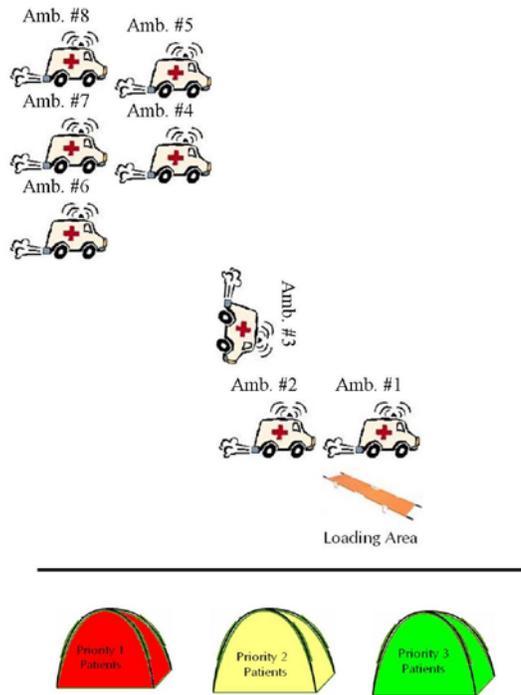
Off-Site Staging

Have incoming ambulances report to an area close to, but not directly at, the incident scene. Ambulances are then called up as needed.
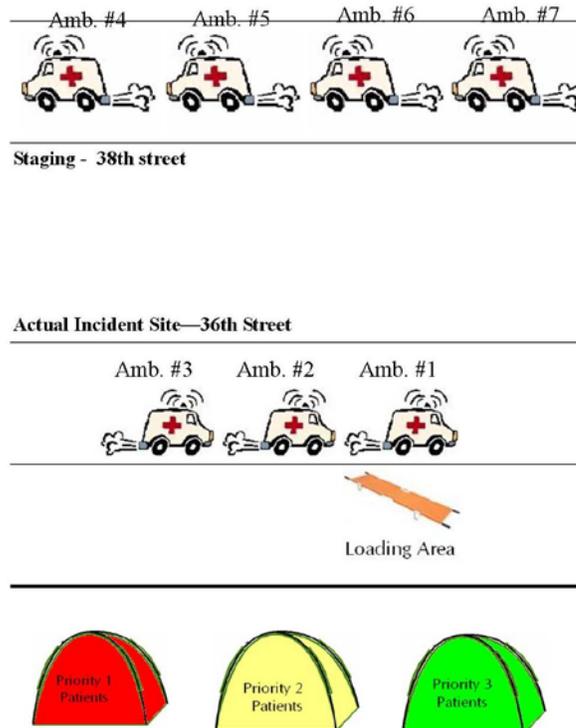
Staging Area Manager - Checklist

Completed	
	Put on Green Staging Manager vest or identifier
	Notify EMS Official that the Staging Area is "In Service"

|	Select a Vehicle Staging Area near the Casualty Collection Area (Area large enough for the amount of units responding)	
		Will vehicle fumes enter patient treatment area?
		Determine how to stage ambulances (Pattern)
		Direct/Straight Line Staging
		Horseshoe Staging
		Lateral Staging
		"Cattle-Chute" Staging
		Off-Site Staging
		Driver with every vehicle (**At All Times**)

	Notify EMS Official & Transportation Supervisor of your location
	Establish Equipment & Personnel Staging Area

	Verify Communications with Transportation Supervisor	
Ch. _____		EMS communications to Incoming Ambulances
Ch. _____		EMS communications to Transportation Supervisor

	Does a decontamination issue exist? Consider equip. reduction.

	Meet all incoming EMS units as they arrive	
		Remind drivers to remain with their vehicles
		Have crew members off-load needed equipment to equipment stockpile area

	Notify Transportation Supervisor of ambulance census on a regular basis throughout incident operations.
	Ensure adequate equipment is available

	Keep drivers informed of what is going on	
		Location of the patient loading areas
		Procedures for loading patients
		Other procedures as required

	Document all ambulances in the Staging Area
	Coordinate w/Transportation Supervisor the movement of patients to hospitals
	Terminate operations w/consensus of Transportation Supervisor
	Documentation is forwarded to Logistics Section upon termination of operations

Staging Area Manager – Worksheet
This form can be used to backup the ICS-211 form during "on-scene" activities

Directions: To be completed by the Staging Area Manager to aid in documenting ambulance flow through the Transportation Section, as designated by the Transportation Supervisor

Unit Number	Arrival at Staging Area	Depart Staging Area

Page _____ of _____

Rehabilitation Unit Guidelines

Purpose: To insure that the physical and mental condition of personnel operating at an incident are maintained to avoid deterioration to a point that would affect their health and safety or that of other personnel, or that would jeopardize the safety or integrity of the incident. **REHAB** is designed to ensure personal safety.

Scope: The guideline applies to ALL Emergency Services Personnel who are operating on incidents, under the jurisdiction of Seven Mountains EMS Council and/or any other agencies, who choose to adopt these guidelines. REHAB should occur when: significant physical activity is being undertaken and/or exposure to unusual weather conditions occur and/or prolonged duration of the event and/or the Incident Commander or EMS Official request that a REHAB Unit be established.

Section 1 – RESPONSIBILITIES

The Incident Commander will evaluate the incident, considering physical, mental and environmental circumstances, and make provision for rest and rehabilitation of ALL personnel operating at the incident.

These provisions will include:
- Medical monitoring, evaluation and necessary treatment and transport to an appropriate medical facility.
- Food and fluid replenishment
- Mental rest and recovery
- Relief from environmental and abnormal weather

Incident Leadership Staff: The individual officers responsible for teams as provided for within their span of control will continual monitor their personnel to ensure that their physical and mental health is maintained through utilization of the REHAB unit and rotation of personnel.

EMS Official: The EMS Official, or designee, will continuously evaluate the need for and effectiveness of the REHAB unit to ensure that its purpose is being maintained. He/She will request additional resources as required to maintain the necessary Rehabilitation of personnel on the incident. On major (large scale) incidents, REHAB will be established under the Logistics Section of incident command system and will not be the responsibility of the Operational Section's EMS Official.

On-Scene Personnel:
- *Climate - During extended periods of operation or highly physical working conditions, all personnel involved in the incident should be encouraged to continuously maintain their hydration through drinking of water, activity beverages (such as Gatorade) or non-caffeinated hot drinks (during cold weather operations).
- *Fatigue - Throughout the operation of the incident, personnel will monitor their own, as well as other individuals, level of fatigue and report to any Incident, Rehab, or EMS Official when they feel that the level of physical or mental fatigue or exposure to the environment could affect the health and/or safety of themselves, other personnel involved, or the incident itself.

Section 2 – ESTABLISHMENT OF REHABILITATION UNIT

The Incident Commander and/or EMS Official will establish the Rehabilitation Unit whenever conditions indicate that rest and rehabilitation are necessary to ensure adequate personal and scene safety. As the incident expands, the Rehab Unit may be re-assigned under the Logistics Chief as the incident command system expands.

In the event that a REHAB Unit is established, it will be manned at a minimum by one EMT or Paramedic. An EMT or Paramedic will be placed in charge of the REHAB Unit and will be identified as the REHAB Unit Leader in coordination with the incident command structure.

When should REHAB occur:
- ➤ All Structure Fires
- ➤ Large multi-agency response incidents including MCI, MCD, CCD incidents
- ➤ Hazardous Materials Incidents
- ➤ Extended Rescue Operations
- ➤ Temperatures > 80 degrees and <32 degrees
- ➤ Training Operations >2 hours in length
- ➤ At the discretion of the Incident Commander

The REHAB Unit Leader will:
- ➤ Wear a **Brown Vest** with the identification of REHAB Leader visible on both the front and back.
- ➤ Have an operational portable radio or other communications device that is capable of direct communications with the Command Post, EMS Official, and Triage/ Transportation Supervisors.
- ➤ Have available to him/her a checklist and clipboard to assist in the timely establishment of the REHAB Unit, listing all necessary equipment and supplies.
- ➤ The REHAB Unit Leader will report directly to the EMS Official (unless specifically instructed otherwise by Incident Command). In the event that an EMS Official has not been established, the REHAB Unit Leader will report to the Incident Commander.

Locating the REHAB Unit

The placement of the REHAB Unit will be designated by the REHAB Unit Leader or the EMS Official in conjunction with the site characteristics and site designation guidelines herein. The location should be upwind from the incident site.

The preferred location of the REHAB Unit should be adjacent to the SCBA changing area and/or manpower staging area, but not within the operational area of the incident. A remote location is appropriate only when it is easily accessible to personnel.

The Incident Commander will be notified of the REHAB Unit location and will pass this location on to all on-scene supervisory personnel. The REHAB Unit Leader will notify Incident Command when the Unit has been placed in service.

REHAB Unit Site Characteristics

The REHAB area should be established in a location that will provide physical rest for personnel. The area should be free of loud noise disturbances, and away from situational operations, crowds, and equipment caches.

The REHAB area should be placed far enough away from the incident scene to insure that personnel can safely remove protective gear (pending environmental conditions). This should include an area that is "out-of-sight" of the incident for proper rehabilitation.

The location will be suitable for environmental conditions:
- ❖ HOT WEATHER – Cold, shaded area.
- ❖ COLD WEATHER – Warm, dry, and wind-free area.

The REHAB area should allow personnel to be free of exhaust fumes and other factors that would compromise the purpose of the sector.

The REHAB area should be large enough to accommodate personnel proportionally to that operating at the scene and dependent on factors such as environment, amount of physical or mental fatigue or duration of the incident.

Potential for expansion should be considered in the initial setup, as well as the potential for relocation should the incident warrant such.

Larger incidents may require the establishment of sub-areas within the REHAB area such as Entry, Treatment, and Exit.

The location of the REHAB area should allow for easy access to EMS vehicles as well as support vehicles for the unit.

Site Designation of the REHAB Unit

An ample sized area, sheltered from the environment where a REHAB Unit can be established utilizing tarps; salvage covers, canopies, fans, heaters, lighting, etc.

Optimally, the REHAB Unit should be established next to the SCBA area to allow for appropriate rehabilitation after removing SCBA:

> *The USFA suggests the "two air bottle rule" or 45 minutes of work time to be considered maximum workload prior to mandatory REHAB. After the appropriate work time, the responder should spend no less than ten (10) minutes and may exceed one hour, depending on the physical appearance and condition of the responder, in the REHAB area. After REHAB is complete, the responder will be sent to the Staging Area for re-assignment. This will be completed only after being medically cleared by the REHAB Unit Leader.*

A nearby garage, carport, driveway, building, or other stable and easily accessible structure is sufficient facilities for REHAB Unit establishment. The front lawn of an adjacent house could be utilized for REHAB at the scene of a house fire, but may not be appropriate for an incident of larger magnitude.

Ambulances, Fire Apparatus (such as the back of a rescue truck), or other vehicle on scene or called for, can be utilized for REHAB purposes.

In a high-rise situation, REHAB should be established on the floor below the staging floor, only after clearing for safety and operations by the Incident Commander.

Specialty REHAB vehicles may be utilized when available.

REHAB Resources

The REHAB supplies secured should include, at a minimum, the following:

- **FLUIDS** – Water, activity beverages and ice. NO caffeinated beverages should be utilized.
- **FOOD** – Short Term – Granola Bars (less than three (3) hours activity)
    Long Term – Make arrangements for soup, broth, stew, and sandwiches.*
- **MEDICAL –** Blood Pressure Kits (Multiple Cuffs & Sizes)
    Oxygen Supplies and Delivery Devices (Multi-port, Non-Rebr.)
    Extra Oxygen Cylinders
    Thermometers
    Hot / Cold packs
    Stair / Folding Chairs, Folding litter
    ALS & BLS medical kit(s) – this should include IV Fluids (warm / Room temperature) and cardiac monitor when appropriate.

*May be obtained through support agencies such as the American Red Cross, Salvation Army, local fire department auxiliary groups or local civic/food service agencies.

➢ **OTHER SUPPLIES -**   Portable Radio(s)
Cooling Vests
Misting Fans
Drinking Cups
Clipboards, log sheets and REHAB flow chart
Towels (for soaking in cold water for cooling or
         used to dry off cold, wet areas)
Fans (for warm weather cooling)
Heaters (for cold weather warming)
Hear dryers (for cold weather re-warming)
Dry clothing (scrubs, sweats, socks, etc.)
Quartz lights (for area lighting and heat)
Blankets
Spray bottles (for warm weather cool downs)
Traffic cones, marker flags, and/or emergency scene
         tape to establish area
Awning(s) / Tent(s) / Shelter(s)

Section 3 – REHABILITATION UNIT OPERATIONAL GUIDELINES

Climate and environmental conditions at the emergency scene shall not be the sole justification for establishing a Rehabilitation Unit.

Any activity or incident that is large in size, long in duration, and/or labor intensive will rapidly deplete the energy and strength of personnel and therefore merits consideration for rehabilitation.

Climate and environmental conditions that indicate the need to establish and maintain a rehabilitation unit are:

       Heat Stress Index = Above 90 degrees F.
       Wind Chill Index = Below 30 degrees F.

Hydration
A critical factor in the prevention of heat exhaustion, heat stroke, or heat related injuries is the maintenance of water and electrolytes. Water must be replaced during training exercises and at emergency scenes.

During heat and physical stress situations, REHAB staff will attempt to have personnel who are actively working at the scene consume AT LEAST ONE (1) QUART OF WATER PER HOUR.

If an activity beverage is used, the re-hydration solution should be a 50/50 mixture of water and the commercially prepared activity beverage. It should be administered at about 40 degrees F.

Re-hydration is also important during cold weather operations where heat stress may occur during firefighting, rescue operations, or other strenuous activity – especially when protective equipment is being worn.

Alcoholic and caffeinated beverages should be avoided BEFORE and DURING heat stress because both interfere with the body's water conservation mechanisms. Carbonated beverages should also be avoided.

Nourishment

Food should be provided at the scene of an extended incident where units are engaged FOR MORE THAN THREE (3) HOURS.

Soup, broth, and stew are recommended because of quicker digestion by the body.

Foods such as apples, oranges, and bananas provide supplemental forms of energy replacement. Fatty and salty foods should be avoided.

Mandatory Rest Periods

Two Air bottles or 45-minutes of strenuous work is the recommended level prior to mandatory rehabilitation.

Rest periods should be no less than ten (10) minutes and may exceed too greater than one (1) hour, depending on responder's physical condition.

Personnel should not be moved from a hot environment to an air conditioned environment because the body's cooling system could shut down in response to the shock of external cooling. An air-conditioned environment is acceptable after an appropriate cool-down period in ambient temperatures.

Twelve (12) hours is the maximum amount of time **ANY** emergency personnel, **Including Incident Command,** should be continuously involved at an emergency scene, no matter how many rest/rotation sequences are provided. Personnel should be rotated through heavy, moderate and light work between each REHAB period.

Recovery

After being fully rehabilitated and medically evaluated in the REHAB unit, the emergency responder will be released to the Equipment / Personnel staging area.

Section 4 – MEDICAL EVALUATION IN THE REHAB UNIT

EMS Responsibilities

Personnel reporting to the REHAB Unit will receive a complete evaluation (Assessment) and treatment (if needed), for environmental emergencies, as well as for any injuries.

Heart Rate should be checked as soon as the responder arrives at REHAB. If the heart rate is greater than 110 bmp, a tympanic (middle ear) temperature is necessary. If the temperature exceeds 100.6 degrees F, the responder should NOT be medically cleared to return to service and/or wear protective gear.

If the heart rate is greater than 110 bpm and the temperature is less than 100.6 degrees F., an extended REHAB time is necessary.

If the heart rate is less than 110 bpm, normal REHAB should be instituted.

Continue with the assessment of the responder including blood pressure and respirations every 5-10 minutes. Blood pressure will tend to drop with increased fluid loss, as the heart rate increases to compensate for the loss. With increased fluid intake, if heart rate does not decrease and blood pressure return to normal, EKG monitoring and IV therapy may be necessary (if available). This should be initiated on a per patient/per assessment basis.

If, after continued rehabilitation, no changes occur in patient status, immediate ALS transport to the hospital is necessary. If resistance is met by the responder, the REHAB Unit Leader should seek the advice of a medical command physician and the responder's incident supervisor.

Vital Signs

Vital signs will be taken on every individual that enters the REHAB Unit with the heart rate being the determining factor for level of rehabilitation.

Documentation

Personnel will enter the REHAB area as a crew. Crews entering the REHAB Unit will be required to fill out the "Check-In/Check-Out" form at the entrance to the REHAB Unit. The Form will include, at minimum, the following information…..
  - Unit / Team Number
  - Number of Persons
  - Time In
  - Time Out

Crews will not leave the REHAB Unit until being released by the REHAB Unit Leader.

All medical evaluations shall be documented on the Rehabilitation & Monitor Check List. Additionally, all individuals that receive treatment beyond the standard medical evaluation shall have a Pennsylvania Patient Care Report generated for them. This includes all patients receiving transport to the hospital, as well as any invasive ALS treatments performed.

Heat Stress Index

Relataive Humidity

Temp °F.	10%	20%	30%	40%	50%	60%	70%	80%	90%
104	98	104	110	120	132				
102	97	101	108	117	125				
100	95	99	105	110	120	132			
98	93	97	101	106	110	125			
96	91	95	98	104	108	120	128		
94	89	92	95	100	105	111	122		
92	87	90	92	96	100	106	115	122	
90	85	88	90	92	96	100	106	114	122
88	82	86	87	89	93	95	100	106	115
86	80	84	85	87	90	92	96	100	109
84	78	81	83	85	86	89	91	95	99
82	77	79	80	81	84	86	89	91	95
80	75	77	78	79	81	83	85	86	89
78	72	75	77	78	79	80	81	83	85
76	70	72	75	76	77	77	77	78	79
74	68	70	73	74	75	75	75	76	77

(Add 10°F when PPE is worn and add 10°F when in direct sunlight)

	HUMITURE F	DANGER	INJURY THREAT
A	Below 80°	None	Little/ no threat under normal circumstances
B	80 - 90°	Caution	Fatigue possible if prolonged exposure and physical activity
C	>90 - 105°	Extreme Caution	Heat Cramps/Exhaustion possible with prolonged exposure & physical activity
D	>105 -130°	Danger	Heat Cramps likely - Heat stroke possible if prolonged exposure & physical activity
E	ABOVE 130°	Extreme Danger	HEAT STROKE IMMINENT

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WIND CHILL INDEX

TEMPERATURE °F

WIND SPEED (MPH)	45	40	35	30	25	20	15	10	5	0	-5	-10	-15
5	43	37	32	27	22	16	11	6	0	-5	-10	-15	-21
10	34	28	22	10	10	3	-3	-9	-15	-22	-27	-34	-40
15	29	23	16	2	2	-5	-11	-18	-25	-31	-38	-45	-51
20	26	19	12	-3	-3	-10	-17	-24	-31	-39	-46	-53	-60
25	23	16	8	-7	-7	-15	-22	-29	-36	-44	-51	-59	-66
30	21	13	6	-10	-10	-18	-25	-33	-41	-49	-56	-64	-71
35	20	12	4	-12	-12	-20	-27	-35	-43	-52	-58	-67	-75
40	19	11	3	-13	-13	-21	-29	-37	-45	-53	-60	-69	-76
45	18	10	2	-24	-24	-22	-30	-38	-46	-54	-62	-70	-78

ZONE	Wind Chill Temp F	DANGER
A	Above 10 F	No Danger
B	10 F / -25 F	Little danger if person is properly clothed
C	-25 F / -75 F	Increasing danger, person's flesh may freeze
D	Below -75 F	Great danger - flesh may freeze in 30 seconds

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REHAB Unit Leader - Checklist

Completed	
	Put on BROWN REHAB Unit Leader vest or identifier

	Select a REHAB area	
		Near to, but not visible from or within hearing of, the main action area
		Near SCBA changing area – if fire incident

	Notify EMS Official & Incident Command of your location

	Obtain Equipment & Supplies to operate the REHAB Unit.		
		Portable Radio – with good working battery to link to EMS Official	
		Salvage Covers – for ground cover (Pull off a near-by Engine w/permission	
		Traffic Cones – for cattle chutes and boundary markers (approx. 12)	
		Stretcher and Stair Chair	
		Oxygen supplies – Tank & Regulator(s)	
		"Cooling" and "Dry" towels – Cooler & Crate	__Cold Weather__
		Ice (Get from Freezer), Water & Cups	Hot Packs
		Activity Drink Mix (use 50-50 mixture)	Heavy Blankets
		Granola Bars	Grounded Electric
		Timpanic Thermometer(s) & probe covers	Supplemental Heaters
		Chairs or benches for seating	Windbreakers/Shelter
		BLS Trauma Kit	Quartz Lights (heat)
		Cooling Sprayers	Hair Dryers
		Adequate Lighting	Spare Clothing
		Clipboards & Log sheets	
		Triage Tags & Pens	
		ALS Trauma Kit (if appropriate)	
		Cardiac Monitor (if appropriate)	

	Request that the Communications Center announce the Rehab. Unit's location

	Work with the branch directors. group supervisors, unit leaders, and Safety Officer(s) to direct personnel to the REHAB area

	Log in, Assess, Log out all personnel seen by the REHAB Unit

	Request food support service – if extended operations

	Notify Triage Supervisor if intensive treatment of any personnel is necessary (Do Triage if necessary)

	Notify the appropriate AGENCY'S CHIEF OFFICER if any of their personnel are sent to hospital facilities

REHAB LOG				Location: Date:						Group: Number:			
Name/ Unit #	Times	Total Time/Bottles		Pulse	Resp.	Temp	Skin	B/P	Assessed By	Complaints/ Conditions	Amount of Fluid Given	Referred /Transf. To	Time Out

Page _____ of _____

Seven Mountains EMS Council
MCD/CCD Responsibilities

Planning Phase:

1.   Develop, revise, and maintain a mass casualty plan for the regional council.

2.   Establish and maintain preparedness liaison with the appropriate state and federal agencies with medical response and/or responsibilities.

3.   Compile and maintain a current listing of hospital emergency departments, supplies, air transport units, regional communications centers, and supporting agencies.

4.   Ensure staff personnel are aware of responsibilities.

5.   Support regional EMS units including training and appropriate MCI updates.

Response Phase:

1.   Activate mass casualty plan based on the size of the incident.

2.   Assist in notification to local and state officials.

3.   Assist EMS services, on scene as requested and/or needed, based on individual responsibilities below.

4.   Council can support MCI operations with various patient care equipment items and expendables normally used within regional training programs. We can also support the communications functions including on-scene communications, Commonwealth 800 MHz capabilities and Knowledge Center, patient tracking integration.

5.   Collaborate with county EMA officials.

Recovery Phase:

1.   Facilitate CISM if requested/needed.

2.   Participate in MCI incident critique.

3.   Provide staff assistance for internal critique or Hotwash.

6.   Review after-action report & forward as appropriate. Assist in preparation of report, as available, if requested.

7.   Assist regional EMS services in obtaining additional training based on needs assessment and/or results of MCI After Action Report.
       a. Personal protection
              i.   Know individual limits
              ii.   Transport issues for contaminated patients
              iii. Awareness of possible secondary devices
       b. Decon procedures
       c. Incident Command System & Position Functions
       d. Update on Personal Protective Equipment (PPE)
       e. Address specific patient care issues
       f. Others as needed

8.   Adjust Regional Council MCI plan as needed.

Council Staff – Roles & Responsibilities*

Executive Director
- ➢ Open Council Office
    - o Notify and/or call in staff as appropriate.
    - o Contact communications center for MCI details.
    - o Update PA Department of Health, Bureau of EMS of MCI.
    - o Maintain phone/radio contact with EOC for updates.
    - o Assign staff members to liaison, as needed.

Regional Education Coordinator
- ➢ Report to Council Office
    - o Assemble needed equipment from Council storage.
    - o If necessary, contact training sites to return equipment on loan. May direct equipment directly to MCI site.
    - o Transport equipment to MCI staging area, if necessary.
    - o Other duties as needed.

Regional License Coordinator
- ➢ Report to Council Office
    - o Assist with Hospital notifications and coordination of resources
    - o Assist Education Coordinator as needed
    - o Asset recovery and/or delivery as needed
    - o Other duties as needed.

EMS Program Specialist
- ➢ Report to Council Office
    - o Coordinate CISM activities as needed.
    - o Assist with asset gathering as requested
    - o Other duties as needed

Office Manager
- ➢ Report to Council Office
    - o Direct incoming & outgoing correspondence, including telephone. Log all incoming calls.
    - o Track available resources and event progression.
    - o Other duties as needed.

Area Preparedness Coordinator (housed Off-Site)
- ➢ Report to Council Office
    - o Activate regional strike team if needed.
    - o If directed, report to scene to assist in coordination of patient flow and/or communications with hospitals using Knowledge Center.
    - o Assure coordination of ambulance strike team resources, if needed.

Weapons of Mass Destruction Response

Section 1 – WMD AWARENESS

Responding to a Terrorism, or possible terrorism, Scene

- A. Similarities between terrorism scene response and the more common crime scenes.
    1. The majority of fire, EMS, and emergency management personnel are not well versed in crime scene operations.
    2. Any response to an incident other than a natural disaster may be a response to a crime scene.
    3. Terrorism scene, coordinate closely with other first-responding fire, EMS, and law enforcement personnel to ensure that you and the other responders do not destroy important evidence.
    4. Be aware of warning signs that indicate criminal activity, because some incidents will involve criminal acts.
- B. Be sure to coordinate your actions with law enforcement operations.
- C. There are three ways to help solve a crime:
    1. Confession of the perpetrator
    2. Statements provided by witnesses or victims
    3. Incriminating information obtained through physical evidence

Scene Considerations

- A. May involve entry into a hazardous area
    1. Atmosphere may be contaminated around the scene.
    2. Deadly radioactive, chemical or biological agents may be present
- B. Move more cautiously around the scene.
- C. Wear appropriate Personal Protective Equipment (PPE)
- D. Delay entry into a hazardous scene until it has been cleared by a Haz-Mat team.
    1. Haz-Mat teams utilize sufficient detection and monitoring equipment
    2. Only qualified personnel should enter the scene. Others should remain in the cold zone.
- E. Response to weapons of mass destruction incidents may lead to decontamination needs
    1. Equipment
    2. Entry Personnel
    3. Survivors / Casualties

G. Emergency Decontamination Considerations
   1. **Mass / Gross Decontamination** involves measures to filter or remove but not necessarily neutralize an agent. This involves the utilization of large amounts of water being sprayed from fire apparatus (or like) while moving casualties through a "cattle chute" like process. Large numbers are decontaminated in a short amount of time.
   2. **Fine / Technical Decontamination** – Material should be immediately removed by using a soft brush with soap and water decontamination. Careful washing with soap and water removes a very large amount of the agent from the skin surface. It is important to use a brush to ensure mechanical loosening from the skin surface structures, and then rinse with copious amounts of water (avoid dermal abrasions by brushing gently).
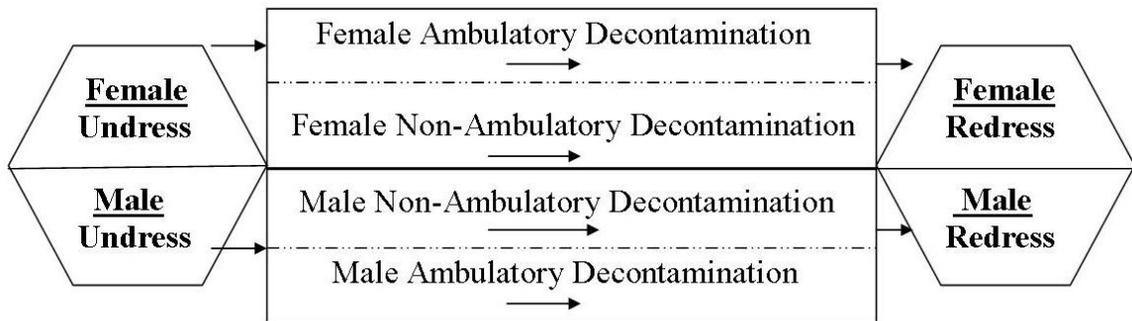
Section 2 – WARNING SIGNS AND INDICATORS OF WMD

At the scene, initial responders need to be on the lookout for the following common warning signs, indicating the presence of lethal agents from the five threat categories:

A. **Biological Indicators**
   1. Present themselves in two ways
      a. Public Health Emergencies
      b. Focused response to an incident.
   2. Onset of symptoms may be days to weeks – usually covert/hidden and hard to diagnose.
   3. No characteristic signs, smells or colors.
   4. Affects a greater area due to delayed onset of symptoms
   5. Indicators of biological attack may include:
      a. Unusual number of sick or dying people or animals
      b. Dissemination of unscheduled or unusual sprays
      c. Abandoned spray devices with no distinct odors
   6. Consider contacting hospitals to see if additional patients with same symptoms have been seen.
   7. Consult requirements for treatment of specific Biological Agents.

B. **Nuclear Indicators**
  1. Radiation detection can occur accidentally or through detection
     a. Observe DOT Placard Signs and Labels
     b. Utilization of monitoring devices carried by Haz-Mat teams

C. **Incendiary / Accelerant Indicators**
  1. Gasoline, rags, or other incendiary device indicators
  2. Remains of component parts in debris
     a. Odors of accelerants
     b. Unusually heavy burning or fire volume.

D. **Nerve / Chemical Agent Indicators**
  1. Outward signs are easy to recognize
     a. Rapid onset of acute symptoms among large groups of people.
     b. Dermal exposure causes clammy skin
     c. Pinpoint pupils
  2. Nerve Agents are extremely lethal
     a. Expect mass fatalities with no signs of outward trauma
  3. Indicators of Nerve Agent release
     a. Hazardous materials or lab equipment that is not relevant to occupancy.
     b. Individuals reporting unusual odors or tastes
     c. Explosions dispersing liquids, mists, or gases
     d. Unscheduled dissemination of unusual spray
     e. Abandoned spray devices
     f. Numerous dead animals, fish or birds
     g. Absence if insect life in warm climate
     h. Mass casualties without obvious trauma
     i. Distinct patterns of casualties.

E. **Explosive Agent Indicators**
  1. Outward signs are easy to recognize
     a. Large-scale damage to structures
     b. Blown out windows and scattered debris
  2. Injuries may be varying
     a. Exhibit signs of blast injury and shock (compartment or crush syndrome)
     b. Shrapnel-induced trauma, lacerations and fractures
     c. Damage to eardrums

Section 3 – PERSONAL PROTECTION FOR WMD

Self-protection as an initial responder is critical so that you can do your job effectively and not become a victim. Using your personal protective equipment (PPE) according to design specifications is your initial step to protecting yourself. However, there are various protective countermeasures for the six common types of hazard.

Recognition
Your primary concern must be self-protection. One commonly accepted classification identifies six types of harm you can encounter at an incident: Thermal, Radiological, Asphyxiates, Chemical, and Mechanical. The acronym, TRACEM, is an easy way to remember them. Since each has different harmful effects, let's take a brief look at each.

A. **Radiological**
   1. Three types of Nuclear Radiation
      a. Alpha – Not dangerous unless it enters the body, least penetrating
      b. Beta – More penetrating, damage skin tissues and internal organs.
      c. Gamma – Great penetrating power, high-energy, skin burns, severe injury to internal organs.
   1. Personal Protection from Radiation
      a. PPE – bunker gear, tyvek, SCBA (for alpha & beta)
      b. Receive proper response training
      c. Radiological monitoring / planning

B. **Asphyxiates**
   1. Two types – both interfere with oxygen during normal breathing
      a. <u>Simple</u> – inert gases that displace oxygen levels and dilute oxygen concentration below useful levels.
      b. <u>Chemical</u> – Blood poisons interrupt flow of oxygen in the blood and to tissues.
   2. Examples of asphyxiates
      a. Hydrogen Cyanide
      b. Cyanogen Chloride
      c. Carbon Monoxide
      d. Hydrogen Sulfide
   3. Personal Protection including the use of an SCBA

C. **Chemical**
   1. Two types of chemicals that can cause harm.
      a. <u>Toxic Materials</u> – harmful depending on concentration and length of exposure.
      b. <u>Corrosive Materials</u> – liquid or solid that causes visible destruction to site of contact

2. Examples of chemicals
   a. Nerve agents – act as toxic materials
   b. Sulfuric acid and blister agents act as corrosive materials
3. Personal protection could include level A or B Haz-Mat protection, SCBA and distance buffering

D. **Etiological**
   1. Exposure to a living microorganism, which causes human disease
   2. Examples include Biological Agents
   3. Personal Protection includes Saranex / Tyvek PPE with Level C Respiratory protection (P100, N95)

E. **Mechanical**
   1. Trauma caused by contact with mechanical or physical hazards
   2. Examples include
      a. Explosives
      b. Falls
      c. Secondary Devices
   3. Personal Protection includes full turn out gear, coveralls (or like Clothing), eye wear, helmet, steel-toe boots, and gloves.

The keys to self protection and much of the traditional training in hazardous materials response builds on the methods of **Time, Distance and Shielding**, all of which should be taken into serious consideration when dealing with WMD.

SMEMSC Mass Casualty Trailer Deployment

Purpose:
To provide guidelines on the use, deployment and restocking of the Mass Casualty Incident (MCI) response trailers located in Centre County (MCI 14, currently located at the Pleasant Gap Fire Department) and in Juniata County (MCI 34, currently located at the Juniata County Department of Emergency Services). These trailers are able to provide basic emergency medical supplies for up to 50 victims each. This guideline is intended to offer suggested usage of the trailers to gain the most effect in emergency situations involving multiple casualties within the region and for the purpose of stand-by readiness at pre-identified and planned events with large numbers of attendees to reduce response times in the event of a large scale incident

Scope:
Trailers will be made available whenever a mass causality incident develops which requires resources beyond the normal day-to-day operation, mutual aid or which may overwhelm an individual department, service, or community.
It is important to remember the inherent delay associated with attaching and towing a trailer, therefore the guideline suggests early consideration for response to an emergency event. It is also suggested that EMS agencies incorporate the MCI trailers into their box alarms and MCI Plans.
Pre-deployment will be categorized as
1.) Large Pre-Planned event or
2.) Training/Public Relations.

Examples of Pre-Planned event types: Large Political Conventions, Town Festivals, National level conferences/ educational/ sporting gatherings and/or events, or any mass gathering of people in which large numbers of attendees are anticipated. (Not an all-inclusive list)
Examples of Training/ Public Relations type events: Agency MCI Training exercise or class, Disaster drill, Department/Agency open house, Safety "Fair" and Fire/EMS Conference (Not and all-inclusive list) **NOTE** Pre-planned events shall have priority over Public Relations or Training events.

Policy:
During an MCI event, the appropriate trailer will be activated and transported to the scene by either the agency storing the trailer or by SMEMSC staff. SMEMSC will be the lead agency responsible for coordinating trailer response to the incident scene.

Emergency Deployment Procedures:

Activation will be initiated by the jurisdiction/agency affected by either 1) a request through their local PSAP or 2) direct communications with the Juniata County Communications Center at 1-877-436-2602. Juniata County will notify Council staff of the request.

It is recommended that upon notification the host agency attach the MCI trailer to a tow vehicle and begin response. If the host agency is unable to mobilize the trailer SMEMSC staff will mobilize and transport the trailer to the MCI site.

It is the goal of SMESMC to have the trailer(s) mobilized and en-route to the incident site within 30 minutes of receiving the request; however, mobilization times will vary depending on time of day and day of week.

All activities related to the demobilization of the MCI trailer(s) should be coordinated through the Incident Commander in conjunction with the EMS Branch Director. Upon release of the trailer(s) they should be returned to the requesting agency/ jurisdiction for cleaning and restocking, this can be accomplished with the assistance of SMEMSC staff. Once the trailer(s) are ready to be returned to service it should be returned to the hosting agency in coordination with SMEMSC staff.

Pre-Deployment Procedures:

The requesting EMS agency shall contact the SMEMSC with the request a minimum advance notice of 30 days prior to a planned event. The requesting EMS agency shall make arrangements directly with the SMEMSC for pick-up of the trailer after approval has been given. The requesting EMS agency shall be financially responsible for the replacement of any contents used during the pre-deployment. Trailer(S) shall be secured and in a response ready state when pre-deployed at pre=planned events. The trailer(s) shall be promptly returned to the appropriate housing location and SMEMSC notified of such.

Responsibilities:
It shall be the responsibility of SMEMSC staff to mobilize the appropriate MCI trailer. SMEMSC staff along with the using EMS agency/jurisdiction shall inventory trailer(s) before placing back into service after use. SMEMSC staff shall assure the trailers receive periodic inspection to insure they are safe and roadworthy.

The agency having jurisdiction/borrowing agency has ultimate responsibility to replace used or damaged equipment and supplies used. If the equipment/supplies are used within the SCMTF region "local" without SCMTF involvement, the agency is responsible; if SCMTF incident (SCMTF notification at the time of the incident or as soon as possible

afterword's), replacement may be accomplished using SCMTF funds if available and the incident is an allowable expense. If the equipment is used in a "local" or Task Force training event, the equipment would be eligible for replacement if approval is made prior to the use, must go through the training request process. Any hard equipment lost or broken, do to misuse or carelessness, is the responsibility of the borrowing agency/jurisdiction.

The trailers and equipment were purchased with federal (DHS) funds, the holder/ user is not permitted to charge for use/ replacement.

Glossary

Advanced Life Support (ALS) – the advanced pre-hospital and inter-hospital emergency medical care of serious illness or injury by appropriately trained health professionals and recognized EMT-Paramedics.

Assistant – Title for subordinates of principal Command Staff positions. The title indicates a level of technical capability, qualifications, and responsibility subordinate to the primary position. Assistants may also be assigned to unit leaders.

Basic Life Support (BLS) – The pre-hospital or inter-hospital emergency medical care and management of illness or injury performed by specially trained, certified, or licensed personnel.

Branch – The organizational level of having functional or geographical responsibility for major aspects of incident operations. A branch is organizational situated between the section and the division or group in the Operations Section, and between the section and units in the Logistics Section. Branches are identified by the use of Roman numerals or by functional area.

Bureau of Emergency Medical Services (BEMS) – the bureau within the Department of Health responsible for planning, developing and implementing the emergency medical services system as defined in the EMS Act, P.L. 164, No. 45.

CBRNE – Classifications of possible terrorism incidents types: Chemical, Biological, Radioactive, Nuclear, Explosive.

Catastrophic Casualty Disaster (CCD) – an event that results in massive injuries and/or deaths, causes extensive damage or destruction of facilities, produces an overwhelming demand on state and local resources, and causes severe long-term effects on general economic activity.

Chain of Command – A series of command, control, executive, or management positions in hierarchical order of authority.

Chief – The ICS title for individuals responsible for management of functional sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established as a separate section).

Command – The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority.

Command Post (CP) – The site near or at an MCI, MCD, or CCD from which the Incident Commander directs activities to control/contain/resolve the event.

Command Staff – In an incident management organization, the Command Staff consists of the Incident Command and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed.

Cooperating Agency – An agency supplying assistance other than direct operational or support functions or resources to the incident management effort.

Critical Incident Stress Management (CISM) – Stress management through psychological support of disaster-affected response personnel.

Deputy – A fully qualified individual who, in the absence of a superior, can be delegated the authority to manage a functional operation or perform a specific task. In some cases, a deputy can act as relief for a superior and, therefore, must be fully qualified in the position. Deputies can be assigned to the Incident Commander, General Staff, and Branch Director.

Division – The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A division is located within the ICS organization between the branch and resources in the Operations Section.

Emergency Operations Center (EOC) – a site from which government officials (municipal, county, state, and federal) exercise direction and control in an emergency or disaster.

Knowledge Center- Healthcare Incident Management System (HIMS) - The knowledge Center is a secure, web-based information management and communications framework. The knowledge Center integrates people and data through a virtual collaborative environment and provides intuitive, robust decision-support environment to aid Emergency Managers to mitigate large scale incident and planned events. The Knowledge Center helps facilitate cooperation between Emergency Managers and provides instant access to integrated data sources such as asset lists, GIS mapping capabilities, real-time weather, streaming cameras, and much more.

Function – Function refers to the five, or six, major activities in ICS: Command, Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established as a separate section). The term function is also used when describing the activity involved, e.g., the planning function.

General Staff – A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, Finance /Administration Sections Chief, and Intelligence Section Chief (if established as a separate section).

Group – Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. Groups, when activated, are located between branches and resources in the Operations Section.

Incident Action Plan – An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.

Incident Commander (IC) – The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

Incident Management Team – The IC and appropriate Command and General Staff personnel assigned to an incident.

Incident Objectives – Statements of guidance and direction necessary for selecting appropriate strategy(s) and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow strategic and tactical alternatives.

Joint Information Center (JIC) – a facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating agencies should collocate at the JIC.

Liasion – A form of communication for establishing and maintaining mutual understanding and cooperation.

Logistics – Providing resources and other services to support incident management.

Multiple Casualty Incidents (3-100 Causalities) – Multiple Casualty Incidents are incidents involving multiple casualties that can be managed, with heightened response (including mutual aid, if necessary), by a single EMS agency or system. Multi-casualty incidents typically, do not overwhelm the hospital(s) capabilities of a jurisdiction or region, but may exceed the capabilities of one or more hospital within a locality. There is usually a short, intense peak demand for health and medical services, unlike the sustained demand for these services typical of mass casualty incidents

Mass Casualty Incident (MCI) – Mass Casualty Incidents are incidents resulting from man-made or natural causes resulting in injuries or illness that exceed or overwhelm the

EMS and hospital capabilities of a locality, jurisdiction, or region. A mass casualty incident is likely to impose a sustained demand for health and medical services rather than a short, intense peak demand for these services typical of multiple casualty incidents.

Multiagency Coordination Entity (MCE) – a multiagency coordination entity functions within a broader multiagency coordination system. It may establish the priorities among incidents and associated resource allocations, deconflict agency policies, and provide strategic guidance and direction to support incident management activities.

Multi-jurisdictional Incident – An incident requiring action from multiple agencies that each have jurisdiction to manage certain aspects of an incident. In ICS, these incidents will be managed under Unified Command.

Operational Period – The time scheduled for executing a given set of operational actions, as specified in the Incident Action Plan. Operational periods can be of various lengths, although usually not over 24 hours.

Operations Section – The section responsible for all tactical incident operations. In ICS, it normally includes subordinate branches, divisions, and/or groups.

Personnel Accountability – The ability to account for the location and welfare of incident personnel. It is accomplished when supervisors ensure that ICS principles and processes are functional and that personnel are working within established incident management guidelines.

Planning Section – Responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the IAP. This section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.

Position Titles – Proper identifying title for ICS positions:

Primary Position	Title	Support Position
Incident Commander	Incident Commander	Deputy
Command Staff	Officer	Assistant
Section	Chief	Deputy
Branch	Director	Deputy
Division/Group	Supervisor	N/A
Strike Team/Task Force	Leader	N/A
Unit	Leader	Manager
Single Resource	Use Unit Designation	N/A

Resources – Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an EOC.

Resources Unit – Functional unit within the Planning Section responsible for recording the status of resources committed to the incident. This unit also evaluates resources currently committed to the incident; the effects additional responding resources will have on the incident, and anticipated resources needs.

Section – The organizational level having responsibility for a major functional area of incident management, e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established). This section is organizationally situated between the branch and the Incident Command.

Span of Control – The number of individuals a supervisor is responsible for, usually expressed as a ratio of supervisors to individuals. Appropriate span of control is usually agreed to be between 1:3 and 1:7.

Staging Area – Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages the Staging Area(s).

Strike Team – A set number (5) of resources of the same kind and type that have an established minimum number of personnel

Strategy – The general direction selected to accomplish incident objectives set by the IC.

Task Force – Any combination of resources assembled to support a specific mission or operational need. All resource elements within a Task Force must have common communications and a designated leader.

Tools – Those instruments and capabilities that allow for the professional performance of tasks, such as information systems, agreements, doctrine, and capabilities.

Triage – Patient assessment by categorizing and sorting victims according to the severity of injury or illness.

Type – A classification of resources in the ICS that refers to capability. Type 1 is generally considered to be more capable than Types 2, 3, or 4, respectively, because of size; power; capacity; or, in the case of incident management teams, experience and qualifications.

Unified Incident Command (UC) – An application of ICS used when there is more than one agency within incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, to establish a common set of objectives and strategies and a single IAP.

Unity of Command – The concept by which each person within an organization reports to one and only one designated person. The purpose of unity of command is to ensure unity of effort under one responsible commander for every objective.

Weapons of Mass Destruction (WMD) – Weapons, devices, or agents intended to cause widespread harm and/or fear among the population. Classified by the acronym: CBRNE – Chemical, Biological, Radiological, Nuclear, & Explosive.

Pennsylvania Department of Health

Medical Surge Systems

Medical Surge Equipment Cache (MSEC)

The MSEC is a 46 bed surge ward that can be requested for augmenting existing hospitals in the event of a surge incident or as a holding stabilization shelter for low acuity patients evacuated from a medical/nursing facility.

All patients that present will be triaged and stabilized. However the MSEC is designed to care for the low acuity, minor ill or injured for up to three days. Critically/moderately ill or injured patients will be cared for only until an appropriate receiving facility can be found to accept the patient. As many patients as possible will be discharged home to outpatient follow up as soon as possible.

Expendable medical supplies (such as IV fluids and associated supplies, dressings and oxygen, etc.) would need to be obtained from local facilities and vendors outside of this project on a just-in-time basis when necessitated by the evolving situation.

The MSEC Systems are unassembled and stored in trailers and staged at the following locations for potential use: There is a minimum of one MSEC staged at each of the states 14 Regional EMS Councils, with a total of 18 MSEC's available for deployment.

Casualty Collection Point (CCP)

The CCP is a 17 bed complete sheltering system that can be deployed and fully operational in less than 30 minutes with minimal staff. Likewise, the system can be demobilized and repacked in approximately the same amount of time, allowing for the system to be quickly ready for re-deployment to another location or use.

There are 6 CCP Systems strategically located in different locations throughout the state, these systems can be combined to form anywhere from a 34 bed system to a 102 bed system when necessitated by the evolving situation.

The actual utilization of the CCP System will be dictated by the circumstances of the incident. The primary intended purpose is to allow for secondary triage/short term field medical stabilization and coordinated transport to appropriate medical facilities (MMSS, S-MAT, and Bricks & Mortar). However, the systems can also be utilized for temporary aid stations, pharmaceutical dispensing stations, forward operations locations, etc. In short, the versatility of this system allows for a wide variety of initial uses, and also allows for transitional uses as the incident escalates, de-escalates or as other needs arise.

The CCP Systems are unassembled and stored in trailers and staged at the following locations for potential use:

Bradford Susquehanna EMS (1)	Emergency Medical Service Institute (4)
1 Guthrie Square Sayre, PA 18840 (570) 887-6390	1002 Church Hill Road Pittsburgh, PA 15205 (412) 242-7322
Southern Alleghenies EMS (9)	**Montgomery County Emergency Medical Services (13)**
2900 Beale Ave., Suite 126 Altoona, PA 16601 (814) 2012265	Office of Emergency Medical Services 50 Eagleville Road Eagleville, PA 19403 (610) 631-6520
Seven Mountains EMS Council, Inc. (15)	**EMMCO East, Inc. (19)**
44 Universal Road Selinsgrove, PA 17857 (570) 473-7834	1411 Million Dollar Highway Kersey, PA 15846 (814) 834-9212

Mobile Medical Surge System (MMSS)

The MMSS is a 50 bed system that can be requested for augmenting the CCP System or as a holding stabilization area for low acuity patients evacuated from a medical/nursing facility.

Patients that have presented to the CCP and have received secondary triage can be moved to the MMSS for holding so as not to overwhelm the CCP System.

All patients that present will be triaged, stabilized, receive a continuation of care and prepared for transport to the S-MAT System or a bricks and mortar medical facility.

Expendable medical supplies (such as IV fluids and associated supplies, dressings and oxygen, etc.) would need to be obtained from local facilities and vendors outside of this project on a just-in-time basis when necessitated by the evolving situation.

The MMSS Systems are unassembled and stored in trailers and staged at the following locations for potential use:

Eastern PA EMS Council (2)	EHS Federation (3)
4801Kernsville Road, Suite 100	722 Limekiln Road
Orefield, PA 18069	New Cumberland, PA 17070
(610) 820-9212	(717) 774-7911
Emergency Medical Service Institute (4)	**EMS of Northeastern PA (5)**
1002 Church Hill Road	169 Center Point Blvd.
Pittsburgh, PA 15205	Jenkins Township, PA 18640
(412) 242-7322	(570) 655-6818

State Medical Assistance Team (SMAT)

The SMAT is a stand-alone rapid medical response team which is available for deployment to sites within Pennsylvania during and after disasters and other events. The SMAT is available for deployment within four to six hours and can provide 24-50 beds for community or hospital triage, hospital emergency, critical/preoperative care, and medical surgical care until other state and/or federal response teams can be mobilized to support regional assets.

All patients who present at an SMAT will be triaged, stabilized, receive a continuation of care and prepared for transport to a medical facility. Some patients with lesser illnesses or injuries may be treated and directly released from the SMAT.

The medical supplies and equipment accompanying the SMAT includes IV fluids, pharmaceuticals, dressings, and oxygen. In addition, monitoring, resuscitation, and diagnostic equipment are available. The SMAT units can operate for a maximum of 72 hours before resupply is needed from outside agencies.

The SMAT systems are unassembled and stored in trucks/trailers and staged at the following locations for potential use:

Special Medical Response Team-SMAT-1	Health Care Improvement Foundation
529 Fire Academy Rd	1835 Market Street, Ste. 1050
Indiana, PA 15701	Philadelphia, PA 19103-2913
724-549-6033 (Dr. Dickson)	215-575-3745
724-349-1428 (Indiana County EMA)	
Erie Regional DMAT PA-3	
232 W. 25th Street	
Erie, PA 16544-0002	
814-452-5000	

        The process for requesting these State assets is through your county EMA Coordinator. The county EMA Coordinator will put in a request for the resource(s) to PEMA; will move the request to the Health EPLO, who will reach out the Bureau of EMS and the Bureau of Public Health Preparedness. Once approval has been granted the Health EPLO notifies PEMA who will assign it a mission number and push it back out the county coordinator who requested the resource(s).Once a mission number has been assigned the Bureau of EMS will reach out to the Regional EMS Council for deployment of the requested asset. This whole approval process could take up to several hours for approval.

SMEMSC Regional Council Resources

Resource Name	Quantity	Resource Description
Generator	1	70,000 KW Diesel fueled generator
Light Tower	1	
Shower Trailer	1	Shower trailer with the ability to shower 6 persons at a time, Unit also contains 3 washer/dryer combo units. Unit has 450 gal. of fresh water and a gray water holding tank.
Kubota	1	With or without Med bed abilities
HeatStar Heaters	2	390,000 BTU Nulti-fuel heaters
AC Units	2	5 Ton Ac Units
LB White Heater	1	80,000 Btu Propane fired Heater
Western Shelters	2	16' western Shelters
Resq-Trailer	1	Trailer to be hook behing an ATV or UTV with ability to carry a stokes basket for victim removal from remote areas. Unit is also equipped with snow skis for winter usage.
Evaprotive Cooler	2	Coolspace Evaprotive cooler Used to cool tents/Shelters
AC Units	1	Portable In room AC Unit
Folding Tables	2	
Binoculars	Several	Including night vision
Easels	2	Aluminum easels with easel pads
Weather Radios	Several	Emergency weather Radios
Office Supplies		Assorted office Supplies
Paper Products		Assorted Paper products to include Paper towels, Toilet Paper, Paper Plates and cups.
Cookware		Assorted cookware to inclube utensils
Assorted Tarps		Tarps of assorted sizes and colors
Portable Fan	2	10" battery operated portable fan
Cabela's Tent	1	Cabela's Deluxe Alaknak Tent 12'x12'
Coleman Tents	3	13'x11' Coleman Tents
Assorted PPE		
Post Decon Kits		
Grill Top	3	
Portable Kitchen	1	
Assorted EMS Vesta		Assorted EMS MCI/ Command Vests
Propane Lanterns	2	Coleman Propane Lantern
3D Lanterns	4	Cabela's LED Seclusion 3D Battery operated Lantern
EveryReady Flashlights		
Dual Fuel Stove	2	Coleman Dual Fuel Stove Powerhouse 414
Porta Potty	1	Porta Potti 555 with supplies needed to operate
Rolls BioHazaed Tape		
PETT Toilet	1	PETT Compact dry toilet system with supplies needed to operate
DC Powered Cooler	2	Coleman DC Powered Cooler Model 564

Cooling Towels		
Cooling Bandanas		
EMS Safety Vests		
Respirators		N-95 and P-100 Respirators
Florscent Yellow Vests		
Hydration Bag	6	10L Hydration Bag (Dormedary)
Cool Mist Fan		
Shop Lights	5	Telescoping pole shop lights
Commercial Griddle	2	Blackstone Portable commercial griddle Propane operated
Portable Gas Grill	1	Uniflame portable gas grill (Small)
Sidewall Panels	Several	Various sizes of sidewall panels for EZ-Up style shelters
Folding Chair	8	Metal folding style chairs
Multi-Port Oxygen Regulators	2	Reeves First Call Multi-Port Oxygen Regulators includes 10 adult NRB oxygen masks, hose and regulator
Oxygen Gas Manifold	1	Medica Oxygen Gas Manifold includes Hose assembly and regulator
EZ-Up Tents/ Shelter		Various sizes of EZ-Up style Tents/Shelters
Bag Chairs	Several	
Hand Wash Station	3	4 Person Hand wash stations
Evaporative cooling Vests	3	Various sizes
2000 Watt Generator	5	Honda EU Inverter 2000 Watt Generators
Homelite Generator	1	Homelite 2400 Generator
Mr. Heater	1	Big Buddy Mr. Heater Propane heater
Drink Coolers	2	5 Gal. Drinking coolers
Council Support Truck	1	Chevy 2500HD truck with communications and towing capabilities
Inflatable Quick Shelters	2	16'x20'x8' Inflatable shelters with heating and cooling abilities
Pelsue Propane Heater	1	45,000 btu Propane Heater with duct work
Security Cameras	2	Swann pro-series (Pro-530) 12 security camera with IR cut filter.

This is not an all-inclusive list of resources available through the Regional EMS Council.

It is the goal of the Seven Mountains EMS Council to see these assets are utilized whenever needed throughout the region and/or the Commonwealth. If you have an unmet need on an incident, please contact your local EMA/911 center to initiate a PEMA unmet needs request. Council will do everything we can to help fulfill this unmet need upon authorization to do so.

SCMTF Resources

The SCMTF has 7 MCI trailers located in the following counties:

Bedford County   1
Blair County   1
Fulton County   1
Huntingdon Country   1
Mifflin County   1
Snyder County   2 (1 Response trailer and 1 trailer designated form MCI training which can also be used for response if needed)

Emergency Deployment procedure:

1) The requesting agency shall notify their PSAP with the initial request
2) The requesting PSAP will notify the closest PSAP housing an MCI Trailer.
3) The PSAP will dispatch the housing EMS service a MCI trailer response.
4) Both PSAP(s) will notify their respective EMA coordinators.
5) The housing EMA coordinator will contact the requesting EMA coordinator
6) The housing EMS service will notify their home PSAP when responding with an ETA.
7) Personnel from the housing EMS Service will stay with the trailer to track equipment and supplies.
8) All activities related to demobilization will be coordinated through the requesting county's EMA. The decision to demobilize will be that of the Incident Commanders in each of the disciplines who are affected by the incident.
9) Should the trailer need to remain at the scene for an extended event the requesting agency shall coordinate directly with the respective housing EMS agency for pick-up and / or delivery of the trailer after approval from the county EMA director, as well as the return of the trailer.
10) The trailer shall be secured and returned to a response ready state as quickly as possible,
11) The trailer shall be promptly returned to the appropriate housing EMS agency.

NCTF Resources

Mass Causality Response Truck

Greater Valley EMS

904 N. Lehigh Ave.

Sayre, Pa

570-888-6000

Dispatched by Bradford County- 570-265-9101

1 ea.	SMART Command Board
19 ea.	Orange Traffic Cones
4 ea.	Green Traffic Cones
4 ea.	Yellow Traffic Cones
4 ea.	Red Traffic Cones
120 ea.	Long Backboards, Yellow
40 ea.	E- Size Oxygen Cylinder
40 ea.	MX-Pro Oxygen Regulator
1 ea.	Mini-lator Oxygen distribution device, short hose
1 ea.	Mini-lator Oxygen distribution device, long hose
120 ea.	Wool Blankets
2 ea.	Metal Clipboard
4 Cases	N-95 Masks
4 ea.	Green Triage area bandaging bin with supplies
2 ea.	Green Traiage area glove bin wqith tarps
4 ea.	Yellow Triage bandaging bin with supplies
2 ea.	Yellow triage area glove bin with tarps
4 ea.	Red Triage bandaging bin with supplies
2 ea.	Red Triage area glove bin with tarps
2 ea.	Quick shade 10x10 Shelter
2 ea.	Ezup 12x12 Shelter
1 ea.	MCI Treatment area flag kit
4 ea.	Triage area additional bandaging supplies bin
4 ea.	Trtiage area additional towels & sheets bin
2 ea.	Gall's Street Thunder Megaphone
1 Case	Tyvex Coveralls, Small
2 sets	Immoblization box 30 collars, 100 straps, 10 pedi collars
120 ea.	Head Bed II disposable CID
2 ea.	3-1 Extension cord splitter
3 ea.	Tripod work lights, 2 halogen light heads
1 ea.	5500 Watt gasoline Generator
1 ea.	5 gal. plastic gas can
1 ea.	Extenmsion cord reel, heavy gauge black cord
2 ea.	MCI Bag: 5 triage kits, 50 collars, MCI Vest set
1 ea.	NMCI Flag set with poles
2 ea.	3'x4' White dry erase board
1 ea.	Double wide wooden clipboard
4 ea.	Mini-lator 10 LPM flow
4 ea.	Mini-lator 15 LPM flow
1 ea.	M-Tank oxygen regulator
5 ea.	Oxygen supply hose, long
2 ea.	Oxygen supply hose, short
20 ea.	Midland 70-440BP UHF portable radio with charger
10 ea.	Midland 80-150 VHF portable radio with charger

MCI Trailer(s) 2

Lockhaven EMS	Susquehanna Regional EMS
21 N. Liberty Street	700 High Street
Lockhaven, Pa 17745	Williamsport, Pa 17701
570-748-1611	570-321-2417
Dispatch by Clinton County	Dispatch by Lycoming County
570-748-2936	570-433-3166

Patient Immobilization	Adult Backboards	Trauma Patient Care
100	Peds Backboard	100
10	Backboard Straps	31
320	Auto cradle	10
110	Adult adjustable collar	20
100	Peds adjustable collar	30
25	Disposable Body Bags	20
25	MCI Mesh Stretcher	100
10	Haz Mat Decon Sked	20
2	Carrying case for Sked	100
2		20
Oxygen Administration	O2 cylinder rack (20) trailer	50
1	O2 cylinder rack (5) Station	100
1	Adult BVM	150
44	Peds BVM	20
22	"D" oxygen bottles, Aluminum	20
30	O2 Carrying case, Orange	50
20	"M" oxygen tanks	100
2	Hand Truck for O2 tanks	25
2	"M" pressure reducer	25
2	15LPM Minilator	ALS Trauma Patient Care
4	15 Liter Nipple	1
28	30' oxygen hose & connectors	5
4	Oxygen tubing	150
75	Oxygen tubing connector	252
75	Adult NRB Masks	288
300	Adult Nasal Cannula	250
250	Pediatric NRB Masks	1 box of 50
135	Pediatric Nasal Cannula	1 box of 50
135	Nasal Airway Kit	1 box of 50

25	Oral Airway Kit	1 box of 50
25	Res-Q-Vac Suction	5
40	Cartridges for Res-Q-Vac	3
20	V-Vac manual suction unit	3
5		5
		5
Triage Equipment	Tactical command board	
1	Case for command board	
1	Medium Supreno Gloves (50/bx.)	
10	Large Supreno Gloves (50/bx.)	
20	X-Large Supreno Gloves (50/bx.)	
10	MCI Rapid Response Kit	
1	6" Green light stick	
100	6" Yellow light stick	
100	6" Red light stick	
100	6" Blue light stick	
50	Triage tape system	
5	SMART triage tags	
100	SMART EMS Command bags	
2	Triage tags	
100		
Scene Management	10'x10' pop-up tent Green, cart	
1	10'x20' pop-up tent Red, cart	
1	10'x20' pop-up tent Yellow, cart	
1	Green sidewalls	
1 set	Adult Backboards	Trauma Patient Care

ATV- Patient Transport Susquehanna Regional EMS 700 High Street Williamsport, Pa 17701 570-321-2417 Dispatch by Lcoming county 570-433-3166	Western Shelter Dispatch by Lycoming County 570-433-3166
PA Company No. 6 Williamsport Fire Department 440 Walnut Sterrt Williamsporet, Pa 17701 570-327-1602	Communications Resources Incident Management Unit Loyalsock VFC. 715 Northway Rd. Williamsport, Pa 17701 570-3213-3603 Dispatch by Lycoming County 570-433-3166
Incident Management Unit Trailer Dispatch by Tioga County 570-724-9110	Prime Mover- Each county also has a "Prime Mover" with special communications capabilities. These vehicles are available through local EMA.