



# Disaster Operating Guidelines Field Guide

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**Disaster Level**

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Disaster and Mass Casualty Incidents can be designated in the following manners depending on the surviving victims present on scene.

**Level 1** - Mass casualty incident resulting in less than 10 surviving victims.

**Level 2** - Mass casualty incident resulting in 10 to 25 surviving victims.

**Level 3** - Mass casualty incident resulting in more than 25 surviving victims.

**Level 4** - Mass casualty incident resulting in a number of surviving victims that could necessitate an inter-region response and/or activation of an additional disaster plan or additional resources.

**Always consider the need for patients to be decontaminated if they have been exposed to ANY hazardous material.**

## Using this Resource

The Eastern PA EMS Council Disaster Operating Guidelines (DOG) Field Guide is designed to be a useful source of information in a compact, useable format for mass casualty field operations. These guidelines are not intended to replace any established county, municipal, or local emergency response plan. Rather, they are intended to serve as a reference tool for the emergency provider while performing duties in the field. *This guideline is not a substitute for education in mass casualty incidents, or the National Incident Management System (NIMS) and the Incident Command System (ICS).*

## Scope and Objectives

The DOG is designed to assist emergency response providers in properly organizing, controlling, and documenting resources during a disaster. The Eastern PA EMS Council has developed this resource based on the concept of the National Incident Management System and the START Triage Tag System and individual counties Emergency Operations Plan, including the Emergency Response Plan of the Lehigh Valley International Airport, to serve as a basic framework for roles and responsibilities for emergency responders during a disaster.

It is highly recommended that all EMS practitioners take the NIMS ICS for EMS course and other appropriate NIMS related courses which are readily available. The Eastern PA EMS Council can assist you in identifying those courses by contacting the Council office.

## Overview

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## Function Overview

A loss of property, a loss of human life, a large number of injuries ranging from minor to life threatening, separation of family members and an overall disturbance of routine operating procedures characterize disasters. The treatment and/or stabilization, extrication, transportation of the injured to appropriate medical facilities, rehabilitation of responding personnel, recognition and/or institution of the Critical Incident Stress Management (CISM) team, requesting county animal response team (CART), restoring, and maintaining order and identifying the dead are common among the varied responsibilities which may be unexpectedly thrust upon emergency response organizations.

Disasters can occur in varying degrees, at any time, and in practically any conceivable situation. The potential categories for disasters may include, but are not limited to:

Major vehicular accidents with multiple victims	Fires
Transportation Accidents (Aircraft, Train, Bus)	Nuclear
Mining or Construction Accidents	Chemical
Environmental Disasters	Biological / Epidemic
Human-made Disasters	Explosives
Industrial Accidents	Radiological
Building Collapses	Incendiary Devices

The response to a disaster must be scalable to deal with any potential number of victims or incident sites and flexible to manage any variety of on-scene challenges. First and foremost, scene safety and a clear chain-of-command will be established prior to commencing any on-scene operations. On-scene hazards will be mitigated, and rescue and decontamination operations will be conducted, as deemed necessary. Casualties will be triaged, treated, and then transported to the closest most appropriate hospital or approved medical facility to receive further evaluation and definitive care.

The total system of a disaster response consists of many agencies working together on-scene with common objectives to provide a continuous chain of patient care. The management of the overall response begins on-scene and may transition to the Emergency Operations Center (EOC) if the need to coordinate and support operations progresses. This plan divides the response into the following four management strategies: notification, establishing command and control, response operations, and hospital surge. These strategies outline the processes for activating agencies' response, implementing surge capacity, managing resources, and coordinating disaster operations.

Disasters present diverse and unique problems requiring a prompt and organized response. In order to identify the roles and responsibilities of emergency response personnel a concept of operations plan must exist.

## **Roles and Responsibilities**

### **1. Local Municipality / County**

Local / County emergency operations are discussed in detail in the Pennsylvania State Emergency Operations Plan. Support functions could include resource management, communication and dispatch, and coordination of unmet needs requests.

### **2. Regional**

This regional guideline describes the collaboration of Eastern PA EMS Council counties and supporting agencies in planning, interoperable communications, management of a mass casualty incident, ensuring continuity of operations, fostering information sharing (to include emergency public information), and enabling coordination of activities before, during, and after any incident.

### **3. State**

Departments and agencies within the Commonwealth will conduct emergency operations in accordance with direction and guidance published in the Basic Plan of Pennsylvania State Emergency Operations Plan. Specific responsibilities in response to a mass casualty-producing incident are identified in these Disaster Operating Guidelines.

### **4. Federal**

The Department of Health and Human Services (HHS) is the principal Federal Agency for protecting the health of all Americans. State response operations will interface with Federal response assets through a liaison between the State Department of Health and the Centers for Disease Control and Prevention as well as with the Federal Emergency Management Agency. Liaison between the State Emergency Operations Center (SEOC) and the Department of Homeland Security (DHS) will provide access to additional federal health and medical assets.

### **5. Health Care Coalitions**

In Pennsylvania, Healthcare Coalitions serve as the backbone of healthcare system coordination during a Mass Casualty Incident. By integrating hospitals, EMS, Public Health, and Emergency Management, HCCs ensure a unified, efficient, and scalable response that maximizes available resources, enhances communications, and ultimately improved patient outcomes during times of crisis. During a Mass Casualty Incident, HCCs play a vital role in supporting both prehospital and hospital-based operations through the following key functions:

- Coordination & Communication
- Medical Surge Support
- Resource Management
- Incident Support & Integration

**Eastern PA EMS Council  
Disaster Operating Guidelines**

- Continuity of Healthcare Operations
- Preparedness, Training, and Exercises
- Public Health & Medical Coordination

**The emergency contact number for 24/7 responses requests is 570-231-5385**

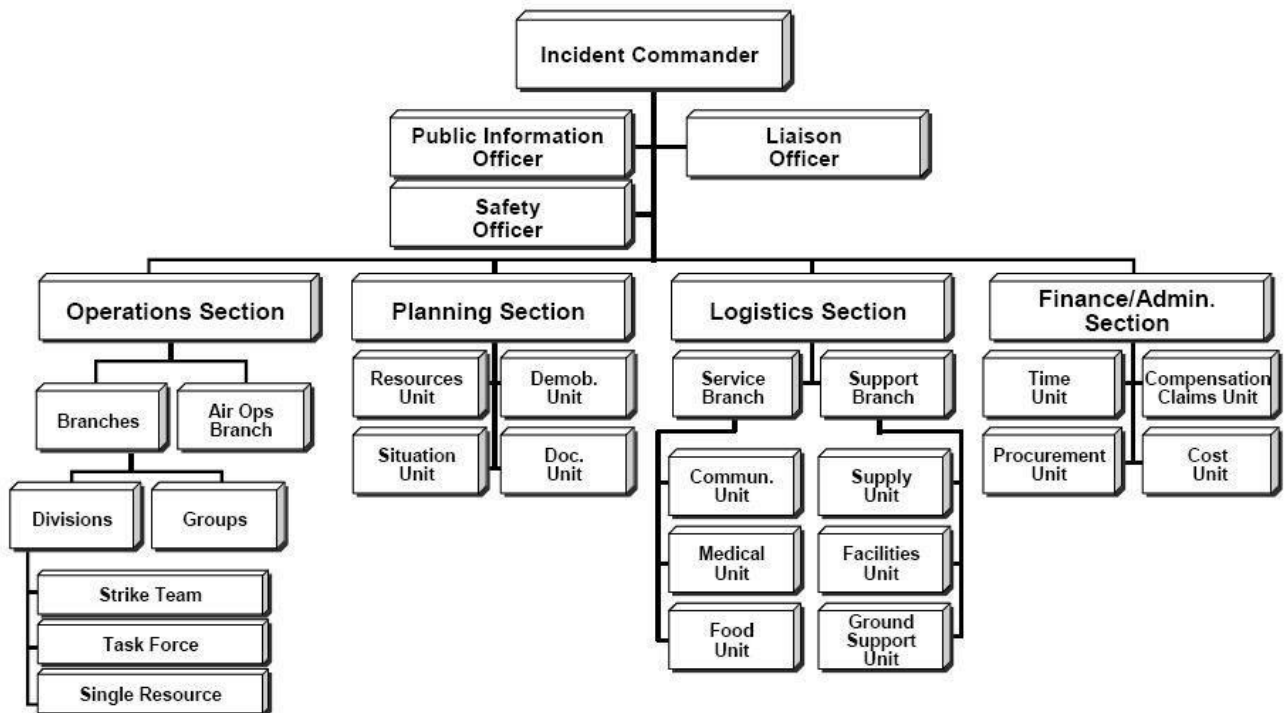
**National Incident Management System (NIMS)**

The Eastern PA EMS Region follows the National Incident Management System and therefore NIMS will be used to manage all incidents or events in the region. As defined in NIMS, the Incident Command System (ICS) will be used for all hazard-incident management.

The National Incident Management System (NIMS) is a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards - regardless of cause, size, location, or complexity – in order to reduce loss of life, property, and harm to the environment. The NIMS is the essential foundation to the National Preparedness System (NPS) and provides the template for the management of incidents and operations in support of all five national planning frameworks.

While these guidelines do not supplant or dictate local department operations, the Disaster Operating Guidelines strongly encourage all agencies to follow consistent procedures. The more a system can be used on routine operations, the easier it will be to use on complex MCIs. The ICS is designed to allow even the smallest department to expand the command structure through the use of mutual-aid resources. All agencies should follow NIMS for all responses.

## ICS Organization



### EMS OPERATIONS STRUCTURE Within the Incident Command System

## QUICK FACTS

**EMS Branch Director:** Responsible for coordinating EMS operations. This role is normally assumed immediately by the first-arriving EMS unit, pending designation by the Incident Commander. This individual should be located at the incident Unified Command Post and coordinates EMS activities with the Incident Commander. This position answers directly to the Operations Chief.

**Emergency Management Coordinator/Director:** The individual within each political subdivision that has coordination responsibility for jurisdictional emergency management.

**Emergency Services Group Supervisor:** The individual responsible for the overall coordination of EMS activities at a disaster scene. This role may be combined with EMS Branch Director on smaller incidents.

**Finance/Administration Section Chief:** The Section responsible for all incident costs and financial considerations. Includes the Time Unit, Procurement Unit, Compensation/Claims Unit, and Cost Unit.

**Incident Action Plan (IAP):** An incident action plan (IAP) formally documents incident goals (known as control objectives in NIMS), operational period objectives, and the response strategy defined by incident command during response planning. It contains general tactics to achieve goals and objectives within the overall strategy, while providing important information on event and response parameters. Equally important, the IAP facilitates dissemination of critical information about the status of response assets themselves. Because incident parameters evolve, action plans must be revised on a regular basis (at least once per operational period) to maintain consistent, up-to-date guidance across the system.

**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.

**JUVARE:** *EMTrack* is a highly configurable, web-based solution designed with a robust mobile integration to effectively track the movement of people and patients during episodic events such as mass casualty incidents (MCIs), public health concerns, as well as natural and human-caused disasters.

**Liaison Officer (LNO):** A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies. The Liaison Officer may have Assistants.

**Logistics Section Chief:** The Section responsible for providing facilities, services, and materials for the incident.

**Operations Section Chief:** The Section responsible for all tactical operations at the incident. Includes Branches, Divisions and/or Groups, Task Forces, Strike Teams, Single Resources, and Staging Areas.

**PAMEDIC:** Many times, the influx or surge of patients pushes our system (emergency departments and EMS) beyond immediate capacity. The benefit of working as a system is we can leverage or compensate each other as needed. However, in those times we need to be as efficient as possible. The tool is a mobile platform allowing EMS providers, emergency department staff, and 9-1-1 communication centers to see the current capacity within a specific geographic area. <https://www.pamedic.org/>

**Planning Section:** Responsible for the collection, evaluation, and dissemination of information related to the incident, and for the preparation and documentation of Incident Action Plans. The Section also maintains information on the current and forecasted situation, and on the status of resources assigned to the incident. Includes the Situation, Resources, Documentation, and Demobilization Units, as well as Technical Specialists.

**Public Information Officer (PIO):** 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. The Safety Officer may have Assistants.

**Transportation Unit Leader:** Responsible to the EMS Supervisor for coordinating the transportation of victims to appropriate medical facilities in an expeditious manner.

**Treatment Unit Leader:** The Treatment Group Supervisor is responsible for patient care at the Patient Treatment Areas. Specifically, the Treatment Group Supervisor reevaluates patients and re-tags casualties if necessary; provides further treatment and care and assists with loading patients in the next available and appropriate transportation units.

**Triage Unit Leader:** Directly responsible to the EMS Supervisor for the coordination of triage operations at the disaster site. Reports to the EMS Group Supervisor and supervises Triage Personnel and the Morgue Manager. Assumes responsibility for providing triage management and movement of patients from the triage area. When triage is completed, the Unit Leader may be reassigned as needed.

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## Sequence of Events at a Disaster

*The **primary** concern of all emergency response operations must be to save as many lives as possible with the resources which are available.*

In incidents such as floods, hurricanes and tornadoes, rescue and evacuation operations may begin before the natural disaster actually strikes. These actions will occur by agencies being alerted to bring their immediate manpower needs up to operational levels.

- Activation of an emergency response plan, to include early warning, notification, and preparation for potential disaster, which may involve multiple patients.
- Local response system implemented. First arriving police, fire and EMS units activate the Incident Command System. This includes the following:
  1. A **single** Incident Unified Command Post (ICP) should be established, and its location transmitted to responding emergency service units by their communications center before their arrival at the scene. Incident Commander is established.
  2. The ICP is a joint effort between the Incident Commander (or Unified Command if established), Command and General Staff personnel represented at the scene. Therefore, key officials and stakeholders (i.e., Fire, Police, EMS, Governmental Officials, EMA Officials, Federal Officials, Building Owners, etc.) should be directed to the ICP upon their arrival at the scene.
  3. The ICP should be identified by the display of a GREEN means of identification that is visible from all sides of the stationary ICP, so that it is easily identified at the scene. For example, a green Incident Unified Command Post sign, flag or light might be used to make this designation.
- First EMS personnel at the scene perform a primary scene size-up of the incident scene and establish the EMS Branch Director.
- Initial Triage consists of a preliminary ‘walk through’ by the Triage Unit Leader and first arriving emergency care personnel so that an approximate patient count can be determined, and patients tagged according to the apparent severity of their injuries. The Triage Unit Leader must quickly present a report on the patient count and approximate number of patients in each category to the EMS Branch Director.

- Initiation of critical life-saving treatment techniques during the rapid initial survey performed by the personnel assigned to triage. For example, opening an airway or control of severe bleeding.
- Notification of EXTENT and NUMBER OF CASUALTIES to the communications center by the EMS Branch Director. The Public Safety Answering Point then notifies all agencies involved.
  - Public Safety Answering Point will activate local response plans and Communications Protocols as needed
- Public Safety Answering Points will ascertain the number of patients each facility may receive within their respective counties.

Casualty Collection Points (CCP) established in well-marked areas by the Treatment Leader.

- Patients arranged by priority at CCP/Treatment Area.
- Incoming emergency units report to designated Vehicle Staging Area, and the highest trained personnel report to Treatment Group Supervisor and requested appropriate supplies/equipment. The driver and the stretcher must remain with the vehicle, awaiting further assignment
- Patient treatment implemented by BLS and ALS practitioners at CCP / Treatment Area.
- Patients shall be transported in priority sequence, if possible, to designated hospitals and approved medical facilities as assigned by Transportation Group Supervisor. In a Mass Casualty Incident, ***several patients SHOULD be transported in each vehicle in order to maximize the transportation resources that are available.*** EMS units should not be allowed to leave the incident scene with only one patient on board.
- Consider De-escalation of resources
- Establish post-incident equipment collection site.
- Equipment and supplies returned to agencies involved.
- Critical Incident Stress Management (CISM) Support should be considered for personnel. The Answering Service will notify the on-call CISM designee as soon as details of the MCI are known so they can assemble the team for possible response

A hot wash should be conducted prior to demobilization.

- Reports and records assembled by EMS Branch Director
- Post-incident analysis of disaster scene operations should be conducted by all agencies involved, shortly after the incident. Review and update of plan.

## Disaster Level

Disasters and Mass Casualty Incidents can be designated in the following manners depending on the surviving victims present on scene.

**Level 1** - Mass Casualty incident resulting in less than 10 surviving victims.  
**Suggested Resource Allocation: 7 Ambulances**

**Level 2** - Mass Casualty incident resulting in 10 to 25 surviving victims.  
**Suggested Resource Allocation: 15 Ambulances**

**Level 3** - Mass Casualty incident resulting in more than 25 surviving victims.  
**Suggested Resource Allocation: 24 Ambulances**

**Level 4** - Mass Casualty incident resulting in a number of surviving victims that could necessitate an inter-region response and/or activation of an additional disaster plan or additional resources.

**Suggested Resource Allocation: 35 Ambulances and Out of Region Strike Team Activation (requested through the PA DOH, Bureau of EMS)**

**\*Remember, Strike Team assets are for events lasting days or weeks, not hours\***

**Suggested Resources follow local response plan that is already in place.**

**Always consider the need for patients to be decontaminated BEFORE transporting if they have been exposed to ANY hazardous material.**

## **Personnel Roles and Responsibilities**

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## **TRIAGE**

Eastern PA EMS Council has adopted this **Simple Triage and Rapid Treatment (START)** which allows for prompt initial rapid identification and classification of patients. This system allows for uniformity throughout the Eastern PA EMS Region.

The **initial triage** is a walk through by the Triage Unit Leader and is performed so that an approximate patient count can be determined. “Tagging” of patients according to the apparent severity of their injuries may also begin at this point if an adequate amount of personnel are available to do so. During initial triage, only care that would correct immediate life-threatening problems, e.g., severe bleeding, airway problems, should be performed.

On extremely large incidents, such as those involving large or multiple buildings, it may be necessary to have several separate triage areas, e.g., 1st floor triage, 4th floor triage, east side triage, etc. The Triage Leader should assign multiple triage/tagging teams for such incidents. As a general rule of thumb, one team for floor or one team per area of an incident should be utilized for these large incidents.

All patients will be initially triaged and tagged according to SMART Triage through the use of the region approved MCI Tags. SMART Triage Tags are a durable, waterproof tag designed to withstand decontamination (DECON) processes.

### **Green Tag - Minor**

Minor injuries which are not life threatening; status is unlikely to deteriorate over days; may be able to assist in their own care. These people are often categorized as ‘walking wounded’.

### **Yellow Tag – Delayed**

Serious and potentially life-threatening injuries but status is not expected to deteriorate significantly over several hours; transportation can be delayed.

### **Red Tag – Immediate**

Serious injuries that can be helped by immediate intervention and transport; requires medical attention within minutes for survival (up to 60 minutes); includes compromises to patient’s Airway, Breathing, and Circulation; injured co-workers and patients with uncontrolled emotional disorders are also placed in this category.

### **Black Tag – Dead**

Victim is unlikely to survive given the severity of injuries, level of available care, or both; palliative care and pain relief should be provided.

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## ***QUICK REFERENCE FOR TREATMENT TEAM***

### **Treatment Group Supervisor**

**Assume responsibility for treatment, preparation for transport and coordination of patient treatment in the treatment areas. Directs the movement of patients to loading locations**

### **MORGUE**

If required, the Treatment Group Supervisor will designate a Morgue and Team Leader. The Team Leader may be relieved by an authorized representative from the County Coroner's Office.

Tasks include:

- Limit access to authorized personnel only.
- Maintain victim confidentiality.
- Maintain necessary records, secure victim's personal effects.

### **Secondary Triage occurs based on the Statewide Protocols**

#### **Red Tag**

These are high priority patients who require high priority of care and high priority transport. Optimal patient to provider ratio of 1:1 or better.

#### **Yellow Tag**

These are medium priority patients who require prompt care but can await transport of higher priority patients. Optimal patient to provider ratio of 3:1

#### **Green Tag**

These are low priority patients who may require minimal care but do not require rapid transport; non-traditional transport methods should be considered. Optimal patient to provider ratio of 5:1

#### **Black Tag**

These patients may be deceased or have injuries not compatible with life or unable to be stabilized with resources at hand. Patients who receive a black tag will be reassessed after all other patients are triaged and resources become available.

Note: Any patient who dies in the treatment area will be reclassified as a black tag and moved to the on-scene morgue.

**Transportation Unit Leader**

(works closely with treatment unit leader)

Works closely with the Treatment Unit Leaders and should **distribute** patients among **several hospitals approved medical facilities** to ensure that they will receive appropriate care and prevent the unnecessary taxing of any one hospital's resources. By utilizing PSAP's, Juvare, Web EOC or other electronic management systems (to include electronic patient tracking), distinct communication pathways, and other as developed by the region in cooperation with our Healthcare Coalitions bed availability can be quickly gathered and provided to the Transportation Unit Leader. Patients will also be assigned to ambulances by the Transport Unit Leader. The Transport Unit Leader will consider the use of both conventional and non-conventional transportation need (i.e. busses, vans, etc.)

All patients assigned from the scene should be logged on flow sheets and the bottom section of the triage tag retained by the Transportation Unit Leader or Member.

SAMPLE DISTRIBUTION  
 DISASTER SCENE TRAUMA PATIENT DISTRIBUTION PLAN  
 (32 TRAUMA PATIENTS)

Closest Trauma Center	Secondary Trauma Center	Nearest Hospital approved medical facilities	Secondary Hospital approved medical facilities
4 – Red Tags	2 – Red Tags	1 – Red Tag	1 – Yellow Tag
2 – Yellow Tags	1 – Yellow Tag	1 – Yellow Tag	10 – Green Tags
	5 – Green Tags	5 – Green Tags	

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MCI PATIENT TRACKING FORM (ICS 306)

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#	Triage Tag No.	Priority R/Y/G	Patient's Primary Injuries	Unit Transporting Pt to ED/Hospital	Time Left Scene	Patient Destination
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
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## **Rehabilitation**

Managed by Rehabilitation Unit Leader. Generally located under Logistics Section, a service need, operating independently or attached to Medical Unit, responsible for periodic monitoring, evaluation, and medical intervention of personnel actively engaged.

### **Reference NFPA 1584 and PA EMS Protocol 150, Rehabilitation at Fire / Incident Scene**

## **DOCUMENTATION AND ACCOUNTABILITY**

Personnel assigned to the Rehab Sector shall enter and exit the Rehabilitation Area as a crew. The following information shall be noted on the Rehab Check In / Out Sheet, a copy of which is provided in the appendices.

- Unit or team number
- Number of persons.
- Time in.
- Time out.

Crews shall not leave the Rehab Sector until authorized to do so by the Rehabilitation Officer. All medical evaluations shall be documented on the Emergency Incident Rehabilitation Report, a copy of which is provided in the appendices. Additionally, any individual that receives treatment beyond the standard medical evaluation mentioned previously shall have a Commonwealth of Pennsylvania Patient Care Report (PCR) completed for him/her.

## HAZARDOUS MATERIALS

**Hazardous Materials-** any material that hurts or harms what it comes in contact with. Examples: Explosives, Gasses, Flammable liquids/solids, Oxidizers and Organic Peroxides, Toxic and Infectious Materials, Radioactive, Corrosives, Miscellaneous Dangerous Goods.

First responders will function at the level of which they are trained and equipped in hazardous materials emergency response.

## WEAPONS OF MASS DESTRUCTION REFERENCE

The following Weapons of Mass Destruction (WMD) Reference is intended to act only as a reference! It does not replace the need for education and training. It is also recommended that you participate with the Regional Counter Terrorism Task Forces, Health Care Coalitions, and your local and county EMA. There are many references that are available to you at low or no cost that would be beneficial at the time of a WMD Incident which include the following:

- The Department of Transportation Emergency Response Guidebook (current edition)
- The NIOSH Pocket guide to Chemical Hazards
- Jane's Chem-Bio Handbook
- Jane's /Unconventional Weapons Handbook
- U.S. Fire Academy's Hazardous Materials Guide for First Responders

Additional resources can also be found on the following web sites:

- Federal Emergency Management Agency ([www.fema.gov](http://www.fema.gov))
- U.S. Department of Homeland Security ([www.dhs.gov](http://www.dhs.gov))
- U.S. Office of Domestic Preparedness
- U.S. Fire Administration ([www.usfa.fema.gov](http://www.usfa.fema.gov))
- Pennsylvania Emergency Management Agency ([www.pema.state.pa.us](http://www.pema.state.pa.us))
- Pennsylvania Department of Health ([www.health.state.pa.us/ems](http://www.health.state.pa.us/ems))

## ACTIVE VIOLENCE

An Active Shooter is an individual actively engaged in killing or attempting to kill people in confined and populated areas; in most cases, active shooters use firearms and there is no pattern or method to their selection. Often times this type of event is quick moving and the situation is over within 10 to 15 minutes. Individuals responding to this type of event often times need to be mentally and physically prepared to deal with this type of incident.

For additional guidance, refer to PA BLS Protocol 915, Civil Disturbance considerations, or local, regional, when applicable, Rescue Task Force Guidelines (RTF)

### INDICATORS

- Is this a hostile event?
- Is there a hazardous spill
- Are there multiple (non-trauma related) victims?
- Are responders victims?
- Are hazardous substances involved with placard?
- Has there been an explosion?
- Are there any visible materials?
- Is there any Tractor Trailer, Railcars, or aircraft involved?

### PROTECT YOURSELF

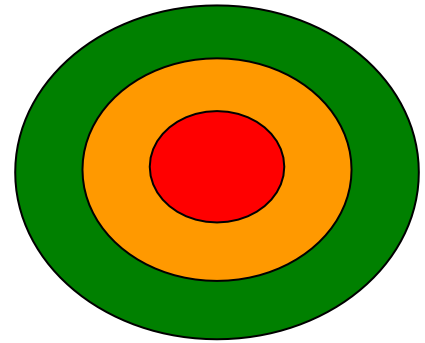
- **Consider a secondary device**
- **Do not get contaminated!**
- Stay uphill and upwind (500-1000ft away)
- Consider weather conditions
- Always have a way out – escape route
- Isolate area and deny entry
- Wear proper personal protection equipment to your level of training
- Stay alert for actions against responders
- Always work in pairs (2 in – 2 out)
- Patients who only have been grossly DECONTAMINATED- Special Training.

### INCIDENT COMMAND

- Establish unified command or assume your appropriate roles

### SCENE CONSIDERATIONS

- Assess decontamination requirements
- (Do your patients have to be decontaminated?)
- Crime scene/security
- Locations of the Unified Command Post, treatment unit, triage unit, transport unit, and staging areas (keep them safe – uphill and upwind, usually in cold zone)
- Public evacuations or shelter in place
- Consider an area of safe refuge



#### **Hot Zone:**

Requires HazMat Technician level training.

#### **Warm Zone:**

Requires HazMat Operations level training.  
Contains Decontamination area.

#### **Cold Zone:**

No specialized training. Generally contains personnel, equipment, and command post. EMS located in this area with triage, treatment, and transport.

### RESOURCES

*North American  
Emergency Response  
Guidebook*

*NIOSH Pocket  
Guide*

## PATIENT AND EQUIPMENT DECONTAMINATION GUIDELINES

- If a State Certified Hazardous Materials Team is on scene, follow their direction for mass decontamination.
- If properly trained EMS personnel are participating in gross decontamination or transporting patients who have been only grossly decontaminated, proper PPE must be worn.
- If the patient is critically injured/ill the patient can be grossly decontaminated to reduce the spread of the contaminant.
- Any patient who was exposed to ANY hazardous material MUST be, at a minimum, grossly decontaminated.
- Proper gross decontamination should consist of the following:
  - Removal of the patients clothing.
  - Patients are flushed with copious amounts of water.
  - Patients are covered with clean sheets, blankets, Tyvek sheets, etc....or placed in a Tyvek or equivalent suit.
  - Patients are placed on litter or backboard and covered again with any of the above.
  - The patient's decontamination status must be reported to the receiving facilities.
- "DECONTAMINATION" should be written on the anatomy section of a triage tag and placed on the patient.
- Ambulance and other equipment that contacts the patient must be decontaminated or properly disposed of (equipment).
- OSHA 1910.120 requires **specialized training** for response to hazardous materials.
- A HAZMAT incident will be structured with a HOT, WARM and COLD zone.
- EMS Operations at a HAZMAT incident will occur in the COLD zone.
- Only if EMS has been trained to the HAZMAT Operations level and they have the proper PPE will they participate in decontaminating patients or caring for patients in the WARM zone.

## **CRITICAL INCIDENT STRESS MANAGEMENT TEAM (CISM)**

CISM is a comprehensive, integrated system of interventions to address stress in emergency responders. These interventions serve to mitigate the acute symptoms of stress, reduce the duration of symptoms, activate good coping strategies, restore adequate functioning, and facilitate access to further care as needed for everyday calls and significant events. CISM services can be provided on scene as well as other locations. CISM team members operate under the command structure on site.

The CISM team should be called out for all disaster events through the dedicated CISM line at **610-973-1624**. The Answering Service will notify the on-call person and the Clinical Coordinator. The on-call person will assemble the team and dispatch them to the site. All CISM personnel responding to the site will have photo ID. On site, one Team member will be assigned to the command center and will arrive at the scene with identification. The remainder of the team will be deployed close to the rehab unit and available to provide services as needed.

CISM services that are most likely to be used on site are one on one mental health assistance and demobilization for groups. Other interventions can be offered off site and will be coordinated by the on-call individuals.

For extended events, the rotation of CISM personnel will be handled through the Answering Service by the on-call individuals.

Post incident staff support (debriefing the debriefers) will also be arranged by the on-call persons.

### *CISM Liaison*

The CISM Coordinator will serve to monitor and assess the signs and symptoms of stress, either personally or through other team members, and make recommendations to the Incident Commander as to the appropriate management of such signs and symptoms. Further, the CISM Coordinator will facilitate mobilization of team members to activations within the Eastern PA EMS Council CISM Team and, if need be, arrange for assistance from other teams through the International Critical Incident Stress Foundation (ICISF) and/or other locales.

Qualification: CISM Coordinator or designated senior team member  
Commanded by: Safety Officer  
Subordinates: CISM Team members

In any mass casualty incident, there is the potential for emergency responders to become victims. Behavioral and/or emotional problems may develop during or after the incident, which will require the attention of specialists in the field of Critical Incident Stress Management (CISM). In the Eastern PA EMS Council region, this function is assigned to the Eastern PA EMS Council's Critical Incident Stress Management Team. The CISM Liaison shall identify and obtain contact and supervisory information of all agencies responded in any way to the incident.

The CISM Team can provide the following services:

- Contact the International Critical Incident Stress Foundation (ICISF) to assist in the mobilization of additional CISM support service for both short-term and long-term crisis management. (if appropriate)
- Observing personnel and conditions for signs of stress and intervening on their behalf.
- Demobilizations may be provided in large groups to inform and consult, allow behavioral decompression, and stress management at the time of the shift disengagement. The activation of demobilization is event driven.
- Crisis Management Briefing (CMB) may be provided in large groups to inform and consult, allow behavioral decompression, and stress management anytime post-crisis.
- Defusing may be provided in small groups to mitigate symptoms, provide closure and/or triage. Activations of defusing are usually symptom driven.
- Critical Incident Stress Debriefing (CISD) may be provided in small groups to facilitate behavioral closure, mitigate symptoms, and/or triage. Activation of CISD is usually symptom driven but may be event driven.
- Individual Crisis Intervention (1:1) may be provided to individuals to mitigate symptoms, assist in the return of function, and/or provide referrals when necessary, on an as needed basis. Individual crisis intervention is symptom driven.
- Follow-up/Referral may be provided to individuals to assess mental status or access a higher level of care if it is needed at any time.
- Coordinate efforts with the Eastern PA Regional Critical Incident Stress Management Team through the 24-hour CISM Hotline at 610-973-1624

## Resources

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## **RESOURCE / UNMET NEEDS REQUEST**

To request a resource to mitigate the effects of an incident, the following process should occur:

- Identify the need: Purpose of Resource
  - Location of where the resource is needed
  - Point of Contact and contact information
- Contact EMA through your local PSAP with unmet needs request

When making unmet needs requests consider some of the following assets to mitigate the effects of an incident

### **Public Safety Answering Points**

#### **Berks County**

Berks County Communications Center 610-655-4937

#### **Carbon County**

Carbon County Communications Center 570-325-9111

#### **Lehigh County**

Lehigh County Communications Center 610-437-5252

#### **Monroe County**

Monroe County Communications Center 570-992-9911

#### **Northampton County**

Northampton County Communications Center 610-330-2200

#### **Schuylkill County**

Schuylkill County Communications Center 570-629-3792

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### **Neighboring Public Safety Answering Points**

#### **Bucks County**

Department of Emergency Communications 888-245-7210  
EMS Dispatch: Select Option 2, then Option 5

#### **Lackawanna County**

Lackawanna County Emergency Communications Center 570-489-4767

#### **Luzerne County**

County of Luzerne Department of Public Safety 570-819-4916

#### **Montgomery County**

Montgomery County Emergency Dispatch Services 610-631-6500

#### **Pike County**

Pike County Communications Center 570-296-1911

#### **Warren County, New Jersey**

Warren County Communications Center 908-835-2056

## Appendix I Triage

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### **SMART / START Triage**

Emergency Medical Responders, Emergency Medical Technicians, Advanced Emergency Medical Technicians and Paramedics are trained to handle emergencies. You know how to quickly assess a patient and intervene. But even the best emergency provider is easily overwhelmed when there are multiple patients who all need emergency care.

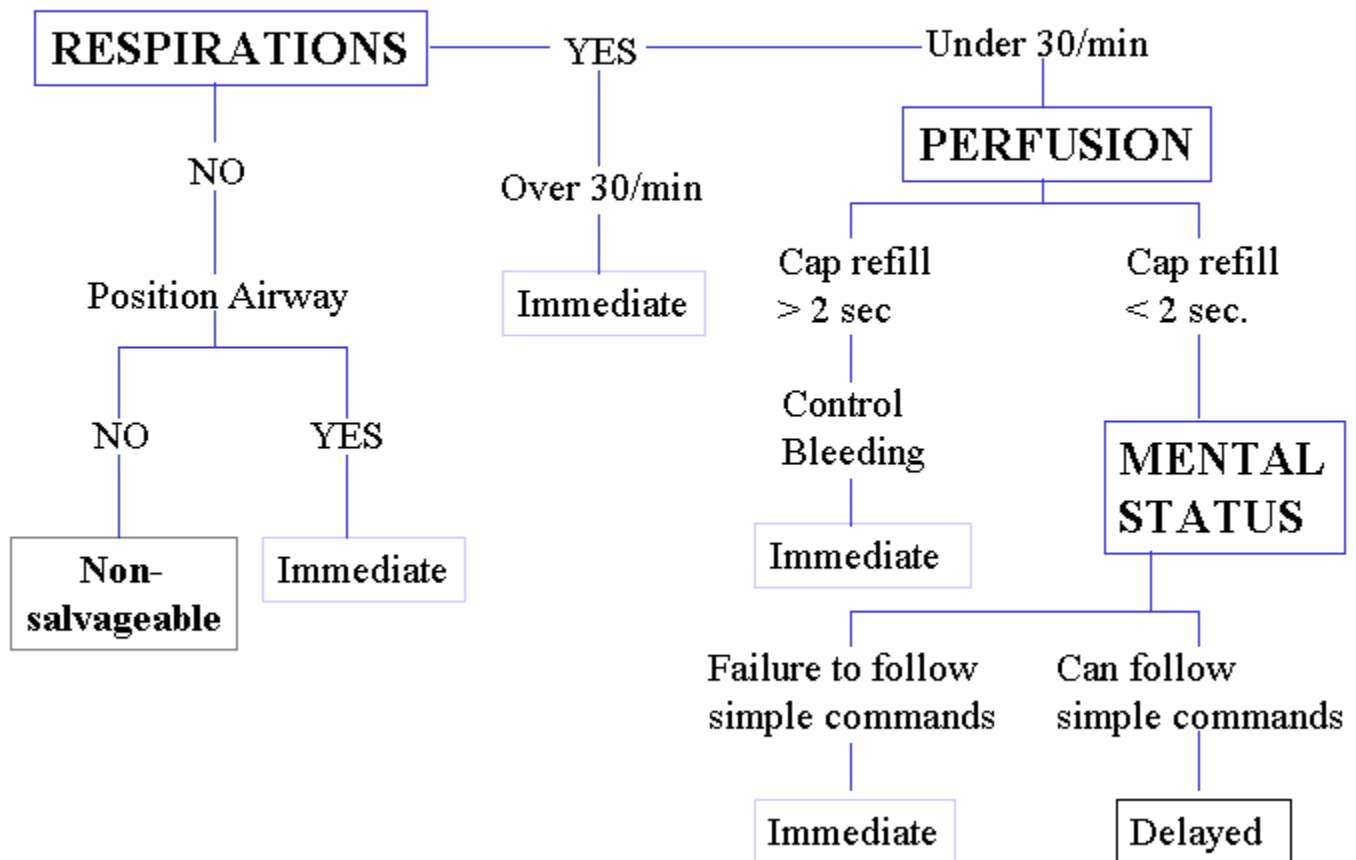
SMART / START (**S**imple **T**riage and **R**apid **T**reatment)

The triage portion of START relies on making a rapid assessment (taking 30 seconds or less) of every patient, determining which of five categories patients should be in, and visibly identifying the categories for rescuers who will treat the patients.

Note: The Eastern PA EMS Council recognizes all brands of triage systems, however, we do encourage the use of the SMART Triage System within the region.



# START Triage



## **Triage Tag Completion Instructions**

Prioritizing victims of a disaster is somewhat different from the routine classification of patients. Depending on the scope of the disaster, the total number of patients in need of care and the resources available to handle those patients will more than likely overwhelm the resources that are available. Depending on the severity of injuries a patient encounters from the disaster the ability to survive may depend on immediate, intensified care, the patient may need to be assigned a lower priority tag for treatment/transport from the incident site. Remember, the objective is to save as many patients as possible with the resources that are available.

### **Priority 1 Patient – Red Tag**

Serious injuries that have life-threatening implications or will become life threatening due to shock and/or hypoxia; are capable of being stabilized; require constant care and are given a high probability of survival if given immediate care and prompt transportation to an appropriate medical facility. Injured co-workers and patients with uncontrolled emotional disorders are also placed in this priority. *Examples: Witnessed Cardiac Arrest, severe or uncontrolled bleeding (including suspected internal bleeding, open chest or abdominal wounds, burns involving the respiratory tract).*

### **Priority 2 Patient – Yellow Tag**

Serious injuries which are not yet life threatening; no severe shock or hypoxia; high probability of survival and can withstand delayed transport until most red tagged patients have been stabilized and/or transported. These patients should also be transported to an appropriate medical facility. *Examples: Severe burns (not affecting the respiratory tract), spinal injuries, moderate blood loss, conscious with head injury, unable to ambulate (fracture leg).*

### **Priority 3 Patient – Green Tag**

Minor injuries without systemic implications and can withstand delayed transport until most priority 1 and 2 patients have been stabilized and/or transported. *Examples: Minor fractures, minor injuries that are controlled, obvious mortal wounds where death appears certain (These types of injuries can be re-triaged later if personnel and/or resources become available)*

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Disaster Operating Guidelines

**NOTE:** Consideration should be given to having these patients transported to one or more hospital(s) or approved medical facilities which is/are more distant from the disaster scene than other hospitals(s) or approved medical facilities and which will probably not be receiving several Priority 1 or 2 patients. This will prevent the unnecessary taxing of any one hospital's resources.

**Deceased Patient – Dead Tag**

Deceased patient(s) should not be moved unless necessary to access or treat surviving victims. If it becomes necessary to move a deceased victim, then the location and position that the deceased was found in must be noted in order to assist in identification and/or further investigation.

*Example: Obviously dead (D.O.A)*

## **JumpSTART Pediatric Triage**

The JumpSTART Pediatric Triage Tool is the world's first objective tool developed specifically for the triage of children in the multi-casualty / disaster setting. JumpSTART was developed in 1995 to parallel the structure of the START system, the adult MCI triage tool most commonly used in the United States and adopted in many countries around the world.

JumpSTART's objectives are:

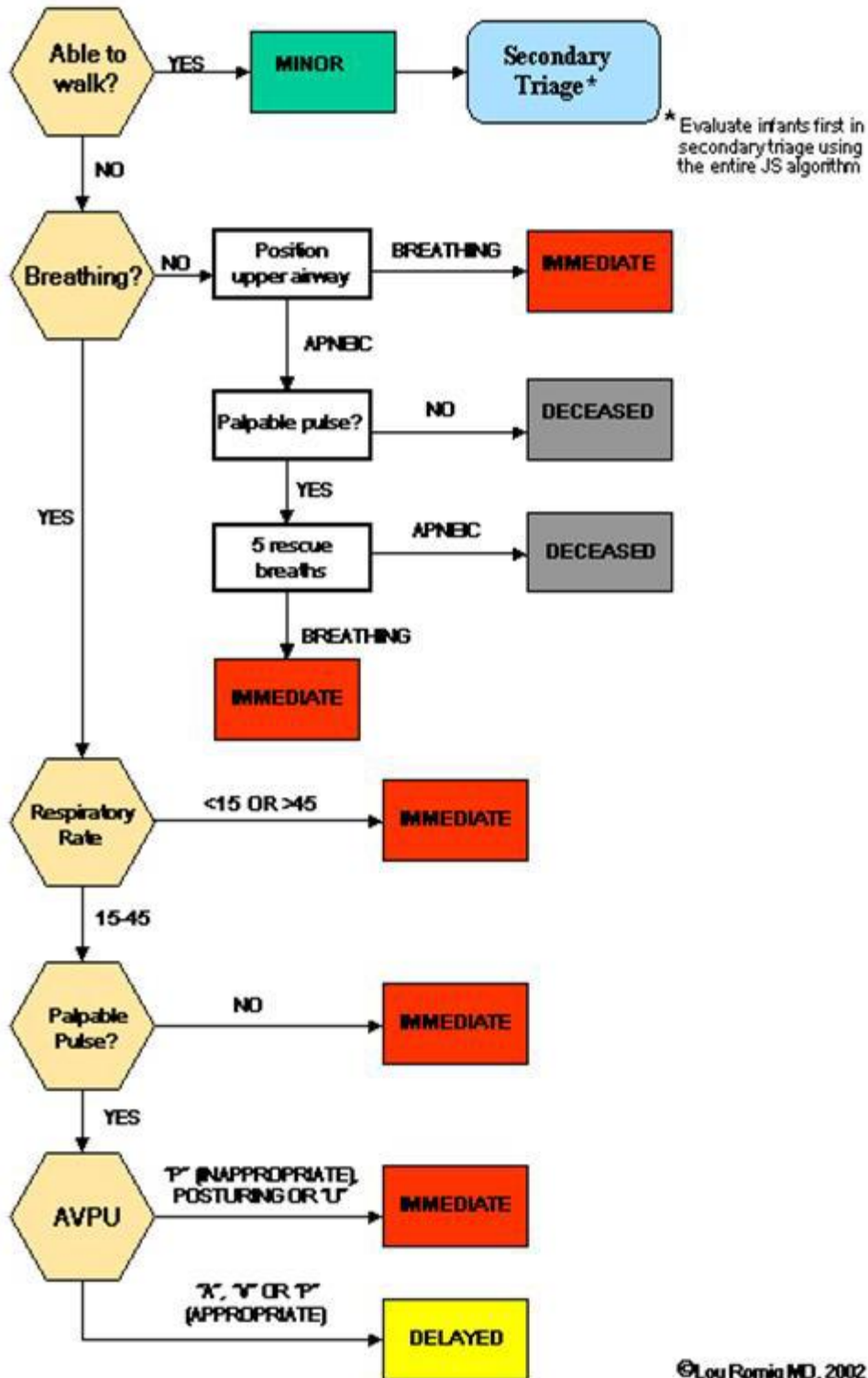
- To optimize the primary triage of injured children in the MCI setting
- To enhance the effectiveness of resource allocation for all MCI victims
- To reduce the emotional burden on triage personnel who may have to make rapid life-or-death decisions about injured children in chaotic circumstances

JumpSTART provides an objective framework that helps to assure that injured children are triaged by responders using their heads instead of their hearts, thus reducing over-triage that might siphon resources from other patients who need them more and result in physical and emotional trauma to children from unnecessary painful procedures and separation from loved ones. Under-triage is addressed by recognizing the key differences between adult and pediatric physiology and using appropriate pediatric physiologic parameters at decision points.

JumpSTART has rapidly gained acceptance by EMS agencies and hospitals throughout the US and Canada and is being taught in numerous countries internationally. The tool has been recognized for use by groups such as the US National Disaster Medical System's federal medical response teams and EMS providers in the National Park Service. JumpSTART is referenced in numerous EMS and disaster texts and has been incorporated into courses such as Pediatric Disaster Life Support (PDLIS) and Advanced Pediatric Life Support (APLS).

Please note that JumpSTART was designed for use in disaster/multi-casualty settings, not for daily EMS or hospital triage. The triage philosophies in the two settings are different and require different guidelines (see the Principles of MCI Triage lecture). JumpSTART is also intended for the triage of children with acute injuries and may not be appropriate for the primary triage of children with medical illnesses in a disaster setting. Note also that no MCI triage tool, including START and JumpSTART, has been clinically or scientifically validated at the time of publication of this website.

## JumpSTART Pediatric MCI Triage®



Appendix II  
Job Action Sheets

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**First Responder – [First on Scene]  
Job Action Sheet**

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The first trained personnel to arrive on scene at all Mass Casualty Incidents regardless of jurisdiction, extent, or type of disaster shall have initial command and control authority. You should ensure the following is completed:

**Safety Assessment:** Assess the scene, observing for:

- Electrical hazards
- Flammable liquids
- Chemical, Biological, Radiological, Nuclear, or Explosive (CBRNE)
- Other life-threatening situations

**Scene Size-Up:** Survey Incident Scene for:

- Type, nature, and cause of incident
- Approximate number of casualties
- Severity level of injuries (major or minor)
- Area involved, including problems with scene access

**Contact the 9-1-1 Communications Center:** Send the following information:

- You are in command and there is an MCI
- Size-up information (as defined above)
- Give exact location of the preliminary Unified Command Post
- Request additional resources

**Set up the scene for management of the casualties:**

- Establish a Casualty Collection Point (CCP)
- Establish staging (if required)
- Identify access and egress routes
- Establish hazard control zones (as appropriate)
- Identify adequate work areas for triage, treatment, and transport
- The Eastern PA EMS Council recognizes all brands of triage systems, however, we do encourage the use of the SMART Triage System within the region.
- Contact 9-1-1 Communications Center with additional information

### **Incident Command / Unified Command Job Action Sheet**

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The Incident Commander or Unified Command is the individual or group responsible for all incident activities, including the development of strategies and tactics and the ordering and release of resources. The Incident Commander has overall authority and responsibility for conducting incident operations and is responsible for the management of all incidents at the incident site.

**Location:** Incident Unified Command Post

**Duties shall include:**

- Have clear authority and know agency policy
- Ensure incident safety
- Establish the Incident Unified Command Post (ICP)
- Set priorities and determine incident objectives and strategies to be followed
- Develop a scalable incident command system to fit the needs of the situation
- Establish ICS organization needed to manage the incident
- Approve the Incident Action Plan (IAP)
- Coordinate Command and General Staff activities
- Approve resource requests and use of volunteers and auxiliary personnel
- Order demobilization as needed
- Ensure after-action reports are completed
- Authorize information release to the media
- Complete Incident Briefing (ICS 201)
- Complete Incident Objectives (ICS 202)

## **Transfer of Command**

The process of moving the responsibility of the incident command from one Incident Commander to another is called 'transfer of command'. It should be recognized that transition of command on an expanding incident is to be expected. It does not reflect on the competency of the current Incident Commander.

There are five important steps in effectively assuming command of an incident in progress.

**Step 1:** The incoming Incident Command should, if at all possible, personally perform an assessment of the incident situation with the existing Incident Commander.

**Step 2:** The incoming Incident Commander must be adequately briefed.

This briefing must be by the current Incident Commander and take place face-to-face if possible.

### **This briefing must cover the following:**

- Incident history (what has happened)
- Priorities and Objectives
- Resource assignments
- Incident organization
- Delegation of Authority
- Resources ordered / needed
- Facilities established
- Status of communications
- Any constraints or limitations
- Incident potential

The ICS Form 201 is especially designed to assist in incident briefings. It should be used whenever possible because it provides a written record of the incident as of the time prepared. The form contains:

- Incident objectives
- A place for a sketch map
- Summary of current actions
- Organizational framework
- Resources summary

**Step 3:** After the incident briefing, the incoming Incident Command should determine an appropriate time for transfer of command.

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Disaster Operating Guidelines

Step 4: At the appropriate time, notice of a change in incident command should be made to

- Agency headquarters (through dispatch)
- Command Staff members (if designated)
- General Staff members (if designated)
- All incident personnel

Step 5: The incoming Incident Commander may give the previous Incident Commander another assignment on the incident. There are several advantages of this with one of them being that the initial Incident Command retains first-hand knowledge at the incident site.

This strategy allows the initial Incident Commander to observe the progress of the incident and to gain experience.

**Safety Officer  
Checklist Worksheet**

Position Assigned To:	
You Report To:	
Unified Command Post Location:	
Telephone: (    ) -	Radio Channel:

**Recommended Equipment:**

- Appropriate vest
- Clipboard
- Highlighter
- Personal Protective Equipment
- Flashlight
- ICS Form 215a
- Radio
- Paper
- Telephone
- Pencils / pens

**Role:** The Safety Officer monitors incident operations and advises Incident Command on all matters relating to operational safety, including the health and safety of emergency personnel operating the scene

Location: Joint Information Center

Duties shall include:

- Monitor incident operations and advise Incident Command on all matter relating to operational safety, including the health and safety of emergency response personnel
- Develop the Incident Safety Plan – the set of systems and procedures necessary to ensure ongoing assessment of hazardous environments, coordination of multi-agency safety efforts, and implementation of measures to promote emergency management / incident personnel safety, as well as the general safety of incident operations
- Authority to stop and / or prevent unsafe acts during incident operations

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- ❑ The Safety Officer, Operations Section Chief, Planning Section Chief, and Logistics Section Chief must coordinate closely regarding operational safety and emergency health and safety issues
- ❑ Ensure the coordination of safety management functions and issues across jurisdictions, across functional agencies, and with NGOs and the private sector
- ❑ Some types of incidents, such as hazardous material incidents, require Assistant Safety Officers to have special skill sets. The Assistant Safety Officer position described below are examples of such positions.
  - The Assistant Safety Officer for hazardous materials would be assigned to carry out the function outlined in 29 CFR 1910.120 (Hazardous Waste Operations and Emergency Response). This person should have the required knowledge, skills, and abilities to provide oversight for specific hazardous material operations at the field level
  - The Assistant Safety Officer for fire would be assigned to assist the Branch Director providing oversight for specific fire operations. This person would have the required knowledge, skills, and abilities to provide this function
  - The Assistant Safety Officer for food would be assigned to the Food Unit to provide oversight of food handling and distribution. This person would have the required knowledge, skills, and abilities to provide this function. An example would be a food specialist from a local health department

### **EMS Branch Director Job Action Sheet**

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Role: The EMS Branch Director is responsible for coordinating EMS operations. This role is normally assumed immediately by the first responding EMS Agency Unit pending designation by the Incident Commander. This individual should be located at the incident Unified Command Post and coordinates EMS activities with the Incident Commander.

Location: Incident Unified Command Post with

Operations Chief Duties shall include:

- Establishing and identifying a location for the incident Unified Command Post *if this has not already been accomplished by other emergency personnel*. The location of such a Unified Command Post must be transmitted to the Communications Center for relay to other responding emergency personnel. Such a relay of information may be made by a special radio alert tone and announcement of the initiation of a unified Unified Command Post and its' location.
- Rapidly assess the scope of the disaster scene, paying particular attention to the following:
  - The nature of the incident and identify any hazards
  - Types and extent of injuries including a rough estimate of the number of casualty's present
  - Additional resources that may be required at the scene
  - Responding unit's route of approach to the scene
  - Location(s) of potential staging area(s)
- Transmit a preliminary report to the communications center for relay to other responding emergency personnel.
- Transmit a preliminary report to the communications center(s) within the operational zone so that initial notification of the existence of a mass casualty incident can be made to area hospitals and approved medical facilities. (Further information as to the number and extent of injuries, hospital resources available, etc. can be made as the incident progresses)
- Establish an EMS communications structure for the disaster scene. This structure may later be relocated to a specialty vehicle, if one is available.
- Determine if additional response, including the mobilization of regional mass casualty equipment caches, is required at the incident

**Assign Unit Leaders:**

- a. Operations Group Supervisor (**as incident expands**)
- b. Triage Unit Leader
- c. Treatment Unit Leader
- d. Transportation Unit Leader

Eastern PA EMS Council  
Disaster Operating Guidelines

Note: It may be necessary to combine the roles of unit leaders until sufficient manpower is available to fill these positions. Also, dependent upon the “size” of the incident, it may be possible to combine the roles of unit leaders and other positions permanently.

- Assign medical teams to the Triage or Treatment Units, based on the needs of those units
- Work in conjunction with the Incident Commander to assign crews to carry and transfer patients to the Casualty Collection Point/Treatment Area.
- Responds to the needs of the Unit Leaders base on the need for additional resources and the safety and well-being of all EMS personnel operating at the incident (to include the provision of rehab and CISM services if necessary)
- Establish liaisons with other emergency services agencies operating at the incident
- Evaluate the effectiveness of EMS operations and make changes as required and necessary
- Transmit periodic progress report on the EMS Systems to the Communications Center
- Reassign EMS personnel / units as EMS status deescalate.
- If necessary, establish a temporary morgue location and coordinate the management of fatalities with the Triage Unit Leader and Coroner of jurisdiction. (working with the County Coroner)
- Maintain documentation as to the overall provisions of EMS operations at the incident
- Demobilize and terminate EMS operations, including the cessation of the EMS Branch and Operations.

## **EMS Group Supervisor Job Action Sheet**

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**Role:** The EMS Group Supervisor, added as an incident grows, is responsible for the overall coordination of EMS activities at the disaster site. This role may be combined with EMS Branch Director on smaller incidents.

**\*the request for this position should be sent to the EMS Branch Director\***

**Location:** On-scene

**Duties shall include:**

- Establishing and identifying a location for the Incident Unified Command Post if this has not already been accomplished by other emergency personnel. The location of such a Unified Command Post must be transmitted to the communications center for relay to other responding emergency personnel. Such a relay of information may be made by a special radio alert and announcement of the initiation of a unified Unified Command Post and its' location.
- Rapidly assess the scope of the disaster scene, paying particular attention to the following:
  - The nature of the incident and identify any hazards
  - Types and extent of injuries including a rough estimate of the number of casualty's present
  - Additional resources that may be required at the scene
  - Responding unit's route of approach to the scene
  - Location(s) of potential staging area(s)
- Transmit a preliminary report to the communications center for relay to other responding emergency personnel
- Transmit a preliminary report to the communications center so that initial notification of the existence of a mass casualty incident can be made to area hospitals and approved medical facilities. (Further information as to the number and extent of injuries, hospital resources available, etc. can be made as the incident progresses)
- Establish an EMS communications structure for the disaster scene. This structure may later be relocated to a specialty vehicle, if one is available.
- Determine if additional response, including the mobilization of regional mass casualty equipment caches, is required at the incident

Eastern PA EMS Council  
Disaster Operating Guidelines

**Assign Unit Leaders:**

- e. Operations Leader
- f. Triage Unit Leader
- g. Treatment Unit Leader
- h. Transportation Unit Leader

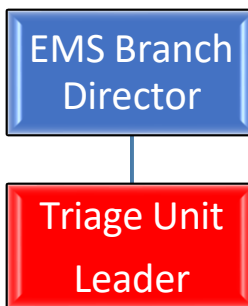
Note: It may be necessary to combine the roles of unit leaders until sufficient manpower is available to fill these positions. Also, dependent upon the “size” of the incident, it may be possible to combine the roles of unit leaders and other positions permanently.

- Assign medical teams to the Triage or Treatment Units, based on the needs of those units
- Work in conjunction with the Incident Commander to assign crews to carry and transfer patients to the Casualty Collection Point
- Consult with Unit Leaders frequently to ascertain the need for additional resources and the safety and well-being of all EMS personnel operating at the incident (to include the provision of rehab and CISM services if necessary)
- Establish liaisons with other emergency services agencies operating at the incident
- Evaluate the effectiveness of EMS operations and make changes as required and necessary
- Transmit periodic progress report on the EMS Systems to the Communications Center
- Reassign EMS personnel / units as EMS status deescalate.
- If necessary, establish a temporary morgue location and coordinate the management of fatalities with the Triage Unit Leader and Coroner of jurisdiction.
- Maintain documentation as to the overall provisions of EMS operations at the incident
- Demobilize and terminate EMS operations, including the cessation of the EMS Branch and Operations.

**EMS Group Supervisor  
Determining Command Structure – Level 1 Response**

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**Level 1 Response – 10 Victims or Less**



**EMS Group Supervisor:** The individual that is responsible for the overall coordination of all EMS activities at a disaster scene. This individual should be located at the unified Unified Command Post and coordinates EMS activities within the overall Incident Command.

- In a Level 1 response the EMS Supervisor should also be able to perform the duties normally assigned to the EMS Operations Leader and the Transportation Unit Leader

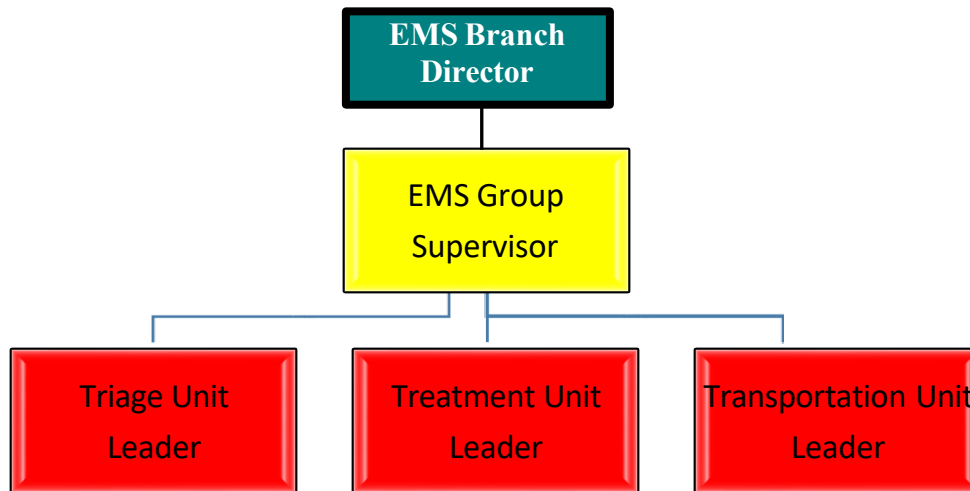
**Triage Unit Leader:** The individual that is responsible for the overall coordination of triage activities at a disaster scene. Answers to the EMS Group Supervisor.

- In a Level 1 response the Triage Unit Leader should also be able to perform the duties normally assigned to the Treatment Leader

**EMS Group Supervisor  
Determining Command Structure – Level 2 Response**

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**Level 2 Response, 10 to 25 victims**



**EMS Branch Director:** The individual that is responsible for the overall coordination of all EMS activities at a disaster scene. This individual should be located at the unified Unified Command Post and coordinates EMS activities within the overall Incident Command.

**EMS Group Supervisor:** The EMS Group Supervisor is responsible for the overall coordination of EMS activities at the disaster site. This individual should be located on scene. Again, this position could be added depending on the growth and complexity of the incident.

**Triage Unit Leader:** The individual that is responsible for the overall coordination of triage activities at a disaster scene. Answers to the EMS Group Supervisor.

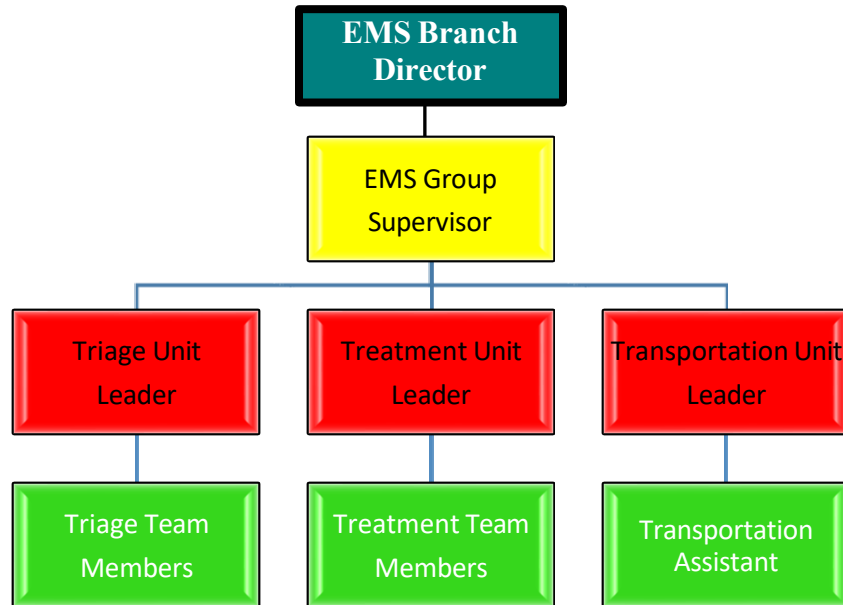
**Treatment Unit Leader:** The individual that is responsible for the coordination of the treatment of patients at the Casualty Collection Point. Answers to the EMS Group Supervisor.

**Transportation Unit Leader:** The individual that is responsible for communicating with sector officers and hospitals to manage the transport of patients to hospitals from the scene of the disaster. Answers to the EMS Group Supervisor.

### EMS Group Supervisor Determining Command Structure – Level 3 Response

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#### Level 3 Response, 25 Victims or greater



**EMS Branch Director:** The individual that is responsible for the overall coordination of all EMS activities at a disaster scene. This individual should be located at the unified Unified Command Post and coordinates EMS activities within the overall Incident Command.

**EMS Group Supervisor:** The EMS Group Supervisor is responsible for the overall coordination of EMS activities at the disaster site. This individual should be located on scene.

**Triage Unit Leader:** The individual that is responsible for the overall coordination of triage activities at a disaster scene. Answers to the EMS Group Supervisor.

- Triage Team Member: Group of medically trained personnel that assist the Triage Leader in the triaging of victims

**Treatment Unit Leader:** The individual that is responsible for the coordination of the treatment of patients at the Casualty Collection Point. Answers to the EMS Group Supervisor.

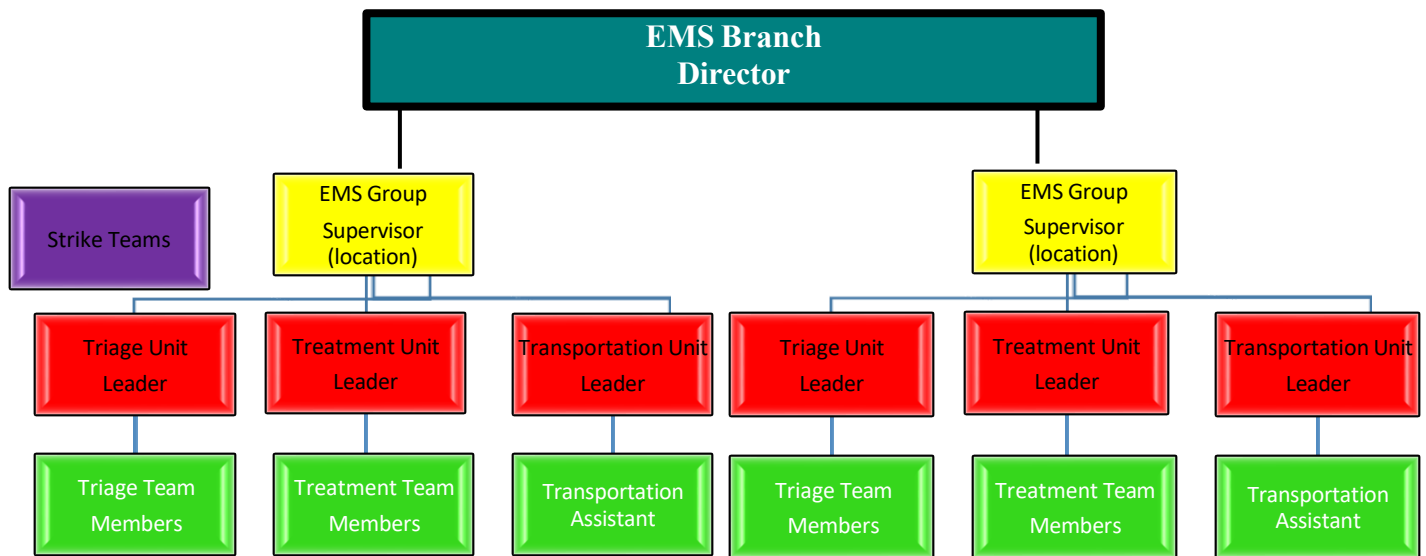
- Treatment Team Members: Groups of medically trained personnel (BLS and ALS) including physicians and nurses that assist the Treatment Leader with the treatment of victims brought to the Casualty Collection Point

**Transportation Unit Leader:** The individual that is responsible for communicating with sector officers, hospitals and approved medical facilities to manage the transport of patients to hospitals from the scene of the disaster. Answers to the EMS Group Supervisor.

- An individual that assists the Transportation Unit Leader in the performance of his / her duties. As the level of the incident escalates, more assistants may be needed
- Control, accountability and distribution of patients to the appropriate facility will be coordinated at a regional level engaging a variety of assets to include, but not limited to, PSAP's, Knowledge Center, Web EOC and other communications pathways as developed by the region in cooperation with our Emergency Management Agencies, Healthcare Coalitions, PSAP's Taskforces, and other partners.

### EMS Group Supervisor Determining Command Structure – Level 4 Response

**\*Level 4 response, number of victims that could necessitate a region wide response or other resources**



**EMS Branch Director:** The individual that is responsible for the overall coordination of all EMS activities at a disaster scene. This individual should be located at the unified Unified Command Post and coordinates EMS activities within the overall Incident Command.

**EMS Group Supervisor:** The EMS Group Supervisor is responsible for the overall coordination of EMS activities at the disaster site. This individual should be located on scene.

**Triage Unit Leader:** The individual that is responsible for the overall coordination of triage activities at a disaster scene. Answers to the EMS Group Supervisor.

- Triage Team Member: Group of medically trained personnel that assist the Triage Leader in the triaging of victims

**Treatment Team Members:** Groups of medically trained personnel (BLS and ALS) including physicians and nurses that assist the Treatment Leader with the treatment of victims brought to the Casualty Collection Point

**Transportation Unit Leader:** The individual that is responsible for communicating with sector officers, hospitals and approved medical facilities to manage the transport of patients to hospitals and approved medical facilities from the scene of the disaster. Answers to the EMS Group Supervisor.

- An individual that assists the Transportation Unit Leader in the performance of his / her duties
- Control, accountability and distribution of patients to the appropriate facility will be coordinated at a regional level engaging a variety of assets to include, but not limited to, PSAP's, Knowledge Center, Web EOC, or other web based monitoring systems presently utilized in the Commonwealth (to include electronic patient tracking), and other distinct communication pathways as developed by the region in cooperation with our Emergency Management Agency, Healthcare Coalitions, PSAP's Taskforces, and other partners.

### **Triage Unit Leader Job Action Sheet**

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**Role:** The Triage Unit Leader is directly responsible to the EMS Supervisor for the coordination of triage operations at the disaster site. Reports to the EMS Group Supervisor and supervises Triage Personnel / Litter Bearers and the Morgue Manager. Assumes responsibility for providing triage management and movement of patients from the triage area. When triage is completed, the Unit Leader may be reassigned as needed.

**Location:** Triage Area

**Duties shall include:**

- Assigning medically trained personnel to assist in carrying out the triage of patients, to include the proper tagging of patients based upon their condition and the administration of basic care that would correct immediate life-threatening problems (airway problems or severe bleeding). Triage normally occurs at the immediate site, or impact area of the incident. However, safety concerns for the patients and medical personnel may force triage to be performed in an area adjacent to this site or at the Casualty Collection Point. Should this be the case, coordination with the Treatment Leader and EMS Supervisor is imperative
- Obtaining an actual total victim count and an approximate victim count for each triage priority category. This information shall be immediately communicated to the EMS Group Supervisor and / or the EMS Operations Leader
- Ensuring that an adequate number of personnel and equipment is available for the triage of patients. Personnel and equipment needs shall be communicated to the EMS Supervisor and / EMS Operations Leader
- Ensuring that an adequate number of personnel and equipment is available to remove patients from the triage area to the Casualty Collection Point. Personnel and equipment needs shall be communicated to the EMS Supervisor
- Coordinating operations within the triage area with EMS Branch Director as needed
- Maintaining documentation as to the operations within the triage area
- Providing the EMS Group Supervisor and / or EMS Branch Director with updates as to the operations within the triage area. This shall include timely notification to the EMS Group Supervisor when all of the patients have been triaged and moved to the Casualty Collection Point
- Coordinating with the EMS Branch Director and/or the Coroner of jurisdiction, the management of fatalities. This may include the designation of a temporary morgue location
- Terminating, with consensus from the EMS Group Supervisor and / or the EMS Branch Director within the Triage and re-assigning personnel as directed by the EMS Group Supervisor / Branch Director
- After all victims are triaged this position will report to the treatment area to assist as needed.

## **Triage Unit Leader Reference**

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Reference for Triage and Treatment Team priorities of patients at Collection Points

### **Priority 1 Patient – Red Tag**

Serious injuries that have life-threatening implications or will become life threatening due to shock and/or hypoxia; are capable of being stabilized; require constant care and are given a high probability of survival if given immediate care and prompt transportation to an appropriate medical facility. Injured co-workers and patients with uncontrolled emotional disorders are also placed in this priority.

### **Priority 2 Patient – Yellow Tag**

Serious injuries which are not yet life threatening; no severe shock or hypoxia; high probability of survival and can withstand delayed transport until most red tagged patients have been stabilized and/or transported. These patients should also be transported to an appropriate medical facility.

### **Priority 3 Patient – Green Tag**

Minor injuries without systemic implications and can withstand delayed transport until most priority 1 and 2 patients have been stabilized and/or transported.

**NOTE:** Consideration should be given to having these patients transported to one or more hospital(s) which is/are more distant from the disaster scene than other hospitals(s) and which will probably not be receiving several Priority 1 or 2 patients. This will prevent the unnecessary taxing of any one hospital's resources.

### **Deceased Patient – Dead Tag**

Deceased patient(s) should not be moved unless necessary to access or treat surviving victims. If it becomes necessary to move a deceased victim then the location and position that the deceased was found in must be noted in order to assist in identification and/or further investigation.

### Treatment Unit Leader Job Action Sheet

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**Role:** The Treatment Unit Leader is directly responsible to the EMS Group Supervisor for coordinating the treatment of victims at Casualty Collection Area and Supervises Treatment Managers. Assumes responsibility for treatment, preparation for transport, and directs movement of patients to loading location(s).

**Location:** Treatment Area

**Duties shall include:**

- Establishing and identifying Casualty Collection Area which should be in close proximity to the treatment area and communicating their location to the EMS Director and/or the EMS Operations Leader.
  - This area must be large enough to accommodate the anticipated number of patients that could be received.
  - This area should be marked, by flags or markers color coded to match the patient triage tag, (Red - immediate, Yellow - moderate, Green - delayed).
- Establishing an area adjacent to the Casualty Collection Area for those individuals that have been involved in an incident but have sustained no apparent injuries. Non-injured individuals that subsequently complain of injuries or illness may be re-triaged and moved to the appropriate Casualty Collection Area.
- Ensuring that an adequate amount of equipment, supplies and medically trained personnel, both BLS and ALS, are available at the Treatment Area to provide appropriate treatment for all patients. Equipment, supplies and personnel needs shall be communicated to the EMS Group Supervisor and/or the EMS Branch Director.
- Ensuring that patients arriving at the Casualty Collection Area have been triaged and that they are separated by priority. Non-triaged patients must be assessed and tagged before being moved to the appropriate Casualty Collection Area.
- Ensure ALL patients entering Treatment area have been decontaminated.
- Remember, when placing patients in the Treatment Area, adequate space must be provided between patients to allow working room for medical personnel.
- Ensuring that all patients receive treatment that is appropriate for their condition and that is within established state and regional medical protocols.
- Coordinating the activities of ALL medical personnel in the Treatment area, (physicians, nurses, flight team members, etc.).

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- Ensuring the continual assessment and, where necessary, re-triaging of patients within the Treatment Area.
- Determining the transport priorities of patients within the Treatment Area and coordinating their movement with the Transportation Unit Leader.
- Coordinating operations within the Treatment area with other leaders and command, as needed.
- Maintaining documentation as to the operations within the Casualty Collection Area.
- Providing the EMS Group Supervisor and/or the EMS Branch Director with updates as to the operations within the Casualty Collection Area. This shall include timely notification as to when all of the patients have been transported from the Casualty Collection Area.

Terminating, with consensus from the EMS Commander and/or the EMS Operations Leader, operations within the Casualty Collection Area and re-assigning personnel as directed.

## Transportation Unit Leader Job Action Sheet

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

**Location:** Staging / Transportation Area

**Duties shall include:**

- Establishing and identifying ambulance staging / transportation areas that are easily accessible from the Casualty Collection Area. Access and egress must be taken into account and the location shall be communicated to the EMS Director. This may also require, at times, establishing a helicopter-landing zone in coordination with the Fire Group Supervisor.
- Determining the treatment capabilities, “beds available”, of receiving hospitals and or approved medical facilities within the area of the disaster.
- Determining the transportation needs for the potential number of patients that will be treated at the Casualty Collection Area. Coordination with the Triage and Treatment Leaders to obtain exact numbers is suggested.
  - In determining the transportation needs, keep in mind, non-EMS forms of transportation, e.g. school buses to transport large numbers of minor injuries.
- Accepting patients from the Treatment Area and assigning them to vehicles, ground transport OR air ambulance, for transportation to appropriate receiving facilities. The Transportation Leader will designate which facility the patient(s) are to be transported to.
- Patients transported in priority sequence, if possible, to designated hospitals as assigned by Treatment Unit Leader. In a Mass Casualty Incident, several patients SHOULD be transported in each vehicle in order to maximize the transportation resources that are available. EMS units should not be allowed to leave the incident scene with only 1 patient on board.
  - In Mass Casualty Incidents, effective utilization of available EMS transportation resources is critical. As such, multiple patients should be assigned to EMS vehicles that are transporting to facilities. For every priority 1 patient assigned to a transporting EMS unit, at least 1 priority 2 or 2 priority 3 patients should also be assigned to that unit for transport, (keeping in mind what sort of immobilization devices have been applied).
- Communicating with receiving facilities about an ambulance vehicle’s ETA to that facility, the number of patients on-board that unit, the priority of the patient(s), their triage tag number, and their primary injuries.

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- ❑ Maintaining a written or electronic record of each patients priority, primary injury, disaster tag number, emergency vehicle assigned to transport the patient, hospital facility to which the patient was sent, and the time the patient left the scene.

*To support efficient patient distribution during a Mass Casualty Incident, regional healthcare facilities have established predetermined patient acceptance capacities. These allocations are designed to ensure that patients are transported to the most appropriate facility based on clinical need, while preventing any single facility from becoming overwhelmed.*

Hospital Bed Availability	Red	Yellow	Green
LVHN- CC adult	8	10	
LVHN-CC children	5	8	
St. Lukes Allentown	2	8	
LVHN-17th Street	0	2	10
St. Lukes Bethlehem	6	12	
St. Lukes Sacred Heart	1	4	
LVHN- Muhlenberg	3	7	
St. Lukes Anderson	6	10	
LVHV-Hecktown Oaks	2	5	
Reading	8	10	
St Joes, Reading	2	5	
St Lukes Carbon	1	4	
LVHN- Carbon	2	5	
St Lukes Upper Bucks	2	4	

**Appendix IV**  
**Checklists**

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### EMS Branch Director Checklist

**Personnel Assigned:** EMS Personnel on-scene or on-board the first arriving ambulance

**Functions:** Command and control of all EMS activities at a multi-casualty incident. Reports to the Incident Commander.

- Don BLUE Vest labeled '**EMS Officer / Command**'
- Assess situation** – Information Communications Center of
  - **Type of Incident** \_\_\_\_\_
  - **Approximate Number of Victims** \_\_\_\_\_ **Disaster Level** \_\_\_\_\_
    - Level 1 <10 victims
    - Level 2 10 to 25 victims
    - Level 3 > 25 victims
- If not already performed, identify the location of the Unified Unified Command Post and identify yourself to the Incident Commander. Maintain position at the Unified Unified Command Post.
- Determine your plan. Identify treatment area. Identify patient loading area.**
- Identify **EMS Staging Area** and **Route of Travel** into the incident. Notify the Communications Center of this information. **Be specific** \_\_\_\_\_
- Set up a **Communications Network**
  - Use the Regional MCI or county specific operating Channel for on-scene communications
  - Use your specific counties Med 9 or 10 Channel to communicate with the County
    - Units will operate on the appropriate county-designated Med Channel to maintain continuity of communications. 📞
- Set up initial **Command Structure**
  - Triage Unit (Name and Unit Number) \_\_\_\_\_
  - Treatment Unit (Name and Unit Number) \_\_\_\_\_
  - Transport Unit (Name and Unit Number) \_\_\_\_\_
- Ensure **Drivers and Litters** stay with their vehicle. (With the exception of the first arriving units which will be part of the command structure and will not initially transport patients).
- All responding attendants should be reporting to the treatment area. Remind them of such as needed.
- Coordinate establishment of a **landing zone** for aeromedical services if needed
- Consider assigning additional personnel to the Command Structure:
  - Rehab (Name and Unit Number) \_\_\_\_\_
  - Mass Care (Name and Unit Number) \_\_\_\_\_
  - Staging (Name and Unit Number) \_\_\_\_\_
- Determine if **adequate resources** are enroute:
  - Level 1 – expect 7 EMS units
  - Level 2 – expect 15 EMS units
  - Level 3 – expect 24 EMS units
- Obtain building / vehicle **roster of potential victims** housed or transported (advise triage). Determine responsible person; coordinate accountability of those involved
- Contact EMS Council for any specialized resources needed (tarps, tents, backboards, etc.)
- Assist in establishing a Mass Care Center (if needed) and assign an EMS unit.
- Notify the Coroner, if necessary. Set up a temporary morgue area.
- Provide regular updates and reports of EMS operations to the Incident Commander
- Establish an off-site logistics center to coordinate additional supplies / returning equipment.

### **Triage Unit Leader Checklist**

**Personnel Assigned:** Paramedic or other person as designated by the EMS Officer

**Function:** Coordinate and direct the triage and tagging of victims of a multi-casualty incident.

- Don **RED** vest labeled '**Triage Officer**'
- Obtain situation briefing / approximate number of victims / and disaster level from EMS officer, if available
- Determine or assign personnel to determine an actual victim count for each priority level
- Coordinate interaction with rescue / extrication teams and filter all patients to appropriate treatment areas
- Confirm the **communications structure**
  - EMS Director / Operations / Triage / Treatment should be on every event
    - If not, \_\_\_\_\_
- Tag all non-injured parties. Confer with EMS Operations regarding temporary placement
- Assign re-triage team at the entrance to the **Patient Collection Point**
- Keep Transport Officer updated on the number of victims per triage priority
- Advise EMS Operations when all patients have been triaged and moved to the Patient Collection Point
- Assist EMS Operations and Coroner with establishment of a temporary morgue, if required
- Verify final patient count** with the Transport and Treatment Officers in order to accurately determine if all patients have been accounted for or transported
- Notify EMS Operations that all patients have been transported or accounted for
- Terminate operations with the consensus of EMS Operations and / or EMS Director

*START Triage – Assess, Treat  
Find color, STOP, TAG, MOVE ON*

### Treatment Unit Leader Checklist

**Personnel Assigned:** Paramedic or other person as designated by the EMS Officer

**Functions:** Coordinate and direct the treatment of patients with the Patient Collection Point

- Don vest labeled '**Treatment Officer**'
- Obtain situation briefing / approximate number of victims / and disaster level from EMS Officer, if available
- Create patient collection area (ensure you have a large enough space)
  - **Immediate**, marked **RED**
  - **Moderate**, marked **YELLOW**
  - **Delayed**, marked **GREEN**
  - Adjacent **area for the uninjured**
- Confirm the communications structure
  - EMS Director/ Operations / Triage / Triage / Treatment should be on Regional MCI.
- Ensure patients arriving at the Patient Collection Point have been triaged and are **sorted by severity**
- Ensure you have enough **personnel** in the treatment area (**Red 1:2 patients, Yellow 1:3 patients, Green 1:5patients**), coordinate needs with EMS Director/Operations
- Ensure you have **adequate supply** of medical equipment, coordinate with EMS Director/Operations
- Contact **Medical Command** for standing orders, if needed
- Oversee all treatment of patients, verify appropriate level of care (BLS / ALS) for patients based on injuries and severity
- Assign a sector coordinator for each Patient Collection Point (red, yellow, etc.) for large scale incidents to assist in management of the treatment area
- Determine transport priorities and coordinate movement from the Patient Collection Point with the Transport Officer
- As patients are moved to transportation, **ensure the attendant for the unit transporting is sent with the patient** (since only the driver remains with the unit)
- Verify final patient count** with the Transport and Triage Unit Leader in order to accurately determine if all patients have been accounted for or transported
- Provide progress updates to EMS Operations
- Terminate operations with the consensus of EMS Operations and / or EMS Officer

### Transportation Unit Leader Checklist

**Personnel Assigned:** Paramedic or other person as designated by the EMS Director

**Function:** Coordinate the transportation of patients to receiving facilities

- Don **GREEN** vest labeled '**Transportation Officer**'
- Obtain situation briefing / route of travel for incoming units / and staging area from EMS Officer
  - Consider a staging officer
- Create / **Confirm treatment area and ambulance loading area**
- Seek out a **Transport Officer Assistant**
- Confirm the **communications structure**
  - EMS Officer / Operations / Triage / Treatment should be on every event
    - If not, \_\_\_\_\_
  - On every event, communications should be conducted on specific counties Med 9 or 10 Channel to communicate with the County
    - If not, \_\_\_\_\_
    - *There should be little reason to converse with these units. They should report to staging and standby with drivers and litters until waived to the loading area*
- Coordinate with the Triage and Treatment Unit Leaders to determine transportation needs for potential number of patients.
  - Are enough ambulances responding? Can ambulances committed to the incident make multiple trips?
  - Determine if alternative means of transportation (buses, wheelchair vans, etc.) will be needed.
    - Contact EMS Operations to request these resources as soon as possible
  - If aero-medical is to be utilized, coordinate with EMS Operations for FD assistance.
- Contact PSAP on the County designated operations frequency to request notification of specific hospitals and secure bed availability.
- Fill out the 'Bed Availability' page of the transport officers' book with information received from the MCI patch
- Transfer information from the '**Bed Availability**' page to the page for each individual hospital
- Begin moving patients.** Coordinate with Treatment Unit Leader to get the most red tag patients transported first. **Assign multiple patients to each vehicle** if possible
- Rip off and record only critical information on the transport officer's portion of the triage tag. Place this portion in the appropriate page of the Transport Unit Leader's book.**
- Make every possible attempt to ascertain patients' name prior to patient leaving the scene on the back of the transport unit leader's portion of the tag.**
- Instruct departing ambulances to maintain radio silence. You provide a report to receiving facilities** on each patient on the MCI patch channel. Include:
  - Priority
  - Primary Injury
  - Tag Number
  - Transporting Unit
  - Time the unit left the scene

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- Once all patients are transported, **verify final patient count** with the Triage and Treatment Officers in order to accurately determine if all patients have been accounted for or transported
- Notify EMS Operations that all patients have been transported or accounted for
- Terminate operations with the consensus of EMS Operations and / or EMS Officer.

√	Hospital Bed Availability	Red	Yellow	Green
hospital notified				
<input type="radio"/>	LVHN- CC adult	8	10	
<input type="radio"/>	LVHN-CC children	5	8	
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<input type="radio"/>	St Joes, Reading	2	5	
<input type="radio"/>	St Lukes Carbon	1	4	
<input type="radio"/>	LVHN- Carbon	2	5	
<input type="radio"/>	St Lukes Upper Bucks	2	4	
<input type="radio"/>	Other			

## References / Sources

1. Federal Emergency Management Agency ([www.fema.gov](http://www.fema.gov))
2. U.S. Department of Homeland Security ([www.dhs.gov](http://www.dhs.gov))
3. U.S. Office of Domestic Preparedness
4. U.S. Fire Administration ([www.usfa.fema.gov](http://www.usfa.fema.gov))
5. Pennsylvania Emergency Management Agency ([www.pema.state.pa.us](http://www.pema.state.pa.us))
6. Pennsylvania Department of Health ([www.health.state.pa.us/ems](http://www.health.state.pa.us/ems))
7. Pennsylvania Office of Administration, Public Safety Radio ([www.oa.state.pa.us](http://www.oa.state.pa.us))
8. SMART Triage Method
9. The National Incident Management System: U.S. Department of Homeland Security, 2004
10. **Emergency Contact Numbers (24/7)**
  - i. **PA Department of Health Emergency Preparedness Liaison Officer**
    - **717-214-1906**
  - ii. **Healthcare Coalition Desk (HCD)**
    - **570-231-5385**
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