Emergency Medical Services
of Northeastern Pennsylvania

MCI and Disaster Management Guidelines

June 2023

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Version 06.2023

1. Introduction, Purpose and Assumptions
2. Command and Management
    a. Unified Command Structure
    b. Unified Command EMS branch
3. Roles and Responsibilities
    a. EMS Command
    b. Safety Officer
    c. Triage Officer
        i. Triage Team
    d. Treatment Officer
        i. Treatment Team
    e. Transportation Officer
        i. EMS Staging Officer
    f. Rehabilitation Officer
        i. Rehabilitation Team
4. Response Levels
    a. Level 1 Response
    b. Level 2 Response
    c. Level 3 Response
    d. Level 4 Response
5. Special Response
    a. Active Shooter
    b. HAZ MAT Response
    c. Local Evacuation
6. Triage
    a. Triage System
    b. Triage Tags
    c. Initial Triage
        i. START Adult Triage
        ii. Jump START Pediatric Triage
    d. Secondary Triage
7. Transportation
8. EMS Staging
9. Rehab
10. Response Preparation
    a. Identify potential Hazards
    b. Incident Action Plan (IAP)
    c. Drill and Evaluate
11. Response
    a. Implementation of Command
        i. Identify response Level
        ii. Establish Command Structure
        iii. Operational Period
        iv. Incident Termination
        v. After Action Report
            1. Who

2. What
3. Why

12. Post Incident Response
    a. Critical Incident Stress Management (CISM)
    b. Hot Wash or Incident Critique
    c. Update IAP, Drill and Evaluate

13. Pandemic Preparedness and Response
    a. Stay Informed
    b. Consider Changes in Response
    c. Responder Safety
14. Requesting EMSNP Resources
15. Regional Council Resources
    a. Bradford/ Susquehanna
        i. MSEC Trailer
        ii. CCP Trailer
    b. Main Office
        i. Vehicles
        ii. Medical Care Trailers
        iii. Specialized Trailers
        iv. Portable Equipment
    c. Manpower Resources- Strike Team Response
        i. Strike Team Agency
        ii. Strike Team Crew Member
        iii. EMS Group Supervisor
    d. Request for Strike Team Response
        i. Strike Team Response
        ii. Strike Team Demobilization
        iii. Required Reports
        iv. After Action Critique
16. Annex
    a. Definitions
    b. ICS Forms
        i. ICS 201 Incident Briefing
        ii. ICS 202 Incident Objectives
        iii. ICS 203 Organization Assignment List
        iv. ICS 204 Assignment List
        v. ICS 205 Communication Plan
        vi. ICS 206 Medical Plan
        vii. ICS 207 Incident Organization Chart
        viii. ICS 208 Safety Plan
        ix. ICS 213 RR Resource Request
        x. ICS 214 Activity Log
        xi. ICS 215 Operational Plan
        xii. ICS 215a Incident Action Plan
        xiii. ICS 221 Demobilization Check Out

c. County Agency Resource List
    i. Bradford County
    ii. Lackawanna County
    iii. Luzerne County
    iv. Susquehanna County
    v. Wayne County
    vi. Wyoming County
d. EMSNP Forms

INTRODUCTION, PURPOSE AND ASSUMPTIONS

The Emergency Medical Service Northeast Pennsylvania Council (EMSNP), Mass Casualty Incident (MCI) Plan outlines the role of Emergency Medical Services (EMS) providers in the event of an MCI in Bradford, Lackawanna, Luzerne, Susquehanna, Pike, Wayne and Wyoming counties. The plan was developed utilizing command structures and emergency management directives specified in the National Incident Management System (NIMS), March 1, 2004, promulgated by the U.S. Department of Homeland Security.

These guidelines will only address the key elements of the EMS segment within the Unified Command Structure, outlining how the EMS sector should operate within the Unified Command System. EMS Operations shall be headed by EMS Command supported by the EMS Operations, EMS Safety, Triage, Treatment, Transport and Rehab Officers. Not every incident will have a separate individual for each role, depending on size and staffing several roles maybe combined into one. Keep in mind the recognized span of control of 5-7 per section head.

The EMSNP MCI Plan is intended as a guideline to be used to coordinate an emergency medical response to an MCI within the EMSNP region. It recognizes support systems such as strategic planning by three Pennsylvania Regional Counter Terrorism Task Force groups, activation of trained and equipped interstate and intrastate ambulance services (PA EMS STRIKE TEAMS), availability of CHEMPACK and National Stockpile pharmaceutical and EMS equipment caches in support of regional and statewide MCI responses.

A Mass Casualty Incident (MCI) may be defined, as an event creating injuries and/or deaths of a number of patients beyond what the jurisdiction involved is routinely capable of handling. An MCI may be caused by natural disaster, accident, human error, terrorist activities including weapons of mass destruction, bio-terrorism or any other event where multiple injuries or deaths result.

This plan covers small MCI EMS operations with jurisdictional mitigation to large MCI EMS operations controlled by a regional Emergency Operations Center (EOC) response and beyond. The purpose of this plan is to define objectives and specific actions such as organizing emergency medical resources, controlling the scene, assigning appropriate response and establishment of a common organizational management structure during an MCI within the region The plan also recognizes the importance of a Joint Information Center (JIC) to facilitate media needs and accurately disseminate information to the general public.

This plan assumes that within the EMSNP Region, Hospitals, Fire, Rescue, Law Enforcement, EMA, Communications Centers and other agencies involved in an MCI have plans compatible with this document. It also assumes each EMSNP provider has mutual-aid agreements with appropriate jurisdictions from which they expect to receive or to which they expect to provide MCI assistance.

EMSNP Regional Protocols for triage, patient care and transport will be followed during an EMS MCI response as outlined in this plan.

Scene safety and use of personal protective equipment (PPE) are of paramount importance. All directives and guidelines relative to these areas will be adhered to at all times. The use of psychological and support services provided by Critical Incident Stress Management (CISM), American Red Cross and other crisis response teams are essential.

COMMAND AND MANAGEMENT

As stated above, EMSNP has adopted the Unified Command Structure as the standard operational response to all MCI incidents within the region. All providers will utilize The Unified Command Structure specified by the U.S. Homeland Security Directives and NIMS Guidelines in response to, or mitigation of a Mass Casualty Incident.

1. The use of the Incident Command System (ICS) is beneficial for the following reasons as outlined by the U.S. Homeland Security Department in their National Incident Management System publication.

    - **A basic premise of ICS is that it is widely applicable.**
    - **It is used to organize both near-term and long-term field-operations for a broad spectrum of emergencies from small to complex incidents.**
    - **It is flexible and can expand or contract with the escalation and de-escalation of the incident.**

2. On-scene operations are usually managed by the agency having the most involvement if the agency has the resources for the type of incident that is encountered. The ICS structure more easily supports the integration of non-public safety agencies into the structure. This allows all agencies to participate in the development of strategies to be employed in the mitigation of the incident. It ensures integration and consolidation of action plans and maximizes the use of resources.

3. The ICS command structure plays an important role in maintaining and managing "span of control". It assists those who have experience in managing large-scale incidents as well as those who do not commonly manage such operations. "Span of control" is vital to the success of any incident and is maintained as follows:

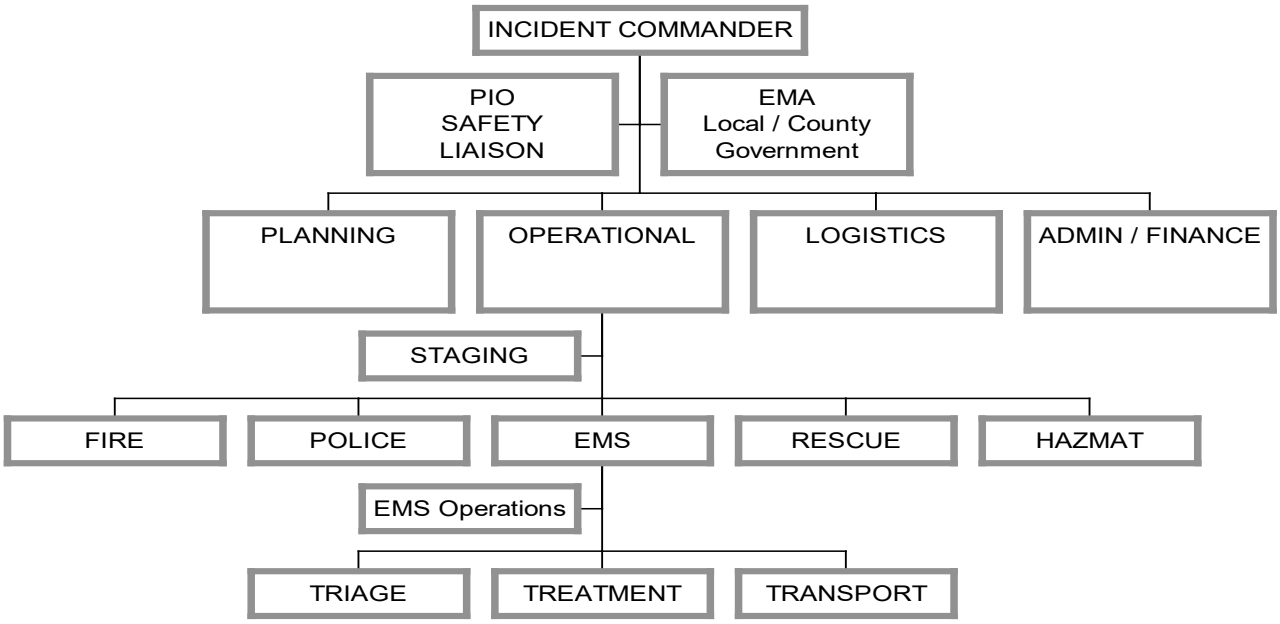
- **A manageable span of control should be kept between 3 to 7 people. The optimum number is 5 people.**

4. As the incident escalates, the lines of responsibility can be expanded. As the incident de-escalates and a demobilization of resources occurs, the system can be downsized to meet the operational needs at any time up to termination of the entire incident.

5. The ICS command structure affords the ability for relief or change in command during large scale or extended incidents going beyond regular or customary shift or work patterns. The system easily adapts to written forms of communications and planning where mitigation plans may need to be approved in writing.

UNIFIED INCIDENT COMMAND STRUCTURE

Unified Command Structure- Below is an outline of the Unified Incident Command Structure with the responsibilities of each Branch of the Command Structure



Incident Commander: The individual in overall command of MCI/disaster or other emergency incident.

PIO (Public Information Officer): The individual that is responsible for the release of information about the incident to the news media and other appropriate agencies and organizations.

Safety: The individual that is responsible for monitoring and assessing hazardous and unsafe situations and developing measures for assuring personnel safety of everyone involved in the incident.

Liaison: The individual that is responsible for interacting, (by providing a point of contact), with the other agencies and organizations involved in a disaster.

Emergency Management / Local - County Government: Individuals from these agencies that might have a role in the mitigation of a mass casualty incident. May serve as overall incident commander dependent upon jurisdiction and situations of the event.

Planning: Responsible for the collection, evaluation, dissemination and use of information regarding the development of the incident and status of resources.

Operational: Responsible for the management of all operations directly applicable to the primary mission.

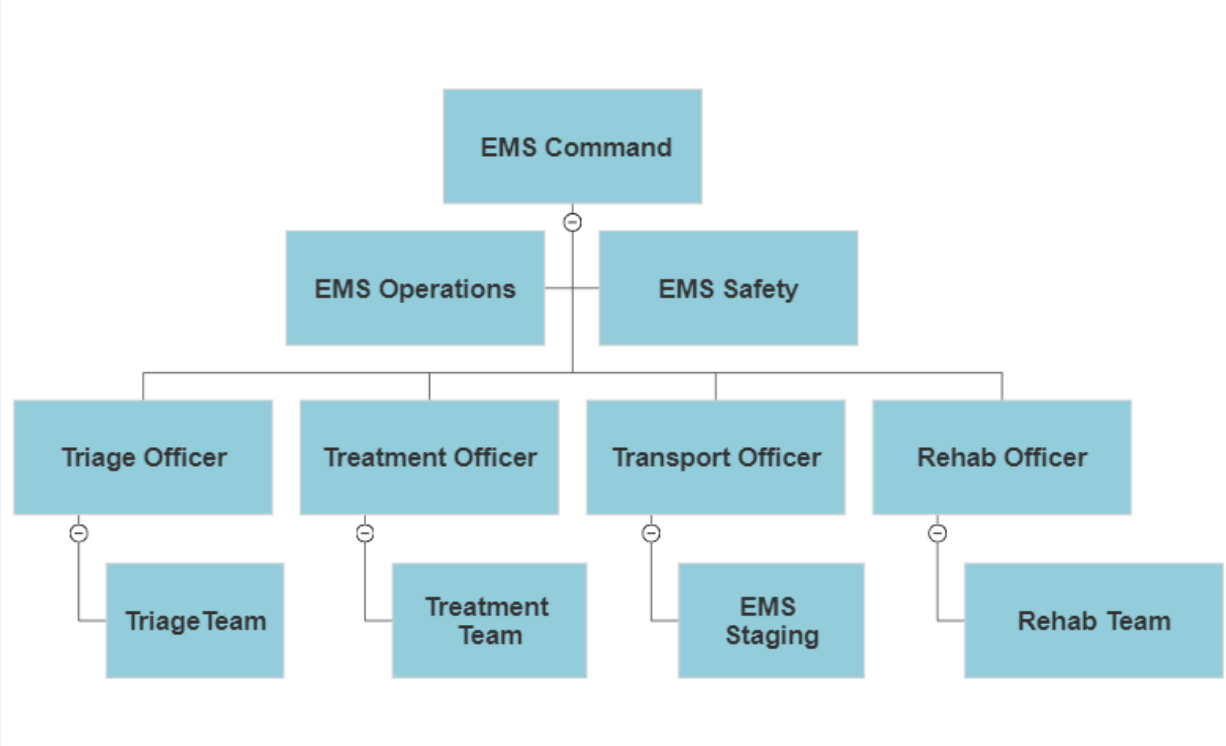
Logistics: Responsible for providing facilities, services, materials and other resources in support of the incident.

Administration/ Finance: Responsible to organize and operate the finance section within the guidelines, policy and constraints established by the incident commander and the responsible agency. The constraints will vary dependent upon the type of event.

Fire, Rescue, EMS, Police and Haz Mat- Each branch has its own organization flow chart for command and control. The head of each branch is to report to either operations or to Incident Command their operational status.

EMS Branch of the Unified Command Structure- Below is an outline of the EMS Branch of the Unified Incident Command Structure with the responsibilities of each designated position of the EMS Branch. Not every incident that EMS establishes Command will need separate personnel filling these positions. In most cases providers will fill multiple positions and the size and complexity of the event dictates.

EMS Operations Structure within the UNIFIED COMMAND SYSTEM



EMS Branch Roles and Responsibilities

EMS Command- The individual that receives a delegated assignment for a specific span of control under the EMS Operation Branch. This individual is responsible for the overall coordination of EMS activities at a disaster scene. This individual reports directly to the Incident Commander.

EMS Operations- The individual to provide operational support to the EMS branch. This includes medical supplies, rehab supplies or any other supplies needed to support the EMS operations.

EMS Safety Officer- The individual that is responsible for the accountability and security of all responders operating under the EMS Branch. Refer to the Annex for 2the recommended policy as it refers to Credentialing and Security.

Triage Officer - The individual that is responsible for the overall coordination of triage activities at a disaster scene. Reports operational status to EMS Command.

> **Triage Team Members -** Groups of medically trained personnel that assist the Triage Unit Leader in the triaging of victims. As the level of the incident escalates, more teams may be needed.

Treatment Officer - The individual that is responsible for the coordination of the treatment of patients at the patient collection stations. Reports operational status to EMS Command.

> **Treatment Team Members -** Groups of medically trained personnel, including physicians and nurses that assist the Treatment Unit Leader with the treatment of victims brought to the Patient Collection Stations. As the level of the incident escalates, each patient collection station may need to have individual Team Leads to better coordinate patient care.

Transportation Officer- The individual that is responsible for communicating with supervisors and hospitals to manage the transport of patients to hospitals for the scene of the disaster. Reports operational status to EMS Command.

> **EMS Staging Officer-** responsible for to coordination of EMS units on the scene and sending the appropriate unit as requested by the Transportation Officer. If the incident scale requires this may need to be split between Air and Ground coordination as needed.

Rehabilitation Officer- Is responsible for the health and wellbeing of all responders operating on the incident. Reports operational status to EMS Command.

> **Rehabilitation Team-** Medical personnel who provide medical screening to responders checking on only their vital signs and hydration, but their mental status as these incidents are not only physically demanding, but can be mentally over whelming as well. Any responder that is taken out of service for either situation shall be reported immediately to the Rehabilitation officer for further action and reporting.

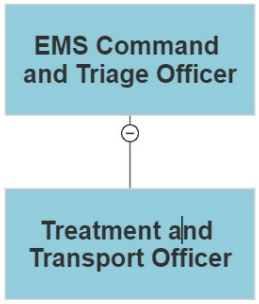
Most MCI incident require only one Triage and Collection area, however if an incident covers a large area, it may require multiple Triage and Collection areas. These areas should be designated by their specific location with separate Triage and Treatment Officers reporting back to EMS Command. However the Transportation Officer should continue to be the same, if needed additional personnel could be assigned to assist with communications and staging. Keeping EMS staging together will help with the efficient use of resources during the incident or identify the need for additional resources.

Response Levels.

Response Levels- Response levels are utilized to request appropriate resources to meet the needs of the number of survivable victims and to support the incident. These levels are driven by the anticipated causality counts, not the severity of injury. These levels are based on a National Standard followed nationally, just as the Incident Command System is followed.

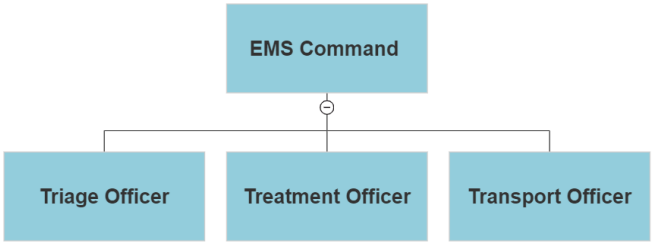
Level One Response- Anticipates 1 - 10 causalities of various severities and should have a modified EMS Command initiated. Initial EMS response of 3-5 transport capable EMS units.

Possible Level One Command Structure



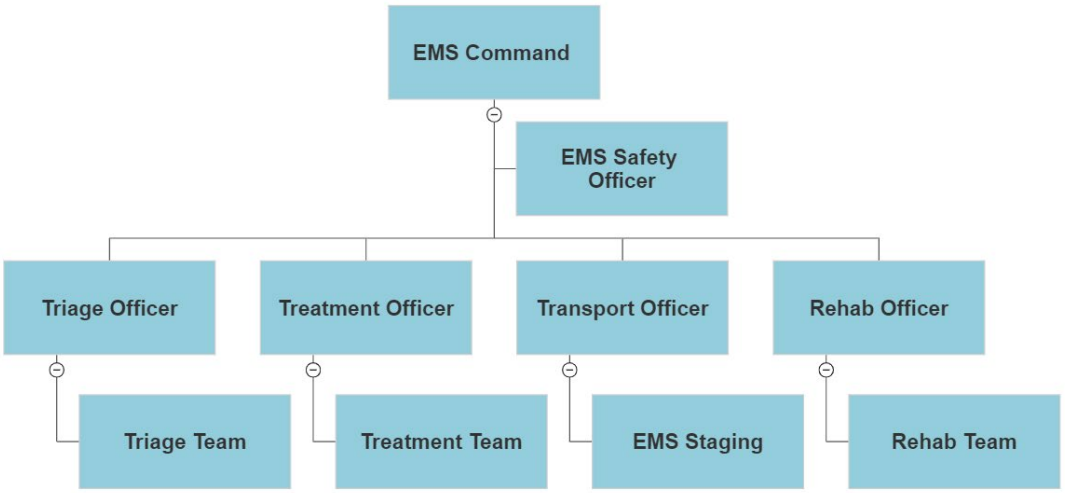
Level Two Response- Anticipates 11 – 25 causalities of various severities, this response requires a formal establishment of designated EMS Command Staff, to include but not limited to, Triage, Treatment and Transport Officers. Initial EMS response of 5 – 10 transport capable EMS units. Additional EMS resources are recommended to handle emergencies not associated with the incident.

Possible Level Two Command Structure



Level Three Response- Anticipates 26 causalities or greater of various severities, the Level Three response requires full designation of EMS Command staff, and the formation of Triage and Treatment Teams for extended on scene treatment of causalities. Initial EMS response of 10 – 15 transport capable EMS units and consider alternate transportation modes for the walking wounded.

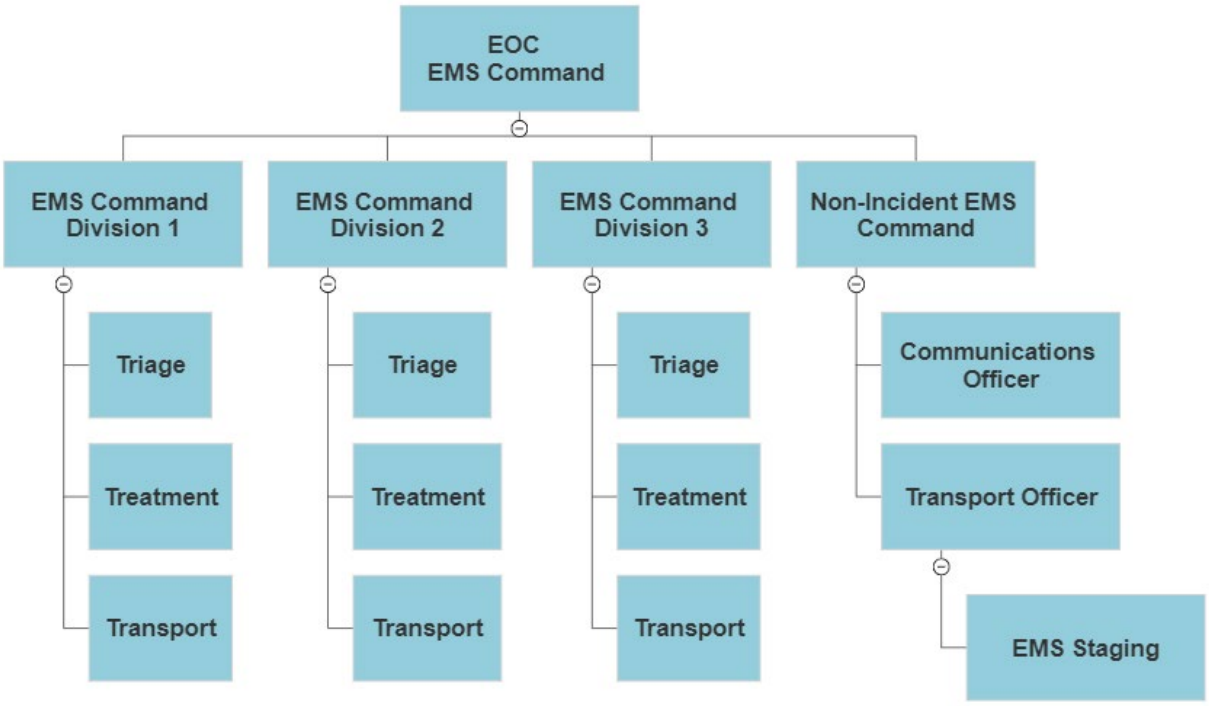
Possible Level Three Command Structure



Level Four Response- Anticipates causalities that would require a Regional response of EMS units for the incident and unassociated emergencies until the incident is mitigated. This response will require a second EMS Command structure to maintain accountability of the units operating outside the initial incident.

This size incident would have an EOC set up under the unified command where EMS Command would be located. Depending on the scope, EMS Command may require the incident site or geographical area divided into Divisions of Operations. Each of these division would have their own EMS command structure with each EMS commander communicating EMS Area Command at the EOC. In addition a command structure not associated with the incident may need to be established to oversee the provision of EMS care to the area not affected by the incident.

Possible Level Four Command Structure



Special Situation Response

During any of the responses below the EMS Command structure can be adjusted to fit the specific needs of each incident. Every incident is different and can pose it's own challenges and obstacles to overcome.

Active Assailant / Terroristic Incidents- An Active Assailant is an individual who engages in killing, or attempting to kill, people in a confined and populated area. Active Assailant and Terroristic Incidents have the potential for multiple, deferred, and hidden patients including the potential for assailants to be mistaken as patients. The standard EMS safety processes need to aware of clandestine risks while being extended to include "safe-enough" responses into warm zones.

The complexity of the evolving incidents indicates the greater need to establish planning and standard operating procedures (SOPs) for these very volatile and dangerous situations. The primary objective is to prepare immediate and first responders to save the maximum number of lives possible. Several recommendations may strengthen the EMS response including:

- **Level Three Response** is indicated until the situation is deemed under control. EMS Command will define a "safe" staging area outside of the estimated scene perimeter.

- **Scene Safety and Security** is the first consideration and begins at the staging area. Responders should be verified by using State or Employer issued identification as defined by 2009 Act 37 CHAPTER 81 SUBCHAPTER A § 8113. Emergency medical services providers. (j) Identification. Enhanced awareness should be utilized to identify potential assailants, actors, or media who may embed into the Staging or Response areas.

- **Triage area(s)** should be identified prior to teams making entry into the incident, so they know where they are taking the patients. Triage areas should have two main characteristics, first setup outside of the immediate crime scene and second, if possible, with some type of protective cover from the incident. Vehicle access however is important, the safety of patients and responders needs to be addressed as well.

- **Training:** New patient stabilization and rescue techniques should be implemented such as incorporating tactical emergency casualty care (TECC) into planning and training. Training must include hemorrhage control techniques, including use of tourniquets, pressure dressings, and hemostatic agents. Training must also include assessment, triage and transport of victims with lethal internal hemorrhage and torso trauma to definitive trauma care.

- **Training:** Stop the Bleed just-in-time (JIT) training can be provided to all responders in the staging area to include Compressing the Zones of Care and the critical actions contained in the acronym **THREAT as recommended by the Hartford Consensus.**

    - **T**hreat suppression
    - **H**emorrhage control
    - **R**apid **E**xtrication to safety
    - **A**ssessment by medical providers
    - **T**ransport to definitive care

- **Planning:** The Hartford Consensus suggested that the plan be modified to allow earlier access to victims outside the real hot zone, the location of the active shooter, or a possible bomb. Building a new systems of integration and coordination between law enforcement and other teams of responders is needed to ensure the mutual understanding and sequencing of roles.* The Compression of the Hot Zone will create a "safe enough" area for first responders to implement rapid interventions and transportation through the Rescue Task Force model.

  - cite on source page *Source: The Hartford Consensus. Improving Survival Strategies to Enhance Survival in Active Shooter and Intentional Mass Casualty Events: A Compendium. Published by American College of Surgeons, September 2015. www.facs.org/~/media/files/publications/bulletin/hartford%20consensus%20compendium.ashx. Retrieved July 25, 2016.

HAZ MAT Response- This response must be coordinated with the fire department to utilize the expertise in HAZ MAT response. A response level can be updated after HAZ MAT Response provides information on the potential causality count. Credentialing of EMS providers entering any area above the cold zone is a must. Triage and Treatment areas should be established well within the cold zone with input of the fire department. No patient should be brought to the triage treatment area without going thru the fire department established decontamination process.

Local Evacuations- These pose a different situation when it comes to EMS operations as we are not treating and moving injured patients. During these incidents the need to identify residence with medical mobility concerns need to be identified, documented and transported to a designated safe area until the incident is resolved or another form of accommodations can be arranged.

Medical Facility Evacuations- Licensed healthcare facilities should have an Emergency Operations Plan, External Disaster Plan, or similar emergency plan for managing evacuations. EMS agencies are encouraged to review these plans with area facilities to anticipate potential system impacts to ambulances and first responders. If evacuation is indicated, EMS can mitigate some system impact by including communications with local and county emergency management and extending communications with the state ESF-8 component. A regional or statewide resource, such as trailer mounted power or HVAC units, may provide evacuation relief and minimize the impact to EMS.

Special Events- These events have the potential to become a mass event. EMS providers should have an IAP, or EMS Special Event Plan filed and reviewed with the communications center, EMA and neighboring response agencies. Pre-event tabletop exercises provide a review of plans and identify potential gaps.

Triage

By definition is the preliminary assessment of patients or casualties in order to determine the urgency of their need of treatment and the nature of treatment required.

To keep uniformity within the Region, EMS of Northeastern Pa. has adopted the **S**imple **T**riage and **R**apid **T**reatment **(START)** triage system, for the purpose of identifying and assessing the injured during a Mass Casualty incident.

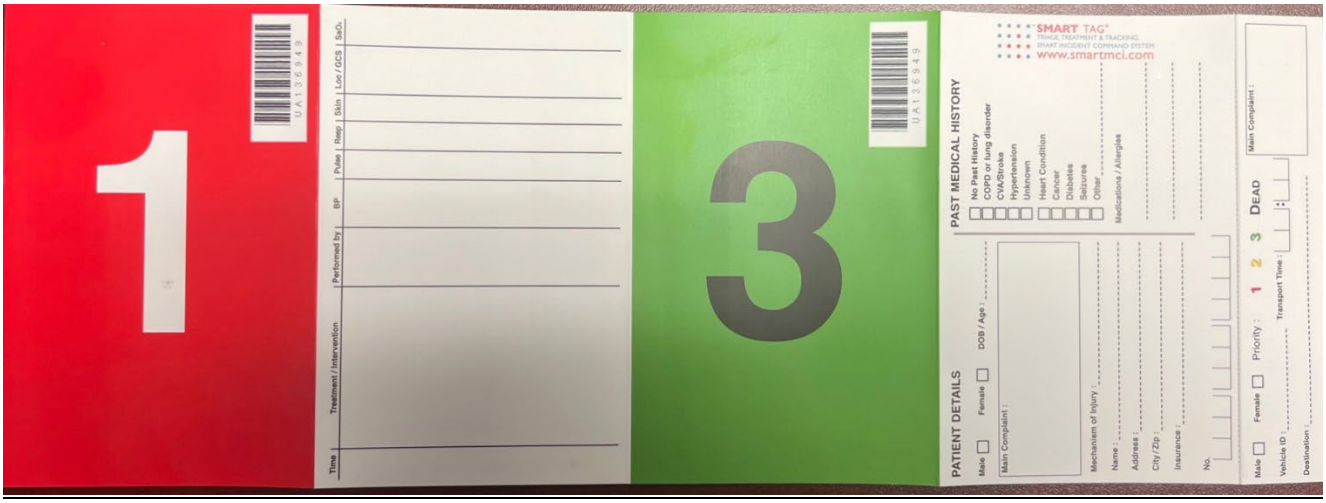
The START triage system uses two different style of triage tags to identify the injured:

The first card if folded with the numbers 1, 2, 3 and standard red, yellow and green back grounds, see below. The cards are in a protective plastic pouch with a rubber band to attach the card to the patient. After identify the priority of the patient that is the number that should be displayed.

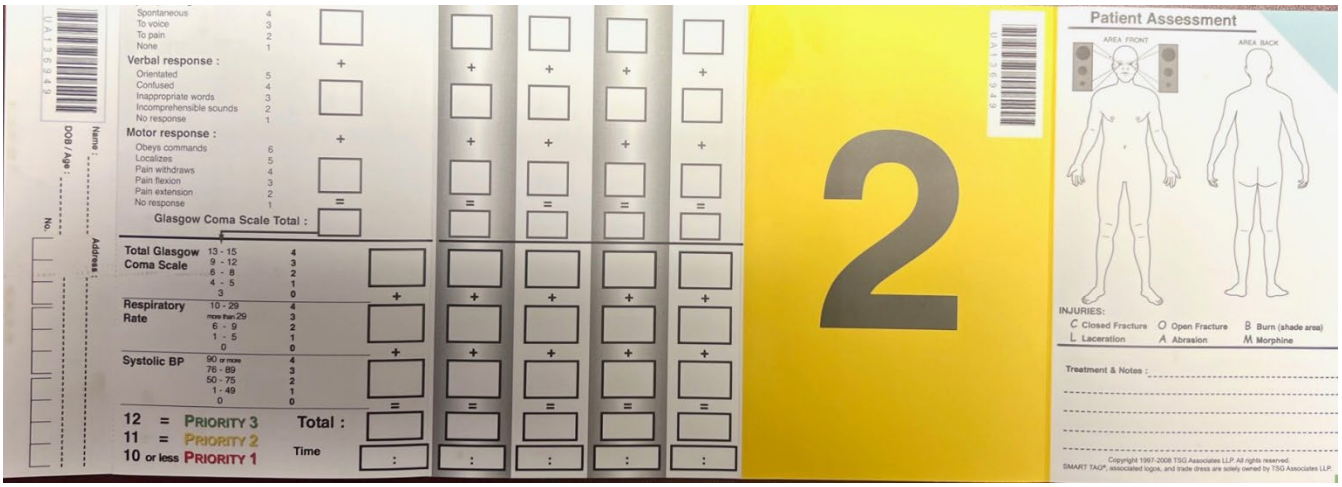
The second card is Black in color for the patients that are unlikely to survive given the severity of their injuries, given the availability of resources, or have succumbed to their injuries.

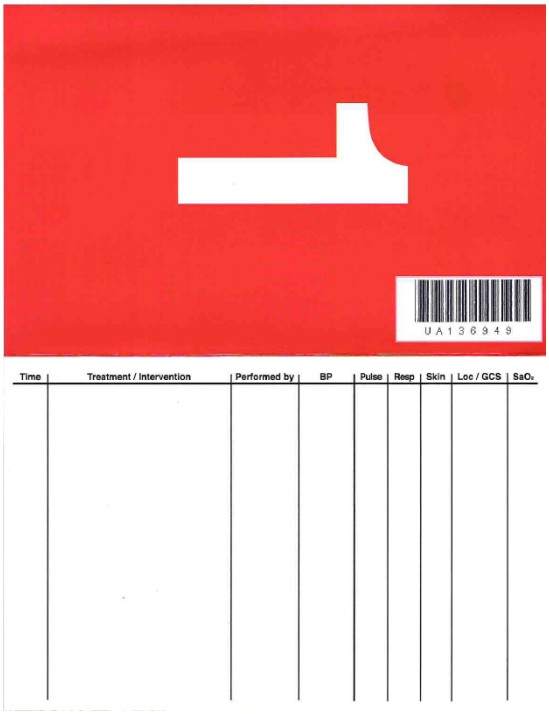
Triage Tags

The triage tags are two sided and designed to be folded with the patient priority to be exposed. The one side contains the priority 1 (Red) and 3 (green) with patient documentation panels between.



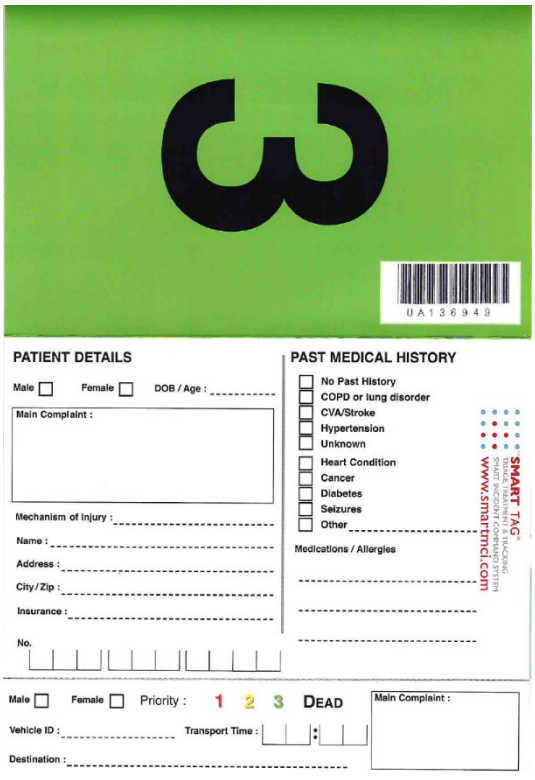
The other side has the priority 2 (yellow) and additional patient documentation panels.

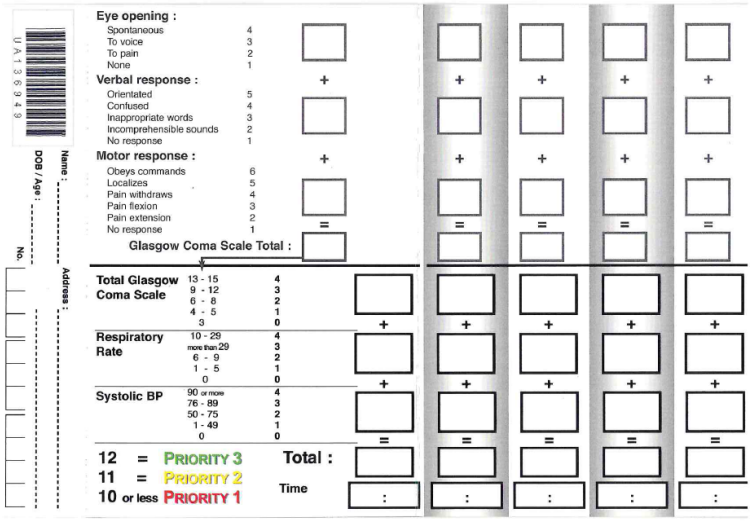




Patient Documentation – This patient documentation is for Patient treatments, who did the treatments and vital signs during patient care.

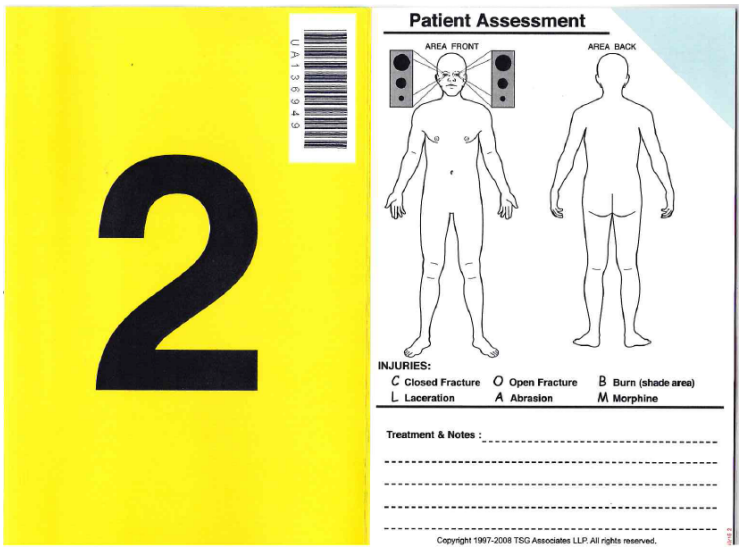
These panels are for documentation of patient demographics, Past Medical History, Medications/ Allergies. The small panel is for the transport officer to have record of the patient priority, who transported the patient, the time they left the scene, destination and the Main Complaint.





AVPU and GCS panel allows for the documentation of initial and reassessments of these values during the care of the patient. It also gives a standard format when using the GSC for deciding the priority of a patient. The back side of the transport tear off tab allows for patient identification such as Name, DOB or age and address.

The patient assessment panel allows documentation of injuries found on the patient during secondary assessment to include pupils and simple documentation by letter for fractures, burns, laceration and abrasions. There is room for additional treatment documentation as needed



Initial Triage:

The purpose if the initial triage is twofold, first to identify the number of causalities and second to get an approximate number of patients involved. Depending on the scope of the incident this may be done by the Triage Officer, of if a large-scale incident the Triage Team operating under the Triage Officer. Patient severity will be identified as:

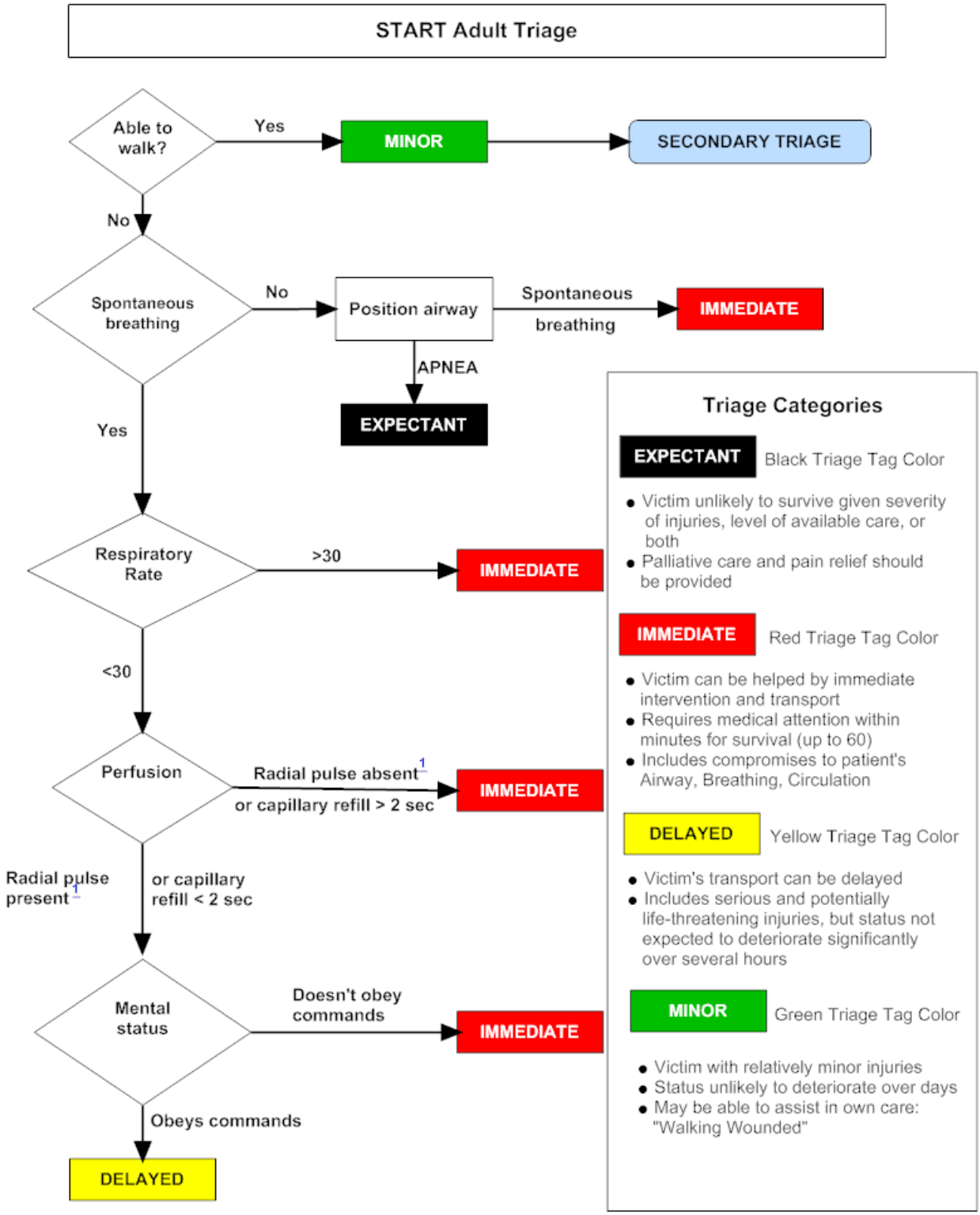
Green Tag (3) – These patients have minor injuries that are not considered life threatening, and is able to assist with their own care as needed. These patients are often categorized as "walking wounded".

Yellow Tag (2) – These patients have serious and potentially life-threatening injuries, however are not expected to deteriorate in a short period of time. These patients do require some medical attention, however are stable and can be delayed in transport.

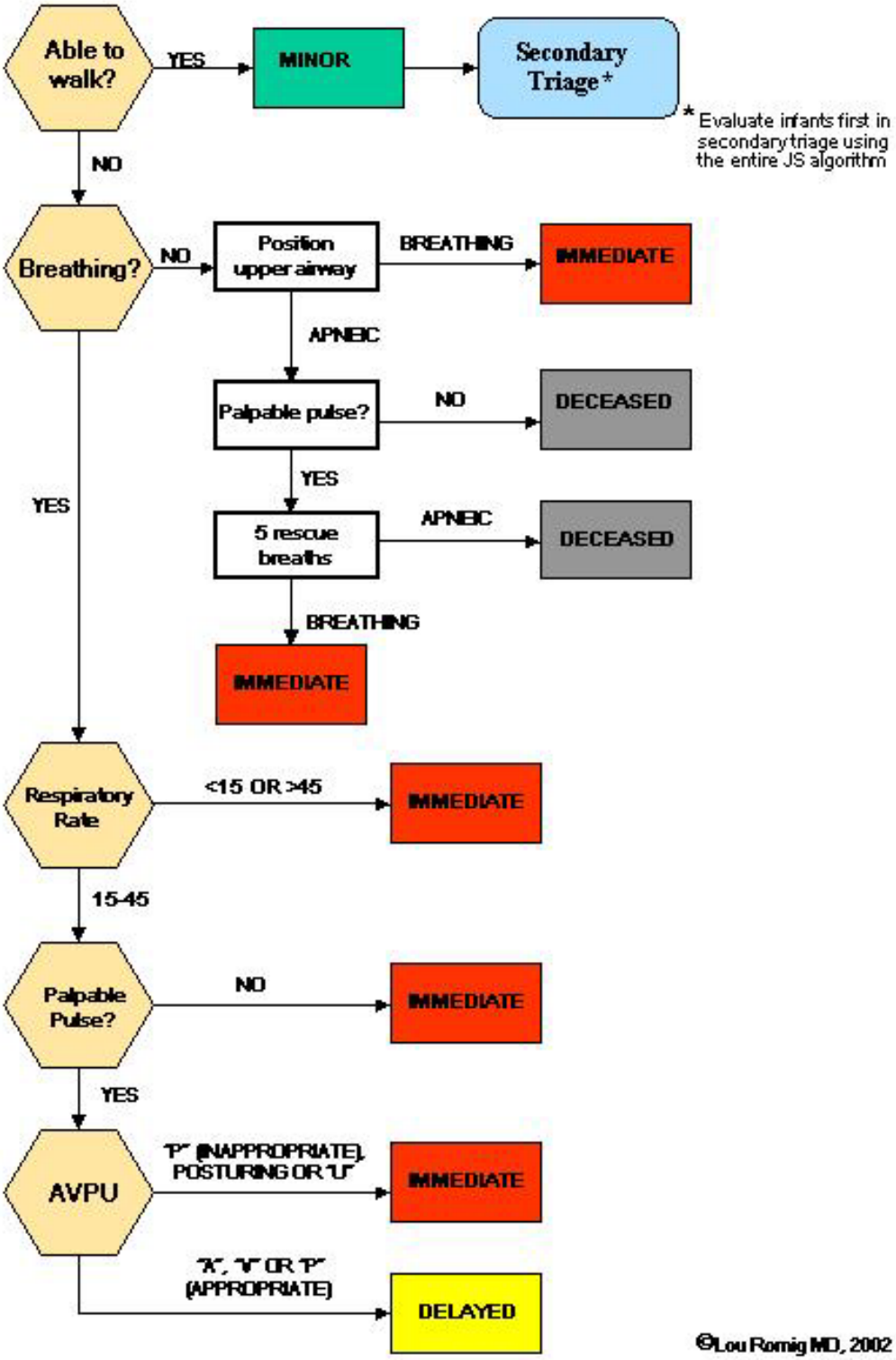
Red Tag (1) – These are the most seriously injured and need immediate medical intervention and transport. These patients have compromised airways and or circulation or patients with uncontrolled emotional disorders.

Black Tag – These patients have succumbed to their injuries, or are unlikely to survive given the severity of injuries, of the level of available care or both. These patients should be provided palliative care and pain relief should be provided.

Below is the START triage algorithm for both adult and pediatric patients:


START Adult Triage
Able to walk?
Yes
MINOR
SECONDARY TRIAGE
No
Spontaneous breathing
No
Position airway
Spontaneous breathing
IMMEDIATE
APNEA
EXPECTANT
Yes
Respiratory Rate
>30
IMMEDIATE
<30
Perfusion
Radial pulse absent[1]
or capillary refill > 2 sec
IMMEDIATE
Radial pulse present[1]
or capillary refill < 2 sec
Mental status
Doesn't obey commands
IMMEDIATE
Obeys commands
DELAYED
Triage Categories
EXPECTANT
Black Triage Tag Color
Victim unlikely to survive given severity of injuries, level of available care, or both
Palliative care and pain relief should be provided
IMMEDIATE
Red Triage Tag Color
Victim can be helped by immediate intervention and transport
Requires medical attention within minutes for survival (up to 60)
Includes compromises to patient's Airway, Breathing, Circulation
DELAYED
Yellow Triage Tag Color
Victim's transport can be delayed
Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours
MINOR
Green Triage Tag Color
Victim with relatively minor injuries
Status unlikely to deteriorate over days
May be able to assist in own care: "Walking Wounded"

JumpSTART Pediatric MCI Triage©



Secondary Triage and Treatment:

Secondary triage will be done as per State Protocol by the Treatment Officer and or Treatment Team. Patient maybe triaged to a lower or higher level of priority as their medical condition dictates. The following are suggested patient to provider ratios and transport priorities:

Red tag – These are the highest priority and require the highest level of care available, i.e. Air medical, Critical Care or ALS optimal provider ratio is 1:1.

Yellow tag – These are moderate priority patients who require prompt care, but can wait for delayed transport. These patients can be transported ALS or BLS with a ratio of 3:1.

Green tag – These are low priority and require minimal care, however require transport for treatment. Non-traditional methods of transport can be considered (school or transit bus), however must be accompanied by medical personnel during transport. Optimal provider ratio is 5:1.

Black tag – These patients may have succumbed to their injuries or have injuries not compatible with life or is unable to be stabilized with available resources on scene. Patient who receives a black tag will be reassessed after all patients are triaged and resources become available. Any patient that dies in the treatment area will be reclassified as a black tag and moved to the on-site morgue.

On Site Morgue – This initially falls under the Treatment officer's responsibility until relived by the county Corner. The on-site morgue should be established in a secure area away from the treatment area and out of the view of the general public and media. The morgue will initially be for patients who succumb to their injuries while in the treatment area. Patients that are black tagged during triage should not be moved until ordered by a County Official.

Transportation

The transportation officer is responsible for the organized movement of the sick and injured from the scene to the appropriate facilities. To start the transportation officer needs to request the local PSAP to contact local receiving facilities to establish what their patient capabilities are. For example, hospital A can handle 4 critical, 6 moderate and 10 minor. Trauma Center A can handle 4 trauma's, 10 moderate and 10 minor patients. Once this established then patients can be distributed accordingly.

Sample Patient Capability and Distribution Form

EMSNP		Patient Intake Capacity			Patients Transported		
	Facility	Red Tag	Yellow Tag	Green Tag	Red Tag	Yellow Tag	Green Tag
Level 1	Geising Wyoming Valley	5	6	10	II	III	I
	Geisinger Danville	2	8	7	II		
Level 2	Geisinger CMC	1	4	5		III	III
Level 3							
Level 4	Lvh Hazleton	2	5	5		I	I
General	Wilkes Barre General	0	8	10		III	IIII

Modes of transportation need to be patient condition appropriate ie; Air medical, ALS or BLS may also consider alternate modes of transportation such as vans or busses for the walking wounded. When using alternative modes of transportation, patients must be accompanied by medical personnel, medical supplies and a form of communication in the event of a patient's condition changing. All patient assigned transportation from the scene should be logged on a flow sheet with transport time, transporting unit, Triage Tag number, priority and destination facility.

Sample Transport Log

Resource	Time Assigned	Triage Tag #	Priority	Primary Injury	Destination
Helicopter 1	7:55	1258760	1	Head Injury	Trauma Center 1
ALS 2	8:00	658724	1	Femur Fracture	Trauma Center 2
		5498725	3	Leg Laceration	Trauma Center 2
BLS 1	8:05	4685721	2	Fractured Arm	Facility 1
		4687254	3	Multiple Lacerations	Facility 1
BLS 3	8:15	4687241	2	Clavicle Fracture	Facility 2
		4587935	3	Abdominal Pain	Facility 2
ALS 5	8:25	6834251	1	Chest Pain	Trauma Center 1
BLS 4	8:30	4658754	3	Multiple Lacerations	Facility 2
		6458721	3	Multiple Lacerations	Facility 2
Stretcher 2	8:40	4588796	3	Multiple Lacerations	Facility 1
W/C 1	8:50	1334823	3	Sprained Ankle	Facility 2
		1468792	3	Sprained Ankle	Facility 2
Bariatric 1	9:00	1358438	2	Leg fracture	Trauma Center 2

EMS Staging

EMS staging officer is responsible for the organization of EMS transportation resources during the incident. This includes landing zones for air medical services as well as accounting for specialized resources and units' level of care. The accounting of these units is not only accounting for those on the scene, but those assigned to transportation duties until they return to the scene.

Sample Resource List

EMSNP		Staging Resource List											
Unit	Unit ID	Air Medical	ALS Transport	ALS Squad	I-ALS Transport	I-ALS Squad	BLS Transport	BLS Squad	Bariatric Unit	Stretcher Vans	Wheelchair Vans	Bus	Alternate Contact Information
Geisinger Life Flight	Life Flight 4	X											570-123-4567
Med Evac	Med Evac 4	X											
Trans Med	Medic 10-D		X										
	W/C 5										X		
	Stretcher 5									X			
Sweet Valley									X				

Sample Resource Tracking

Resource	Level of Care	Arrived at Staging	Time Assigned	Time Returned	Time Assigned	Time Returned	Time Released
Helicopter 1	CC	7:45	7:55	9:00			10:00
ALS 2	ALS	7:35	8:00	9:45			11:00
BLS 1	BLS	7:45	8:05	9:30			10:30
BLS 3	BLS	7:30	8:15	9:40			10:30
ALS 5	ALS	7:55	8:25	9:30			11:00
BLS 4	BLS	8:00	8:30	10:00			12:00
Stretcher 2	STR	8:00	8:40	10:15			11:30
W/C 1	W/C	8:05	8:50	10:15			11:45
Bariatric 1	BARI	7:45	9:00	11:00			12:00

Rehab

Rehab is an important part of keeping our responders safe and healthy during these types of responses. It is important that all responders have periodic medical and emotional monitoring due to the elevated stress levels during these events. It is important that all responders periodically take time for themselves as it is in our nature to care for the sick and injured, sometimes over our own wellbeing. Any responder treated above routine rehab services must have a PCR generated documenting the medical care provided.

Sample Rehab Sheet

Name or Unit Number	Time In	Repeat Assessment	Complaints (if any)	Pulse	Blood Pressure	Treatment (if any)	Time Out

Response Preparation

Identify Potential Hazards: Potential hazards can be grouped into two categories:

> **Fixed:** These include Schools, Hospitals, Nursing facilities (skilled or personal care), Industrial sites (hazardous materials), Sports or Entertainment venues and elderly high-rise apartment buildings. These sites are established gathering, long term care or residences that are occupied on daily basis.
>
> **Temporary or Mobile:** These include Community or County fairs, Marathons or any large gathering of people that runs for a short period of time or is seasonal in nature. These events can be further identified as a prolonged gathering of 250 people or more. Gatherings of 5,000 to 25,000 should have one staffed and licensed ambulance.

Incident Action Plan (IAP): An Incident Action Plan or IAP provides a structure to previous "pre-planned" processes. An IAP is a formal document that establishes incident plans and goals in the event of an emergency at a fixed site or during a temporary or mobile operational period. It contains general tactics to achieve goals and objectives during a period of operation. An IAP disseminates critical information to the roles and responsibilities of responders will have in the event of an emergency. This covers not only large-scale incidents, but can also address minor incidents as well. IAP's for fixed sites should be reviewed yearly, temporary or mobile plans should be reviewed prior to every event. The purpose of reviews are to maintain accurate information on the venue or residence or to address concerns raised during past responses or events. IAP's for temporary or mobile events are to be filed with EMSNP for review and documentation purposes.

Drill and Evaluation: Frequent drills either actual on-site or table top are essential to limit confusion during an actual event. Drills can be directed to specific parts of an IAP or the whole IAP. Once these drills are completed, they can be evaluated to see what worked well or areas that need to be adjusted or changed because problems were identified.

Response

Implementation of Command: Early implementation of a Command structure is critical to successful incident. The first arriving EMS unit to a Mass Causality incident should identify themselves as EMS Command. When doing so the site location should also be included, _____ County, Ambulance 10 has Arena EMS Command.

Identify Response Level: Once EMS Command is established a response level needs to be established. Command needs to take a quick overview of the incident, get an estimate of possible injuries and request the corresponding response level. Arena EMS Command to _____ County requesting a Level 2 EMS response.

Establish Command structure: As dictated by the level of response, first in ambulances should be assigned to Command roles as needed. Once the Command structure is established additional in-coming units can be directed thru the Command structure. Arena EMS Command Ambulance 5 requesting assignment, Command Ambulance 5 you will establish Triage.

Operational Period: This is the period of time that the incident is being mitigated. This time can be a few hours to few days depending on the scope of the incident. If there is an extended operational period, documentation of responders coming and going is essential for final incident reporting.

Incident Termination: During this period units will be released for the incident to return to normal service and EMS Command structure will be adjusted during this period until Command is terminated.

After Action Report: After action reports serve two very important purposes, first it documents the Who, What and Why of the incident.

Who: Units or Medical personnel that responded, personnel involved in the Command structure

What: What actions were taken, was triage set up, how many patients treated, how many patients were transported and to where, how many class 1, 2, 3 or 5 patents were there, challenges or problems that arose during the operation.

Why: If the IAP was deviated from why or if something unexpected arose what lead to the decisions that were made.

The second purpose is to help identify updates or changes to the IAP that will improve future responses.

Post Incident Response

Critical Incident Stress Management (CISM) – On scene psychological first aid or peer support may be needed for all incidents regardless of the scope, number of injuries, fatalities, or circumstances of violence. EMSNP has a peer based CSIM Team available respond to the needs of responders. The Team can be requested during normal business hours through the office, or after hours thru Luzerne County 911 Centers by calling 570-819-4923.

Hot Wash or Incident Critique: A hot wash is a facilitated discussion held immediately following an incident or exercise among participants from each functional area that is designed to capture feedback about any issues, concerns, or proposed improvements about the incident or exercise. Lessons learned, areas of improvements and identified gaps in capabilities can be included in an After-Action Report / Improvement Plan. A Hot Wash can be conducted at the end of an operational period to add corrections and recommendations to the next IAP. The hot wash is a collaborative and constructive process without placing blame or criticism for individual actions.

Pandemic Preparedness and Response

- Worldwide, health organizations are monitoring and tracking strains of infectious disease on a daily basis. All attempts are made to control outbreaks and/or eliminate their cause and further spread. However, even with the most modern technology the spread of disease virulent enough to cause a pandemic outbreak is possible. Influenza pandemics are used as a model for the purposes of planning and training of emergency services response.

- Influenza pandemics have occurred four times in the 20th and 21st centuries: 1918, 1957, 1968 and 2020. These pandemics totally taxed outpatient medical care professionals and hospitals.

- Experts predict that another influenza pandemic is highly likely, if not inevitable.

- The Center for Disease Control, Pennsylvania Department of Health, Bureau of EMS and EMSNP are working with state, county and local agencies to prepare for immunization, medical treatment and transport of patients during a pandemic influenza outbreak. Plans include use of the Strategic National Stockpile (SNS) to provide "push packages" with 300,000 units of medications to locations in the United States within 12-hours. Logistically, Receipt, Storage and Staging (RSS) locations will be established for receipt and control of the medications. The (RSS) sites will be located within the nine Regional Counter Terrorism Task Force (RCTTF) areas. Point of Distribution (POD) sites will be established within the RCTTF to receive and distribute medications. Emergency health providers such as EMS will receive the medication immediately.

- During a pandemic disease outbreak, EMS services and personnel may be taxed with increased call volume, interruption in supply chains, and psychological stress. Some basic guidelines to follow are:

Stay informed:

Agency leadership should remain in constant contact with local government officials and County EMA officials for updates on ongoing efforts that affect EMS response.

Individuals should subscribe to the PA Health Alert Network (PA-HAN) and CDC Health Alert Network (HAN) for pandemic and other public health emergencies.

Agency leadership should also remain in contact with responders keeping them informed on changes that affect their response to calls, treatment of patients or changes as it related to changes in hospital policies when it comes to receiving patients or the need to isolate patients entering the hospital.

Monitor the Department of Health public service announcements thru local media. Identify a public information officer (PIO) to address media requests for incident information and recommendations.

Consider Changes in Response:

Many agencies allow responders to go directly to the scene, agencies may consider stopping this practice during these conditions to protect responders from being exposed due to the lack of isolation protection.

Implement required PPE as directed by the Department of Health when treating patients. The standard gloves may not be the appropriate protection for responders, utilizing the PPE suggest by the Department of Health will only help to protect responders while caring for the sick and injured.

Consider changes in uniform policy, maybe have responders change out of clothing they are wearing during patient care before going home. This will reduce the possibility of responders taking home contamination to their families.

Vehicle and equipment decontamination should be done after every patient contact more now than on a routine basis. Heightening our efforts in keeping our unit and equipment clean and ready, no matter the patient complaint, will help reduce the possibility of spreading disease. Alternative and more comprehensive decontamination solutions are available by contacting contact EMSNP for possible alternative decontamination procedures.

Responder Safety:

Wash hands frequently with soap and water, if not available use foam or alcohol-based hand cleaners.

Refrain from touching your face during patient care and make sure any open cuts or abrasions are covered as well.

Consider following the Department of Health guidance when in public areas, this will not only keep you safe, but your family, fellow responders and patients safe.

Requesting EMSNP Resources

Requests for EMSNP resources and/or Strike Teams need to be made thru the local EMA office, as an unmet need request. They will relay that request to PEMA, the State Emergency Operations Center as a resource request. It will then be forwarded to the Department of Health's EPLO to the Bureau of EMS. The Bureau of EMS will then notify EMSNP of the specific detail of the activation, conditions and location.

Upon receipt of the request EMSNP office staff will be requested to respond to the office to make additional notification of the request as needed. These requests would be made to our Strike Team agencies for either personnel, ambulances or both. All responding agencies will report to the EMSNP office for coordinated response to the requested area. If the request is for the Susquehanna and Bradford Counties Teams from that area will be advised of the designated assembly area.

EMSNP Resources

Susquehanna/ Bradford Counties

MSEC 1– Trailer containing 45 beds and support supplies, capable of establishing an Alternative Care Site within a fixed structure such as a school gymnasium. The trailer can provide as a multipurpose space including a medical countermeasure mass distribution site.

CCP-1 – Trailer containing a 19x35 foot tent and 16 beds with support staff and supplies. Once emptied the trailer can become a multipurpose vehicle.

EMSNP Office

Vehicles:

2 Ford Explorers – Able to move providers or supplies as needed.
1 Ford F 450 Utility- 5 passenger vehicle with a removable rescue box and pickup insert as needed.
1 Dodge 3500 Pick Up – 5 passenger pickup with a cap
1 Polaris UTV – This vehicle is capable of transporting a single patient and also has an off-road trailer capable of transporting a second patient.
1 Forklift- Available at the EMNP Office

Medical Care Trailers:

MSEC 5- Trailer containing 45 beds and support supplies, capable of establishing an Alternative Care Site within a fixed structure such as a school gymnasium. The trailer can provide as a multipurpose space including a medical countermeasure mass distribution site.

CCP 0501 – Western Shelter Tent System

PA-H6- Medical Support Trailer

F&I 0501- HVAC Support System

Specialized Trailers:

Mobile Emergency Support System (MESS) Trailer Respond to feeding needs of response force during disasters or at mass care locations

85kvw Trailered Generator

Strike Team Support Trailer

Enclosed Trailer for UTV/ Utility Purposes

Air Conditioning Trailer (Special Request)

Heat Trailer (Special Request)

Portable Equipment

2 Fast Shelters

Portable Generators – Multiple sizes

Portable Lighting – Trailered, Inflatable, Fixed and Handheld

Portable Radio System

Manpower Resources: Strike Team System

Strike Team Agency: Strike Team Agencies will maintain an up to date on-call roster of personnel trained to deploy with the Team. Service management will appoint a service Strike Team Coordinator who is assigned to facilitate deployment of personnel. Teams will be required to respond immediately with crew status and availability to any deployment request by EMSNP. Timeframes for departure will depend on the requirements of the mission, any Team deploying must be able to fulfill a minimum two (2) week deployment.

Strike Team Crew Member- Strike Team crew members must be trained in the operation of Strike Team assets and maintain a state of readiness for deployment on short notice. Timeframes for departure will depend on the requirements of the mission, crew members must be available for a minimum 2-week deployment.

EMS Group Supervisor- Prior to departure, EMSNP will designate an EMS Group Supervisor to coordinate all activities of the deployment. Upon arrival, the EMS Group Supervisor will join the local Incident Commander's staff or report to an IC Sector Leader, as necessary. The EMS Group Supervisor will maintain communications with EMSNP to provide mission status reports for each operational period. Specific reporting times will be coordinated after arrival on scene. The status reports will be forwarded by EMSNP to the Bureau of EMS.

Request for Strike Team Response

EMSNP maintains a roster of Agencies within the Region that have agreed to participate in the Strike Team system. These Agencies maintain a roster of providers that have been trained on and in the use of EMSNP Strike Team assets. Should a request for manpower and or ambulances be made thru PEMA and the Bureau of EMS, these agencies would be contacted by EMSNP to assemble available staff and resources for deployment.

Strike Team Response- Once responding Agencies have been identified, a rallying point will be assigned. Once everyone has arrived at the rallying point, EMSNP staff will assign the Command staff that will directly over see the Team during the Operational period. The Command staff will be responsible to report to the On-scene or Regional Command for in processing or assignments for the Team. The Command staff will oversee the completion of any and all assignments given to the Team during the operational period. The Command staff is to report back to the EMSNP office with daily status reports on the Team's activity. The Command staff is also responsible for record keeping of the activity of the Team during the operational period.

Strike Team Demobilization- After being released by Incident Command, the EMS group Supervisor shall initiate and organize the demobilization of the Team. The Team will return to a designated location before being released to their home station. During this period the resources deployed will be inventoried and packed for the return trip to EMSNP. All assets deployed will be returned to the EMSNP office for restocking and inventory before being placed back in-service for deployment. Prior to the return the status must be reported back to EMSNP by the EMS Group Supervisor.

Reports- All necessary reports completed by deployed agencies must be turned into the EMS Group Supervisor daily. Prior to return to EMSNP copies of these reports must be left with Incident Command for their records. The EMS Supervisor must also have a copy to complete deployment reports for EMSNP and the Bureau of EMS. An after-action report is to be filed by the EMS Supervisor providing an over view of the Teams activity during the deployment. This is to include, but not limited to, number of missions carried out, number of transported patients, areas of operations or special assignments. Also, to be included are problems encountered, equipment, staffing or discipline carried out. Finally include any suggesting on making future deployments better whether in documentation, procedures or anything not previously covered.

After Action Critique- EMSNP will conduct a critique of the mission with participating crews to review successes, problem areas and solutions. EMSNP will prepare an after-action report for the Bureau of EMS due within 30 days of the event.

Credentialing - Accountability – Security

EMSNP providers are issued PA Department of Health certification cards with the name, certification level, expiration date and personal certification number of the individual, these may be utilized for identification.

Recommendations for statewide use of electronic systems to identify and track emergency providers are being explored. When issued, they will provide greater accountability than is now available.

EMSNP GENERAL SECURITY INFORMATION

- **It is imperative that EMSNP EMS Group Officers and other supervisory personnel are aware of all ambulance services and individuals responding to the MCI. Those who subsequently arrive on scene must be identified, positioned and maintain accountability through the command management system in place.**

- **It is very important during large operations that all EMSNP EMS Group Officers and other supervisory personnel are constantly aware of the location of providers under their control.**

- **EMSNP EMS Group Officers and other supervisory personnel take whatever steps necessary to prevent unauthorized persons entering their areas of responsibility.**

- **All EMSNP providers must report any actual or suspected security breach to Unit Leaders or other supervisory personnel immediately.**

NOTE: Credentialing and accountability have a direct impact on scene security and individual safety.

Annex

Definitions:

After Action Report – This report will be completed by each member of the Incident Command Staff to document what actions worked, problems noted and what was done to correct the problems incurred. Also offer suggestion to improve the system. These reports will be reviewed and discussed during the Hot Wash/ After Action Review.

ALS Services – Advanced Life Support Services – The advanced prehospital and inter-facility emergency medical care of serious illness or injury by appropriately trained health professionals and EMT-paramedics. (EMS Rules and Regulations).

Air Ambulance – A rotorcraft specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to, and air transportation of patients. (EMS Rules and Regulations).

Ambulance – A vehicle specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to patients, and the transportation of patients if used for that purpose. The term includes ALS or BLS vehicles that may or may not transport patients. (EMS Rules and Regulations).

Bioterrorism - The use of living organisms, or the toxins produced by living organisms, deliberately used to cause disease or illness in a target population.

BLS services – Basic Life Support Services – The basic prehospital or inter-facility emergency medical care and management of illness or injury performed by specially trained, certified or licensed personnel. (EMS Rules and Regulations).

Clear Text - The use of "plain English" in radio communications transmissions. Ten codes or agency specific codes are not used when using Clear Text.

Command - The act of directing, ordering and/or controlling resources by virtue of explicit legal, agency or delegated authority.

Disaster - An event, either natural or man-made, that is characterized by loss of human property, loss of human life, a potential for large number of injuries, separation of family members and an overall disturbance of routine operating procedures.

Dispatch Center - A facility from which resources are directly assigned to an incident. Also referred to as a public service answering point (911 calls).

EMS Command - The individual that is responsible for the overall coordination of all EMS activities at a disaster scene.

EMS Operations Officer - The individual that is responsible for the coordination and management of EMS related resources at a multiple casualty incident. The Operations Officer acts as a liaison between the EMS Commander and other EMS providers on location.

EMS System – The arrangement of personnel, facilities and equipment for the effective and coordinated delivery of EMS required in the prevention and management of incidents which occur either as a result of a medical emergency or of an accident, natural disaster or similar situation. (EMS Rules and Regulations).

EMS – Emergency Medical Services –The services utilized in responding to the needs of an individual for immediate medical care to prevent loss of life or aggravation of physiological or psychological illness or injury. May also be called providers.

Facility – A hospital. (EMS Rules and Regulations).

Federally Declared Emergency – A state of emergency declared by the President of the United States, upon the request of a governor. Once the President declares the situation a "major disaster," the Federal government supplements State and local efforts to meet the crisis. (EMS Rules and Regulations).

Hot Wash/ After Action Review - A review of an incident by the Incident Command Staff to assess the chain of events that took place, the methods used to control the incident and how the actions of emergency personnel contributed to the eventual outcome. The lessons learned during this review should be used to update the established IAP for future responses.

Impact Area - The immediate area of an incident scene where the patients received their injuries and they were initially found.

Incident Action Plan – (IAP) Is a formal document setting incident goals and objectives during planned/ non planned events. This document contains general tactics and structure to an event directing responders to a common goal or objective. As this is a fluid document it should be reviewed, updated and drilled to ensure the readiness of the plan a on a regular basis.

Incident Command System – A structure that allows for the management of an MCI or disaster.

Incident Command - The individual responsible for the management of all operations at a disaster scene.

Mass Casualty Incident - An emergency incident involving the injury and/or death of a number of patients beyond what the jurisdiction is routinely capable of handling. Also called Multiple Casualty Incident or Multiple Patient Incident.

Medical Command – An order given by a medical command physician to a prehospital practitioner in a prehospital, inter-facility, or emergency care setting in a hospital, to provide immediate medical care to prevent loss of life or aggravation of physiological or psychological illness or injury, or to withdraw or withhold treatment. (EMS Rules and Regulations).

Morgue - An area on or near the incident site that is designated for the temporary placement of deceased victims.

Patient Collection Station (PCS) - A specific area, designated by the Treatment Officer, for the collection and treatment of patients prior to transport to a medical facility.

Priority Treatment Area - An area of the Patient Collection Station specifically designated for IMMEDIATE, SECONDARY or DELAYED patients.

QRS – Quick response Service – An entity recognized by the Department to respond to an emergency and to provide EMS to patients pending the arrival of the prehospital personnel of an ambulance service. (EMS Rules and Regulations).

Receiving Facility – A fixed facility that provides an organized emergency department, with a physician who is trained to manage cardiac, trauma, pediatric, medical and behavioral emergencies, and is present in the facility and available to the emergency department 24 hours-a-day, 7 days-a-week, and a registered nurse who is present in the emergency department 24 hours-a-day, 7 days-a-week. The facility shall also comply with Chapter 117 (relating to emergency services). (EMS Rules and Regulations).

Rehab Services - Services provided at a disaster for the rest, nourishment and hydration of ALL emergency workers.

Resources - All personnel and major items of equipment available, or potentially available, for assignment to incident tasks on which status is maintained.

Sector - A tactical level management unit having responsibility for either a geographic or functional assignment.

Staging Area - An area where personnel and equipment are initially assigned to respond to and to await further assignment.

State Declared Emergency – An emergency declared by the Governor. (EMS Rules and Regulations).

Transportation Officer - The individual that is responsible for communicating with sector officers and hospitals in order to manage the transport of patients to hospitals from the scene of the disaster.

Treatment Officer - The individual that is responsible for overseeing activities conducted within the patient collection station. These activities will include ensuring that an adequate amount of equipment and personnel are present to provide both basic and advanced care.

Treatment Team Personnel - Individuals responsible for treatment of patients in priority treatment areas, as assigned to by the Treatment Sector Officer.

Triage - Sorting or categorizing victims of a disaster into priority categories based on the severity of injuries.

Triage Officer - The individual that is responsible for overseeing triage at a disaster scene. This individual is also responsible for the establishment and maintenance of a triage team(s).

Triage Team Personnel - Individuals that are responsible for assisting in the initial triage evaluation and priority designation of victims of a mass casualty incident, as assigned by the Triage Sector Officer..

Unified Command Structure - A structure that allows for all agencies with jurisdictional responsibility to contribute to the planning, strategy, objectives and mitigation of a disaster.

Weapons of Mass Destruction – The use of nuclear, radiological, biological, chemical, incendiary or explosives as a weapon to cause a desired effect in a target population. In some circumstances, these agents are also referred to as weapons of mass effect.

Bradford County

Bradford County 911 570-265-9101

Service	ALS	ALS Squad	BLS	4x4 Ambulance	QRS	Bariatric	W/C (str) Vans	MCI Traler	ATV/ Golf Cart/ UTV	UTV Transport	Golf Cart Transport
Barnes Kasson EMS					1						
Bradford County Department of Public Safety					2						
Canton Fire QRS					2						
Greater Valley EMS	7	3		1	1	7	7 (7)	1			
Global Tungsten					1						
Guthrie Towanda Memorial	7			1		5	7 (5)				
H.O.P.S. Ambulance			2	1							
Smithfield Fire QRS					1						
South Creek Ambulance			1								
Tri Township Ambulance			5								
Western Alliance EMS	4		3	1		1	11 (11)				
Windham Township Volunteer Fire Company									1		
Total	11	0	11		2	6		0		1	

Lackawanna County

Lackawanna County 911 570-342-9111

Service	ALS	ALS Squad	BLS	4x4 Ambulance	QRS	Bariatric	W/C Vans	MCI Traler	ATV/ Golf Cart/ UTV	UTV Transport	Golf Cart Transport
Archbald Ambulance			2								
Blakely Ambulance			2		2			1			
Chinchilla Hose			2		1						
Clarks Summit Fire Co.			1								
Cottage Ambulance	1							1			
Cottage Hose Co. Ambulance	4	1	1	1			4				
Covington Fire EMS			1								
Dalton Fire Co. Ambulance			1								
Dunmore Frie QRS					3						
Greenfield Twp. EMS			1		1						
Greenwood Fire/ Penn Amb								1			
Jefferson Twp. EMS			2		1						
Jessup Hose 2 EMS			2	1							
Justus Fire EMS			1								
Moscow Fire/EMS			2		1						
Olyphant Ambulance			1		1					1	
Pennsylvania Ambulance	16	10	7			2					
Scott Hose EMS			1								
William Walker Ambulance			2		1			1			
	21	11	29		11	2		4			

Luzerne County

Luzerne County 911 570-819-4916

Service	ALS	ALS Squad	BLS	4x4 Ambulance	QRS	Bariatric	W/C (str) Vans	MCI Traler	ATV/ Golf Cart/ UTV	UTV Transport	Golf Cart Transport
Avoca Ambulance			2								
Back Mountain Regional	2		1	2						1	
Dorrance Ambulance			1								
Fairmount Twp. EMS			1							1	
Franklin Westmoreland			1								
Freeland Northside			1	1		1					
Greater Hazleton Ambulance			2		1						
Greater Pittston	5	2		2							
Hanover Twp. EMS	3	1						1			
Harding Mt. Zion EMS			1	1							
Harvey's Lake EMS			1		1						
Hobbie Fire EMS			1							1	
Hughestown Fire EMS			2	1		2		1			
Hunlock Creek Ambulance					1						
Huntington Valley EMS			1								
Kingston Fire EMS	3										
Kunkle Fire EMS	2		1		1			1			
Lake Silkworth EMS			1								
Larksville EMS			2								
LVHN EMS	6		4					1			
Med Stat Ambulance			3			2	11 (6)				
Mountain Top Ambulance	1		2	1							
Nanticoke Ambulance	2	1	1								
Nanticoke Fire QRS					2						
Pittston Twp. EMS			2								
Plains EMS	4				1					1	
Plymoth Borough			2								
Pond Hill Lilly Lake			1								
Salem Twp VFC					1						
Shickshinny EMS			2	1		1					
Total	28	4	36		8	6		4			

Luzerne County

Luzerne County 911 570-819-4916

Service	ALS	ALS Squad	BLS	4x4 Ambulance	QRS	Bariatric	W/C Vans	MCI Traler	ATV/ Golf Cart/ UTV	UTV Transport	Golf Cart Transport
Total from page one	28	4	38		6	1		4			
Slocum Twp. EMS			2	2		2					
Sugarloaf Fire EMS			2								
Sweet Valley Ambulance			4	1							
Trans Med Ambulance	10	2	7			2	15				
Valley Regional Fire/ Rescue	2	1	1	2							
White Haven Rescue			2								
Wilkes Barre Fire	4				4						
	44	7	56		10	5		4			

Pike County

Pike County 911 570-296-7700

Service	ALS	ALS Squad	BLS	4x4 Ambulance	QRS	Bariatric	W/C Vans	MCI Traler	ATV/ Golf Cart/ UTV	UTV Transport	Golf Cart Transport
Delaware Twp. EMS	1		1	3							
Dingman Township			2	2				1			
Hemlock Farms EMS			2								
Lackawaxen Twp. EMS			3	1							
Lehman Pike Emergency Medical Services	2		1	1	1						
Matamoras Fire/ EMS					2						
Milford Fire/ EMS			1								
Promised Land			1								
Shahola Fire											
Shahola Twp.			1								
Taton Fire/ EMS			2	2							
Westfall Fire EMS			2	1							
Woodloch QRS					2						
	3		16		5			1			

Susquehanna County

Susquehanna County 911 570-278-3841

Service	ALS	ALS Squad	BLS	4x4 Ambulance	QRS	Bariatric	W/C (str) Vans	MCI Traler	ATV/ Golf Cart/ UTV	UTV Transport	Golf Cart Transport
Barnes Kasson EMS	1	1	1								
Clifford Fire EMS			1		2						
Columbia Hose Co.			2	1	1						
Forest City EMS			3	1	1					1	
Forest Lake Fire QRS					1						
Great Bend Hallstead EMS			2								
Hartford Fire EMS			2					1			
Little Meadows EMS			1								
Montrose EMS	4			1		1	2 (1)	1			
Rush Fire QRS					1						
Silver Lake EMS			2	2			1			1	
Susquehanna Fire EMS			1		2					1	
Thompsone Hose Co. EMS			2								
	5	1	17		8	1		2			

Wayne County

Wayne County 911 570-253-3109

Service	ALS	ALS Squad	BLS	4x4 Ambulance	QRS	Bariatric	W/C Vans	MCI Traler	ATV/ Golf Cart/ UTV	UTV Transport	Golf Cart Transport
Damascus Twp. EMS			2			2					
Gouldsboro EMS			1								
Hamlin Ambulance			3		2						
Hawley Ambulance			1	1							
Maplewood Fire QRS					1						
Newfoundland Ambulance			2			1					
Northern Wayne EMS			1	2						1	
Pleasant Mount EMS			1								
Tusten Ambulance			2								
White Mills Fire EMS			2								
			15		3						

Wyoming County

Wyoming County 911 570-836-6161

Service	ALS	ALS Squad	BLS	4x4 Ambulance	QRS	Bariatric	W/C Vans	MCI Traler	ATV/ Golf Cart/ UTV	UTV Transport	Golf Cart Transport
Factoryville Fire EMS			1					1			
FWM EMS			2	1							
Lake Winola EMS			2	1		2					
Meshoppen Fire/ EMS			2	2							
Noxen Ambulance			1	1		1					
Tunkhannock Ambuance			3	2		1		1			
Wyoming County EMA								1			
			11			4		3			

INCIDENT BRIEFING (ICS 201)

1. Incident Name:	2. Incident Number:	3. Date/Time Initiated: Date: Time:

4. Map/Sketch (include sketch, showing the total area of operations, the incident site/area, impacted and threatened areas, overflight results, trajectories, impacted shorelines, or other graphics depicting situational status and resource assignment):

5. Situation Summary and Health and Safety Briefing (for briefings or transfer of command): Recognize potential incident Health and Safety Hazards and develop necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards.

6. Prepared by: Name: _____ Position/Title: _____ Signature: _____

 Date/Time: _____

INCIDENT BRIEFING (ICS 201)

1. Incident Name:	2. Incident Number:	3. Date/Time Initiated: Date: Time:

7. Current and Planned Objectives:

8. Current and Planned Actions, Strategies, and Tactics:

Time:	Actions:

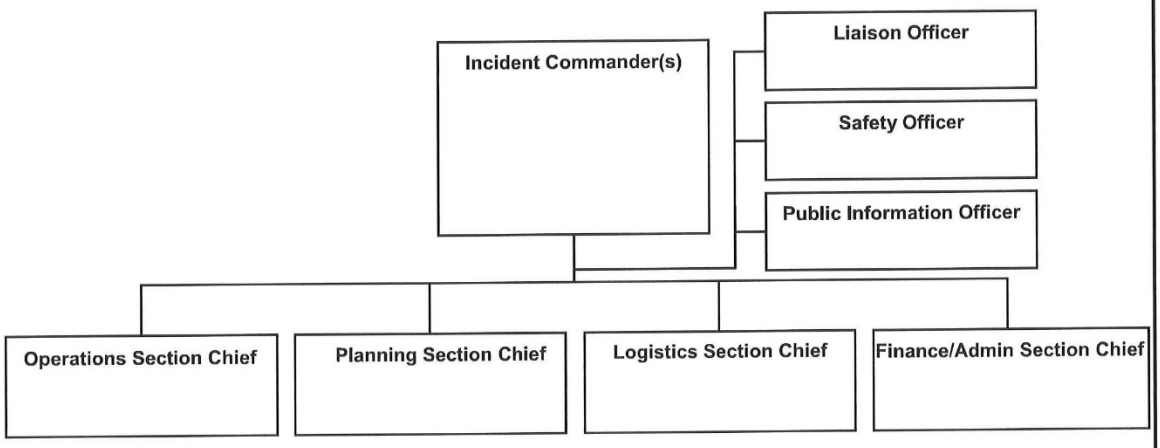
6. Prepared by: Name: _____ Position/Title: _____ Signature: _____

Date/Time: _____

INCIDENT BRIEFING (ICS 201)

1. Incident Name:	2. Incident Number:	3. Date/Time Initiated: Date: Time:

9. Current Organization (fill in additional organization as appropriate):



6. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 201, Page 3 Date/Time: _____

INCIDENT BRIEFING (ICS 201)

1. Incident Name:	2. Incident Number:	3. Date/Time Initiated: Date: Time:

10. Resource Summary:

Resource	Resource Identifier	Date/Time Ordered	ETA	Arrived	Notes (location/assignment/status)
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	

6. Prepared by: Name: _____ Position/Title: _____ Signature: _____

Date/Time: _____

INCIDENT OBJECTIVES (ICS 202)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:

3. Objective(s):

4. Operational Period Command Emphasis:

General Situational Awareness

5. Site Safety Plan Required? Yes ☐ No ☐

Approved Site Safety Plan(s) Located at:

6. Incident Action Plan (the items checked below are included in this Incident Action Plan):

☐ ICS 203	☐ ICS 207	Other Attachments:
☐ ICS 204	☐ ICS 208	☐ _____
☐ ICS 205	☐ Map/Chart	☐ _____
☐ ICS 205A	☐ Weather Forecast/Tides/Currents	☐ _____
☐ ICS 206		☐ _____

7. Prepared by: Name: _____ Position/Title: _____ Signature: _____

8. Approved by Incident Commander: Name: _____ Signature: _____

ICS 202	IAP Page _____	Date/Time: _____

ORGANIZATION ASSIGNMENT LIST (ICS 203)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:

3. Incident Commander(s) and Command Staff:	
IC/UCs	
Deputy	
Safety Officer	
Public Info. Officer	
Liaison Officer	

4. Agency/Organization Representatives:	
Agency/Organization	Name

5. Planning Section:	
Chief	
Deputy	
Resources Unit	
Situation Unit	
Documentation Unit	
Demobilization Unit	
Technical Specialists	

6. Logistics Section:	
Chief	
Deputy	
Support Branch	
Director	
Supply Unit	
Facilities Unit	
Ground Support Unit	
Service Branch	
Director	
Communications Unit	
Medical Unit	
Food Unit	

7. Operations Section:		
Chief		
Deputy		
Staging Area		
Branch		
Branch Director		
Deputy		
Division/Group		
Division/Group		
Division/Group		
Division/Group		
Division/Group		
Branch		
Branch Director		
Deputy		
Division/Group		
Division/Group		
Division/Group		
Division/Group		
Division/Group		
Branch		
Branch Director		
Deputy		
Division/Group		
Division/Group		
Division/Group		
Division/Group		
Division/Group		
Air Operations Branch		
Air Ops Branch Dir.		

8. Finance/Administration Section:	
Chief	
Deputy	
Time Unit	
Procurement Unit	
Comp/Claims Unit	
Cost Unit	

9. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 203 | **IAP Page** _____ Date/Time: _____

ASSIGNMENT LIST (ICS 204)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:	3. Branch: Division: Group: Staging Area:

4. Operations Personnel: Name / Contact Number(s)

Operations Section Chief: _____

Branch Director: _____

Division/Group Supervisor: _____

5. Resources Assigned:

Resource Identifier	Leader	# of Persons	Contact (e.g., phone, pager, radio frequency, etc.)	Reporting Location, Special Equipment and Supplies, Remarks, Notes, Information

6. Work Assignments:

7. Special Instructions:

8. Communications (radio and/or phone contact numbers needed for this assignment):

Name/Function	Primary Contact: indicate cell, pager, or radio (frequency/system/channel)
/	
/	
/	
/	

9. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 204 | **IAP Page** _____ Date/Time: _____

INCIDENT RADIO COMMUNICATIONS PLAN (ICS 205)

1. Incident Name:	2. Date/Time Prepared: Date: Time:	3. Operational Period: Date From: Date To: Time From: Time To:

4. Basic Radio Channel Use:

Zone Grp.	Ch #	Function	Channel Name/Trunked Radio System Talkgroup	Assignment	RX Freq N or W	RX Tone/NAC	TX Freq N or W	TX Tone/NAC	Mode (A, D, or M)	Remarks

5. Special Instructions:

6. Prepared by (Communications Unit Leader): Name: _____ Signature: _____

ICS 205	IAP Page _____	Date/Time: _____

MEDICAL PLAN (ICS 206)

1. Incident Name:	2. Operational Period: Date From: Time From:	Date To: Time To:

3. Medical Aid Stations:

Name	Location	Contact Number(s)/Frequency	Paramedics on Site?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

4. Transportation (indicate air or ground):

Ambulance Service	Location	Contact Number(s)/Frequency	Level of Service
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS
			☐ ALS ☐ BLS

5. Hospitals:

Hospital Name	Address, Latitude & Longitude if Helipad	Contact Number(s)/ Frequency	Travel Time		Trauma Center	Burn Center	Helipad
			Air	Ground			
					☐ Yes Level:____	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes Level:____	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes Level:____	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes Level:____	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes Level:____	☐ Yes ☐ No	☐ Yes ☐ No

6. Special Medical Emergency Procedures:

☐ Check box if aviation assets are utilized for rescue. If assets are used, coordinate with Air Operations.

7. Prepared by (Medical Unit Leader): Name: _____ Signature: _____

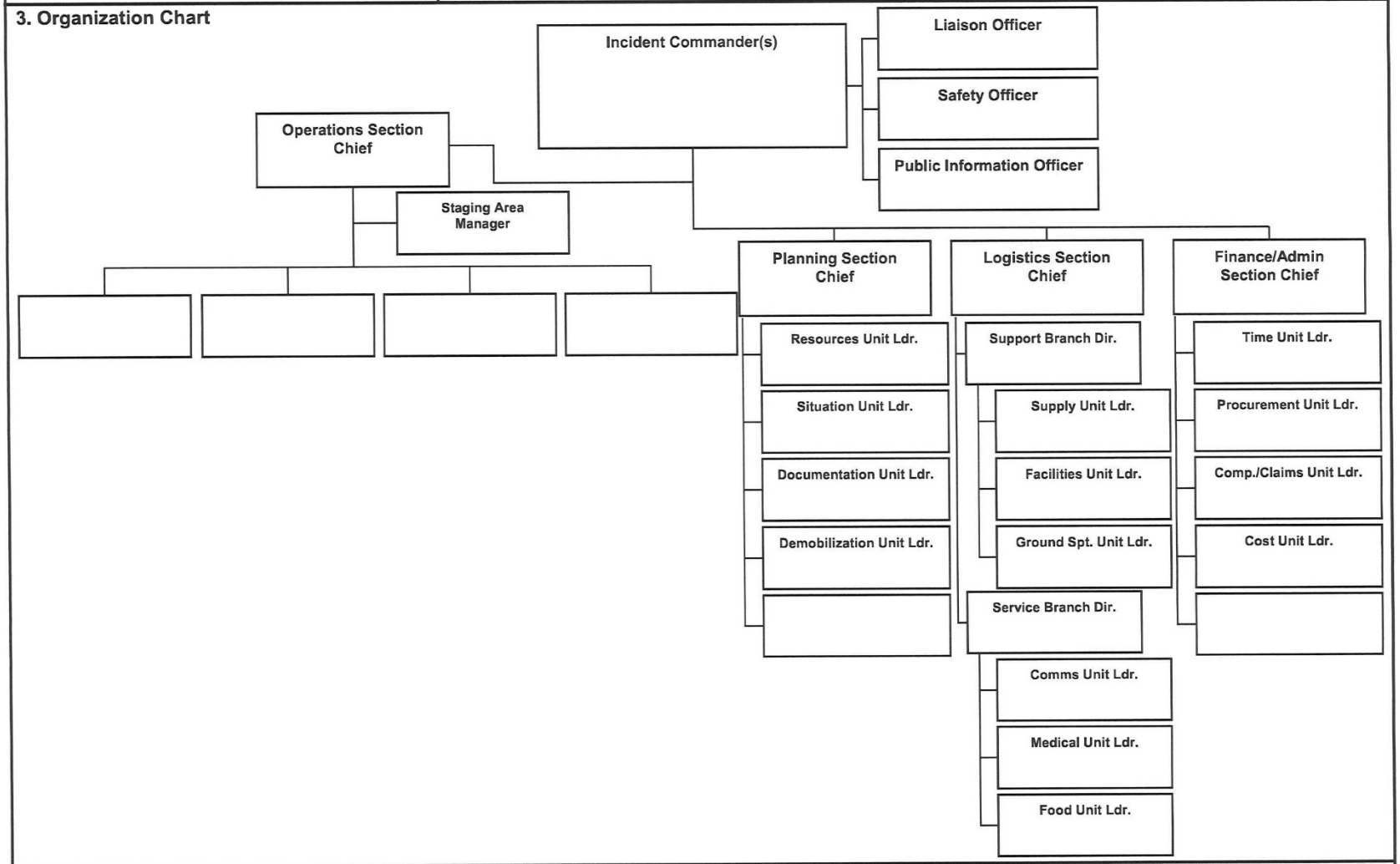
8. Approved by (Safety Officer): Name: _____ Signature: _____

ICS 206	IAP Page _____	Date/Time: _____

INCIDENT ORGANIZATION CHART (ICS 207)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:

3. Organization Chart



ICS 207	IAP Page ___	4. Prepared by: Name:_____ Position/Title: _____ Signature: _____ Date/Time: _____

SAFETY MESSAGE/PLAN (ICS 208)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:

3. Safety Message/Expanded Safety Message, Safety Plan, Site Safety Plan:

4. Site Safety Plan Required? Yes☐ No☐
Approved Site Safety Plan(s) Located At:

5. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 208	IAP Page _____	Date/Time: _____

RESOURCE REQUEST MESSAGE (ICS 213 RR)

1. Incident Name:	2. Date/Time	3. Resource Request Number:

Requestor

4. Order (Use additional forms when requesting different resource sources of supply.):

Qty.	Kind	Type	Detailed Item Description: (Vital characteristics, brand, specs, experience, size, etc.)	Arrival Date and Time		Cost
				Requested	Estimated	

5. Requested Delivery/Reporting Location:

6. Suitable Substitutes and/or Suggested Sources:

7. Requested by Name/Position:	8. Priority: ☐ Urgent ☐ Routine ☐ Low	9. Section Chief Approval:

Logistics

10. Logistics Order Number:	11. Supplier Phone/Fax/Email:
12. Name of Supplier/POC:	

13. Notes:

14. Approval Signature of Auth Logistics Rep:	15. Date/Time:

16. Order placed by (check box): ☐ SPUL ☐ PROC

Finance

17. Reply/Comments from Finance:

18. Finance Section Signature:	19. Date/Time:

ACTIVITY LOG (ICS 214)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:	
3. Name:	4. ICS Position:	5. Home Agency (and Unit):

6. Resources Assigned:

Name	ICS Position	Home Agency (and Unit)

7. Activity Log:

Date/Time	Notable Activities

8. Prepared by: Name: _____ Position/Title: _____ Signature: _____

Date/Time: _____

ACTIVITY LOG (ICS 214)

1. Incident Name:	**2. Operational Period:** Date From: Date To: Time From: Time To:

7. Activity Log (continuation):

Date/Time	Notable Activities

8. Prepared by: Name: ________________ Position/Title: ________________ Signature: ________________

ICS 214, Page 2 Date/Time: ________________________________

OPERATIONAL PLANNING WORKSHEET (ICS 215)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:

3. Branch	4. Division, Group, or Other	5. Work Assignment & Special Instructions	6. Resources													7. Overhead Position(s)	8. Special Equipment & Supplies	9. Reporting Location	10. Requested Arrival Time
			Req.																
			Have																
			Need																
			Req.																
			Have																
			Need																
			Req.																
			Have																
			Need																
			Req.																
			Have																
			Need																
			Req.																
			Have																
			Need																
			Req.																
			Have																
			Need																
		11. Total Resources Required																	
		12. Total Resources Have on Hand																	
ICS 215		13. Total Resources Need To Order																	

14. Prepared by:

Name: ______________________

Position/Title: ______________________

Signature: ______________________

Date/Time: ______________________

INCIDENT ACTION PLAN SAFETY ANALYSIS (ICS 215A)

1. Incident Name:	2. Incident Number:
3. Date/Time Prepared: Date: Time:	4. Operational Period: Date From: Date To: Time From: Time To:

5. Incident Area	6. Hazards/Risks	7. Mitigations

8. Prepared by (Safety Officer): Name: _____ Signature: _____

Prepared by (Operations Section Chief): Name: _____ Signature: _____

ICS 215A Date/Time: _____

DEMOBILIZATION CHECK-OUT (ICS 221)

1. Incident Name:	2. Incident Number:	
3. Planned Release Date/Time: Date: Time:	**4. Resource or Personnel Released:**	**5. Order Request Number:**

6. Resource or Personnel:

You and your resources are in the process of being released. Resources are not released until the checked boxes below have been signed off by the appropriate overhead and the Demobilization Unit Leader (or Planning Section representative).

LOGISTICS SECTION

	Unit/Manager	Remarks	Name	Signature
☐	Supply Unit			
☐	Communications Unit			
☐	Facilities Unit			
☐	Ground Support Unit			
☐	Security Manager			
☐				

FINANCE/ADMINISTRATION SECTION

	Unit/Leader	Remarks	Name	Signature
☐	Time Unit			
☐				
☐				

OTHER SECTION/STAFF

	Unit/Other	Remarks	Name	Signature
☐				
☐				

PLANNING SECTION

	Unit/Leader	Remarks	Name	Signature
☐				
☐	Documentation Leader			
☐	Demobilization Leader			

7. Remarks:

8. Travel Information:

Estimated Time of Departure: _____

Destination: _____

Travel Method: _____

Manifest: ☐ Yes ☐ No

Number: _____

Room Overnight: ☐ Yes ☐ No

Actual Release Date/Time: _____

Estimated Time of Arrival: _____

Contact Information While Traveling: _____

Area/Agency/Region Notified: _____

9. Reassignment Information: ☐ Yes ☐ No

Incident Name: _____

Location: _____

Incident Number: _____

Order Request Number: _____

10. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 221

Date/Time: _____

EMSNP		Staging Resource List											
Unit	Unit ID	Air Medical	ALS Transport	ALS Squad	I-ALS Transport	I-ALS Squad	BLS Transport	BLS Squad	Bariatric Unit	Stretcher Vans	Wheelchair Vans	Bus	Alternate Contact Information

EMSNP

Resource Tracking

Resource	Level of Care	Arrived at Staging	Time Assigned	Time Returned	Time Assigned	Time Returned	Time Released

EMSNP		Patient Intake Capacity			Patients Transported		
	Facility	Red Tag	Yellow Tag	Green Tag	Red Tag	Yellow Tag	Green Tag
Level 1							
Level 2							
Level 3							

EMSNP		Patient Intake Capacity			Patients Transported		
	Facility	Red Tag	Yellow Tag	Green Tag	Red Tag	Yellow Tag	Green Tag
Level 4							
General							

EMSNP	Transport Log					
Resource	Level of Care	Time Assigned	Triage Tag #	Priority	Primary Injury	Destination

EMSNP

Rehab Sheet

Name or Unit Number	Time In	Repeat Assessment	Complaints (if any)	Pulse	Blood Pressure	Treatment (if any)	Time Out