PHILADELPHIA FIRE DEPARTMENT **OPERATIONAL PROCEDURE #35 SEPTEMBER, 2015**

SUBJECT: MULTIPLE PATIENT/ MASS CASUALTY INCIDENTS

1. PURPOSE

To provide guidelines and policy for Fire Department operations at multiple patient / mass casualty incidents.

2. DEFINITIONS

2.1 CBRNE

Chemical, Biological, Radiological, Nuclear, or Explosive refers to incidents or events in which any of these five hazards have presented. CBRNE incidents are responded to under the assumption that they are deliberate, malicious acts with the intention to kill, sicken and/or disrupt society and pose an immediate and/or ongoing threat to the health and safety of human beings and/or the environment.

2.2 EMS BRANCH DIRECTOR

The EMS Branch Director is responsible for the implementation of the Incident Action Plan within the Branch. This includes the direction and execution of Branch planning for the assignment of resources within the Branch. The EMS Branch Director reports to the Operations Section Chief and supervises the Medical Group, Patient Transportation Group Supervisor, and Medical Supply Coordinator. The first arriving EMS Chief Officer on the scene will assume the role of EMS Branch Director. This position will only be implemented on Level 4 and higher MCI's.

2.3 EVERBRIDGE MASS NOTIFICATION SYSTEM

Everbridge is an emergency alert and notification system utilized by the City of Philadelphia. The system quickly and efficiently disseminates emergency notification alerts to key emergency personnel and predetermined groups during routine events, all hazards incidents, major disasters, or developing events. Everbridge is capable of alerting multiple communications devices through one action including pagers, cell phones with voicemail and text, email, and landlines.

2.4 KNOWLEDGE CENTER HEALTHCARE INCIDENT MANAGEMENT SYSTEM

Knowledge Center - HIMS is a web-based incident management system that enables users from different healthcare facilities to track incidents, enter key information that aids in maintaining situational awareness and supports the real time collection of information about available hospital beds and vital resources during an emergency.

2.5 GENERAL STAFF

A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Logistics Section Chief, Planning Section Chief, and Finance/Administration Section Chief.

2.6 HASTE SYSTEM

The HASTE System is an abbreviation for the Hospital Alert System-Tone Encoded. The HASTE System is a VHF Low Band radio frequency used to notify the hospitals of incoming critical patients. The HASTE System is utilized for one-way communication only, from the Fire Communications Center to the hospitals.

2.7 HAZARDOUS MATERIALS

A hazardous material is any material which, when released from its container, poses a threat to the health and safety of human beings and/or the environment.

2.8 INCIDENT COMMANDER (IC)

The person in charge of the emergency incident or planned event. The IC is responsible for the command function at all times. As the identity of the IC changes through transfers of command, this responsibility shifts with the title. The term “Command” in this procedure refers jointly to both the person and the function. This individual is responsible for the overall management of all incident activities including the development and implementation of strategy. As the incident becomes more complicated and/or progresses to multiple alarm status, the IC should begin to delegate some of the responsibilities of the incident to other personnel. In all cases, the primary responsibility of the IC is the safety of all persons involved in the incident, whether they are members, non- members, representatives of other agencies, news media, observers, etc. The IC should be aware of existing conditions and the potential for rapidly deteriorating conditions regarding both interior and exterior operations that are present at the scene of an emergency.

The Incident Commander will initially be the first arriving company officer, replaced by the first arriving Battalion Chief until relieved by a higher ranking officer.

2.9 INCIDENT SAFETY OFFICER (ISO)

An officer responsible for monitoring and assessing hazardous and unsafe situations and for developing measures to assure personnel safety. The ISO will also assist the IC in the monitoring and accounting of members during all emergency operations. The ISO can be designated to oversee but not direct an emergency evacuation or RIT deployment. The ISO will be assigned by the IC.

2.10 LIAISON OFFICER (LNO)

An officer designated to act as the control point for all outside agencies. This will initially be staffed by a Battalion Chief or Assistant Fire Marshal as assigned by the IC. When a representative of the Office of Emergency Management (OEM) responds, they will fill the role of LNO. Representatives from outside agencies report their arrival to the Field Communication Unit or the Incident Command Post (ICP) and meet with the LNO.

2.11 LOGISTICS SECTION CHIEF (LSC)

This member of the General Staff is responsible for providing facilities, services, and materials in support of the incident from Department resources and outside agencies. This support will include water supply, air supply, communications support, and rest and rehabilitation support. The LSC will be the 1st in Battalion Chief on the 2nd alarm.

2.12 MASS CASUALTY INCIDENT (MCI)

An incident resulting from manmade or natural causes resulting in injuries or illness that may exceed the EMS and hospital capabilities of a locality, jurisdiction or region. There are five levels of Mass Casualty Incidents for the PFD.

2.13 MCI LEVEL FIVE (5)-INITIAL RESPONSE

A LEVEL FIVE Mass Casualty Incident is a declared event defined as any incident involving a number of surviving patients which requires 6 ambulances, an ACCIDENT RESPONSE (1 Engine, 1 Ladder, 1 SOC Company,1 Battalion Chief) an EMS Field Operations Supervisor (ES-8/9/10/11) and the EMS Field Operations Captain (ES-6) . It will require activation of KC HIMS, HASTE, and Everbridge systems for alerting hospitals. It will also require partial implementation of the Incident Command System

(ICS). A LEVEL FIVE MCI will be handled exclusively by the PFD.

2.14 MCI LEVEL FOUR (4)-REINFORCED RESPONSE

A LEVEL FOUR Mass Casualty Incident consists of all of the resources dispatched on a LEVEL FIVE in addition to a full box alarm, 6 additional ambulances for a total of 12, 2 additional EMS Field Operations Supervisors (ES-8/9/10/11) and the EMS Operations Chief (ES-3). A LEVEL FOUR Mass Casualty Incident involves a sufficient number of surviving patients as to require expanded implementation of the Incident Command System (ICS) and activation of the KC HIMS, HASTE, and Everbridge systems for alerting hospitals. A LEVEL FOUR Mass Casualty Incident will be handled exclusively by the PFD.

2.15 MCI LEVEL THREE (3)-FULL RESPONSE

A LEVEL THREE Mass Casualty Incident consists of all of the resources dispatched on a LEVEL FOUR in addition to a 2nd alarm assignment, 6 additional ambulances for a total of 18, a mass casualty response vehicle, and the activation of EMS staff officers. A LEVEL THREE MCI involves a sufficient number of surviving patients as to require full implementation of the Incident Command System (ICS), activation of the KC HIMS, HASTE, and Everbridge systems for alerting hospitals, and may require the assistance from outside agencies. It will also require deployment of EMS Staff Officers.

2.16 MCI LEVEL TWO (2)

A LEVEL TWO Mass Casualty Incident consists of all of the resources dispatched on a LEVEL THREE in addition to 6 additional ambulances for a total of 24, additional alarm assignments at the discretion of the IC. A LEVEL TWO MCI involves a sufficient number of surviving patients as to require full implementation of the Incident Command System (ICS), activation of the KC HIMS, HASTE, and Everbridge systems for alerting hospitals, and will require assistance from outside agencies. It will also require deployment of EMS Staff Officers.

2.17 MCI LEVEL ONE (1)-MASS CASUALTY DISASTER (MCD)

A LEVEL ONE Mass Casualty Incident consists of all of the resources dispatched on a LEVEL TWO in addition to a minimum of 6 additional ambulances for a total of at least 30. Additional resources will be requested at the discretion of the IC. A LEVEL ONE MCI will be classified as a MASS CASULATY DISASTER (MCD) and will require expanded

implementation of the Philadelphia Incident Command System. It will also require deployment of EMS Staff Officers.

2.18 MASS CASUALTY VEHICLE-MASS CASUALTY-1 (MC-1) and MASS CASULATY-2 (MC-2)

An apparatus stocked with additional medical supplies and equipment for use at a Mass Casualty Incident. MC-1 is located in Division 1 and MC-2 is located in Division 2. See Addendum #3 for contents of each vehicle. MC-1 carries traditional mass casualty supplies for trauma as well as portable shelters with lighting and heaters/air conditioners. MC-2 carries supplies for WMD incidents including pharmaceuticals for exposure to nerve agents, cyanide, and hydrofluoric acid.

2.19 MEDICAL COMMUNICATIONS COORDINATOR

The Medical Communications Coordinator (MCC) reports to the Patient Transportation Group Supervisor, supervises the Transportation Recorders, and maintains communications with the FCC. The MCC will receive information on hospital bed availability via KC HIMS and use it to ensure proper patient distribution and destination selection for patients leaving the scene. They also coordinate information between the Patient Transportation Group Supervisor and the Patient Treatment Manager. On a Level 5 MCI the first arriving EMS Field Operations Supervisor will fill the role of Transportation Group Supervisor and Medical Communications Coordinator and will report directly to the IC.

2.20 MEDICAL GROUP SUPERVISOR

The Medical Group Supervisor reports to the EMS Branch Director, once established, and supervise the Triage Unit Leader and Treatment Unit Leader. The position will be filled by the EMS Field Operations Captain (ES-6).

2.21 MEDICAL SUPPLY COORDINATOR

The Medical Supply Coordinator reports to the EMS Branch Director and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group including Mass Casualty Response Vehicles (MC-1 and MC-2). This position will be filled by the Engine Officer of the Medical Supply Support Company until relieved by an EMS Equipment staff member or Paramedic. This position will not be staffed for a Level 5 or 4 MCI unless a Mass Casualty Response Vehicle is requested.

2.22 MEDICAL SUPPLY SUPPORT COMPANY

An Engine or Ladder Company who is assigned by the FCC to deliver the Mass Casualty Response Vehicle (MC-1 or MC-2) to the incident scene. The Engine or Ladder Company will assume the function of Medical Supply Support Company.

2.23 MORGUE MANAGER

The morgue manager reports to the Triage Unit Leader and assumes responsibility for Morgue Area functions until properly relieved by Medical Examiner's office. This position will be established as needed.

2.24 MULTIPLE CASUALTY INCIDENT CBRNE (MCI CBRNE)

Any incident where it has been determined that a chemical, biological, radiological, nuclear, or explosive agent has been released, or discovered. A MCI CBRNE can exist at any level, i.e., MCI Level 5 CBRNE or MCI Level 4CBRNE.An MCI CBRNE may require operations to conform to OP #2, Hazardous Materials.

2.25 MULTIPLE PATIENT INCIDENT

A multiple casualty incident is any incident involving more than one patient, but the incident is able to be handled and mitigated using the normal resources available to the PFD, such as requesting additional ambulances. A multiple patient incident for the PFD will be any incident utilizing 2 to 5 ambulances.

2.26 OPERATIONS SECTION CHIEF (OSC)

This member of the General Staff is responsible for the management of all operations directly applicable to the primary mission and ensuring the overall safety and welfare of all Section personnel. The OSC activates and supervises organization elements in accordance with the IAP and directs its execution. The OSC also directs the preparation of unit operational plans, requests or releases resources, makes expedient changes to the IAP as necessary, and reports such to the IC and implements the tactics necessary to achieve the IC's strategic plan. The OSC supervises the tactical operations of Branch level activities. Additional resources if activated also report to the OSC. The Operations Section Chief will be the 1st in Battalion Chief on initial assignment, after being relieved as Incident Commander by higher ranking officer.

2.27 PATIENT TRANSPORTATION RECORDER(S)

This position is established when demands of the incident require and the transport function is needed. The Patient Transport Recorder(s) works in patient transportation loading area with the Treatment Dispatch Manager to record patient information data prior to patients being transported to a hospital or medical facility. They will be assigned from the pool of available personnel by the IC and do not need to be certified medical providers. Paramedics are not to be used in this role.

2.28 PATIENT TRANSPORTATION GROUP SUPERVISOR

The Patient Transportation Group Supervisor reports to the EMS Branch Director and the Medical Communications Coordinator, and is responsible for the coordination of patient transportation and maintenance of records relating to patient identification, injuries, and destination. The Patient Transportation Group Supervisor will be the second arriving EMS Supervisor.

2.29 PATIENT TREATMENT MANAGER(S)

The Patient Treatment Manager reports to the Treatment Unit Leader and is responsible for the treatment and re-triage of patients assigned to the Patient Treatment Area. A Patient Treatment Manager will be assigned to manage the Priority 1 (RED) section, Priority 2 (YELLOW) section, and Priority 3 (GREEN) section of the Patient Treatment Area by the Treatment Unit Leader as needed. The Red Section Treatment Area Manager will be the Attendant on the 2nd arriving ambulance. The Yellow Section Treatment Manager will be the Driver of the 2nd arriving ambulance. The Green Section Treatment Manager will be the driver of the 3rd arriving ambulance. Consideration should be given to using paramedics if available in Treatment Area Manager positions.

2.30 TRIAGE PHYSICIAN / TRIAGE PHYSICIAN TEAM

The Triage Physician will be an emergency medicine physician with State-certification as a medical command physician, who works at a Medical Command Hospital. If necessary, the Triage Physician may be assisted by additional physicians and nurses. All members of a Triage Physician Team should be capable of prehospital triage and patient stabilization. Physician triage should be utilized whenever the number and/or severity of patients exceed the capability of available Fire Department personnel, or whenever the Incident Commander determines the expertise of a physician would be beneficial to a particular incident.

2.31 PUBLIC INFORMATION OFFICER (PIO)

A Department spokesperson responsible for the gathering and release of information about the emergency incident to the news media and other appropriate agencies and organizations, as dictated by the IC.

2.32 STAGING AREA MANAGER (SAM)

An officer will be assigned by the Operations Section Chief to manage the Staging Area. This officer will ensure that the units assigned to the Staging Area are deployed as directed by the IC or OSC.

2.33 SURGICAL RESPONSE TEAM

A Surgical Response Team will be composed of an attending trauma or orthopedic surgeon, or specially trained prehospital emergency physician and may have one assistant. All members of a Surgical Response Team should be capable of performing surgical procedures on confined victims. Surgical Response Teams should be utilized when surgical intervention is required at the scene of an incident; e.g., the amputation of an entrapped body part, etc.

2.34 TRANSPORT LOADERS

Transport Loader(s) report to the Patient Transportation Group Supervisor or Air Operations Officer as directed. The position is established when demands of the incident require and the transport functions are needed. Transport Loaders will work in the patient / transportation loading area with Treatment Dispatch Manager.

2.35 TREATMENT DISPATCH MANAGER

The Treatment Dispatch Manager reports to the Treatment Unit Leader and is responsible for coordinating, with the Patient Transportation Group Supervisor, the movement of patients out of the Treatment Area to loading locations The Treatment Dispatch Manager will be the attendant on the 3rd arriving ambulance.

2.36 TREATMENT UNIT LEADER

The Treatment Unit Leader reports to the Medical Group Supervisor and assigns and supervises the Treatment Managers, Treatment Dispatch manager, and Treatment Support personnel. The Treatment Unit Leader assumes responsibility for coordination of patient treatment in the Treatment Areas and preparation of patients for transport. The Treatment Unit Leader will initially be the attendant on the 1st in Ambulance and will continue in this role until relieved by an EMS Officer.

2.37 TRIAGE UNIT LEADER

The Triage Unit Leader reports to the Medical Group Supervisor and supervises Triage Support Personnel/Litter Bearers and the Morgue Manager. The Triage Unit Leader will initially be the driver of the 1st in Ambulance who will be responsible for ensuring that appropriate triage of all patients is initiated. They will continue in this role until relieved by an EMS Officer.

2.38 TRIAGE and TREATMENT SUPPORT PERSONNEL

Triage and Treatment Support Personnel will assist with performing patient triage, providing treatment, and participating in movement of patients between Triage, Treatment, and Transportation Areas. They will be comprised of additional personnel from fire suppression units and ambulance personnel who will report to the Triage Unit Leader or Treatment Unit Leader. The IC will assign personnel when requested by the EMS Branch Director or Medical Group Supervisor.

2.39 TRIAGE TAG

A color coded tag indicating the severity of an injury sustained by a person after a multiple patient incident or mass casualty incident. The triage tag is usually affixed to the injured person on the wrist or ankle. A colored light may also be used at night or in poor lighting conditions. The triage tags priority level and corresponding color is as follows: Priority 1 (RED), Priority 2 (YELLOW), Priority 3 (Green) and DEAD (BLACK).

3. RESPONSIBILITY

3.1 MEMBERS

3.1.1 It will be the responsibility of each member to exercise the appropriate control dictated by their rank in the implementation of this operational procedure.

3.1.2 In any MCI, consideration must be given to the potential of hazardous materials and the need for appropriate personal protective equipment (PPE) and for decontamination of patients.

3.2 INCIDENT COMMANDER (IC)

3.2.1 The INCIDENT COMMANDER (IC) is responsible for the development and implementation of strategy. The IC approves or disapproves requests for resources and the release of same. The IC is also responsible for the overall welfare and safety of all responders, the immediate public and all activities occurring at the incident scene.

3.2.2 A primary consideration of the IC is the safety and accountability of all members which will be achieved through the appropriate control and monitoring of personnel operating on the incident scene. All measures regarding interior and exterior operations are absolutely critical for the safety of all involved. This may require a significant number of dedicated safety resources.

3.2.3 The initial IC will be first arriving company officer until relieved by the first arriving Battalion Chief. As the IC transfers "Command" to a new IC, that individual will give the new IC a complete and up to date "face to face" briefing on the incident status, and account for all members on the incident scene. The relieving IC should conduct a 360 degree assessment of the incident, physically if possible or by radio communications.

3.2.4 The IC will also ensure that all personnel utilize all appropriate Personal Protective Equipment (PPE) including Self Contained Breathing Apparatus (SCBA).

3.2.5 Additional responsibilities of the IC include:

a. All of the command staff functions when they are not staffed.

b. All of the general staff functions when they are not staffed.

c. Assessment of the incident priorities.

d. Naming the incident (The address of the incident will be used).

e. Establishing the Incident Command Post (ICP).

f. Determining the strategic goals of the incident.

g. Develop and/or approve and implement the Incident Action Plan (IAP).

h. Develop an incident command structure appropriate for the incident.

i. Create Divisions and Groups as needed.

j. Brief Section Chiefs and Division/Group Supervisors of the IAP.

k. Authorize release of information to news media.

l. Termination of the incident.

3.3 OPERATIONS SECTION CHIEF (OSC)

3.3.1 The Operations Section Chief (1st In Battalion Chief on 1st alarm, after being relieved as Incident Commander) will:

a. Designate a staging area for all incoming emergency vehicles. Patient transport vehicles should be staged separate from all other apparatus.

b. Ensure that all patient transport vehicles are left unlocked with the keys remaining in the vehicle.

c. Establish a pool of qualified PFD drivers to drive Ambulances from the incident to a hospital. Ensure that after transporting patients to a hospital, the ambulances return to the staging area, if ordered back to the incident. Transportation of members back to the scene to restore companies will be coordinated through the FCC. Paramedics should not be utilized to drive ambulances.

d. If a hazardous materials incident, have the FCC notify the hospitals to prepare for contaminated patients who may self-refer to the hospitals nearest the incident.

e. Designate the location of the Patient Treatment Area.

f. Designate the location of the Patient Transportation Area.

g. Allocate personnel and equipment as needed.

h. Designate the driver EMT or Paramedic on the 1st in ambulance to act as Triage Unit Leader.

i. Keep the Incident Commander apprised as to the need for additional transport vehicles.

j. Designate an Air Operations Officer if needed to facilitate the use of medical helicopters if their use is anticipated.

3.4 LOGISTICS SECTION CHIEF (LSC)

3.4.1 The Logistics Officer, the 1st in Battalion Chief on the 2nd alarm will:

a. Establish a security perimeter around the staging area(s), in conjunction with the ranking police supervisor.

b. Ensure that all incoming companies report to the appropriate staging areas.

c. Coordinate with the Treatment Unit Leader and the Patient Transportation Group Supervisor the need for air transportation of patients and if necessary, establish a landing zone as described in Operational Procedure #25.

d. Arrange for alternative patient transportation vehicles such as mass transit (SEPTA) buses, ferries/watercraft, etc, as required and requested by the Incident Commander.

e. Designate an appropriate site for rest and rehab as described in Operational Procedure #19.

f. Determine the need for and identify a suitable location for a temporary and/or protected shelter. Make recommendation to the IC.

3.5 INCIDENT SAFETY OFFICER (ISO)

3.5.1 The Incident Safety Officer is assigned on the 2nd Alarm or as designated by the Incident Commander. The ISO will:

a. Confirm that a security perimeter has been established.

b. Assist the Incident Commander in providing for the general safety and welfare of all personnel at the incident.

c. Identify hazardous and/or potentially unsafe situations associated with the incident and inform the Incident Commander.

d. Exercise emergency authority to stop and prevent unsafe acts.

e. Ensure that apparatus placement and positioning is monitored for safety.

f. Establish safe corridors of operation as required.

g. Ensure adequate relief of personnel.

3.6 PUBLIC INFORMATION OFFICER (PIO)

3.6.1 The Public Information Officer, as designated by the Incident Commander will:

a. Coordinate public information activities in cooperation with the Incident Commander.

b. Prepare an initial information summary as soon after arrival as possible.

c. Obtain approval for information release from the Incident Commander and coordinate with the Liaison Officer (LNO) to protect sensitive information.

d. In coordination with the ranking Police Supervisor, establish a marshalling area for all media personnel.

e. On large incidents or events of long duration, keep media personnel apprised of changes in the incident by conducting periodic press briefings.

3.7 LIAISON OFFICER (LNO)

3.7.1 The Liaison Officer will be an officer/individual designated to act as the control point for all outside agencies:

a. The position may be staffed by a fire officer or representative from the Office of Emergency Management (OEM).

b. Coordinate with the Public Information Officer, the Department's interaction with outside agencies.

3.8 EMS BRANCH DIRECTOR

3.8.1 The EMS Branch Director will be the first arriving EMS Chief Officer at the scene. The EMS Branch Director will:

a. Report to the IC and or Operations Section Chief.

b. Be responsible for the implementation of the Incident Action Plan within the Branch.

c. Review Group assignments for effectiveness of current operations and modify as needed.

d. Direct and execute Branch planning for the assignment of resources within the Branch and ensure required MCI positions are filled within Branch.

e. Supervise Branch activities.

f. Supervise the Medical Group Supervisor.

g. Supervise the Patient Transportation Group Supervisor.

h. Supervise the Medical Supply Coordinator.

i. Will expand Group Supervisors as needed.

j. Maintain log of activity.

k. Consider moving EMS Operations to a Tac Channel as necessary to avoid overloading the incident channel.

3.9 MEDICAL GROUP SUPERVISOR

3.9.1 The Medical Group Supervisor will be the EMS Operations Captain (ES-6) and will:

a. Establish command and controls the activities within the Medical Group, in order to assure the best possible emergency medical care to patients during a multiple patient or mass casualty incident.

b. Assign arriving PFD medically trained personnel to positions as needed and request additional personnel and resources sufficient to manage the magnitude of the incident.

c. Designate Triage and Treatment Unit Leaders and Treatment Area Managers if not previously assigned.

d. Ensure that effective triage has been initiated following any needed decontamination.

e. Designate, if not previously established by the Operations Section Chief, a suitable area for the Patient Treatment Area and ensure command and control of same.

f. Determine the need for additional Triage and Treatment Unit Leaders.

g. Determine the need for a Physician Triage Team and/or Surgical Response Team (EMS OP # 6)

h. Maintain log of activity.

3.10 TRIAGE UNIT LEADER

3.10.1 The Triage Unit Leader will:

a. Direct incoming EMS/Fire personnel to assist in the triage of patients as needed.

b. Ensure that triage tag system is utilized.

c. Request additional support personnel to assist in the triage efforts as needed.

d. Request sufficient equipment and supplies to triage and move patients.

e. Establish stockpile of patient moving devices and supplies in conjunction with the Medical Supply Coordinator.

f. Direct patients to be moved to the Patient Treatment Area after all patients have been triaged.

g. Coordinate movement of patients from the Triage Area to the Treatment Area.

h. Provide periodic status and progress reports to the Medical Group Supervisor of number and classification of patients triaged.

i. Maintain log of activity.

3.11 TRIAGE AND TREATMENT SUPPORT PERSONNEL

3.11.1 Triage and Treatment Support Personnel will:

a. Triage and tag injured patients

b. Provide appropriate medical treatment (ABC's) to patients prior to movement as incident conditions dictate.

c. Firefighter/EMTs will be used to provide BLS treatment and or serve as litter bearers.

d. Non-EMT firefighters will work in pairs as litter bearers.

e. Firefighter/EMTs, Fire Service Paramedics and/or Fire Service EMTs will assist in the triage, secondary triage, and treatment of victims in their assigned area.

3.12 MORGUE MANAGER

3.12.1 The Morgue Manager will:

a. Establish a location for a temporary Morgue.

b. Assess resource/supply needs and order as needed through Triage Unit Leader.

c. Coordinate all Morgue Area activities.

d. Keep area off limits to all unauthorized personnel with the assistance law enforcement as needed.

e. Ensure that identity of deceased persons is kept confidential as much as possible.

3.13 TREATMENT UNIT LEADER

3.13.1 The Treatment Unit Leader will:

a. Take charge of patients arriving at the Patient Treatment Area, ensuring that each arriving patient has been appropriately tagged and receives secondary triage.

b. Designate Treatment Managers for the Priority 1 (RED), Priority 2 (YELLOW), Priority 3 (GREEN) Treatment Areas. The Red Treatment Area Manager will be the Attendant on the 2nd arriving ambulance. The Yellow Treatment Manager will be the Driver of the 2nd arriving ambulance. The Green Treatment Manager will be the driver of the 3rd arriving ambulance. Consideration should be given to using paramedics if available in Treatment Area Manager Positions.

c. Request additional personnel and resources sufficient to manage Treatment Area.

d. Organize patients by triage priority for appropriate treatment and expedient transport. Ensure that reassessment of patients is performed on a continual basis in all Treatment Areas.

e. Coordinate with the Patient Transportation Group Supervisor for the transportation of patients to the appropriate hospitals.

f. Continually assess the medical needs of the incident and request additional resources through the Medical Group Supervisor.

g. Utilize all available medical resources, including the physician triage team, to initiate treatment of patients in the Patient Treatment Area.

h. Maintain log of activity.

3.14 PATIENT TREATMENT MANAGER(S)

3.14.1 The Patient Treatment Manager(s) will:

a. Request support personnel and resources as needed through the Patient Treatment Unit Leader to assist in designated treatment area.

b. Assign treatment personnel to patients received in the Patient Treatment Area.

c. Ensure that patients are re-triaged after arriving in the Patient Treatment Area.

d. Ensure that patients are thoroughly assessed and triage tags are attached and completed appropriately.

e. Ensure treatment of patients received in the Patient Treatment Area.

f. Coordinate transportation of patients with Treatment Unit Leader and or Treatment Dispatch Manger.

g. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.

h. Ensure that patients are prioritized and prepared for transport to a hospital as needed.

i. Provide periodic status and progress report to Treatment Unit Leader.

3.15 TREATMENT DISPATCH MANAGER

3.15.1 The Treatment Dispatch Manager will:

a. Establish communications with the Priority 1 (RED), Priority 2 (YELLOW), and Priority 3 (GREEN) Treatment Managers.

b. Establish communications with the Patient Treatment Group Supervisor.

c. Verify that patients are prioritized for transportation.

d. Advise Medical Communications Coordinator of patient readiness and priority for transport.

e. Coordinate the transportation of patients with the Medical Communications Coordinator.

f. Ensure that appropriate patient tracking information is recorded if not already done or established by the Transportation Recorder.

g. Coordinate ambulance loading with the Treatment Managers, ambulance personnel and or Transport Loaders.

3.16 MEDICAL SUPPLY COORDINATOR

3.16.1 The Medical Supply Coordinator will:

a. Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group.

b. Request additional medical supplies as needed.

c. Distribute medical supplies and equipment to the Triage and Treatment Units.

d. Maintain log of activity.

3.17 MEDICAL SUPPLY SUPPORT COMPANY

3.17.1 The Medical Supply Support Company will:

a. Deliver Mass Casualty Response Vehicle to incident scene, parking in close proximity of Patient Treatment Area.

b. Assist the Medical Supply Coordinator

c. Facilitate the movement of medical supplies and equipment to the Triage and Treatment areas as requested

3.18 PATIENT TRANSPORTATION GROUP SUPERVISOR

3.18.1 Patient Transportation Group Supervisor will be the 2nd arriving EMS Field Operations Officer (ES-8/9/10/11) assisted by an EMT or Paramedic and will:

a. Coordinate with the Logistics Officer and the police supervisor to determine the location of a designated area for the staging of all patient transportation vehicles. Staging of patient transportation vehicles should be in close proximity to the Patient Treatment Area when possible.

b. Work closely with the Treatment Dispatch Manager and Medical Communications coordinator to coordinate the orderly transport of patients from the Patient Treatment Area to the appropriate hospitals when they are readied for transport.

c. Ensure that paramedics are not utilized to drive ambulances to the hospital. All paramedics should be used to provide treatment, either in the Patient Treatment Area or in the patient compartment of the ambulance.

d. Maintain records to reflect vehicles utilized for patient transport, patient allocation to area hospitals, and current hospital capabilities.

e. Ensure that patient information and hospital destination is recorded.

f. Request updates on hospital capabilities and availability from the Medical Communications Coordinator, and provides the Medical Communications Coordinator updates on hospitalized.

g. Ensure that victims are transported to appropriate hospitals. Whenever possible, Priority 1 (Red) Tag patients should be distributed to trauma centers. If there are entrapped Priority 1 (Red) tag patients, consideration may be given to holding beds at the closest trauma center(s) for them. Priority 3 (Green) tag patients can be transported to more distant hospitals. Do not overload any individual hospital, if possible.

h. Consideration should be given to refrain from transporting patients to the closest hospital. In a MCI, the closest hospital is often overwhelmed with patients who self-refer or who are transported there by private vehicles.

i. Request additional ambulances and or other transportation vehicles as needed from the EMS Branch Director.

j. Establish a checkpoint through which all patient transport vehicles must depart.

k. Ensure proper coordination is maintained with Staging Area Manager.

l. Establish and maintain communications with the LZ Control Officer when necessary in accordance with OP #25, Utilization of Helicopters for Medical Transport.

m. At the departure checkpoint, the Patient Transportation Group Supervisor or Patient Transport Recorders will:

(1) Remove and retain the appropriate detachable portion of the triage tag by removing it from the sleeve and unfolding the tag, and ensure that the required information is properly recorded on the tag.
(2) Record on the tag the transporting unit, the triage priority of the patient, time, and the receiving hospital.
(3) Advise the driver of the transport vehicle which hospital to transport the patient to and provide directions if needed.
(4) Record on the tag the time of departure for each transporting unit and notify the FCC of the number of patients, categories of the patients being transported and the receiving hospital.
(5) The F.C.C. will use this information to notify the hospital of the incoming patients.
(6) Maintain custody of the removed portion of the triage tag to later provide total count of patients transported and or triaged.

n. Maintain log of activity.

3.19 MEDICAL COMMUNICATIONS COORDINATOR

3.19.1 The Medical Communications Coordinator will be the first arriving EMS Supervisor and will:

a. Establish communications with the FCC.

b. Determine and maintain current status of hospital/medical facility availability and capability.

c Receive basic patient information and injury status from Treatment Dispatch Manager.

d. Communicate hospital availability to Treatment Dispatch Manager, and Transportation Group Supervisor.

e. Coordinate patient hospital destination with FCC.

f. Communicate patient transportation needs to Patient Transportation Group Supervisor based upon request from Treatment Dispatch Manager.

g. Maintain log of activity.

3.20 PATIENT TRANSPORTATION RECORDER(S)

3.20.1 The Patient Transportation Recorder will:

a. Assist Patient Transportation Group Supervisor as needed

b. Maintains appropriate incident documentation relating to the patients transported from the scene, to include:
   (1) triage tag / assigned tag number
   (2) ensure triage tag / documentation is attached to the patient
   (3) transporting unit
   (4) number of patients being transported by unit
   (5) hospital destination
   (6) transporting triage status, age, sex, chief complaint and ETA

c. Provide patient information to Medical Communications Coordinator as needed.

3.21 TRANSPORT LOADERS

3.21.1 Transport Loader(s) will:

a. Coordinate activities with Treatment Dispatch Manager.

b. Ensure patients selected for transportation are:
   (1) Ready for movement
   (2) Loaded on the correct transport unit cross checked by the Recorder and Patient Transportation Group Supervisor for the correct triage tag information.

4. PROCEDURES

4.1 The first arriving PFD unit on scene at an MCI will:

a. Give initial report to FCC, including the exact location and nature of incident i.e., motor vehicle crash, mass transit accident, building collapse, etc., and the approximate number of victims involved to determine the appropriate level of MCI to declare.

b. Notify the FCC of what MCI level is being declared.

c. Establish command until relieved.

d. Identify and/or report any fire suppression, environmental hazards (CBRNE) or decontamination needs.

e. Request additional resources as needed

f. Identify and establish a staging area.

g. Initiate triage utilizing triage tags and immediate life saving efforts.

4.2 The first arriving ambulance will:

a. Report to the Incident Commander

b. The Driver EMT or Paramedic will assume the role of Triage Unit Leader and will ensure that triage tags are utilized.

c. The Attendant will establish the Treatment Area and assume the role of Treatment Area Manager until relieved by an EMS Operations Officer

4.3 INCIDENT COMMAND POST (ICP)

The field location at which the primary tactical-level, on-scene incident command functions are performed. The ICP may be co-located with the incident base or other incident facilities and is normally identified by a red rotating or flashing light.

4.3.1 A command post will be established by the first-in Battalion Chief, who will be the Incident Commander(IC) until relieved by a higher-ranking fire officer.

4.3.2 The command post will be the decision making hub and coordinating point for all on-site emergency operations.

4.3.3 All arriving key personnel will be directed to the command post.

4.3.4 A Field Communications Unit will be dispatched to serve as the field communications center.

4.4 SECURITY PERIMETER

4.4.1 In coordination with the ranking police officer, the Incident Commander or Incident Safety Officer will ensure that a security perimeter will be established to prevent unauthorized entry and interference with on-site operations.

4.4.2 The security perimeter, if possible, should encompass all essential PFD operations such as Staging, the Patient Treatment Area, the Rest and Rehab area, etc.

4.5 STAGING

This area operates under the direction of the IC or the OSC when activated. Staging can be classified under two levels. Level 1 Staging is achieved when the order, "proceed in and standby" is given. Level 2 Staging is a specific and clear area (street, parking lot, etc.) in close proximity to, but not a part of, the emergency incident where apparatus, personnel and equipment that are not as yet committed may be assembled to await instructions from the IC. Units in Staging should be immediately deployable within three minutes. When Level 2 Staging is employed the IC or the OSC will assign a Staging Area Manager (SAM). This will typically be an officer of a unit already in Staging. The SAM will ensure that the assigned units are in Staging and deploy them as directed by the IC or the OSC.

NOTE: Patient transport vehicles are to be kept separate from other apparatus in an area that allows for easy access to the Patient Treatment Area and rapid egress from the incident scene. PFD Ambulances are to have the keys left in the ignition and all compartments/cabinets are to be unlocked for access to equipment and supplies. EMS personnel arriving in the staging area should report to the Medical Group Supervisor with their first-in bag, SMART triage pack, and any other equipment or supplies requested after parking their vehicle.

4.5.1 Police will be utilized to ensure that a safe corridor of operation remains open for patient transport vehicles.

4.6 TRIAGE OPERATIONS

4.6.1 Triage involves the sorting of casualties according to the severity of their injuries to establish treatment and transport priorities.

4.6.2 Triage should be initiated by the first-arriving PFD unit at the scene. The first-in unit should quickly survey the entire scene to ascertain the number of patients and the severity of the injuries.

4.6.3 The 1st in PFD Ambulance (EMT or Paramedic Driver) will be responsible for assuming the role of Triage Unit Leader.

4.6.4 In the event of contamination by a hazardous material or CBRNE incident, emergency decontamination should be conducted to remove contaminants from casualties exposed or presumably contaminated.

4.6.5 Triage tags will be utilized on all multiple patient and mass casualty incidents.

4.7 TRIAGE PROCESS

4.7.1 The PFD utilizes the SMART System for triage which rapidly assesses four vital parameters in only 30-60 seconds:

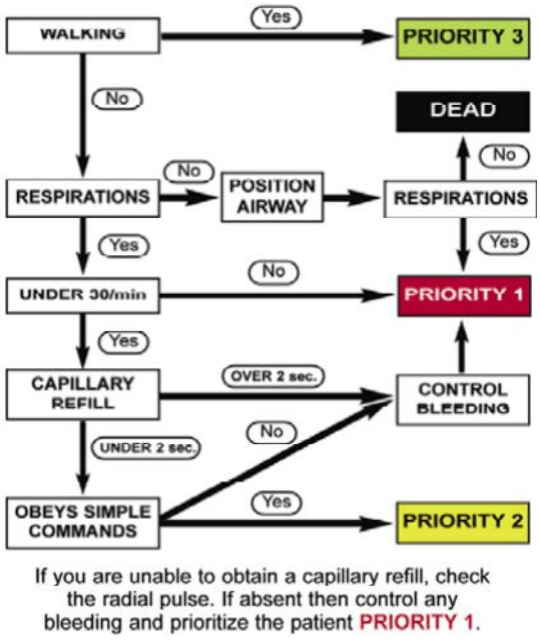
a. Ability to walk

b. Respiratory Status

c. Perfusion

d. Neurological Status

4.7.2 These parameters are assessed according to the following chart:



4.7.3 Triage tags and cyalume glow-sticks are available for patient tagging.

4.7.4 Triage tags are divided into 4 categories for patient classification; Priority 1(Red), Priority 2(Yellow), Priority 3(Green), and Black.

4.7.5 The triage tag should be affixed securely to the patient to prevent it from becoming dislodged, thereby requiring duplication of efforts to re-triage the patient.

4.7.6 Be sure that the colored triage priority is folded to the appropriate color. DEAD (Black Tag) victims are indicated by utilizing the separate black tag found in the SMART triage pack.

4.7.7 Attach the tag securely to the patient using the attached rubber band. The tag is to remain with patient until the patient is delivered to the hospital.

4.7.8 Patients with catastrophic injuries of the head, chest, and/ or abdomen, who are expected to expire prior to being able to be transported, may be green tagged. Because these mortally wounded patients have not expired, they cannot yet be tagged as DEAD (Black) tagged. Tag them with a Priority 3 (Green) tag and place them in a separate area away from those patients with minor injuries within the Priority 3 (Green) Patient Treatment Area. If, after triage has been completed and there are fewer critical patients than anticipated, the mortally injured Priority 3 (Green) tag patients can be re-tagged as Priority 1 (Red) tag and given priority transport. If the mortally injured patient expires in the green tag area as expected prior to transport, re-tag them as DEAD (Black) tag and remove them to the temporary morgue area.

4.7.9 Pediatric patients should be triaged using the algorithms on the SMART tape included in the SMART triage pack.

4.7.10 As soon as a patient has been triaged; the patient should be tagged and triage personnel should move on to another patient.

4.7.11 Track the number and class of patients triaged utilizing the casualty count card in the SMART triage pack and give a report to the Triage Unit Leader including the number and classification of patients triaged.

4.7.12 Triage personnel who find a victim that is not breathing should open the victim's airway. If the victim begins spontaneous breathing an airway adjunct should be inserted and the patient should be tagged Priority 1 (Red). Patients who do not begin breathing will be tagged Dead (Black).

4.7.13 No treatment should be provided to casualties during triage except for simple BLS airway maneuvers to establish a patent airway and control of life-threatening hemorrhage. All other treatment should take place in the Patient Treatment Area.

4.7.14 Secondary triage will be performed in the patient treatment area as more resources become available.

4.7.15 Black Tag patients who are found to be deceased during the initial triage survey should be moved only on the orders of the Incident Commander, unless it is necessary to establish a route to survivors. Patients, who expire in the Treatment Area prior to being transported, should be removed to the temporary morgue area.

4.7.16 Deceased patients should only be moved after consultation with law enforcement and investigative agencies. Black Tag patients, when moved, should be segregated from the other patients.

4.7.17 Patients who are suspected to be contaminated with a hazardous material or exposed with an infectious agent will have the appropriate section of the contamination card facing out and inserted in the outer packet of the triage tag plastic sleeve.

4.7.18 The Triage Unit Leader should consider having Priority 3 (GREEN) patients who are ambulatory and have minor injuries escorted to an area near the Priority 3(GREEN) Treatment Area or a mass transit bus. These patients will receive secondary triage and may be transported to a medical facility as a group.

4.8 PATIENT TREATMENT AREA

4.8.1 The Treatment Area is a specific area to provide medical treatment during an emergency medical incident. The function of the treatment area is to provide patient stabilization and continuing care of patients. It can be the most demanding function in terms of operations and support, during a multiple casualty or mass casualty incident. The treatment area should be:

a. Readily identifiable and have a clearly visible patient entrance

b. Large enough to handle all patients and treatment personnel involved in the incident.

c. Easily accessible for ambulances coming from the ambulance staging area.

d. Separated by triage categories Priority 1(Red), Priority 2 (Yellow), and Priority 3 (Green).Dead (black tag) victims will be handled by the Morgue Manager and not be a part of the Patient Treatment Area.

4.8.2 The Treatment Unit Leader assumes responsibility for treatment, preparation for transport, and coordination of patient treatment in the Patient Treatment Area and directs movement of patients to loading locations.

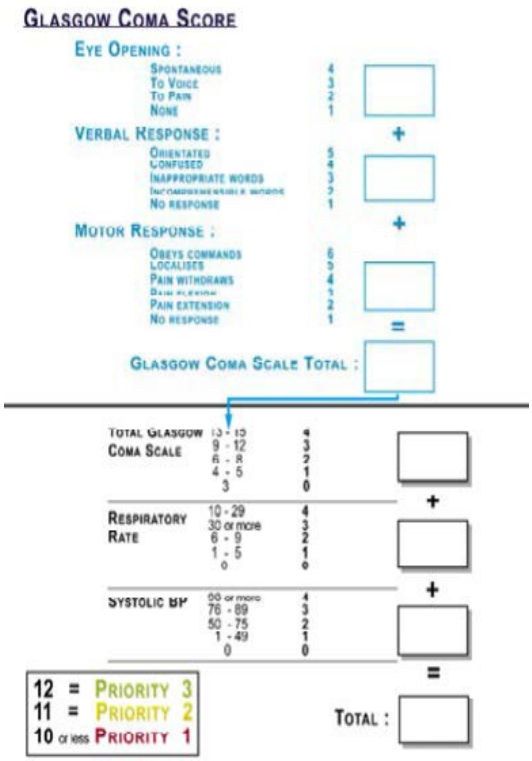
4.8.3 Patients will be moved to the treatment area by teams of Firefighter/EMT's and/or civilians working under the guidance of a Firefighter/EMT. Priority for moving patients will be based on the triage tag affixed by the triage teams. Patients should be properly immobilized with a cervical collar and long backboard if appropriate, prior to being moved to the treatment area.

4.8.4 Any patient who arrives at the treatment area without a SMART triage tag should be triaged immediately, tagged with the appropriate triage tag, and sent to one of three treatment areas. Priority 1 (Red), Priority 2 (Yellow), or Priority 3 (Green).

4.8.5 If a Physician Triage Team has been activated, the responding medical team should be utilized in the treatment area to assist with ongoing triage and treatment.

4.8.6 Personnel in the treatment area will provide continuing evaluation and reassessment of patient's conditions utilizing secondary triage. Patients will be upgraded or downgraded using the following secondary triage chart:

SECONDARYTRIAGE



4.8.7 When adequate resources are available, all patients will be provided emergency care as indicated by injury.

4.9 PATIENT TRANSPORTATION

4.9.1 Priority 1 (RED) tag patients should be transported to accredited Trauma Centers. Consider air transport to more distant Trauma Centers to avoid overloading those Trauma Centers closest to the incident.

4.9.2 Priority2 (YELLOW) tag patients will be transported to trauma centers and general surgical hospitals that are designated trauma-receiving hospitals. Appropriate patient distribution will avoid overloading any one facility.

4.9.3 Priority3 (GREEN) tag patients can be transported to hospitals somewhat further away so the closest hospitals can utilize their resources to manage the more serious red and yellow tagged patients.

4.9.4 Priority 3 (GREEN) tag patients can be transported using non-traditional means such as a SEPTA or school bus, or non-ambulance vehicles.

4.9.5 Police vehicles will only be used for patient transportation with the permission of the EMS Branch Director or Patient Transportation Group Supervisor. Only patients who have properly assessed and triaged as Priority 3 (GREEN) will be transported by police. The Transportation Group Supervisor in consultation with the Medical Communications Coordinator will ensure that those patients are transported to appropriate facilities for minor treatment and not sent to Trauma Centers or hospitals in close proximity to the event. To facilitate communication with police vehicles a police supervisor will be requested and should be assigned to the Transportation Group to allow for direct communications with police units.

5. GUIDELINES

5.1 COMMUNICATIONS - GENERAL

5.2 Communications will be maintained at all times between the Incident Commander and the F.C.C.

5.2.2 In the event of an MCI, the following information, when available, will be provided by the Incident Commander to the F.C.C. as soon as possible:

a. Nature of the incident and exact location.

b. Level of the MCI and approximate number of patients.

c. The need for additional personnel, equipment, and resources.

5.2.3 ROLE OF F.C.C. - MASS CASUALTY INCIDENTS

5.2.4 On all Mass Casualty Incidents, the F.C.C. will:

a. Refer to Addendum1, Mass Casualty Notification procedures whenever the IC announces an MCI event or 6 ambulances have been dispatched to an incident.

b. Notify the following:

(1) Fire Commissioner or designee.
(2) On call Deputy Fire Commissioner
(3) Deputy Commissioner EMS
(4) Executive Officer EMS
(5)Deputy Managing Director, Office of Emergency Management.
(6)PFD EMS Medical Director.
(7)PFD Public Information Officer.
(8)Philadelphia Regional EMS Director.
(9)Second Alarmers Association.
(10)Medical Examiner's Office, if applicable.

c. Upon request of the EMS Branch Director or Medical Group Supervisor in conjunction with the Incident Commander, notify the PFD EMS Medical Command Facility which is closest and unaffected by the incident to activate their Physician Triage Team. Dispatch a Battalion Chief, PFD staff vehicle or police vehicle to the Medical Command Facility to transport the Physician Triage Team to the incident scene.

NOTE: Ambulances are normally utilized to facilitate transport of the Physician Triage Team. However, in a mass casualty incident, the ambulances and paramedics will be needed at the MCI scene or to maintain emergency readiness for the remainder of the City. In an MCI, ambulances should not be utilized to transport the team.

d. Upon notification of an event or emergency which threatens to overwhelm the available conventional EMS resources the FCC will notify the Commissioner or designee. At the direction of the Fire Commissioner or designee, the FCC will refer to Addendum 2, EMS Surge Procedure to issue both an Everbridge and KC HIMS alert. These alerts will be sent to all designated non-municipal ambulance companies and instruct them to respond with designated non-municipal ambulances available for use by the city. This surge activation may occur in conjunction with mutual aid requests.

e. Upon notification of a Level 3 or greater MCI during business hours (Monday thru Friday 0800-1630) notify the EMS Administration Building and EMS Training at the Philadelphia Fire Academy to prepare to deploy staff officers to augment the working EMS Officers on scene. The EMS Branch Director will make the final determination to use EMS staff officers.

f. During the hours of 2000-0800 the remaining EMS Operations Officer (ES-8/9/10/11) not assigned to the MCI will report to the FCC to facilitate Medic Unit coordination and availability until relieved. ES-14 will relocate to the FCC to take over these duties and allow the EMS Operations Officer to return to service.

5.2.5 The following will be dispatched by the FCC on Mass Casualty Incidents:

a. MCI LEVEL FIVE (5) – 6 Ambulances

(1) Accident Assignment as dictated by Directive 39, Initial Dispatch
(2) 1 EMS Supervisor (ES-8/9/10/11)
(3) 6 Ambulances
(4) The EMS Operations Captain (ES-6)
(5) Additional Resources as requested by the IC

b. MCI LEVEL FOUR (4) – 12 Ambulances

All resources dispatched on a Level 5 with the addition of:
(1) Full Box Alarm
(2) 2 EMS Supervisors (ES-8/9/10/11)
(3) The EMS Operations Chief (ES-3)
(4) 6 additional Ambulances
(5) Mass Casualty Response Vehicle (MC-1) and/or MC-2) as requested by the Incident Commander
(6) Mass Transit Vehicle(s) (as requested by the Incident Commander)

c. MCI LEVEL THREE (3) – 18 Ambulances

All resources dispatched on a Level 4 and 5 with the addition of:

(1) 2nd Alarm Assignment
(2) 6 additional Ambulances
(3) Mass Casualty Response Vehicle MC-1 (MC-2 only on request of IC)
(4) EMS Apparatus & Equipment Officer or Paramedic to act as Medical Supply Coordinator
(5) EMS Administrative Chief
(6) EMS Administrative Captain
(7) EMS Training Captain

d. MCI LEVEL TWO (2) – 24 Ambulances

All resources dispatched on a Level 3, 4, and 5 with the addition of:

(1) Additional Alarms as requested by the IC
(2) Regional EMS Chief and staff officers
(3) 6 additional Ambulances
(4) EMS Administrative staff officers
(5) EMS Training staff officers

e. MCI LEVEL ONE (1) MASS CASUALTY DISASTER– 30 Ambulances

All resources dispatched on a Level 2, 3, 4, and 5 with the addition of:

(1) Additional Alarms as requested by the IC
(2) 6 additional Ambulances

Note: Preparations will begin for requesting mutual aid from surrounding regions by the EMS Regional Office and the Office of Emergency Management (OEM) on any MCI Level as needed.

5.2.6 Information sharing between partner agencies is not a HIPPA violation and patient demographic and identification data will be shared as requested. Partner agencies for the purposes of information sharing related to patients involved in a mass casualty incident are the Philadelphia Police Department and the Philadelphia Office of Emergency Management.

6. REFERENCES

6.1 EMS PROCEDURE #6-PHYSICIAN TRIAGE/SURGICALRESPONSE TEAM ACTIVATION.

6.2 OPERATIONAL PROCEDURE #2-HAZARDOUS MATERIALS

6.3 OPERATIONAL PROCEDURE #2, ADDENDUM #4-INCIDENTS INVOLVING NUCLEAR, BIOLOGICAL, OR CHEMICAL AGENTS AS TERRORIST WEAPONS

6.4 OPERATIONAL PROCEDURE #19-INCIDENTCOMMAND SYSTEM

6.5 OPERATIONAL PROCEDURE #25-HELICOPTERS, UTILIZATION FOR MEDICAL TRANSPORTATION

6.6 CITY OF PHILADELPHIA, "MASS CASUALTY PLAN" FORMERLY ANNEX "J"

6.7 DIRECTIVE #39-FCC, INITIAL DISPATCH

BY ORDER OF THE FIRE COMMISSIONER

EMS Branch Organizational Chart

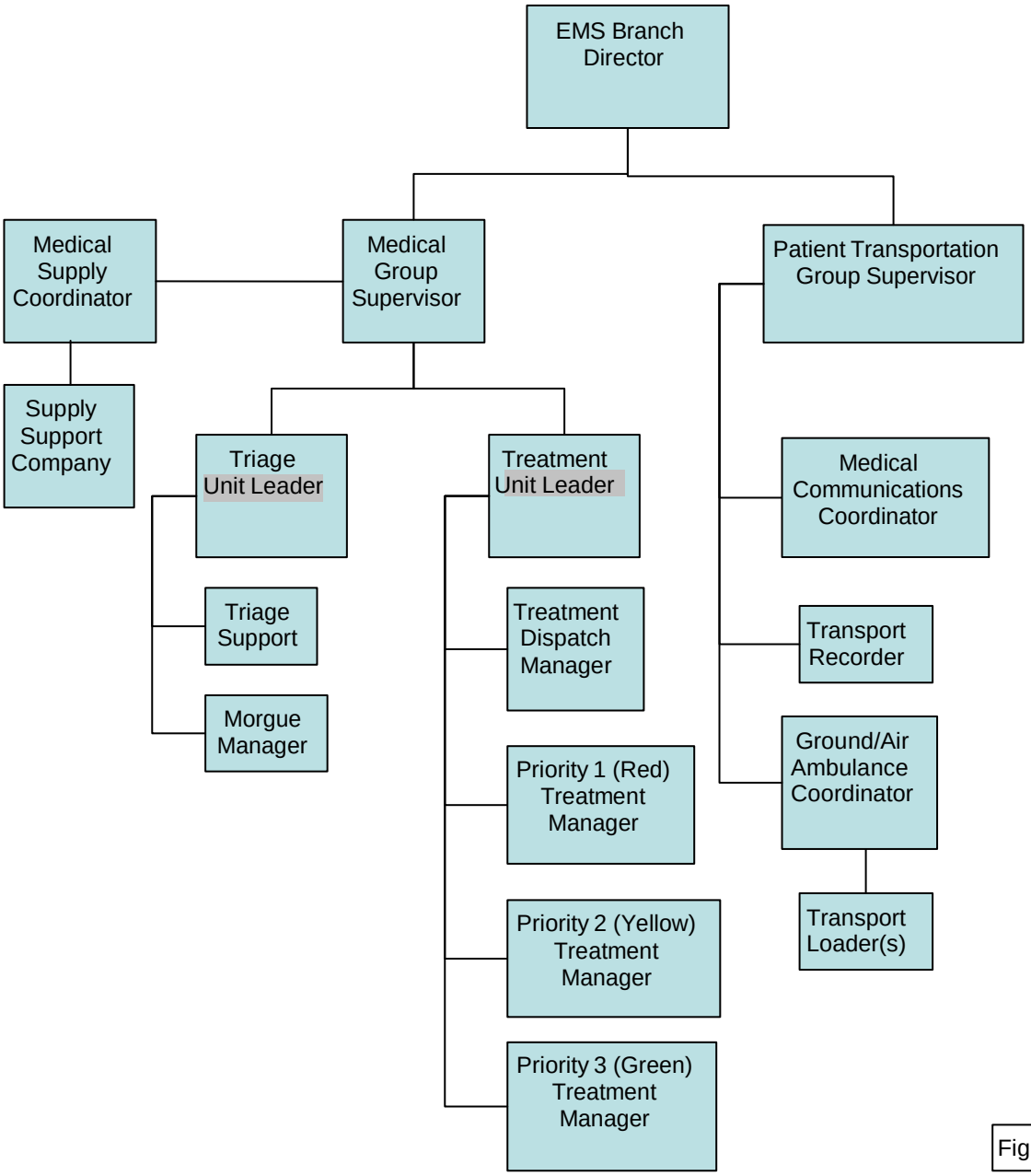
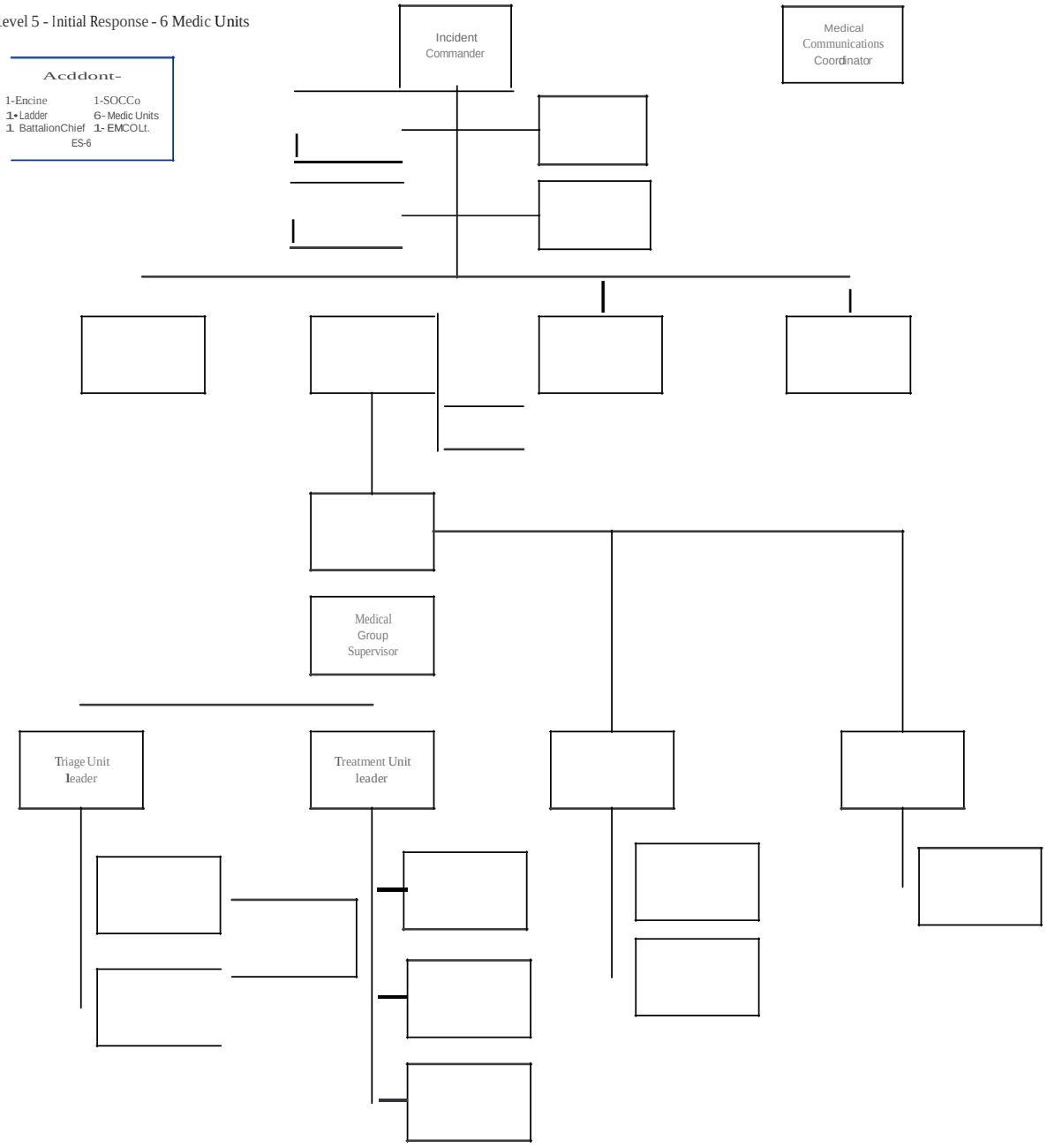


Figure 1

level 5 - Initial Response - 6 Medic Units

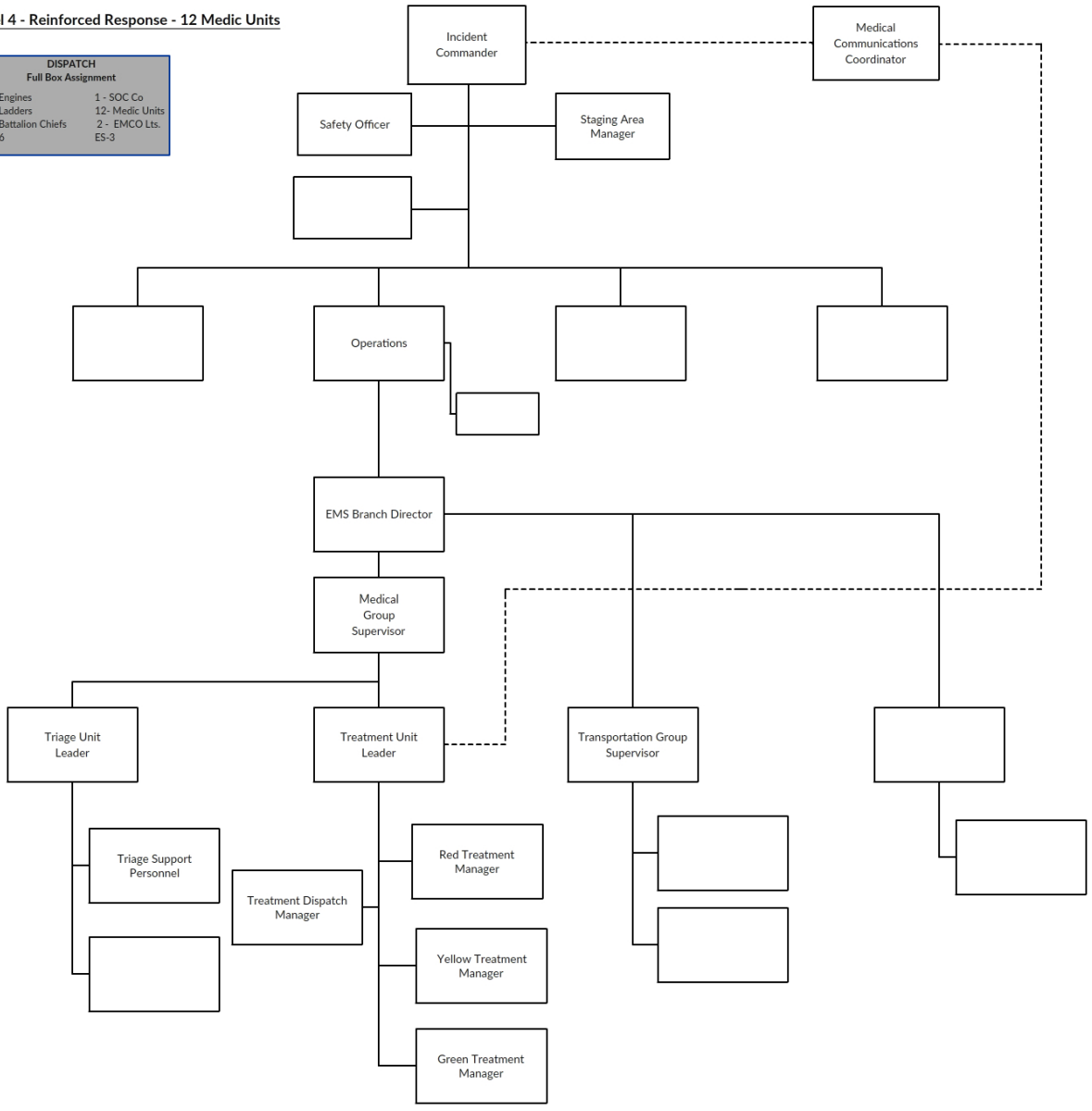
Acddont-

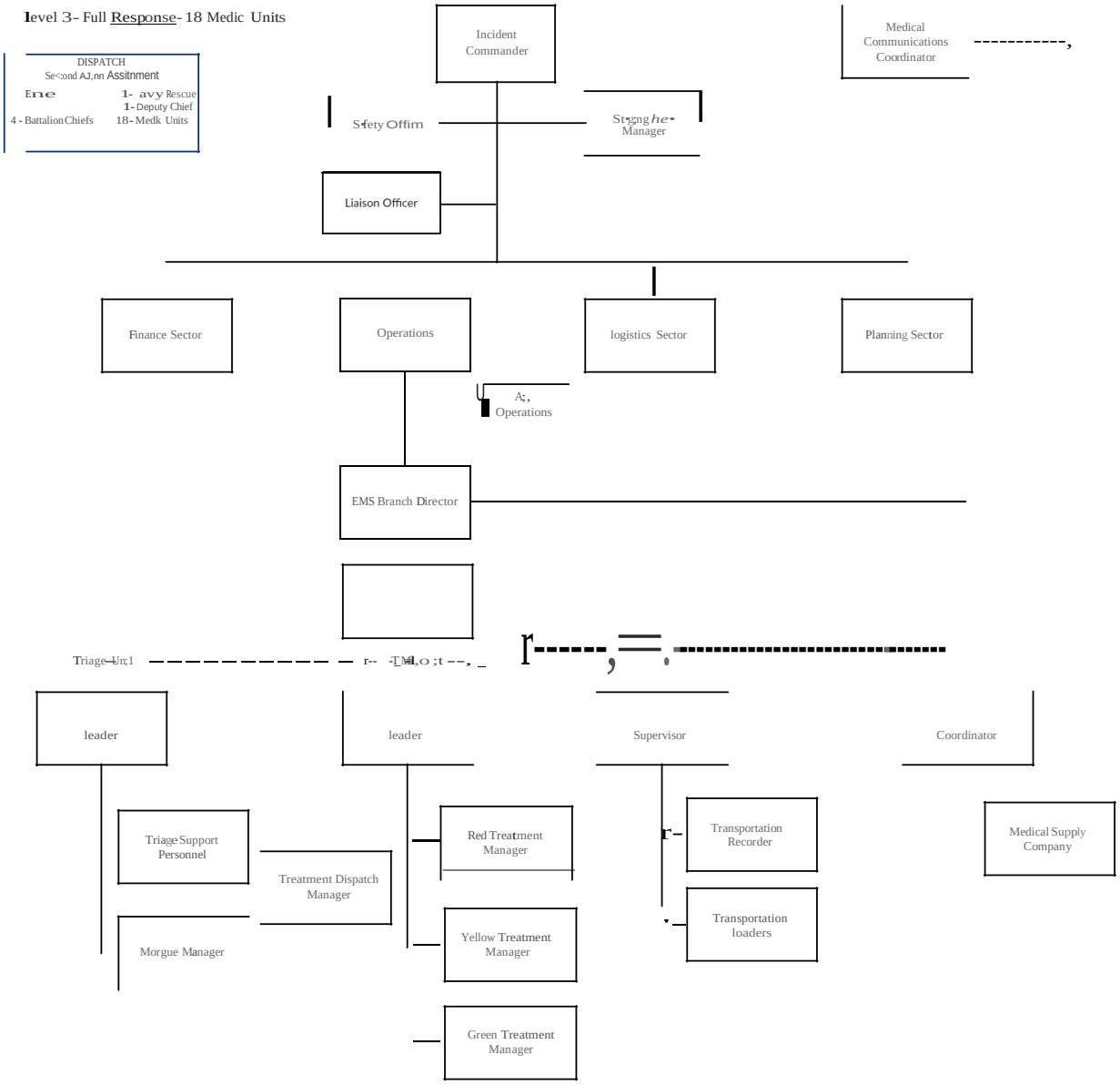
1-Encine 1-SOCCo
1- Ladder 6- Medic Units
1 BattalionChief 1- EMCOLt.
ES-6



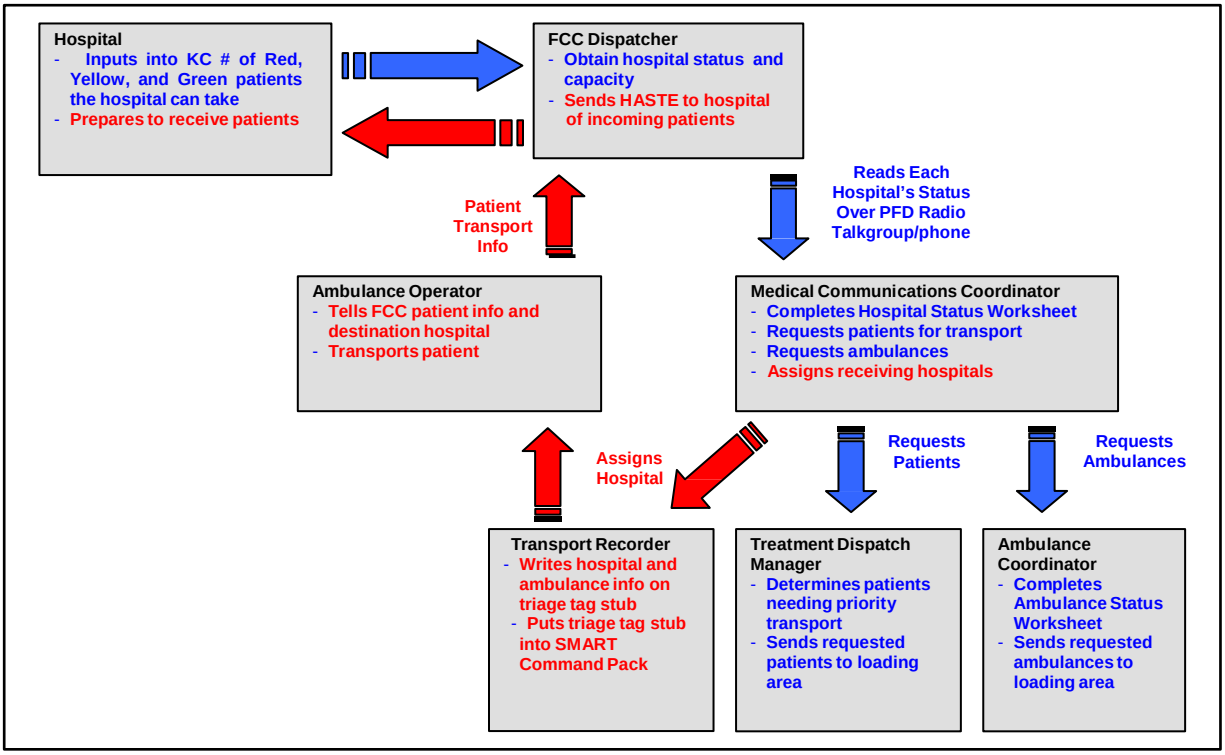
Level 4 - Reinforced Response - 12 Medic Units

DISPATCH Full Box Assignment	
4 - Engines	1 - SOC Co
2 - Ladders	12- Medic Units
2 - Battalion Chiefs	2 - EMCO Lts.
ES-6	ES-3




level 3- Full Response- 18 Medic Units
DISPATCH
Second Assignment
One
4 - Battalion Chiefs
1- Navy Rescue
1- Deputy Chief
18- Medic Units
Incident Commander
Medical Communications Coordinator
Safety Offim
Staging Manager
Liaison Officer
Finance Sector
Operations
logistics Sector
Planning Sector
Air Operations
EMS Branch Director
Triage Unit
leader
leader
Supervisor
Coordinator
Triage Support Personnel
Treatment Dispatch Manager
Morgue Manager
Red Treatment Manager
Yellow Treatment Manager
Green Treatment Manager
Transportation Recorder
Transportation loaders
Medical Supply Company

Patient Transportation
Information Flow Diagram



UNIT LOG	1. Incident Name	2. Date Prepared	3. Time Prepared
4. Unit Name/Designators	5. Unit Leader (Name and Position)		6. Operational Period

7. Personnel Roster Assigned

Name	ICS Position	Home Base

8. Activity Log

Time	Major Events

9. Prepared by (Name and Position) ICS 214

PHILADELPHIA FIRE DEPARTMENT

OPERATIONAL PROCEDURE #35
SEPTEMBER, 2015
ADDENDUM #1

SUBJECT: MASS CASUALTY NOTIFICATION

1. PURPOSE

This procedure addresses how the Philadelphia Fire Communications Center (FCC) will notify hospitals and key stakeholders during the event of a mass casualty incident. There are three primary methods for communicating with hospitals and stakeholders about the number of incoming casualties: The KC HIMS (Knowledge Center Healthcare Incident Management System), the HASTE (Hospital Alerting System Tone Encoded), and Everbridge (Mass Notification System). The FCC will use Everbridge to contact the region's Non-Municipal Ambulance (NMA) providers and HASTE and KC HIMS to contact the region's hospitals giving them needed information from on-scene personnel.

2. DEFINITIONS

2.1 EVERBRIDGE MASS NOTIFICATION SYSTEM

Everbridge is an emergency alert and notification system utilized by the City of Philadelphia. The system quickly and efficiently disseminates emergency notification alerts to key emergency personnel and predetermined groups during routine events, all hazards incidents, major disasters, or developing events. Everbridge is capable of alerting multiple communications devices through one action including pagers, cell phones with voicemail and text, email, and landlines.

2.2 HOSPITAL ALERT SYSTEM-TONE ENCODED (HASTE) RADIO

The HASTE System is an abbreviation for the **H**ospital **A**lert **S**ystem -**T**one **E**ncoded. The HASTE System is a VHF Low Band radio frequency used to notify the hospitals of incoming critical patients. The HASTE System is utilized for one-way communication only, from the Fire Communications Center to the hospitals.

2.3 KNOWLEDGE CENTER HEALTHCARE INCIDENT MANAGEMENT SYSTEM

Knowledge Center Healthcare Incident Management System (KC HIMS) is a web-based incident management system that enables users from different healthcare facilities to track incidents, enter key information that aids in maintaining situational awareness and supports the real time collection of information about available hospital beds and vital resources during an emergency.

2.4 NON-MUNICIPAL AMBULANCE (NMA) PROVIDER

A Pennsylvania Department of Health (PA DOH) licensed ambulance company authorized to provide pre-hospital care which, is not part of the PFD, is registered to the EMS region defined as Philadelphia County, has signed the "Memorandum of Understanding", and has met the vehicle, staff, equipment (including VHF radio), and training requirements to be included in an activation of surge NMA.

2.5 STATEWIDE 800 MHZ RADIO SYSTEM

A network of fixed radio control stations located at Pennsylvania Department of Health facilities, Regional EMS Councils, County and Municipal Health Departments, Poison Control Centers and Hospitals. It is an advanced wireless communications network for both voice and data.

2.6 SURGE MASS TRANSIT GROUP

An Everbridge group consisting of SEPTA and other mass transit providers. Buses may be requested to transport the minimally to moderately injured, allowing ambulances to be used to transport the more severely injured casualties

2.7 SURGE MUTUAL AID GROUP

An Everbridge group consisting of Emergency Management Agencies of the Southeast Pennsylvania and Southern New Jersey counties that may be requested to provide ambulances to supplement on-scene PFD transportation resources.

2.8 SURGE NON-MUNICIPAL GROUP

A PA DOH licensed ambulance company authorized to provide pre-hospital care, which is not part of the PFD, is registered to the EMS region defined as Philadelphia County, and has not yet signed a memorandum of understanding, but may be requested to supplement on-scene PFD transportation resources.

2.9 SURGE TRANSPORTATION PROVIDERS

Organizations, agencies, and jurisdictions that have identified themselves as wanting to provide ambulances or mass transit vehicles for EMS surge capacity during a mass casualty incident. These include non-municipal Ambulance providers in Philadelphia, SEPTA, and the Emergency Management Agencies of the Southeast Pennsylvania and Southern New Jersey counties.

3. RESPONSIBILITY

3.1 MEMBERS

It will be the responsibility of each member to exercise the appropriate control dictated by his/her rank in the implementation of this operational procedure.

3.2 FCC SUPERVISOR

The FCC Supervisor will be in charge of coordinating, sending out the KC HIMS, Everbridge and HASTE alerts to all Philadelphia EMS receiving hospitals in the event of a mass casualty incident and will relay information to hospitals from on-scene personnel.

4. PROCEDURES

4.1 MASS CASUALTY ALERT

Upon receipt of initial on scene report and notification of a mass casualty event by the Incident Commander, the FCC will notify the Fire Commissioner or designee.

4.1.1 The FCC will transmit a HASTE message alerting hospitals that:

a. A mass casualty incident has occurred

b. A KC HIMS alert has been sent out, follow instructions upon receiving

c. Staff is requested to access KC HIMS and input requested information

d. Staff is requested to stand-by for further instructions

4.1.2 The FCC will activate an alert in the Knowledge Center Healthcare Management System (KC HIMS) system to request users to identify the amount of resources available. The KC HIMS alert will:

a. Describe the nature of the incident and exact location

b. Identify the approximate number of casualties and the severity of injuries

c. Request KC HIMS users to identify the availability of the following resources:

(1) Hospital beds
(2) Ambulances
(3) Other types of equipment or supplies, if needed

4.1.3 In the event of a communications failure utilizing the HASTE radio, the FCC will utilize the statewide 800 MHz radio system to communicate the above information and the ongoing needs of on-scene operations to Philadelphia EMS receiving hospitals emergency departments. If the HASTE and the 800 MHz radio system are not operational, then the FCC will contact area hospitals via landline telephone.

4.1.4 Because the KC HIMS alert may not reach all other KC HIMS users throughout the region, potentially due to the KC HIMS system not being active at that facility or due to an error in the KC HIMS system, the FCC will send an Everbridge message to each of the following Everbridge groups:

a. Philadelphia County Hospital Group

b. Surge Non-Municipal Group

c. Surge Mass Transit Group

d. Surge Mutual Aid Group

4.1.5 The Everbridge message will contain the following information:

a. A mass casualty incident has occurred

b. A KC HIMS alert has been activated

c. Go to KC HIMS and input requested information

d. Follow instructions provided and or stand-by for further instructions

4.2 SITUATION UPDATES

4.2.1 The FCC will check the KC HIMS system on a periodic basis to obtain a list of the available resources described above. The FCC will then contact the on-scene Patient Transportation Group Supervisor and/or Medical Communications Coordinator, and provide him/her with a list of hospitals that patients may be transported to based on the following:

a. Patient status (Priority 1 – RED, Priority 2 – YELLOW, Priority 3 – GREEN)

b. Local hospital resources (i.e. trauma centers, burn centers, specialized pediatric facilities, etc.)

c. Number of hospital beds

4.2.2 As patients depart the on-scene Patient Treatment Area(s), the Patient Transportation Group Supervisor will notify the FCC of hospitals that have been sent patients. The FCC will then notify those hospitals of their incoming patients by either of the following methods:

a. Transmitting a HASTE message to Philadelphia EMS-receiving hospitals

b. Contacting hospitals by telephone

c. Contacting hospitals via the statewide 800 MHz radio

5. GUIDELINES

5.1 REFERENCES

City of Philadelphia Mass Casualty Plan

PHILADELPHIA FIRE DEPARTMENT

OPERATIONAL PROCEDURE #35
SEPTEMBER, 2015
ADDENDUM #2

SUBJECT: EMERGENCY MEDICAL SERVICES SURGE PROCEDURE

1. PURPOSE

This addendum provides guidelines and a policy for requesting, utilizing, directing, and supervising dispatched non-PFD EMS resources during large scale events. During a major incident or event, additional transportation resources from SEPTA, Non-Municipal EMS providers and mutual aid sources can be utilized to augment the 911 system and/or support on-scene operations at any large scale Mass Casualty Incident.

2. DEFINITIONS

2.1 NON-MUNICIPAL AMBULANCE PROVIDER (NMA)

A Pennsylvania Department of Health (PA DOH) out of state licensed ambulance company authorized to provide pre-hospital care which, is not part of the PFD, is registered to the EMS region defined as Philadelphia County, has signed the "Memorandum of Understanding" and has met the vehicle, staffing, equipment (including VHF radio), and training requirements to be included in a activation of surge NMA. These resources will be classified as non-PFD ambulances.

2.2 OUT OF COUNTY AMBULANCE PROVIDER

A Pennsylvania Department of Health (PA DOH), New Jersey, or Delaware licensed ambulance company authorized to provide pre-hospital care which, is registered to an EMS region outside of Philadelphia County, and has met the vehicle, staffing, equipment, and training requirements to be included in a mutual aid activation. These resources will be classified as non-PFD ambulances.

2.3 VETTING PERSONNEL

PFD personnel assigned to staff the Vetting station. PFD personnel will be responsible for facilitating the vetting and check-in of all non-PFD ambulances requested to respond to an event.

2.4 VETTING STATION

Designated PFD fire station or other designated area as required (i.e. Staging Area) where non-PFD ambulances will be vetted.

2.5 SURGE MASS TRANSPORTATION

Surge Mass Transportation is the utilization of vehicles other than ambulances to assist with patient transportation i.e. Mass Transit (SEPTA).

3. RESPONSIBILITY

3.1 MEMBERS

3.1.1 It will be the responsibility of each member to exercise the appropriate control dictated by his/her rank in the implementation of this operational procedure. In any incident that may potentially overwhelm municipal resources, consideration must be given to the early notification and activation of additional EMS resources arriving from Out of County or NMA EMS providers. Activating such resources will require ample deployment time.

3.1.2 Members will be aware that personnel operating on non-PFD vehicles in an MCI may require a higher level of support and direction than normally provided. Every effort should be made to prevent non-PFD EMS providers from being placed in unsupported situations.

3.2 PFD OFFICERS

3.2.1 Provide logistical and tactical support, direction, supervision, and instruction to non-PFD pre-hospital providers operating on an incident scene.

3.2.2 Mitigate, resolve, and report to the best of their ability any conduct, behavior, event, or occurrence directly connected to a non-PFD ambulance activation, which has a direct impact on the PFD's ability to provide EMS triage, treatment and/or transportation at the event.

3.3 INCIDENT COMMANDER (IC)

3.3.1 The Incident Commander will be ranking fire officer at the emergency scene.

3.3.2 The Incident Commander will:

a. Be responsible for directing all PFD related operations at the incident scene.

b. Be responsible for the determination or recommendation to utilize Non-PFD ambulances.

3.4 OPERATIONS SECTION CHIEF (OSC)

3.4.1 The Operations Chief will:

a. Designate staging areas for all incoming emergency vehicles both PFD and non-PFD.
In an MCI the patient transport vehicles should be staged separately from other non-EMS apparatus.

c. When possible, designate a geographically separate staging area for incoming self-deployed EMS vehicles, which have not been requested or vetted by the PFD.

d. Ensure that all PFD patient transport vehicles are left unlocked with the keys remaining in the vehicle, and that non-PFD ambulance drivers remain with their vehicles at all times.

e. Establish a pool of qualified PFD drivers to drive PFD Ambulances from the incident to a hospital. Ensure that PFD drivers are not utilized to operate non-PFD vehicles.

f. Allocate all personnel and equipment as needed.

g. Keep the Incident Commander apprised of the need for additional transport vehicles.

3.5 MEDICAL GROUP SUPERVISOR

3.5.1 The Medical Group Supervisor will ensure that all available medical resources, including the physician triage team, PFD and non-PFD ambulances, and other EMS resources are utilized to initiate treatment and transport of casualties.

3.6 STAGING AREA MANAGER (SAM)

An officer will be assigned by the Operations Section Chief to manage the Staging Area and will ensure that ambulances are properly staged for deployment by capability (ALS & BLS).

3.7 TRIAGE UNIT LEADER

3.7.1 The Triage Unit Leader will direct incoming PFD and non-PFD EMS personnel to assist in the triage of casualties as needed.

3.8 PFD PARAMEDICS

3.8.1 Provide patient care and treatment, at the BLS and ALS levels, in accordance with the Pennsylvania statewide ALS and statewide BLS protocols.

3.8.2 Assume command positions as needed I relation to triage, treatment, and transport of patients on an incident scene.

3.8.3 Provide logistical and tactical support, direction, supervision, and instruction as necessary for non-PFD pre-hospital providers operating on an incident scene.

3.9 PFD EMTs

3.9.1 Provide patient care and treatment, at the BLS level, in accordance with the Pennsylvania statewide BLS protocols.

3.9.2 Provide logistical and tactical support, direction, supervision, and instructions as necessary for non-PFD pre-hospital providers operating on an incident scene.

3.10 FCC

3.10.1 **Upon** notification by the Incident Commander of an event or emergency, which has the potential to exceed the available PFD EMS resources, the FCC will notify the Commissioner or designee. At the direction of the Fire Commissioner or designee, FCC will issue both an EVERBRIDGE and KC alert. These alerts will request equipment and personnel availability, and provide directions for responding to the designated Vetting Company.

3.10.2 Monitor responses to KC of the availability of resources.

3.10.3 Upon the direction of the Fire Commissioner of his designee, begin the activation of the approved communications network for each designated non-PFD ambulance.

3.10.4 Upon the direction of the Fire Commissioner or designee the FCC will begin the deployment of designated non-PFD ambulances to one of the four vetting stations situated throughout Philadelphia. The four vetting stations are:

a. Engine 5-4221 Market Street (43rd & Market Streets) (04)

b. Ladder 16–2601 Belgrade Street (Belgrade & Huntingdon Streets) (25)

c. Engine 10 –1357 S. 12th Street (12th & Reed Street) (47)

d. Engine 59 –2207 W. Hunting Park Avenue (Hunting Park Avenue & Schuyler Street) (40)

3.10.5 Upon activation of non-PFD ambulances, the FCC will ensure that PFD Personnel are assigned to staff the activated Vetting station(s). If necessary the FCC will send a cover-up company to the Vetting station.

3.11 VETTING PERSONNEL

3.11.1 Upon arrival at the Vetting station, the Vetting Officer will retrieve vetting container.The vetting container will contain instructions, non-PFD ambulance checklist, vehicle placards, traffic cones and vest. The vetting container for Engine 5, 10, and 59 will be secured in the EMS Stores area. Ladder 16 will secure vetting container in Ladder office bathroom storage locker. A placard will be posted in the watch desk area of each Vetting station identifying location of the vetting container. The Vetting Officer will contact the FCC for a list of the non- PFD ambulances authorized to report to the Vetting station.

3.11.2 Upon arrival of non-PFD ambulances, the Vetting Officer will supervise PFD personnel in greeting, staging, and inspecting the incoming non-PFD ambulances to expedite the process of deployment. In addition, Vetting personnel will ensure station security.

3.11.3 Vetting Personnel will complete a non-PFD ambulance checklist for each vehicle inspected and ensure security of completed check-in form.

3.11.4 Upon deactivation of the Vetting station, the Vetting Officer will place all completed non-PFD ambulance check-in forms in non-PFD ambulance checklist packet, and return packet to the station office. The EMS Field Operations Chief (ES-3) will ensure that completed check-in forms are retrieved from the Vetting stations and delivered to the Regional EMS Office and Fiscal Officer.

3.11.5 Vetting personnel will ensure that every non-PFD ambulance has a completed check-in form on file and a valid placard placed on the vehicles dashboard before allowing them to proceed to the staging area.

3.11.6 After completing the check-in process at the Vetting station, the Vetting Officer or the FCC will give non-PFD ambulances direction for response to the staging area.

3.11.7 After the last non-PFD ambulance has been checked in the, Vetting Officer will notify the FCC of their status and request further instructions.

4. PROCEDURES

4.1 SURGE TRANSPORTATION PLAN

4.1.1 If requested to activate one or more of the Surge Mass Transit, Surge NMA, or Surge Mutual Aid options, the FCC will send an RSAN message to the designated Everbridge group(s) with the following information:

a. The exact location and nature of the incident

b. The number of Mass Transit vehicles and/or ambulances needed

c. The location of designated Staging Areas and helicopter Landing Zones

4.1.2 When a non-PFD ambulance arrives at a Staging area, the Staging Area Manager (or designee) will confirm that the ambulance has been vetted and determine if interoperable communications have been established.

4.1.3 If the ambulance is not from an authorized EMS provider (a county or NMA EMS provider with an existing Memorandum of Understanding or Mutual Aid Agreement with the City of Philadelphia), that ambulance will be sent to an alternative Staging Area so it can be vetted and interoperable communications can be established, of necessary.

4.1.4 When Mass Transit vehicles arrive at the Staging area, they will report to the staging area and a firefighter with a PFD 800 MHz radio will provide radio communications capability to each vehicle.

5. REFERENCES

5.1.1 City of Philadelphia Mass Casualty Plan

OPERATIONAL
PROCEDURE #35
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ADDENDUM #2

Vetting Officer Non-Municipal Ambulance
Position Checklist

RADIO DESIGNATION:

Function	Manages the Non-Municipal Ambulance Vetting Area	
Report To:	**Supervisor Name and Rank**	**Company**
Subordinates:		
Vetting Station Location		
Duties:	… Obtain Briefing from FCC … Go to Fire station designated as the Non-Municipal Ambulance Vetting Area … Log Check in time of Non-Municipal Ambulance upon their arrival at Vetting Station … Conduct Non-Municipal Ambulance inspections and complete the Non-Municipal Ambulance Inspection Checklist for each ambulance inspected (see copy on reverse side of this page) … Place Placard on Non-Municipal Ambulance dashboard after inspection is passed … Advise FCC of credentialed Non-Municipal Ambulance … When inspection process is complete log the Non-Municipal Ambulance check out time. **Ambulances that do not pass inspection will not be placarded and will not be permitted to proceed to the PFD staging area.**	

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ADDENDUM #2

NON-MUNICIPAL AMBULANCE INSPECTION CHECKLIST

<table>
<tr><td>Company Name & PA DOH Seal #</td><td colspan="2"></td><td>NMA Unit No.</td><td></td><td>ALS</td></tr>
<tr><td></td><td colspan="2"></td><td></td><td></td><td>BLS</td></tr>
<tr><td>Check-in Time</td><td></td><td>Check-out Time</td><td colspan="3"></td></tr>
<tr><td rowspan="2">NMA Employee Names & Cert #</td><td colspan="2">1.</td><td colspan="3">3.</td></tr>
<tr><td colspan="2">2.</td><td colspan="3">4.</td></tr>
<tr><td>Items to Inspect</td><td colspan="5">Valid Driver’s License * Valid
Vehicle Registration * Valid
Vehicle Insurance Card *
EMT/Paramedic Certification Card (Non Carded Ambulance Attendant status may drive BLS ambulance) *
Company-issued Employee ID (If available) *
PA Department of Health (PA DOH) Vehicle Seal on both sides of vehicle
VHF Radio Operational Test (It is preferred, but not yet mandatory that responding vehicles have a VHF radio, but vehicles with radios should be inspected first)
Quick visual survey inside patient compartment for <u>mandatory</u> equipment:
Vital signs monitor for ALS (LifePak or similar)
Automated External Defibrillator (AED)for BLS
Portable Oxygen, suction, and EMS First In bag
* Note: Where provided and appropriate the names and/or photos should match on all documents
Quick visual survey of the outside of vehicle to assess general roadworthiness.
Note any deficiencies on rear of form</td></tr>
<tr><td rowspan="2">When Inspection is Passed</td><td colspan="2">‡ Contact FCC to: (preferably with VHF radio as part of operational test)

1. Confirm call sign for ambulance with company name and unit number (example StarCare-13)
2. Notify FCC ambulance is Available.
3. Identify Staging Area/Fire Station this ambulance is assigned to

‡ Sign, date, and place PFD Placard in windshield</td><td>FCC Call Sign

Staging Location Assigned</td><td colspan="2"></td></tr>
<tr><td colspan="3"></td></tr>
</table>

OPERATIONAL
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PHILADELPHIA FIRE DEPARTMENT

OPERATIONAL PROCEDURE #35
SEPTEMBER, 2015
ADDENDUM #3

SUBJECT: MASS CASUALTY VEHICLE

1. PURPOSE

To provide information and operational guidelines for the deployment of Mass Casualty Vehicles assigned to the Philadelphia Fire Department.

2. DEFINITION

2.1 MASS CASUALTY VEHICLE

An apparatus stocked with additional medical supplies and equipment for use at a Mass Casualty Incident.

2.2 ES-10

Mass Casualty Vehicle located in the Second Division, and has the same response boundaries as Deputy 2 and ES-5. The Fire Communications Center will assign a company to respond with ES-10 as a unit when dispatched.

2.3 ES-11

Mass Casualty Vehicle located in the First Division and has the same response boundaries as Deputy 1 and ES-4. The Fire Communications Center will assign a company to respond with ES-11 as a unit when dispatched.

2.4 MASS CASUALTY ONE (MC-1)

MC-1 is a regional asset located at Engine 16 and will respond to mass casualty incidents as requested by the Incident Commander. MC-1 may also be dispatched as part of a mutual aid response to Bucks, Delaware, Chester, or Montgomery counties. The Fire Communications Center will assign a company to respond with MC-1 as a unit when dispatched.

3. RESPONSIBILITY

It will be the responsibility of each member to exercise the appropriate control as dictated by his/her rank in the implementation of this Operational Procedure.

4 PROCEDURES

4.1. RESPONSE CRITERIA

4.1.1 Any declared mass casualty incident.

4.1.2 Confirmed Alert #3 Philadelphia International Airport (PIA) incident.

4.1.3 Confirmed Weapons of Mass Destruction (WMD) incident.

4.1.4 Confirmed prison incident.

4.1.5 Mass transit accidents.

NOTE-A Mass Casualty Vehicle can be dispatched upon request from the Incident Commander at any time.

5. GUIDELINES

5.1 These vehicles have been designed to provide additional equipment and supply resources. They carry large quantities of equipment and supplies for treating and stabilizing patients in a conventional Mass Casualty situation. In addition, they carry pharmaceuticals for use in a Weapons of Mass Destruction (WMD) scenario.

6. EQUIPMENT LIST

6.1 ES-10 and ES-11 each carry the equipment and pharmaceuticals listed in table below.

PHILADELPHIA FIRE DEPARTMENT

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ES-10 / 11 EQUIPMENT & PHARMACEUTICALS	
QUANTITY	**ITEM**
15	Backboards
50	Backboard Straps
20	Cervical Collars, Small
20	Cervical Collars, Medium
20	Cervical Collars, Large
20	Cervical Collars, Pediatric
50	Cervical Immobilization Devices (CID)
10	Reeves Stretchers
15	Stairchairs
5	Oxygen Bottles, Size “D” with regulators
200	N-95 Masks
450	Duo-Dote Kits
400	Mark 1 Kits, Pediatric
150	Valium, Auto-Injector
1000	Cyanide Antidote Kit
31,500	Potassium Iodide Tablets

6.2 MC-1 equipment and supplies are listed in table below.

MC-1 EQUIPMENT & SUPPLIES LIST	
QUANTITY	**ITEM**
70	Blankets (10/case)
48	Oxygen Cylinder, "D"
48	Oxygen Regulator
64	Body Bag (8/case)
30	Stretcher, Raven
10	Stretcher, Reeves
5	Man Sac
1	Air Shelter
4	Window, Air Shelter
4	Screen, Air Shelter
1	Heater, Air Shelter
2	Propane Tank, Heater
2	Air Conditioning unit, Air Shelter
8	Light, Air Shelter
1	Stake Package, Air Shelter
2	Tent, Without Side Walls
1	Generator, Gas, 5 Kw
2	Fan, Misting
6	Table, Folding
24	Chair, Folding
24	Bag, BLS (stocked) : trauma dressings, burn sheets, 4x4 bandages, gloves, oral airways, sterile gauze dressings, shears, *Sam* splints, oxygen "d" cylinder, oxygen regulator, bag valve mask

PHILADELPHIA FIRE DEPARTMENT

OPERATIONAL PROCEDURE #35
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ADDENDUM #4

SUBJECT: USE OF NERVE AGENT ANTIDOTE AUTO-INJECTORS BY EMERGENCY MEDICAL TECHNICIANS

1. PURPOSE

To provide responsibility, procedures, and guidelines for Philadelphia Fire Department Emergency Medical Technicians to administer Nerve Agent Antidote Auto-injectors under unique circumstances.

2. DEFINITIONS

2.1 NERVE AGENT ANTIDOTE AUTO-INJECTORS

Nerve agent antidote auto-injectors are spring-loaded, pressure-activated devices containing atropine, pralidoxime chloride, or diazepam that are to be administered in the event of toxic exposure to nerve agents such as GA (Tabun), GB (Sarin), GD (Soman), GF, or VX. The Department keeps in stock several types of auto-injectors. These include: 1) DuoDote (auto-injector containing 2.1 mg atropine and 600 mg pralidoxime chloride, 2) red Atropen (auto-injector containing 1.0 mg atropine), 3) blue Atropen (auto-injector containing 0.5 mg atropine), 4) C-IV (auto-injector containing 10 mg diazepam). The type and number of auto-injectors administered will be determined by the age of the patient and the severity of symptoms.

3. RESPONSIBILITY

It is the responsibility of all members to exercise the appropriate control dictated by his/her rank in the implementation of this procedure.

3.1 RATIONALE FOR USE BY EMTS

Paramedics are authorized to administer Nerve Agents Antidote Auto-Injectors under the appropriate circumstances.

In a large-scale terrorist incident involving release of a nerve agent, the number of victims may overwhelm the paramedics initially on-scene. In addition, Firefighter-EMTs responding to the incident as members of first-responder engine and ladder companies are at risk of sustaining a toxic exposure themselves. It may therefore be necessary, under unique circumstances, for Firefighter-EMTs to administer the antidote auto-injectors to themselves, their fellow firefighters, and/or civilian patients.

4. PROCEDURES

4.1 MEMBERS

4.1.1 In the event of a suspected terrorist incident involving a nerve agent release, hot, warm, and cold zones will be established in accordance with the Fire Department's Hazardous Material Site Control Operational Procedure (O.P. #2). Triage and patient treatment areas will be supervised by the EMS Field Operations Officer and Triage Unit Leader, who
will also be responsible for overseeing the administration of antidote auto-injectors, when indicated. The number of antidote auto-injectors administered to each patient will be guided by age, signs, and symptoms as specified in **TABLE 1**, which is based on Protocol 8083, Nerve Agent/Pesticide Exposure, of the Pennsylvania Statewide Advanced Life Support Protocols. Patients with mild symptoms (pinpoint pupils, runny nose) should be decontaminated as indicated and reassessed for signs of worsening symptoms. Instructions for use of DuoDote auto-injectors are contained in **FIGURE 1** and for Atropen auto-injectors in **FIGURE** 2.

4.1.2 Antidote kits will be administered by paramedics or physician members of the Physician Triage Team on-scene, when possible. If the number of patients exceeds the capabilities of the paramedics and physicians, Firefighter-EMTs may administer the antidote kits to themselves or others under the direction of the attendant paramedic or physician. The paramedic or physician will, when feasible, advise the Firefighter-EMTs on how many auto-injectors a patient should receive. However, Firefighter-EMTs should be able to recognize the signs and symptoms of nerve agent toxicity and the appropriate therapy, should immediate medical supervision not be possible. Firefighter-EMTs will write on patients' triage tags the number and type of auto-injectors administered as well as their State EMT numbers.

Preparation and administration of antidotes to children younger than 2 years of age will be performed only by Fire Service Paramedics.

5. REFERENCES

5.1 OPERATIONAL PROCEDURE #2

TABLE 1

	Adult & Older Children > 90 lbs (>41 kg) ≥ 10 y/o	**Pediatric 40-90 lbs (18-41 kg) 4-10 y/o**	**Pediatric 15-40 lbs (7-18 kg) 6 m/o – 4 y/o**
Moderate Symptoms include: • Blurred Vision • Excessive tearing or runny nose • Drooling • Mild Shortness of Breath / Wheezing • Vomiting • Diarrhea, Stomach Cramps • Muscle twitching or sweating at site of exposure	1 **NAAA** IM [**atropine** 2mg + **pralidoxime** 600 mg IM]	1 **Atropen** (Red) [**atropine** 1 mg IM]	1 **Atropen** (Blue) [**atropine** 0.5 mg IM]
Severe Symptoms include: • Altered Mental Status • Severe Shortness of breath / wheezing • General Weakness / Severe muscle twitching • Incontinence (urine or feces) • Seizures • Unconsciousness	3 **NAAA(s)** IM [**atropine** 6 mg + **pralidoxime** 1800 mg IM] **AND** Anticonvulsant 1 CANA autoinjector [diazepam 10 mg IM]	2 **NAAA(s)** IM **OR** 3 **Atropen** (Red) [**atropine** 3 mg IM]	2 **NAAA(s)** IM (if > 2 y/o) **OR** 3 **Atropen** (Blue) [**atropine** 1.5 mg IM]

Nerve Agent Antidote Table

FIGURE 1
Instructions for Use of DuoDote Auto-Injectors

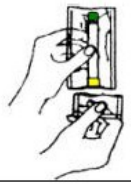
DuoDote Auto-Injector

1. Tear open the plastic pouch at any of the notches. Remove the DuoDote Auto-Injector from the pouch.
2. Place the auto-injector in your dominant hand (if you are right-handed, your right hand is dominant.). Firmly grasp the center of the auto-injector with the green tip (needle end) pointing down.
3. With your other hand, pull off the Gray Safety Release. The DuoDote Auto-Injector is now ready to be administered.
4. The injection site is the mid-outer thigh area. The DuoDote auto-injector can inject through clothing. However, make sure pockets at the injection site are empty.
5. Swing and firmly push the green tip straight down at a 90° angle against the mid-outer thigh. Continue to firmly push until you feel the auto-injector trigger.
6. After the auto-injector triggers, hold it in place against the injection site for approximately 10 seconds.

FIGURE 2
Instructions for Use of Atropen Auto-Injectors

Step 4

DIRECTIONS FOR THE USE OF THE ATROPEN® #00001

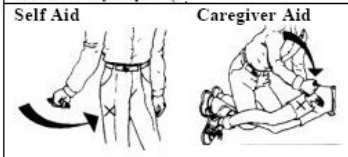


(A) Snap the grooved end of the plastic sleeve down and over the yellow safety cap. Remove the AtroPen® from the plastic sleeve.

Caution: Do not place fingers on green tip.

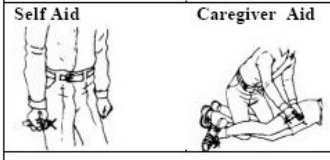
(B) Firmly grasp the AtroPen® with the green tip pointed down.

(C) Pull off the yellow safety cap with your other hand.



(D) Aim and firmly jab the green tip straight down (a 90° angle) against the outer thigh. The AtroPen® device will activate and deliver the medicine when you do this. **It is okay to inject through clothing but make sure pockets at the injection site are empty.**

Very thin people and small children should also be injected in the thigh, but before giving the AtroPen®, bunch up the thigh to provide a thicker area for injection.



(E) Hold the auto-injector firmly in place for at least 10 seconds to allow the injection to finish.

(F) Remove the AtroPen® and massage the injection site for several seconds. If the needle is not visible, check to be sure the yellow safety cap has been removed, and repeat steps C and E, but press harder.

(G) After use, using a hard surface, bend the needle back against the AtroPen® and either pin the used AtroPen® to the victim's clothing or show the used AtroPen® auto-injectors to the first medical person you see. This will allow medical personnel to see the number and dose of AtroPen® autoinjectors administered. Move yourself and the exposed individual away from the contaminated area right away.

Try to find medical help.

FIGURE 3
Pediatric Atropen Conversion Kit – Directions for Use

Pediatric Atropen Conversion Kit

1. Administer the appropriate AtroPen to the pediatric patient in the outer mid-thigh.
   * 1.0 mg red and yellow pen for children 4 to 10 years old (18-41 kg).
   * 0.5 mg blue and yellow pen for children 6 months to 4 years old (7-18 kg).

All patients with severe symptoms should also receive anticonvulsant in accordance with Protocol 8083, Nerve Agent/Pesticide Exposure Protocol of the PA Statewide ALS Protocols.

2. For children < 7 kg or < 6 months with mild symptoms, take a blue and yellow Atropen (0.5 mg in 0.7 mL) and inject contents into the orange-capped empty vial. Withdraw 0.35 mL (half the contents of vial) using the 1cc syringe and the green 18g filter needle. Administer to the pediatric patient I.M. in the outer mid-thigh using the 1cc syringe and the ***23g safety glide needle***.

3. For children < 7 kg or < 6 months with severe symptoms, take a red and yellow Atropen (1.0 mg in 0.7 mL) and inject contents into the orange-capped empty vial. Withdraw 0.5 mL using the 1cc syringe and the green 18g filter needle. Administer to the pediatric patient I.M. in the outer mid-thigh using the 1cc syringe and the ***23g safety glide needle***.