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| | **Susquehanna Regional EMS Council, Inc**<br>Serving: Broome, Tioga, and Chenango Counties<br><br>**REMAC Policy Statement**<br><br>Supersedes/ Updates: NEW | No. 15-02<br><br>Date: 02/05/2015<br><br>Re: Medical Operations in the Incident Command System<br><br>Page 1 of 5 |

## I. Policy

EMS providers operating in this region will utilize the National Incident Management System (NIMS) and Incident Command System (ICS). This policy shall be implemented every time:

a) There are two or more patients involved in an EMS response
b) The potential for multiple patients is likely to exist (e.g. Fire/Rescue/ HAZMAT scenes, high risk law enforcement operations, public events/gatherings, ATV/snowmobile incidents, plane-crashes, water/ice rescue, multi-motor vehicle crashes, etc.)

**This should be considered an everyday use policy**

**SEGMENTS SHOULD BE UTILIZED TO MORE EFFICIENTLY MANAGE ALL EMS SCENES**

## II. Rationale

Implementation of ICS improves a patient's chance for optimal recovery and survival through the establishment of a well-organized, clearly defined management structure that insures timely and optimal utilization of emergency resources. Early notification to hospitals will improve the opportunity for hospitals to prepare (assemble special resources and /or clinical teams) for each inbound patient. The goal is to minimize out-of-hospital time while optimizing pre-hospital care that will ultimately improve patient outcome and minimize disability and death. The primary mission of EMS must always be moving patients safely and expeditiously to definitive care.

**ALL INCIDENTS, REGARDLESS OF SIZE OR COMPLEXITY, WILL HAVE AN INCIDENT COMMANDER.**

**III. Arrival of EMS and Integration of Command**

- If anticipated that you will be the first arriving unit, utilize all available information at your disposal (e.g. dispatch, fire, law enforcement, etc.) to request the response of additional emergency resources at the earliest indication of need.
- The first arriving EMS unit should broadcast a "size-up" to include what you can see and what you are told: (e.g. number of vehicles, actual or potential hazards, number of patients with associated injury severity and a description of the structure or scene, etc.)
- If Incident Command is already established, ascertain staging information and assignments either directly or from dispatch. Shortly after the arrival of EMS resources, the designated EMS provider should join the existing command structure.
    - Example: "EMT/Medic _____ joining Unified Command, located at _____ and operating on frequency _____."
- If Incident Command has not been established, establish "INCIDENT COMMAND" and then broadcast the location of the command post
    - Example: "EMT/Medic _____ establishing Incident Command at _____ and operating on frequency _____."
- Request dispatch to advise incoming units of Command Post or Staging Area location
- Remain present or in direct contact with Command Post
- Assess and continually reassess scene safety
- Put on the **Medical Command** vest and ensure all other positions filled wear appropriate vests
- Delegate or establish, in coordination with Incident Command, any additional ICS positions required. Specifically the **"Medical Branch Director**" may be established
- Begin Triage operations (START Triage). Consider assigning a Triage Unit Leader
- Consider the establishment of **Treatment** and **Staging** Unit Leaders and areas as needed.
- As information is acquired consider what should be communicated, to whom and when:
    - Scene Safety Hazards (Current, Ongoing)
    - Number of patients and severity (RED, YELLOW, GREEN, BLACK)
    - Cause(s) of injuries/illnesses (If known)
    - Best access and egress for EMS to/ from the scene (Road Blocked?)
    - Number of patients trapped/type of rescue required?
    - Staging area location (if required)?
    - Direct 911 Center to make preliminary notification to hospital(s) of the incident and known details. Specify what information you want relayed and begin to query how many available beds there are
- **IMPORTANT NOTE:** Command will be transferred as indicated. Be sure to broadcast transfer of command information after it has occurred.

## IV. Considerations and Requests for Additional Resources

- The assessment of need for additional resources should be conducted as soon as you are dispatched to a call and continued until the incident is over.
- Available resources change frequently so be smart and think outside the box when needed.
- Examples of additional resources include, but are not limited to:
    - Additional Ambulances & EMS Personnel (Plan on an ALS ambulance for every “RED” patient.)
    - Additional supervisory staff (e.g chiefs, county coordinators, etc.)
    - Fire/Rescue
    - Law Enforcement or Tactical Law Enforcement Teams
    - Specialty Terrain Vehicles (e.g Boat, ATVs, snowmobiles, etc.)
    - Air Ambulance (Medevac Helicopter)
        - Consider additional fire support for landing zone operations
    - Specialty teams (e.g HAZMAT, dive teams, etc.)
    - Specialty vehicles (e.g MCI Trailers, communication vehicles)
    - Regional Critical Incident Stress Management (CISM) team.
    - Forest Rangers, EnCon Police
    - Rehabilitation Operations, Staff and Supplies (e.g. Beverages, Nutrition, Shelter, Rest Area(s), Rest Rooms, etc.)
- Any requests for additional should be made through the Incident Command Post. Individual units on scene should not make resource requests through dispatch when a Command Post has been established.
- When a member of Unified Incident Command requests additional resources, the decision should be made in consultation with the other Command Post Staff.
- Ensure that all resources associated with the incident are properly tracked and managed. Due to the origin and significant amount of resources, dispatch centers may not be able to track resources as they normally do.
- **IMPORTANT NOTE:** Responding EMS units will NOT cancel or divert resources while en route to a scene. They may, however, request additional resources to the scene and/or coordinate additional stand-by /back-fill resources.

## V. Hospital Contact

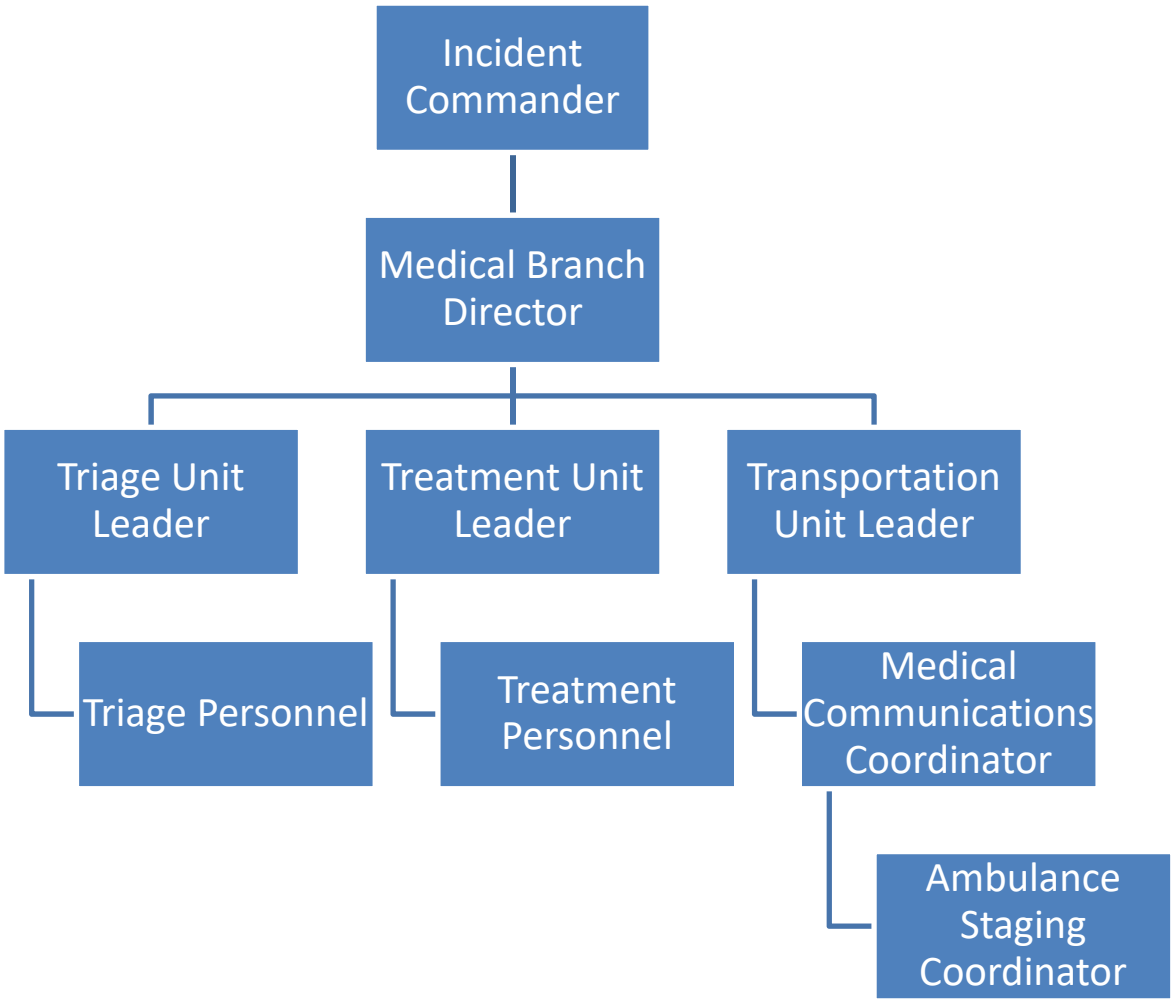
- Establish and maintain early contact with destination hospitals. Develop a specific contact at each hospital (Command Physician, Charge RN or designee) in order to maintain consistency and accuracy of information.
- Consider appointment of a dedicated “**Hospital Liaison**” to maintain communication with hospitals from the scene.
- Consider notification of “out of area hospitals” (e.g. burn, trauma or pediatric centers) for larger incidents. Incident Command should make this decision in consultation with and Medical Command.
    - Consider and discuss the use of air ambulances

## VI. Prolonged Operations and Demobilization

- If it is anticipated that operations will extend into another operational period then request additional command and support staff early so they can be properly briefed.
- Always assess the need of on-scene resources (vehicles, personnel, etc.) There is a finite and limited amount in the region and normal, day-to-day, operations must continue. Release unneeded resources so they may continue to serve the community.
- Ensure a comprehensive operational incident debrief Incident is conduct
- Consider requesting a Critical Incident Stress Management (CISM) team or related psychological support services
- Terminate command and return to normal operations by clearly communicating this over the radio

**Appendix A:** Organizational Chart for Command

The below chart is adopted from ICS as a possible structure of EMS operations. This is not meant to dictate how all operations will be structured. Remember ICS is flexible.



**Appendix B:** START Flow Chart