National Emergency Training Center
16825 S. Seton Avenue
Emmitsburg, MD 21727-8998

FEMA

R152

Dear National Fire Academy Student:

Congratulations on your acceptance into the U.S. Fire Administration's National Fire Academy's *Emergency Medical Services: Special Operations* course. This is an information-rich program that poses a serious challenge to the student. You are asked to arrive prepared to engage in the course with maximum commitment.

This course is intended to assist you in preparing your service to handle those incidents which, because of their nature, require non-routine responses and planning. Through simulations and progressive activities, you will have many opportunities to practice effective approaches to planning for such incidents. This kind of performance-based learning is designed to equip you with the tools that you may apply in your local setting. Providing an experience base in preparing for a broad range of special operations, the course is of value to emergency medical services managers and planners wishing to extend their ability to deal effectively with both scheduled and crisis events that may tax or overwhelm their resources.

Enclosed is a pre-course assignment for you to complete before the first day of class. Initial activities will relate to this information. Also, please familiarize yourself with the Blue Water County information found at www.usfa.dhs.gov/downloads/pdf/pcm/R152-blue-water-county.pdf. This information will be utilized throughout the class.

End-of-class graduation ceremonies are an important part of the course and you are expected to attend. Please do not make any travel arrangements to leave campus until after you and your classmates graduate.

Increasing numbers of students are bringing laptop computers to campus. You alone are responsible for the security and maintenance of your equipment. The Academy cannot provide you with computer software, hardware, or technical support to include CDs, printers, scanners, etc. There are a limited number of 120 Volt AC outlets in the classrooms. A Student Computer Lab is located in Building D and is available for all students to use. It is open daily with technical support provided in the evenings. This lab uses Windows XP and Office 2007 as the software standard.

Should you need additional information related to course content or requirements, please feel free to contact Mr. Michael Stern, Emergency Medical Services Curriculum Training Specialist, at (301) 447-1253 or email at michael.stern@fema.dhs.gov

Sincerely,

Dr. Denis Onieal, Superintendent
National Fire Academy
U.S. Fire Administration

Enclosure

PRECOURSE ASSIGNMENT

Instructions

There are three parts to this pre-course assignment:

Part 1: "Organizational Demographics and Goals" This part will be collected the first day of class

Part 2: "Organizational Structure and Points of Contact List" This information will be used during your program attendance

Part 3: "ICS EMS Self Study" Prior to attendance to the program you should review the enclosed ICS for EMS self study materials. Although your organization may use ICS, please insure that you understand the terminology that this program will use. ***There will be a brief examination concerning this material at the beginning of the program.***

Part 1: Complete the organizational demographics information on the following two pages. After completion, make arrangements to speak with your supervisor concerning your attendance to this program. During the **discussion with your supervisor,** allow them to read the program goal statement below. Solicit your supervisor's input as to a specific educational or informational goal that could be identified as being very helpful or necessary for your organization and record this recommendation in the appropriate box.

Program Goal

The course is designed to provide the Emergency Medical Systems manager with the knowledge, skills, and abilities to prepare their system for response to incidents involving specialized physical or human resource requirements or which, due to the unique characteristics of the operation, require specialized preparation and control.

Precourse Assignment Part 1

ORGANIZATIONAL DEMOGRAPHICS AND GOALS

EMS Service Type	Fire Based Third Service Public Private
Staffing type	Volunteer Career Combination
Employees	Approximate number of members with your organization: _____
Service provided by your organization	First Response BLS only First Response BLS and ALS BLS Transport ALS Transport Other
Population Served	Under 1,000 1,000 to 5,000 5,000 to 10,000 10,000 to 25,000 25,000 to 50,000 50,000 to 100,000 100,000 to 200,000 200,000 to 500,000 Over 500,000
Geographical Area	Approximately how many square miles is your EMS organization responsible for: _____
Response Volume	Approximately how many EMS calls does your organization respond to annually: _____
Position	Which of the following best describes your position within your organization: (Check the single best descriptor) Chief Officer or System Director Upper Level Management EMS Operations Manager Shift Commander EMS Supervisor Station Officer Charge Medic Other Specify:_____
Resources	Does your organization have any of the following resources or capabilities? (Check all that apply.) Hazardous Materials DMAT Structural Collapse Trench Rescue High Angle Rescue Confined Space Rescue Metropolitan Medical Strike Team Swift Water Rescue Wilderness Rescue Dive Rescue Tactical Medical Other unique resources: _____ _____

Local Hazards	Which of the following hazards are <u>likely</u> to occur in your area? (Check all that apply) Earthquakes — Floods Haz-Mat Emergencies — Confined space emergencies Hurricanes — Structural collapses Tsunamis — Trench collapses Blizzards (extreme cold) — Heat Emergencies (extreme heat) Terrorist events — Plane Crashes Mass Gatherings (e.g. stadiums and coliseums) Wildfires Visited by dignitaries (e.g. President, foreign heads of state) Other(s): Specify _____
Your goals for this program.	Briefly describe your major goal for the attendance of this program. What most interests you with regard to EMS Special Operations?
Your supervisor's goal and direction	Briefly describe your supervisor's goal for your attendance to this program. Be as specific as possible. What does your supervisor feel is the most important information with which you should return from this program?

Function	Agency	Contact Person and Phone Number
Hazardous Materials Team		
Technical Rescue Team		
Law Enforcement		
Narcotics:		
SWAT:		
Any Local Funeral Director's Association		
Critical Incident Stress Debriefing Team		
Employee Assistance Programs		
Name of any employee that serves on a DMAT		
Name of any employee that serves on a USAR Team		

Precourse Assignment Part 3

ICS-EMS SELF-STUDY

The following materials contain information necessary for course activities. Although your agency may already operate under an incident management system, it is necessary to insure the use of standardized terminology during the program, without spending an excessive amount of time on the basic concepts of ICS.

Please review the following material prior to your attendance. Your understanding of this information will be evaluated during the start of the program. The results of the evaluation will allow the instructors to adjust program delivery to meet the needs of the class.

MODULE 3:
RESOURCE MANAGEMENT

UNIT 1:
COMMAND AND PLANNING

TERMINAL OBJECTIVES

The Emergency Medical Services (EMS) System Manager will:

1. *Incorporate considerations of the Incident Command System (ICS) into the development of an EMS Special Operations Emergency Response Plan.*

2. *Describe the benefits of the ICS and Standard Operating Procedures (SOP's).*

3. *Identify laws, regulations, and standards relating to ICS.*

4. *Describe the six phases of a multiple casualty incident.*

5. *Describe the structure, use, and function of a Unified Command structure.*

OVERVIEW

We have introduced you to a variety of resources that can be used for special operations and disasters. With the wide array of potential resources that might be used, it is important that we consider how we are going to organize a potentially massive response to such events. Therefore, it is imperative that everyone be thoroughly familiar with the ICS, as it will play a crucial role in an effective and efficient response.

For some, a review of the ICS will be just that, a review of concepts they already use and practice. For those, this will be an opportunity to reinforce their present knowledge base. However, for many in the course, this will be their first exposure to the concept.

BENEFITS OF AN INCIDENT COMMAND SYSTEM

Emergency services, multiple patient, and mass casualty incidents do and will occur. Emergency responders need to be able to manage these events effectively. A proven system, the ICS, is designed to provide the emergency responder with an organization and system to manage these events effectively.

Many benefits can be gained from the use of the ICS. It enables the user to organize, control, and direct responders quickly. It eliminates the possibility of freelancing. It allows the Incident Commander (IC) to direct all responders toward a common goal. This organization, control, and direction minimize confusion and chaos.

The ICS also provides for common terminology and position titles. It ensures that there is a communications plan, and that radio communications to command team members are controlled. Proper radio designations for all command team members also are assured.

The ICS creates a chain of command that ensures the proper flow of critical communications to the appropriate command team members. This information flow is vital; effective decisions cannot be made without proper and timely information.

The ICS groups common functions and responsibilities together within the organization. This assures that related functions are not fragmented and are not competing against one another. For example, all treatment-related functions are grouped under the Medical Group/Division Supervisor.

The ICS provides for responder accountability. Personnel will know how the system will evolve to fit the emergency, who they will be working for, who will be working for them, how to communicate decisionmaking information, and how to request the resources needed for their area of responsibility. The system provides a standardized approach to managing mass casualty incidents.

The ICS will be effective only if all responders are trained in its use and know how to use the system. The goal of this course is to provide the training necessary to implement an ICS effectively at emergency medical incidents.

EFFECTIVENESS OF STANDARD OPERATING PROCEDURES

Written Standard Operating Procedures (SOP's) are essential to the effective application of the ICS. SOP's reflect the policy of the agency regarding the implementation and use of the system. It ensures that there is an organizational-wide, standardized approach to incident management.

With written SOP's in place, a standardized and predictable approach to incident management can be assured. Procedures describe when to implement, what to implement, and how to implement. The system evolves in a predictable manner. Written SOP's also provide a training tool. Procedures can be used for study, training, and promotional exam purposes.

Written SOP's also provide a performance standard or indicator for personnel. They have a written description of what their performance should be for various positions in the command organization. This allows for self-training and self-analysis.

SOP's provide a baseline for critiques and the review of incidents. With SOP's in place, the agency has a baseline to judge its performance. The procedures describe the performance desired, which can be compared to the incident performance. This review permits improved performance for future incidents. Training and equipment needs are identified. Procedural changes also can be identified.

Procedures allow the IC to be more effective. With standard, predictable approaches to scene management, resources are controlled and used more effectively.

Procedures can be effective only if they are all used routinely. They shouldn't be reserved only for the "big one." The application of the system on routine, small incidents provides a continuous opportunity for experience in the system, as well as review, revision, and improvement in operations.

LAWS, REGULATIONS, AND STANDARDS

A number of laws, regulations, and standards apply to the use of the ICS. They may not apply specifically to multipatient or mass casualty incidents, but they describe the current environment that may require the use of the ICS.

The Superfund Amendments and Reauthorization Act (SARA) was passed by Congress in 1986. The law requires any agency that may respond to a hazardous materials incident to use the ICS structure. It will be too late to design a system when a combination mass casualty and hazardous materials incident occurs.

Following the passage of SARA, the U.S. Occupational Safety and Health Administration (OSHA) promulgated regulations that further mandate the use of the ICS for agencies involved in hazardous materials incidents. These regulations are found in OSHA Title 29, Code of Federal Regulations (CFR) 1910 120.

For EMS operations, OSHA regulations also may be interpreted to require an ICS to be implemented at any medical incident. This would fall under the biological and bloodborne hazard and exposure concern.

The U.S. Environmental Protection Agency (EPA) also regulates and monitors all emergency operations and situations affecting or potentially affecting the environment. These regulations can be found in EPA-311.

The National Fire Protection Association (NFPA) has developed standards relating to firefighter health and safety. NFPA 1500, *Standard on Fire Department Occupational Safety and Health Program,* specifically recognizes the safety benefits of the ICS. The standard states that all agencies should establish written procedures for incident management. It requires that all members be trained in and be familiar with the ICS. The standard outlines the responsibility for safety at all supervisory levels.

NFPA 1561, *Standard on Fire Department Incident Management System,* contains and describes broad guidelines on the minimum requirements for the ICS.

MULTIPLE CASUALTY INCIDENT

The definition of a multiple casualty incident (MCI) is not static. It will vary from one community to another, and is dependent on the availability of resources. Typically it may be described as an incident that substantially draws down the local resources in the community and has a negative impact on local hospitals.

A small incident, that has been defined as an MCI, is one that may have produced a minimal number of casualties, but has been complicated by unusual events such as a hazardous materials spill. An MCI would require the response of two or more medical-type units. Local hospitals would be affected, since the number of patients would be disruptive to the hospital's normal operations. This, in turn, will affect a system's capability to maintain routine operations, and adversely affect turnaround time at the hospital, thus diminishing the level of available resources for immediate response to routine emergencies and/or to the MCI.

Six Stages of Incident Management

It is important to understand the various stages of an MCI. Unlike a routine, one-patient EMS response, the focus of the responders needs to be on the evolution of the incident. We as responders cannot focus on the needs of a single patient. Our attention needs to be on accomplishing the greatest good for the greatest number. This goal is tied into the application of ICS for EMS. By modifying our focus from strictly clinical to a combined management/clinical approach, emergency responders are able to understand the incident evolutionary process, forecast events and needs, and structure a management organization based on those needs.

Preplanning and Training

Preplanning and training of rescuers who may respond to an MCI will determine the effectiveness of the scene operation. Plans and procedures need to be developed jointly by all the agencies likely to respond. They include fire, EMS, law enforcement, dispatch, hospitals, public works, etc.

Pre-incident agreements need to be developed to define the roles and responsibilities of all agencies and their resources. Use and application of the ICS must be part of the agreements. Frequent and ongoing training in multiple-patient operations must occur. This also includes training on the application of the ICS. Regular "field" exercises or drills also will sharpen skills.

Initial Response

In the initial response stage, the system is reacting to information received from callers to 911. Consider early confirmation of the incident (i.e., multiple calls into 911 from the same location, information received by competent authorities such as police on scene), and the activation of a predefined response matrix.

The responders during this stage are preparing themselves mentally for the incident and reviewing the MCI response protocol for their local jurisdiction. Concurrently, the dispatch center is gathering more information on the incident, activating the MCI response action plan (SOP), and relaying any pertinent information relative to the incident to the responding units. It is important to remember that the confirmation/ verification process by the dispatch center should not delay the activation of the MCI SOP nor the response of initial units to the reported incident location.

The initial response stage concludes when the first unit arrives on the scene of the incident.

Operations

The operations stage commences with the arrival of the first unit on the scene. During this stage, the incident is confirmed, a suitable Staging Area is identified, an Incident Command Post (ICP) is established, and Command is assumed and announced over the radio. The first unit will provide a preliminary report to dispatch with all pertinent available information regarding the incident (i.e., approximate number and types of patients, hazards present, and request for additional resources). The first-arriving unit will retain Command until the first command-qualified person is present to initiate the transfer-of-command process. The dispatch center should be relaying information to responding units relative to the incident conditions that have been confirmed, the Staging Area location, and the ICP location. It is in the early stages of the incident that many of the ICS positions are activated.

Early in the incident, the level of resources responding may increase dramatically due to the demands of the incident. The IC will employ the ICS structure, as required, to manage the incident effectively in a safe and efficient manner.

Stabilization

During the stabilization stage, the IC continues to manage the incident through the ICS structure using the specified resources determined in the operations stage. Continual progress reporting from the scene, and information exchange regarding the availability of hospital beds, etc., is occurring, and incident operations is adjusting resources and the organization to stay ahead of need. Progress has been made, patient care has been initiated, and the incident is progressing smoothly towards de-escalation and termination.

Demobilization

The demobilization stage is the point at which the IC commences the release of units back into service from the incident. This release of resources can be from the scene, from the hospital after transport of patients, or by canceling units still en route. The reduction of resources for the incident should be as aggressive as was the initial response. It is incumbent upon the IC to ensure an appropriate level of resources on the scene to complete management of the incident. In some cases, hasty decisions to release units from the scene in a less-than-controlled manner have resulted in members requiring EMS assistance with no transport capabilities left on scene. Prudence should guide the IC's decisions regarding the appropriate resource level on scene until the evolution of the incident in the termination stage.

Termination

An incident is terminated when the IC has determined that no further action is required and the scene is secured. The IC will give a final progress report with recap of patient totals and unit status, stating at the conclusion of the report that the scene/incident has been secured.

Who is in Command?

All incidents must have a single IC who directs all incident operations no matter how many agencies may respond to the MCI. The challenge is, who should that be? Which agency? Which discipline?

State and local laws and ordinances may define which agency or discipline has the legal responsibility for managing mass casualty incidents.

Generally, fire departments are given the responsibility to manage fires, mass casualty (when EMS is a component of the agency), hazardous materials, and other non-law enforcement emergency incidents. Where multiple fire departments respond to the incident, command responsibility typically is given to the department of the jurisdiction in which the incident is occurring. All other fire departments work for that fire department to resolve the incident.

In instances where EMS provision is via a third-service system, the EMS agency may be responsible for managing the MCI Branch.

Law enforcement agencies generally are responsible for managing all operations related to criminal incidents such as terrorist events, bombings, snipers, hostage situations, etc. Fire and EMS agencies become subordinate to the police and support their operations.

A single IC must be appointed for an incident unless the incident is to be managed under a Unified Command. Unified Command will be discussed further in Unit 2: Command Responsibilities.

Pre-incident planning is essential in determining the IC and the process for merging all the possible agencies responding to the incident into the ICS. This planning should produce written agreements reflecting the merger, followed by the necessary training.

Most fire departments have broad experience in the use of the ICS. Other agencies, such as law enforcement, may not have any experience in the use of the ICS. Because of this, fire departments should take a lead role in assisting other agencies and disciplines in the adoption, training, and implementation of the ICS. Incident operations will **not** be very effective unless all responders are working within the system.

MODULE 3:
RESOURCE MANAGEMENT

UNIT 2:
COMMAND RESPONSIBILITIES

TERMINAL OBJECTIVES

The students will be able to:

1. *Describe the three responsibilities of the Incident Commander (IC) at special operations events.*

2. *Describe the process of establishing initial Command.*

3. *Explain the transfer-of-command process.*

4. *Explain the limitations of the process of passing Command.*

RESPONSIBILITIES OF COMMAND

For major medical operations, the IC has three basic responsibilities:

- The rescue of all victims.
- Ensuring that patients are extricated, treated, and transported to medical facilities.
- Stabilizing the incident and providing for life safety, accountability, and welfare of personnel.

COMMAND PROCEDURES

All agencies likely to respond to a major medical incident must establish procedures relating to the Incident Command System (ICS). Command procedures should describe in detail the process of establishing Command and developing a command organization.

Command procedures are designed to fix the responsibility of Command on one specific individual through a standardized identification system, depending on the arrival sequence of members, units, and chief officers.

Command procedures should ensure that a strong, direct, visible Command will be established from the onset of the incident. This visible Command is accomplished through the use of the "Command" radio designation, and through a fixed Incident Command Post (ICP) location.

Command procedures establish an effective incident management organization, defining the activities and responsibilities assigned to the IC and to other individuals operating within the ICS.

Command procedures provide a system to process information to support incident management, planning, and decisionmaking. The procedure also provides an orderly process for transferring Command.

Establishing Command

The first member or unit to arrive on the scene of an incident must assume Command. The initial IC will remain in Command until Command is transferred using the transfer-of-command process, or until the incident is stabilized and terminated.

Radio Designation

The designation "Command" or "Incident Command" or "IC" will be used to designate the person presently in command of the incident. An incident name also may be applied to the incident ("I-17 Command" or "Metro Center Command"). This designation will not change throughout the duration of the incident.

The purpose of the "Command" designation is to emphasize the Command authority and to eliminate the extreme difficulty field units would have in trying to track several different individual units as change occurs as part of the transfer-of-command process

FUNCTIONS OF COMMAND

The ICS is used to facilitate the completion of incident objectives. The IC is the person who drives the ICS towards that end. The IC is responsible for building a command structure that matches the organizational needs of the incident.

The IC's responsibility is the overall management of the incident. On most incidents, the Command activity is carried out by a single IC. The IC is selected by qualifications and experience.

The IC may have a deputy, who may be from the same agency or from an assisting agency. Deputies also may be used at section and branch levels of the ICS organization. Deputies must have the same qualifications as the person for whom they work, as they must be ready to assume Command at any time.

Roles and Responsibilities

- assess the situation and/or obtain a briefing from the prior IC;
- determine incident objectives and strategy;
- establish the immediate priorities;
- establish an ICP;
- establish an appropriate organization;
- ensure planning meetings are scheduled as required;
- approve and authorize the implementation of an Incident Action Plan (IAP);
- ensure that adequate safety measures are in place;
- coordinate activity for all Command and General Staff;
- coordinate with key people and officials;

- approve requests for additional resources or for the release of resources;
- keep agency administrator informed of incident status;
- approve the use of trainees, volunteers, and auxiliary personnel;
- authorize release of information to the news media;
- ensure Incident Status Summary is completed and forwarded to appropriate higher authority; and
- order the demobilization of the incident when appropriate.

STRATEGIC PLANNING

The IC is responsible for the overall functions of the incident, including strategic planning. During the incident the IC should continually assess incident needs, including:

- direction and flow of responding units;
- splitting EMS crews to double care-giving roles quickly (one medic to triage/treatment; partner stays with patient for continuous, same-level care during transportation);
- use of nonassigned personnel to drive ambulance;
- location of treatment/care holding areas;
- additional resources specific to incident needs;
- law enforcement for traffic/crowd control;
- specialty equipment (cranes, large tow trucks), lighting;
- potential issues, problems, and needs, including those that affect the community, such as local hospitals, transit system, etc.; and
- initial incident tactical and strategic objectives and the development of a formal IAP.

Strategic planning meetings should occur at time intervals designated by the IC. The time and location of the strategic planning meeting should be announced to all personnel in a leadership role. The IC will facilitate the strategic planning meeting, until the incident organization requires the establishment of a Planning Section. Then, the Planning Section Chief will facilitate the meeting in coordination with the IC. Personnel attending these meetings shall be prepared to discuss the needs and operations of their area briefly and concisely. The IC will make organizational changes based on the information received.

TRANSFER OF COMMAND

The fact that a higher-ranking person has arrived on the scene does not mean that he/she is prepared to assume Command of the incident. The person may or may not have full knowledge of previous orders or current activities. Without a thorough briefing of the situation status (SITSTAT), the officer will compromise the operations.

A standardized approach for transferring Command to a qualified person is essential. This process needs to be described in the Standard Operating Procedures (SOP's). The transfer-of-command process also applies during the demobilization process as Command is transferred down.

Chain of Command

Within the chain of command, the actual transfer of Command will be regulated by the following:

- The person assuming Command will communicate with the person presently in command by radio or face-to-face. Face-to-face is preferred. Once a fixed ICP is established, a face-to-face meeting is carried out easily.

- The person being relieved will brief the new IC, and review at least the following:

  - the incident conditions (patient count, priority, hazards, etc.);
  - the (IAP);
  - progress towards achieving objectives;
  - safety considerations, concerns;
  - deployment and assignment of operating units and personnel; and
  - appraisal of the need for additional resources.

- The person being relieved of Command should review the tactical worksheet or status board with the person assuming Command. The worksheet provides a detailed listing of resources committed and resource positions on the incident site. This sheet provides the most effective framework for the transfer of command as it provides this information in a standardized format.

  - The person being relieved of Command will be assigned to the best advantage by the IC assuming Command.

- Dispatch should be advised of the change and the identity of the new IC. This is required to maintain accurate records of the change.

The transfer of Command downward during demobilization requires the same degree of importance as was placed on the original escalation. A detailed review of the worksheet and the demobilization plan will be required.

It is important to remember that assumption of Command is based on an individual's qualifications to be in the position, and is not predicated on rank.

Passing Command

The practice of passing Command to a later-arriving resource occurs when the just-arriving resource must commit to a time critical life-saving action. This might occur when the first resource arrives to find a burning vehicle with victims trapped. The firefighters and/or rescue needs may prohibit the senior member from assuming full IC responsibilities. In this case, the second-arriving resource would assume the IC's role.

When passing Command, it is highly recommended and preferred that the initial resource announce its arrival, provide the onscene report, and assume initial command responsibilities. Passing Command should occur only when another resource is on scene, or approaching the scene.

To announce the passing of Command prior to arrival of another resource creates a major gap in the Command process. Dispatch and other inbound crews may not have copied the passing of Command. In a sense a football has been kicked and no one knows where it is going. Further, the time-critical task of the first resource may be short lived, and the senior member may be available to assume a Command role prior to the arrival of subsequent resources. In addition, first-in personnel may need to communicate additional resource needs or progress reports. This creates confusion and breaks the continuity of the chain of command.

The more effective approach is for the first resource on scene to assume the Command role, and retain it until the second resource approaches or arrives. Direct communication is established between the two, and a quick transfer of command takes place via radio. The second resource must acknowledge the transfer of command and notify dispatch of the change.

UNIFIED COMMAND

Unified Command is a standard method to coordinate command of an incident when multiple agencies have jurisdiction. Such events are not uncommon, and the understanding and use of a Unified Command structure is important.

In a Unified Command structure, the individuals designated by jurisdiction, or by agency within a single jurisdiction, must determine objectives, strategies, and priorities jointly. It is through this structure that interdisciplinary information can be exchanged and a global strategy can be determined to accomplish the unified goal. The use of a Unified Command structure aids to ensure coordination of all assets operating on the scene.

Generally, a Unified Command structure is called for under the following conditions:

- The incident is totally contained within a single jurisdiction, but more than one department or agency shares management responsibilities due to the nature of the incident (e.g., jetliner down with fire department, EMS, law enforcement, Federal Aviation Administration (FAA), National Transportation Safety Board (NTSB), or similar interdisciplinary response events).

- The incident is multijurisdictional in nature (e.g., large event on city line, major flooding of a large geographic area across community borders, etc.).

In these or similar events the use of a Unified Command system will assist in achieving the goal of an effective, well-coordinated command structure.

INTERPERSONAL SKILLS

EMS providers generally do not have a supervisor respond with them on every call. In most cases, the EMS provider normally responds with just one partner, and makes independent decisions and takes actions based upon a single patient's needs. EMS members may not understand the need for onsite senior supervision; hence they might experience difficulty with the concept of implementation of an ICS structure which assigns officers to each functional area. During the implementation of the ICS a transition of behavior occurs.

During those events in which a structured ICS needs to be established, the normal relationship behavior that allows for discussion relative to an assigned task is inappropriate. The emergency situation does not permit discussion or debate. Time does not permit it. This relationship behavior could prove to be unsafe and counterproductive to effectiveness of incident management.

Task behavior does not allow discussion. A task is assigned/delegated and it is to be executed as directed. The emergent and pressing nature of an EMS response and management demands this type of reaction from subordinates on scene. Discussion may occur, time permitting.

The only deviation that occurs under the task behavior model is when the subordinate perceives or has verification that the direction received is a gross safety risk. If the task is perceived as such it needs to be brought to the attention of the assigning officer.

MODULE 3:
RESOURCE MANAGEMENT

UNIT 3:
ESTABLISHING AN ORGANIZATION

TERMINAL OBJECTIVES

The students will be able to:

1. *Describe the purpose of subdividing the incident into common manageable components.*

2. *Describe when Divisions and Groups should be implemented.*

3. *Describe the general responsibilities of Division/Group Supervisors.*

COMMAND ORGANIZATION

The command organization must be developed at a pace that stays ahead of the tactical deployment of the personnel and resources. In order for the IC to manage the incident, he/she must implement Divisions/Groups.

Divisions/Groups/Units

Divisions, Groups, and Units are tactical-level management positions that group common resources. Divisions represent a geographic operational area (e.g., Division A would be responsible for the north side of the incident). Groups represent a functional area of responsibility (e.g., patient transportation group). A unit is an organizational element having functional responsibility for a specific incident activity.

Divisions and Groups are under the control of a "supervisor" (e.g., Medical Division Supervisor or Patient Transportation Group Supervisor). Units are controlled by a "leader" (e.g., Treatment Unit Leader or Triage Unit Leader).

The use of Divisions/Groups in the command organization provides a standard system to divide the incident into smaller, more manageable elements.

Complex emergency operations often exceed the capacity of one officer to manage the entire operation effectively. Divisions/Groups reduce the span of control to more manageable, smaller-sized elements. This allows the IC to communicate principally with persons in these organizational positions, rather than individual resources or members (control of communications).

The number of Divisions or Groups that can be managed effectively by the IC varies. Normal span of control is three to seven. In fast-moving, complex operations a span of control of no more than five Divisions/Groups is indicated. In slower, less complex operations, the IC may be able to handle more.

To build an effective command organization that stays ahead of demand, the IC must implement Divisions or Groups early. Generally, the first resources assigned to a geographic or functional responsibility should be assigned a Division, Group, or position.

General Division/Group Supervisor Responsibilities

The Division/Group Supervisor must be in a position to supervise and monitor operations directly in his/her area of responsibility. This will require the supervisor to be equipped with appropriate protective clothing, identifying vest, and a portable radio. The supervisor will be responsible for, and in control of, all factions within his/her Division/Group or Unit. This requires each supervisor to:

- complete objectives assigned by the IC;
- account for all assigned personnel;
- ensure that operations are conducted safely;
- monitor work progress;
- redirect activities as necessary;
- coordinate actions with related activities and adjacent units;
- monitor the welfare of personnel;
- request additional resources as needed;
- provide the IC with essential and frequent progress reports; and
- reallocate resources within the area of responsibility as needed.

Division/Group Personnel

The responsibility of the supervisor is the supervision of resources assigned to him/her. The primary responsibility of personnel assigned to the Division/Group is to work for that area of responsibility only. All problems, successes, or communications must be directed to that Division/Group Supervisor.

Any member can bypass his/her supervisor at any time to communicate critical safety concerns to the IC.

Division/Group Assignment Factors

Assigning Resources

The IC should begin to assign Divisions or Groups based on the following factors.

- When situations eventually will involve a number of resources or functions beyond the capacity of the IC to control directly. The IC should begin to assign Division/Group responsibilities to the first resources assigned to a geographic area or function.

- When the IC no longer can cope effectively with (or manage) the growing number of resources involved in the operation.

- When companies are involved in complex or high-risk operations.

- When resources are operating from a tactical position over which the IC has little control (e.g., out of sight).

- When the situation presents special hazards, and close control is required over operating resources (e.g., unstable structural conditions, hazardous materials).

Establishing Divisions/Groups

When establishing Divisions or Groups, the IC will assign each the following:

- the incident objectives (what the IC wants accomplished);
- a radio designation (extrication group, patient transportation group, etc.);
- the identity of other resources being assigned;
- radio channel; and
- any other critical information.

Division/Group Guidelines

Divisions/Groups will be regulated by the following guidelines.

- It will be the ongoing responsibility of the IC to assign Divisions/Groups as required for effective emergency operations; this assignment will relate to both geographic and functional Divisions/Groups.

- The IC will advise each Division/Group of specific tactical objectives. The overall plan and strategy should be communicated (time permitting) so the Divisions/Groups have some idea of what is going on and how their assignment fits into the overall plan.

- The number of resources assigned to a Division/Group will depend on conditions. The IC must maintain an awareness of the number of resources operating within a Division/Group and the ability of that Division/Group Supervisor to direct operations effectively.

- The incident should be subdivided in a manner that makes sense. Common responsibilities or geographic areas should be assigned under a common Division/Group Supervisor.

Each Division/Group should be given a title that best reflects its area of responsibility. Divisions are geographical and are designated starting with "A" and moving clockwise within the incident to "B," "C," etc. (e.g., Division A, Division B). Groups are titled according to function (e.g., Patient Transportation Group, Medical Group, Extrication Group, etc.).

Assignment to Divisions/Groups

When units are assigned to an operating Division/Group they will be told to which position they will be reporting. The Division/Group Supervisor will be advised of which resources are being assigned to him/her. It is the responsibility of the Division/Group Supervisor to communicate any specific instructions relative to specific action needed to the newly arriving resources.

MODULE 3:
RESOURCE MANAGEMENT

UNIT 4:
COMMAND AND COMMUNICATIONS

TERMINAL OBJECTIVES

The students will be able to:

1. *Describe the interpersonal skills required for incident management.*
2. *Describe the key elements in a communication system.*
3. *Describe the Communication Order Model process.*

GENERAL OVERVIEW OF THE INCIDENT COMMAND SYSTEM

We live in a complex world where responding to emergencies, whether from single-car accidents, hazardous materials emergencies or large-scale disasters, requires the cooperation of many agencies. To meet this challenge a management system was developed to allow an organized approach to emergency incident management. The Incident Command System (ICS) was born of experiences from real-world disasters and provides a solid foundation for the effective control and use of numerous resources from multiple agencies.

ICS is based on basic business management principles. Specifically, ICS includes the functions of

- planning;
- directing;
- organizing;
- coordinating;
- communicating;
- delegating; and
- evaluating.

In essence, ICS provides for the overall management and staffing to meet the needs of an emergency incident. ICS allows an incident organization to be built around a modular format, that is, only those components that are needed to manage the incident are activated. The incident organization then grows and shrinks based on demands and specific needs.

There are two basic command types used under the ICS: Single Command and Unified Command. In Single Command, one Incident Commander (IC) is responsible for the overall incident. Under a Unified Command structure, several individuals (by virtue of legal jurisdictional authority) share the responsibilities of command and incident management.

ICS is an all-risk management organization designed to allow for the management of varying emergency problems, not just fires. In its design, ICS is structured around eight common components:

- common terminology;
  - common position titles;
  - common responsibilities;
  - common nomenclature;
- modular organization;
- integrated communication (plain text communications, no "10-Codes");
- Unified Command structure;
- consolidated action plan;
- manageable span of control (three to seven; five is optimum);

- designated incident facilities; and
- comprehensive resource management.

ORGANIZATIONAL STRUCTURE

Beyond the basic common components and command modes, ICS is comprised of two major organizational categories referred to as Command Staff and General Staff. In addition to the IC, the Command Staff is made up of three positions: Safety Officer, Liaison Officer, and Information Officer.

General Staff positions are established for four primary areas of duties and responsibilities: Operations, Planning, Logistics, and Finance/ Administration. These four areas are managed by individuals referred to as Section Chiefs (e.g., Operations Section Chief, Planning Section Chief, etc.).

Subordinate to each of the General Staff Section Chiefs are a number of functional and/or geographically related positions, including Branch Directors, Division/Group Supervisors, Unit Leaders, and Functional Managers/Coordinators. Each subordinate position is designed to carry out specific functions and to maintain a reasonable span of control.

A Branch Director is an organizational level having functional or geographic responsibility for major segments of the incident. A Branch usually consists of Divisions and Groups. Divisions divide an incident into geographical areas of operation. Groups divide the incident into functional areas of operation. Units are specific to functions, e.g., Resource Unit, Food Unit, Communications Unit, etc. Managers are assigned to a specific function such as Staging Area Manager, Treatment Dispatch Manager, and Immediate Treatment Manager.

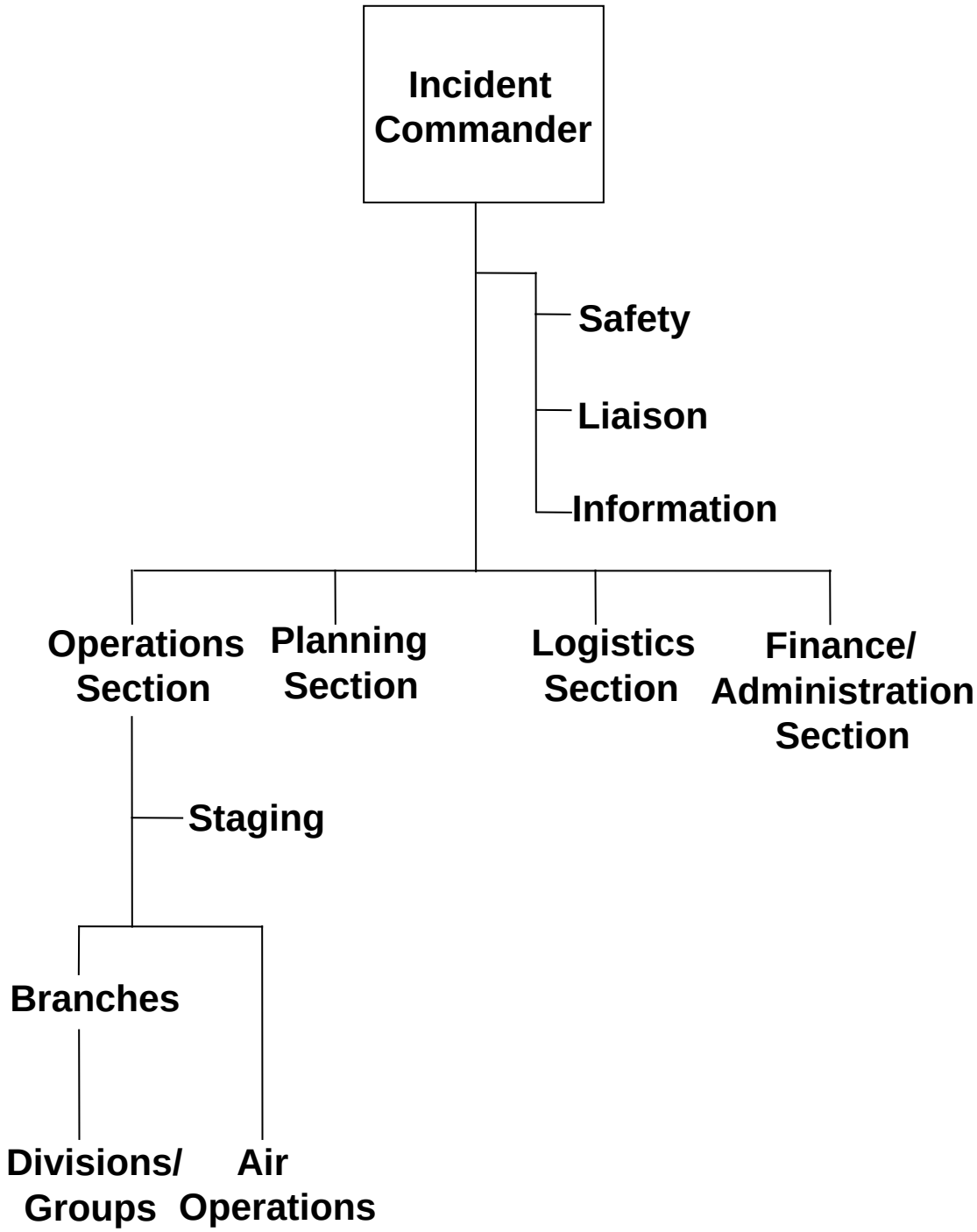

Figure 3-4-1
Model ICS Organizational Chart

INCIDENT COMMAND SYSTEM/EMERGENCY MEDICAL SERVICES ORGANIZATION

Due to its all-risk design, ICS encompasses an organization suitable for use on Emergency Medical Services (EMS) incidents. The medical organization has been developed to, once again, allow for the modular development of an organization to meet the demands of the incident. Only those positions that are required to manage the incident effectively are activated.

In its design, the ICS Multicasualty (MCI) Branch is a component of the Operations Section. With full implementation, medical duties are under the direction of a Branch Director. Two general medical functions have been identified; the Medical Group is in charge of treatment and triage, and the Patient Transportation Group is in charge of providing and coordinating patient transportation. Specifically, the ICS MCI Branch is organized as noted in Figure 3-4-2.

The positions within the MCI Branch will be discussed in detail in later units.

Incident Command Organizational Chart for a Multicasualty Branch Full Branch Response Level

*Air Operations is shown for reference only.

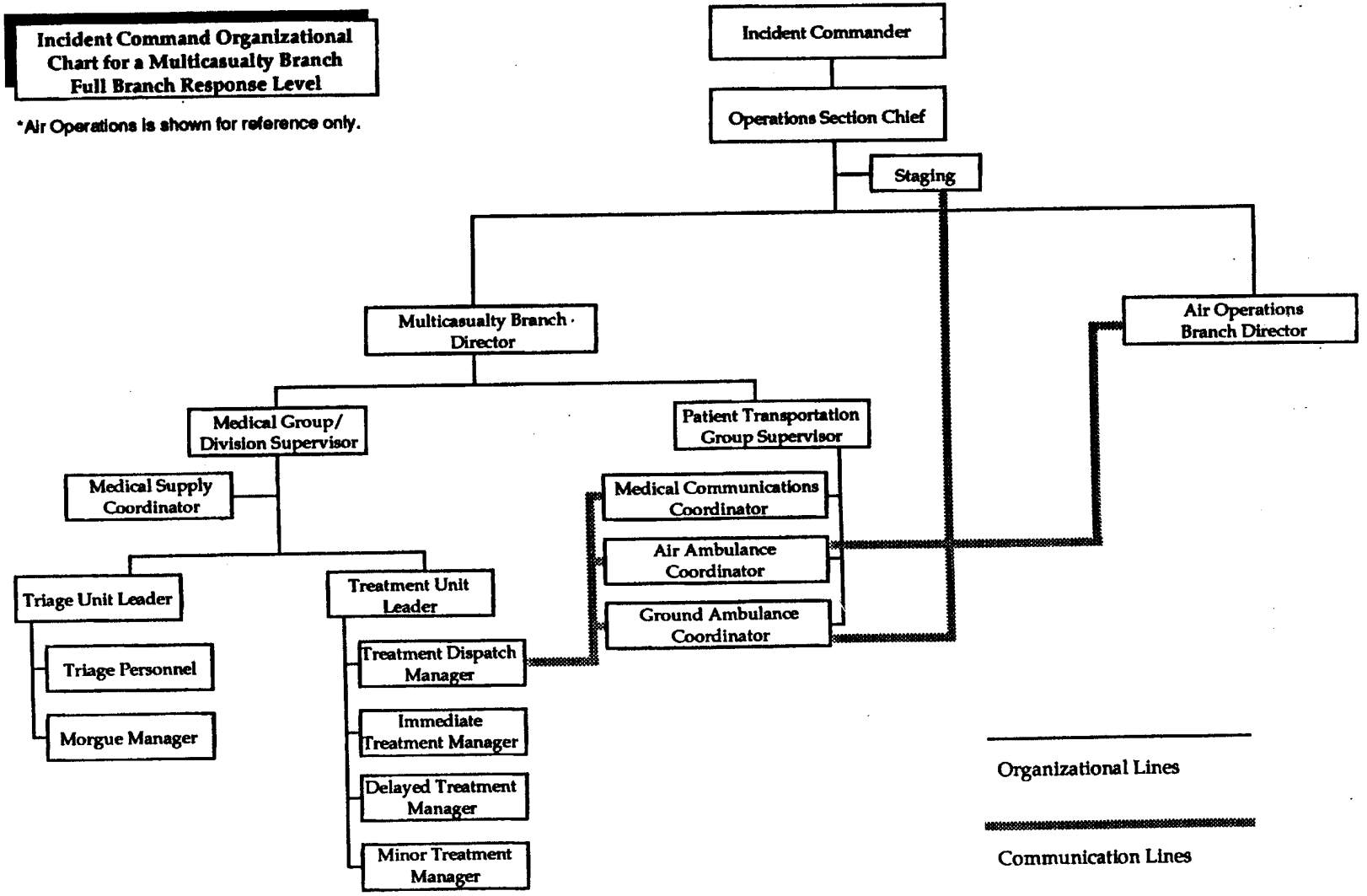

Figure 3-4-2

EFFECTIVE COMMUNICATIONS

Mass casualty incidents typically result in a large response by agencies and rescuers. Radio communications are required to organize, control, and direct these resources. With the response of large resources comes the potential for uncoordinated and saturated radio traffic. Often the radio traffic is nonessential and interferes with the more critical traffic. Communications must be controlled from the onset of the incident. Much of this control must be established in pre-incident planning and agreements.

Multiple radio channels may be needed to allow various support and administrative communications to take place without interfering with the more critical incident tactical channel. These channels need to be identified and designated before the incident occurs.

All potential responding fire and EMS agencies must have the ability to talk on these predesignated channels. It's absolutely critical that responding units be able to talk to one another and directly to the IC.

All persons holding organizational positions must have the ability to talk directly with the assigned supervisor or leader.

Radio "10-Codes" have no place in a multi-agency response to a mass casualty event. Radio codes vary from one agency to another, and their use has a great potential for creating confusion. Codes are antiquated and obsolete. It is essential to use "clear speak," with straightforward language.

Communication Order Model

Radio communications are essential to effective scene operations. Early control of the communications process is essential. Command will be established and announced on the radio. Orders and directions will be provided over the radio. Progress reports will be given. It is important that the sender of the various communications be assured that the order was given to the proper person or unit, and that the order was received, that the receiver understands the order and is taking proper and correct action on the order. The Communication Order Model provides a means to confirm the receipt of orders.

The Communication Order Model is primarily a brief repeat of the original order given that allows the sender to evaluate whether the order was received, understood, and resulted in correct action being taken on the order.

An example of information exchange without the use of the Communication Order Model might be:

- "Rescue 3 from 20th Street Command: Come into the scene, position next to the bus, get a patient count for me, and you'll be the Extrication Group Supervisor."

- "Rescue 3, 10-4"

  In this scenario, the "10-4" means nothing. The "10-4" might have been an override from a more powerful radio. Using the communication order model would have resulted in the following reply:

- "20th Street Command from Rescue 3: Copy. Park next to the bus, get a patient count, and I'll be the Extrication Group Supervisor."

As a result of the Communication Order Model, the IC now is assured that Rescue 3 copied the order, understood the order, and is taking correct action. Had Rescue 3 misunderstood the order, it would have been revealed in the repeat process, and the IC would have had the opportunity to correct the problem immediately. Without the Communication Order Model, the IC must make a lot of assumptions.

Onscene Reports

Complete and descriptive onscene reporting is necessary for effective operations. A descriptive onscene report allows other responders to begin to prepare mentally for the event. In addition, the dispatch center can begin to initiate some "behind-the-scenes" support for the incident, e.g., notifying key officials, alerting hospitals, and calling back off-duty dispatchers.

The initial report should include

- confirmation of the incident;
- CP location;
- Staging location and best access route;
- nature of incident;
- exposure property (if appropriate);
- potential for extension/expansion;
- number of patients presently on site;
- potential for additional patients;
- hazards identified as presently on site;

- responders presently operating; and
- Divisions/Sectors established.

Providing the above 11 points to the dispatcher paints an accurate picture of the incident for him/her to use. In terms of data, the pertinent issues relative to EMS operations have been provided for sharing with responding resources to prepare them for the scene.

It should be noted that the above list of information does not have to be reported in the order or priority listed. Nor does it imply that the information be provided in a single extended report. Information is reported when it becomes available and is confirmed. Followup reports may be needed.

Progress Reporting

Progress reporting plays an important role in effective incident communications. The IC cannot make effective decisions without frequent and current progress reports. Nor can the IC be in all places at all times to see what's going on.

Progress reports allow for effective decisionmaking. They also allow the IC to prioritize the commitment of resources and to refine or revise his/her IAP and site operations. Progress reports should be timely, brief, and concise. Progress reporting often is more frequent during the early stages of the incident and less frequent as the incident approaches conclusion. Progress reports should consist of the following:

- incident status;
- number of patients being treated;
- disposition of any patient previously reported;
- positions established since last report;
- additional resources required; and
- demobilization report and return of units back into service.

Progress reports should be delivered under the following conditions:

- When making progress and achieving objectives. The IC needs to know your progress. This progress and the speed of progress will have an effect on the ongoing revision and refinement of the IAP.

- When not making progress, or when problems are occurring. Lack of progress will cause an immediate change in the action plan. Problems have to be reported immediately and dealt with promptly. This allows the IC to prioritize the resource commitment based on critical needs. Without the progress reports, resources may be committed inappropriately.

- When significant hazards are identified. The IC is responsible for site safety and must be notified immediately of any safety-related situations. Any safety hazards must be eliminated or minimized immediately.

- When Divisions/Groups have not reported for some time. In this case, the IC must initiate a request for a progress report.

- Before any additional arriving resources are committed. This allows the IC to prioritize the resource commitment based on critical needs. Without progress reports, resources may be committed inappropriately.

Portable Radios

Portable radios are essential to mass casualty operations. Divisions/Groups and Units will be operating in their areas of responsibility and cannot be confined to a mobile radio in a vehicle. All Divisions/Groups and Units must be equipped with portable radios to permit direct communications with the assigned supervisors and to support flow of information between cooperating ICS components. Radio frequencies must be assigned as appropriate to keep information flowing (i.e., Command Staff on frequency 1 and technical activities on frequency 2).

Dispatch Centers

Dispatch centers play a critical role in supporting communications and site operations. Dispatch centers find and dispatch the resources requested by the IC. They assign units to appropriate radio channels and process numerous information requests from the IC.

Resources should be dispatched in a standardized and group manner based on the initial report and department operating procedures. The predetermined response matrix should be delineated as a Standard Operating Procedure (SOP).

The automatic recall of off-duty dispatch staff may be necessary. The authorization for recall of staff should be defined in SOP's and should be based on incident progress reports. A report of a school bus accident with multiple serious injuries will have a substantial negative effect on the dispatch center. Such an event can overwhelm the existing staff and cause the dispatch center's critical support to collapse. Therefore, the dispatch center must have the ability to recall staff immediately.

Emergency Traffic Tone

There may be a need for an onscene emergency notification process to alert resources of a critical safety issue or other critical information. Some examples of safety issues for incidents may include downed and energized power lines, unstable wreckage, fuel leaks, or discovered hazardous materials that may affect the life safety of crews and patients.

Many agencies use a special radio tone for their tactical frequencies that is different from a dispatch tone. It is designed to catch everyone's attention at the scene. They recognize the tone as a priority alert to "emergency traffic." Following the tone's activation, Command will advise all units/crews of the hazard and corrective action.

Where a radio tone is not available, onscene sirens and air horns may be used for the purpose of emergency notification.

It should be noted that NFPA 1500, *Standard on Fire Department Occupational Safety and Health Program*, requires some form of emergency traffic notification.

MODULE 3:
RESOURCE MANAGEMENT

UNIT 5:
INITIAL RESPONSE AND ORGANIZATION

ROLES AND RESPONSIBILITIES OF THE INCIDENT COMMANDER

Specific Responsibilities

The person assigned as the Incident Commander (IC) (see Figure 3-5-1) is responsible for overall incident management. In that role he/she will

- initiate a plan by determining objectives, strategies, and setting immediate priorities;
- ensure the life safety of responders and citizens;
- determine/approve tactical objectives for incident management;
- implement the Incident Command System (ICS) structure as required by the demands of the incident;
- ensure that adequate resources are deployed to the incident and that those resources are handled effectively to manage the incident;
- facilitate intra- and interagency coordination;
- authorize release of information to the news media; and
- establish an Incident Command Post (ICP) and coordinate activities of assigned staff.

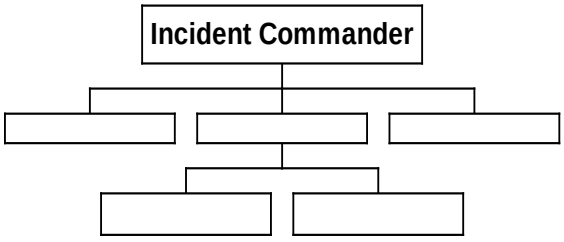

Figure 3-5-1

Initial Response Basic Organization

Although the IC has ultimate responsibility for all activities on the incident ground, through the use of the ICS structure, the IC should delegate tasks for completion to the functional area officers. As was previously explained, the use of the ICS structure permits greater effectiveness and span of control.

The modular design of ICS allows the IC to establish ICS positions on an as-needed or projected need basis. Organizational development therefore will vary from incident to incident. ICS development then should center on maintaining an effective span of control in order to meet incident objectives.

For purposes of presentation, the information contained in this and subsequent units is not presented in mandated development sequence. The presentation is designed to deliver information regarding specific positions within the ICS Multicasualty Branch and to illustrate appropriate organizational design. An IC may choose to fill lower-level positions first and fill in upper-level staff as span of control becomes an issue.

ROLES AND RESPONSIBILITIES OF DIVISION/GROUP SUPERVISORS AND UNIT LEADERS

Rescue/Extrication Group Supervisor

The IC normally establishes the Rescue/Extrication Group position (see Figure 3-5-2) early in the incident. It often is assigned to the first resource in the area. Additional positions would follow as additional resources arrive on the scene. Personnel operating within the extrication area generally do primary care on the patients and then coordinate the transport of patients to the triage areas. Often, the Rescue/Extrication Group is operating within the hazard zone with potential risks to personnel and patients and appropriate action should occur to provide safeguards.

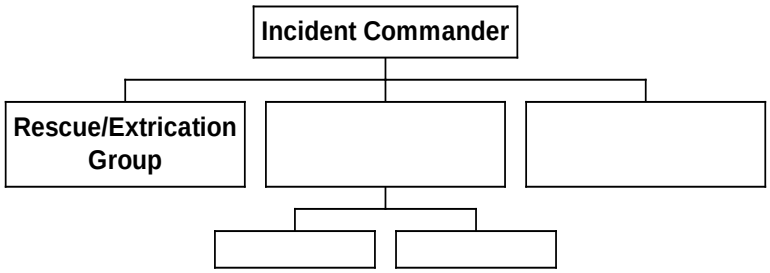

Figure 3-5-2

Where possible, critical patients should be extricated, triaged, and delivered to the treatment area ahead of more stable patients. To do this there will have to be some interface with the Triage Unit Leader. This may not always be possible, as some stable patients must be extricated first in order to reach the more critical patients.

The Rescue/Extrication Group Supervisor is responsible for managing the rescue of entrapped victims. This requires that the Rescue/Extrication Group Supervisor:

- coordinate with Treatment Unit for patient care during the rescue operation;
- determine resources needed to extricate patients:
  - rescue tools,
  - backboards,
  - personnel, and
  - relief personnel;
- implement assigned incident objectives;
- communicate resource requirements to IC as necessary;
- provide tactical direction and supervision to assigned resources;
- ensure safety of members operating in the area;
- ensure efficacy of rescue/extrication operations;
- coordinate patient transportation to triage area;
- provide IC with frequent and timely progress report; and
- maintain incident documentation.

Medical Group/Division Supervisor

The Medical Group/Division Supervisor (see Figure 3-5-3) reports to the MCI Branch Director and supervises the Triage Unit Leader, Treatment Unit Leader, and Medical Supply Coordinator. The Medical Group/Division Supervisor establishes command and controls the activities within a Medical Group/Division in order to assure the best possible emergency medical care to patients during a MCI incident.

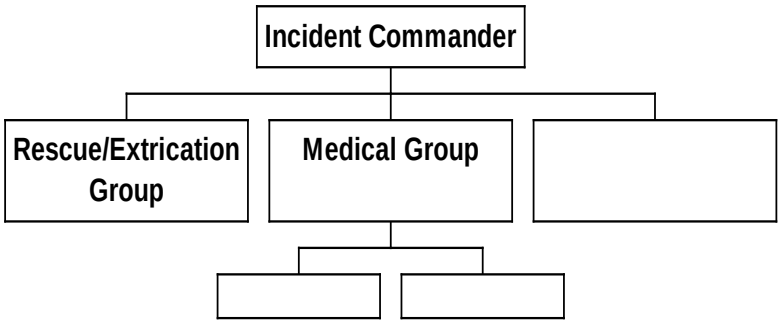

Figure 3-5-3

The Medical Group/Division Supervisor:

- implements assigned incident objectives;
- participates in Multicasualty Branch/Operations Section planning activities;

- establishes Medical Group/Division with assigned personnel; requests additional personnel and resources sufficient to handle the magnitude of the incident;
- designates unit leaders and treatment area locations as appropriate;
- isolates morgue and minor treatment area from immediate and delayed treatment areas;
- requests law enforcement/coroner involvement as needed;
- determines amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, backboards, litters, cots);
- establishes communications and coordination with Patient Transportation Group Supervisor;
- ensures activation of hospital alert system, local EMS/health agencies;
- directs and/or supervises onscene personnel from agencies such as coroner's office, Red Cross, law enforcement, ambulance companies, county health agencies, and hospital volunteers;
- ensures proper security, traffic control, and access for the Medical Group/Division area; and
- directs medically trained personnel to the appropriate unit leader.
- maintains incident documentation.

Triage Unit Leader

The Triage Unit Leader (see Figure 3-5-4) is responsible for the triage and tagging of all patients at major incidents. The triage and tagging may take place either in the extrication area or at the entry to the treatment area. In either case, close coordination must be maintained with the Treatment Unit and Extrication Group. Personnel assigned to triage must have the basic medical skills to make appropriate triage decisions.

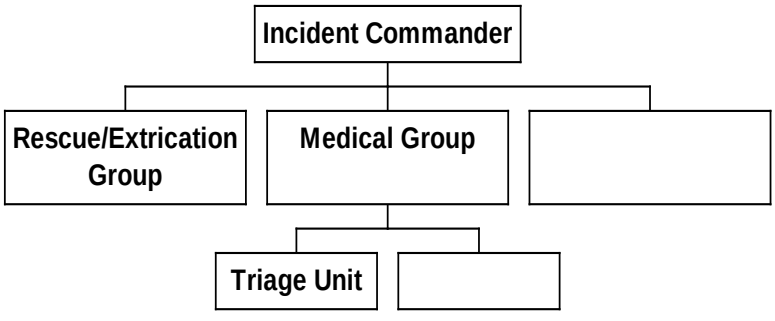

Figure 3-5-4

The Triage Unit Leader will

- determine location of triage areas;
- ensure that all patients are assessed and sorted in accordance with appropriate triage protocols;
- determine resources required to conduct triage operations:
  - communications,
  - personnel,
  - equipment and supplies, and
  - relief units;
- communicate resource requirements to the Medical Group Supervisor as required;
- develop triage organization sufficient to handle assignment;
- ensure safety and security of all members operating in the triage area;
- ensure efficacy of triage operations;
- provide frequent progress reports to the Medical Group Supervisor;
- establish initial morgue operations (as needed);
- coordinate movement of patients from triage area to treatment area; and
- maintain incident documentation.

Treatment Unit Leader

The Treatment Unit Leader position (see Figure 3-5-5) typically is the next to be established. The Treatment Unit Leader will establish an area where patients can be collected and treated. Central treatment areas maximize the limited resources of rescuers in incidents that involve large numbers of patients. It is in the treatment area that extensive treatment and advanced life support care is conducted.

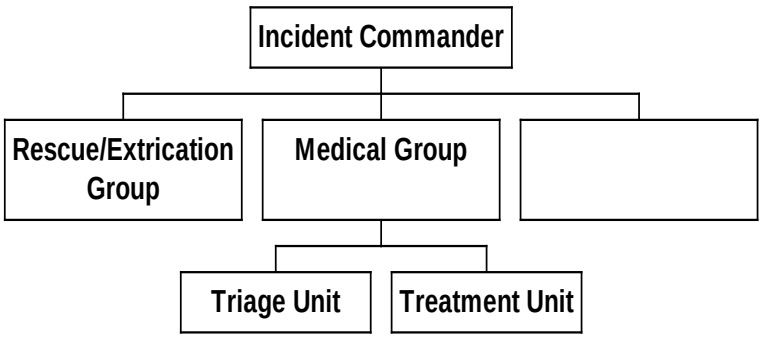

Figure 3-5-5

The Treatment Unit Leader is responsible for the overall management of patient care delivery in the treatment area. He/She will

- identify and establish a suitable area for treatment operations, communicating the location to the Medical Group Supervisor and the Triage Unit Leader:
  - upwind and uphill,
  - sufficient space for operations. Think BIG!
  - unimpeded access and egress for units, and
  - establish separate areas for patients classified as immediate, delayed, and minor;
- identify and request additional resources as needed:
  - communications,
  - personnel,
  - Treatment Dispatch Manager,
  - Immediate Treatment Manager,
  - Delayed Treatment Manager,
  - Minor Treatment Manager,
  - equipment and supplies, and
  - relief or other support units;
- coordinate with Triage Unit Leader the movement of patients from the triage area to treatment areas;
- ensure patients received in the treatment area(s):
  - are separated by triage category,
  - are re-assessed and retriaged as appropriate (continual), and
  - receive prompt and efficient treatment in accordance with established Advanced Life Support/Basic Life Support (ALS/BLS) protocols;
- establish communication and coordination with the Patient Transportation Group Supervisor;
- assign, supervise, and coordinate personnel within area(s);
- ensure safety of all members operating in the treatment area;
- ensure efficacy of treatment operations;
- direct movement of patients to ambulance loading area;
- provide frequent progress reports to the Medical Group Supervisor; and
- maintain incident documentation.

If the incident is large scale, with large numbers of patients, the Treatment Unit Leader may need to assign other support positions within the unit.

Treatment managers--One each for the immediate, delayed, and minor treatment areas. Their role is to ensure that patients are treated and packaged for transport as soon as possible. Activating these positions is primarily a span-of-control need.

Treatment Dispatch Manager--This is also a span-of-control position. The position ensures that the patient is ready for transport, and coordinates with the Patient Transportation Group and Treatment Managers.

These two positions will be discussed in more detail in later.

Patient Transportation Group Supervisor

The Patient Transportation Group Supervisor (see Figure 3-5-6) has a substantial challenge. The supervisor must obtain all required transportation and cause the patients to be transported to the appropriate hospitals. Hospitals will need to be notified. There will be an almost continuous flow of radio communication between the group and the receiving hospitals (either direct radio communications from the scene to the hospital, or relayed through a dispatch center).

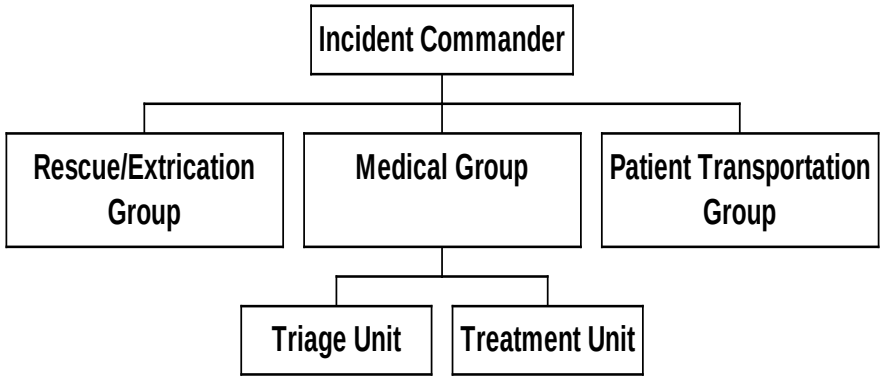

Figure 3-5-6

The Patient Transportation Group Supervisor is responsible for the overall management of patient movement from the scene to the receiving hospitals. Pay special attention to the needs of the patient, and whether transport to a specialty center is required. In addition to patient condition, the receiving hospital's ability to handle additional patients and the overall impact on the EMS system must be part of the decisionmaking process on patient destinations.

To accomplish this the Patient Transportation Group Supervisor must

- establish an adequately sized, easily identifiable patient loading area in coordination with the Treatment Unit Leader;
- establish communication with area hospitals and maintain a list of capacities;
- designate an Ambulance Staging Area (if needed);
- identify and request additional resources as required:
  - communications,
  - personnel,
  - Medical Communications Coordinator,
  - Air Ambulance Coordinator, and

- Ground Ambulance Coordinator;
- direct the transportation of patients in coordination with the Treatment Unit Leader;
- request air and ground ambulances as needed;
- coordinate air ambulance transportation;
- establish an air ambulance helispot(s) as needed; and
- maintain patient tracking records and other incident documents.

Other Subordinates that May be Needed

- Medical Communications Coordinator (hospital communications);
- Air Ambulance Coordinator; and
- Ground Ambulance Coordinator.

The Basic Organization

With this basic command organization (see Figure 3-5-7) in place, additional arriving resources are assigned to existing divisions/groups/ units. These additional resources work for, report to, and communicate to the Division/Group Supervisor or Unit Leader.

Figure 3-5-7