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DRAFT EAST AFRICAN STANDARD

Emergency management — Evacuation for healthcare facilities — Guidelines

EAST AFRICAN COMMUNITY

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Foreword

Development of the East African Standards has been necessitated by the need for harmonizing requirements governing quality of products and services in the East African Community. It is envisaged that through harmonized standardization, trade barriers that are encountered when goods and services are exchanged within the Community will be removed.

The Community has established an East African Standards Committee (EASC) mandated to develop and issue East African Standards (EAS). The Committee is composed of representatives of the National Standards Bodies in Partner States, together with the representatives from the public and private sector organizations in the community.

East African Standards are developed through Technical Committees that are representative of key stakeholders including government, academia, consumer groups, private sector and other interested parties. Draft East African Standards are circulated to stakeholders through the National Standards Bodies in the Partner States. The comments received are discussed and incorporated before finalization of standards, in accordance with the Principles and procedures for development of East African Standards.

East African Standards are subject to review, to keep pace with technological advances. Users of the East African Standards are therefore expected to ensure that they always have the latest versions of the standards they are implementing.

The committee responsible for this document is Technical Committee EASC/TC 076, *Services.*

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Emergency management — Evacuation for healthcare facilities — Guidelines

1. Scope

This draft East African Standard provides guidelines to help healthcare facilities in the development/updating of a facility specific evacuation plan containing detailed information, instructions, and procedures that can be engaged in any emergency situation necessitating either full or partial hospital evacuation, as well as sheltering in place.

2. Normative references

There are no normative references in this document.

3. Terms and definitions

For the purposes of this document, the following terms and definitions apply.

ISO and IEC maintain terminological databases for use in standardization at the following addresses:

— IEC Electropedia: available at http://www.electropedia.org/

— ISO Online browsing platform: available at http://www.iso.org/obp

3.1
Shelter in Place (SIP)
a procedure used to take immediate shelter in a current location

3.2
evacuation
the movement of patients and personnel from a dangerous location to one of relative safety

3.4
horizontal evacuation
evacuation on the same floor, often to the other side of a set of fire barrier or smoke compartment doors

3.5
vertical evacuation
 evacuation to a safe place on another floor, can be upward or downward

3.7
emergency evacuation
urgent immediate egress for escape of people away from an area that contains an imminent, ongoing threat or a hazard to lives or property.

3.9
refuge area
a location within a building that is identified as having relative safety

3.10

assembly point

a pre-identified area outside of the building where departments will assemble upon evacuation from the facility

3.11

surge capacity

the ability to evaluate and care for a markedly increased volume of patients one that challenges or exceeds normal operating capacity

3.12

Hazard Vulnerability Analysis/Assessment (HVA)

a systematic approach to identifying all hazards that may affect an organization and/or its community, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard, and analysing the findings to create a prioritized comparison of hazard vulnerabilities

3.13

Hospital Incident Command System (HICS)

a standardized management system that consists of a flexible organization structure and time-proven management principles

3.14

Incident Command System (ICS)

a standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries

3.15 **Incident Management Team (IMT)**

group of trained personnel that respond to an emergency

4. General plan/policy guidelines

4.1 General

4.1.1 The purpose of this plan is:

a) To direct the activities required to implement sheltering-in-place, partial evacuation/internal relocation or full evacuation.

b) To outline the responsibilities of individuals and departments during shelter-in-place, partial evacuation/relocation, and full evacuation.

c) To prioritize response requirements and establish an orderly shelter, relocation, or evacuation process using the Incident Command System (ICS)

4.1.2 During an actual evacuation, action plans should be made by the unit leaders and communicated to all staff on site. Communication should be done in a proper manner to assure clarity of communication and incident tracking capability

4.1.3 This plan should in cooperate staff roles and responsibilities essential to this process. Staff training for

employees on the evacuation plan will include techniques for lifting and carrying patients and knowledge of alternative evacuation routes. The expectations will be that staff will accompany patients and work at receiving facilities subject to receiving proper emergency credentials. Drills and reviews shall be conductedto ensure that the plan is workable. The plan shall include back up measures for all components and shall be integrated with pertinent protocols in the facility's comprehensive emergency plan such as activation of hospitals incident command system.

4.1.4 Sheltering-in-place, relocation, and evacuation activities may:

   a)   occur as stand-alone response.

   b)   be implemented in a progression, if necessary, as the incident evolves.

   c)   be implemented in a proactive response to impending hazards.

   d)   be implemented in response to an acute incident.

4.1.5 The following are examples of factors that could lead to activation of the shelter-in place / relocation / evacuation plan: OR insert results of your HVA

   a)   Loss of environmental support services including heating, water, air conditioning, sterilization, electrical power, and medical gases.

   b)   Internal emergencies such as fire, smoke, hazardous materials release, or active shooter or threat.

   c)   External emergencies including natural and manmade disasters such as earthquake, urban and wildfires, flood, power outage, civil disturbance, terrorism, hazardous materials spills, contaminatedvictims/toxic agents, radiation exposure, explosions and police actions.

The evacuation of the facility shall only be initiated as a last resort in response to disruption of services caused by an internal or external disaster.

4.2.1 Supporting plans

If necessary, based on the incident, any or all of the following plans may also be activated in support of the evacuation / shelter in place plan: Emergency operations plan (EOP)

   a)   Command center operations

   b)   Department-specific evacuation plans

   c)   Lockdown procedures

   d)   threat specific plan

   e)   Facility closure, restoration and start up

   f)   Business continuity.

5. Plan Activation

5.1　The responsible individual for the activation and implementation of this plan is the head and/or healthcare facility designee.

5.2　The decision to implement whole or parts of the evacuation plan should be determined based on the incident assessment, information and/or recommendations from other facility personnel or community response partners such as the local fire or police department. Decision making resources available are:

       a)　Decision Tree — Annex A,

       b)　Decision Matrix — Annex B

       c)　Incident Assessment Worksheet, — Annex C

6.　Incident management

6.1　Establish Command and Control

6.1.1　The overall management of incident response and recovery is the responsibility of the Incident Commander as designated in the Emergency Management Plan.

       a)　All personnel are authorized to take immediate patient/resident relocation or sheltering actions inresponse to a life safety emergency.

       b)　Every department is responsible for implementing their activities within the evacuation plan.

6.1.2　The Incident Commander will notify and activate:

       a)　Activate Code [internal].

       b)　Activate ICS Incident Management Team members as needed by the incident.

       c)　Activate the Command post. If the primary location is not available, notification shall include the newalternate location.

6.1.3　ICS and Command post operations shall be guided by:

       a)　This plan, and other plans activated in support of this incident.

       b)　ICS Job Action Sheets.

       c)　Including the following evacuation related forms:

　　　　　　　　　　　　　　　　　　　　　　　7

    1) HICS 254: Disaster Victim/Patient Tracking Form

    2) HICS 255: Master Patient Evacuation Tracking Form

    3) HICS 259: Hospital Casualty/Fatality Report

    4) HICS 260: Patient Evacuation Tracking Form

6.1.4 All information related to the incident shall be coordinated and released through the Command Center.

6.1.5 The Command centre will coordinate with outside agencies, other healthcare facilities and facility administration regarding facility status, evolving situational needs, and overall status of the evacuation/shelter in place process.

6.2 Roles and responsibilities

6.2.1 General

In addition to the use of the position Job Action Sheets, the following identifies some key activities and responsibilities for certain ICS IMT members and all personnel. Additional resources available:

    a) Initial critical action sheet for an emergency evacuation and shelter in place.

    b) Defend in place for active threat/shooter.

    c) Command personnel checklist for shelter, relocation, and evacuation.

    d) Evacuation incident response guide.

6.2.2 Incident commander

The incident commander has the full authority and responsibility for the decision making processes for this response.

6.2.3 Public information officer

Coordinate media communications regarding the status of the facility, including the need to evacuate.

Establish a family information center to notify and respond to queries from family members regarding the status and location of patients who have been evacuated. Utilize the tracking information provided to the Command post by the Planning Section Chief.

Assign personnel to notify the patients/residents emergency contact person.

6.2.4   Liaison officer

Notify local agencies that you are experiencing an adverse incident that requires sheltering or evacuation and update your operational status (capabilities, resources needs, etc.).

Notify relevant community response partners,

6.2.5   Safety officer

   a)   Oversee the immediate stabilization of the facility;

   b)   Recommend areas for immediate evacuation to protect life;

   c)   Ensure the safe evacuation of patients, staff and visitors;

   d)   Conduct initial and ongoing analysis of existing evacuation practices for health and safety issuesrelated to personnel, patients, and facility, and implement corrective actions to address.

6.2.6   Operations section chief

   a)   Coordinate the processes necessary to safely evacuate a portion or all of the facility.

   b)   Identify appropriate staging areas for the receipt and movement of patients/residents, personnel andvisitors.

   c)Work with the medical care branch director to identify (number and acuity levels), prioritize, and evacuate patients in a systematic and orderly manner.

   d)   Communicate with the infrastructure branch director to determine the need for and orderly

   e)   implementation of the operational reliability and/or shut down of utilities and structural supportsystems.

   f) Coordinate with the Infrastructure Branch Director to determine and supply necessary utilities and medical gases to the sheltering or evacuation assembly points.

   g)   Coordinate with the Liaison Officer to determine the number and type of transportation vehicles that will be necessary to evacuate patients to alternate care sites.

   h)   Work with the Security Branch Director to establish access and control of key areas of the facilityand campus during the evacuation.

   i) Interface with the Business Continuity Branch Director to assure that the security and availability of vital patient/resident health record, and other key information is maintained.

6.2.7   Planning section chief

Establish and implement processes to track the location of patients/residents, personnel and resources whohave been moved from one location to another including evacuation to alternate sites of care.

6.2.7   Logistics section chief

a)   Work with the Operations Section Chief to provide the necessary medical equipment, beds, medications, and supplies to safely relocate patients to alternate locations. Caches of equipment, supplies, and medications pre- positioned to manage an influx of casualties can be used if they are not required for their intended purpose.

b)   Assure an adequate supply of personnel and other human resources to safely evacuate patients/residents and visitors to alternate locations.

c)   Ensure that potable water and basic food supplies are brought to the sheltering area or assembly points.

d)   Collaborate with the Operations and Planning Section Chiefs to identify and address both internaland external transportation needs.

e)   Establishing a family information centre to notify and respond to queries from family members of personnel regarding the status and location of personnel who have been evacuated.

7.   Communication

Internal notification and external communications should be conducted according to the Emergency Operations Plan. Key communications for facility evacuations include, but are not limited to:

7.1   Personnel on duty

Notification of potentially unsafe situation(s) at the facility. If evacuation activities are possible, an 'evacuation standby' notification should be made as soon as possible so that units may begin accessing appropriate supplies and collecting belongings and records.

7.2   Personnel off duty

Notification of potentially unsafe situation(s) at the facility. Provide guidance on whether personnel should report to duty as usual or not.

7.3   Patient families

Notification of patient/resident families of evacuation destinations.

7.4   Medical providers

Notification of evacuation destinations.

7.5 Personnel families

Notification of incident status and evacuation destinations.

7.6 Public safety

Communication links to facilitate coordination with public safety agencies (security and traffic control), EMS and other transport providers (buses, etc), and fire agencies (lifting assistance).

Public information
Public information reflecting the capabilities of the facility

8. Sheltering in place procedures

When the threat does not permit safe relocation or evacuation, the following actions may be taken. Patientcare and administrative departments upon receiving directives from the commander can initiate these actions.

8.1 Weather – wind, hail, or other weather threat

a) Remain calm.

b) Move patients/residents and personnel away from windows as possible.

c) Close drapes/blinds and exterior doors/windows.

d) Ensure personnel and visitors also advised of weather situation.

e) Update incident command on your operational status and impact on patients/ residents, personnel,and visitors.

f) Personnel will remain with patients/residents

8.2 Security emergency – bomb threat, individual posing security threat, external civil unrest

a) Remain calm.

b) Refer to Active Shooter/Bomb Threat policy.

c) Implement department-specific access controls.

d) Close smoke compartment doors, patient/resident room and office doors, and perform other takecover measures as needed.

e) Ensure personnel and visitors are aware of the situation.

f) Update incident command on your operational status and impact on patients/ residents, personnel,and visitors.

g) Personnel will remain with patients/residents.

8.3 Hazardous materials (HAZMAT) incident

a) Remain calm.

b) If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilationsystem; security will implement access controls as needed.

c) Ensure visitors and personnel aware of threat location and actions to take.

d) Update incident command on your operational status and impact on patients/ residents, personnel,and visitors.

e) Personnel will remain with patients/residents.

9. Evacuation — General guidelines

9.1 Authority and decision making

a) Incident commander or designee can authorise immediate patient/resident relocation actions in response to an immediate life safety emergency.

b) Initiation of a vertical or complete evacuation, with the exception of persons in immediate danger, will be coordinated by the Incident Commander/Command post.

9.2 Evacuation priorities

In an emergency:

a) Persons in immediate danger. If persons are not in immediate danger, personnel shall WAIT forevacuation orders.

b) Ambulatory persons.

c) Non-ambulatory persons.

d) Critical patients will be moved last when the maximum number of personnel and equipment isavailable.

e) Personnel will remain with patients/residents.

f) Evacuation shall be completed in a calm and orderly fashion.

9.3 Evacuation routes

Evacuation and specific guidance for travel route and in-house transportation shall be a systematic coordinated effort in order to remove all patients/residents, visitors, and personnel from affected areas in a safe and timely manner.

a) Evacuation shall be completed in a calm and orderly fashion.

b) When possible, horizontal evacuation is preferred over vertical evacuation.

c) Departments should have pre-identified evacuation routes.

d) Incident specific evacuation routes may be necessary and shall be communicated by the commandcenter quickly to affected areas.

e) Only when absolutely necessary should evacuation result in patient/resident leaving the interior ofthe facility.

f) Visitors, personnel, and ambulatory patients should walk to the designated assembly point. If vertical evacuation is necessary, stairs not elevators should be used for these individuals. Personnel should be assigned at key points along the evacuation route to direct individuals to the assembly points.

g) Elevators if operational are reserved for transporting non-ambulatory patients. Engineering / maintenance personnel should be assigned to take operational control of the elevators using the bypass key to take elevators directly to / from the affected areas. Do not use elevators in a fireor earthquake.

h) If elevators are non-operational, and vertical evacuation is required, non-ambulatory patients will be carried down staircase using assist devices, blanket carry, or two-man carry techniques.

i) Human Chain can be used if you have large numbers of ambulatory patients. Two personnel members are needed, one in the front and one in the rear. Have the first patient put his/her hand on the shoulder of the first personnel member, and everyone else do the same to the person in front. The last person in the chain should be the second personnel member.

9.4 Return to facility

Do not re-enter the facility for any reason unless:

a) Assisting with evacuation of patients/residents, visitors or other personnel/equipment;

b) Authorized by the Incident Commander/Command post;

c) An order to repopulate / reopen the facility has been approved by relevant authority.

10. Moving to a safe refuge — Horizontal evacuation

Refuge areas are used for internal evacuation or relocation. They are internal locations that will receive and hold patients/residents, personnel and visitors for a period of time until they can return to their original location or are evacuated.

10.1 Procedures

a) Remain calm.

b) Follow instructions of the area supervisor.

c) Identify the next functional smoke compartment (i.e., beyond the next set of double fire doors).

d) Movement shall be completed in a calm and orderly fashion.

e) Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.

f) Move patients/residents, personnel and visitors who are closest to the hazard to the next functional smoke compartment or identified refuge area. If you are moving patients to another floor, follow instructions for vertical evacuation.

g) Ambulatory patients should be assisted to the new location, and non-ambulatory patients moved on beds, carts, wheelchairs, or via blanket carry.

h) If possible, take with you the necessary patient/resident care equipment and supplies from the hazardous area.

i) Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.

j) If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.

k) Each room should be marked as evacuated.

NOTE   Each healthcare facility should pre-determine how this will be designated.

l) If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate.

NOTE   Each healthcare facility should pre-determine how this will be designated.

m) The area supervisor should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear

   NOTE   Each healthcare facility should pre-determine how this will be designated.

n) Relocation does not involve formal gathering of medical records, unless this relocation is part of aphased evacuation, then gather patient records.

o) Continue to care for all patients/residents during transport and relocation.

p) Account for all patients/residents and personnel. Check off the names of patients/residents as theyare evacuated, and as they arrive in the new location.

q) Update the Command Center on your operational status and impact on patients/ residents, personnel, and visitors, and if any additional individuals need to be evacuated or if the area is allclear. Receive and implement instructions from the Command Center.

r) Ensure personnel and visitors are aware of the situation.

s) Personnel will remain with patients/residents.

10.2   Horizontal evacuation — Personnel responsibilities

10.2.1 Affected area personnel

Assist with patient care and evacuation of current patients/residents from their area.

10.2.2 Unaffected clinical area personnel

Minimal numbers of clinicians will remain with current patients/residents; additional personnel will report tounit being evacuated to assist — utilize internal stairwells.

10.2.3 Nonclinical personnel

10.2.3.1   All noncritical functions will cease and personnel will report to unit being evacuated to   assist,

10.2.3.2   Utilize internal stairwells.

11.   Vertical evacuation procedures

Unless otherwise indicated by the Incident Commander, the following guideline should be used.

11.1 Procedures

a)   Remain calm.

b)   Follow instructions of the area supervisor or fire department.

c)   Identify evacuation route and relocation area.

d)   Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits asrequired.

e)   Evacuation shall be completed in a calm and orderly fashion.

f) Evacuate patients/residents, personnel and visitors from the hazard

g)   Visitors, personnel, and ambulatory patients should walk to the designated area. Personnel shouldbe assigned at key points along the evacuation route to direct individuals to the area.

h)   Elevators if operational are reserved for transporting non-ambulatory patients.

   i)   Do not use elevators in a fire or earthquake.

   ii) If elevators are non-operational, and vertical evacuation is required, non-ambulatory patients will be carried down staircase using specialized evacuation equipment (if available), blanket carry, ortwo-man carry techniques.

i)   Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from theevacuation route to closest.

j)   If time allows, as each room is cleared, lights should be turned off, nonessential electrical equipmentshould be turned off and unplugged.

k)   Each room should be marked as evacuated

l) If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate.

   NOTE   Each healthcare facility should pre-determine how this will be designated.

m)   The area supervisor should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. and marked as clear

   NOTE   Each healthcare facility should pre-determine how this will be designated.

n)   Continue care for all patients/residents during transport and at the assembly point.

o)   Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.

p)   Keep patient/resident files and records with the patient.

q)   Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.

r)   Update the Command post on your operational status and impact on patients/ residents, personnel, and visitors, and if any additional individuals need to be evacuated or if the area is all clear. Receive and implement instructions from the Command post.

s)   Ensure personnel and visitors are aware of the situation.

t)   Personnel will remain with patients/residents.

11.2   Vertical Evacuation — Personnel responsibilities

a)   Affected area personnel — assist with patient/resident care and evacuation of current patients/residents from their area

b)   Unaffected clinical area personnel — minimal numbers of clinicians will remain with current patients/residents; additional personnel will report to unit being evacuated to assist – utilize internal stairwells.

c)   Nonclinical personnel — all noncritical functions will cease and personnel will report to unit being evacuated to assist — utilize internal stairwells.

12.   Complete Evacuation Procedures

Unless otherwise indicated by the Incident Commander, the following guideline should be used.

12.1   Procedures

a)   Remain calm.

b)   Follow instructions of the area supervisor or fire department.

c)   Identify evacuation route and external assembly point.

d)   Assign personnel to clear obstructions from corridors and control fire/smoke doors and other

exits as required.

e) Evacuation shall be completed in a calm and orderly fashion.

f) Each patient who is evacuated should have the following accompany them:

    i) Their medical record – which should remain in their possession during the entire evacuation process.

    ii) Necessary medications along with their medication administration record.

    iii) Their identification labels.

    iv) Personal belongings (if time permits).

    NOTE : Ideally, these items should be placed in a large plastic belongings bag and the bag marked with the patient's name and medical record number with indelible ink.

g) Evacuate patients/residents, personnel and visitors from the hazard

h) Visitors, personnel, and ambulatory patients should walk to the designated area. Personnel should be assigned at key points along the evacuation route to direct individuals to the area.

i) Elevators if operational are reserved for transporting non-ambulatory patients.

    i) Do not use elevators in a fire or earthquake.

    ii) If elevators are non-operational, and vertical evacuation is required, no ambulatory patients will be carried down stairwells using specialized evacuation equipment (if available), blanket carry, or two-man carry techniques.

j) Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.

k) If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.

l) Each room should be marked as evacuated

    NOTE   Each healthcare facility should pre-determine how this will be designated.

m) If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate.

    NOTE   Each healthcare facility should pre-determine how this will be designated.

n) The area supervisor should identify a single individual to sweep the area for remaining

persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. and marked as cleaning.

o) Continue care for all patients/residents during transport and at the assembly point.

p) Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.

q) Keep patient/resident files and records with the patient.

r) Update the Command Center on your operational status and impact on patients/ residents, personnel, and visitors. Receive and implement instructions from the Command post. Notify the Command Center if there are additional individuals that need evacuating, or if the area is all clear, and if you need additional staffing, supplies, or other resources to manage your patients/residents.

s) Ensure personnel and visitors are aware of the situation.

t) Personnel will remain with patients/residents.

12.2 Guidelines for evacuating specific patient care areas

12.2.1 Operating room, post anaesthesia care unit and haemodialysis

The following personnel are responsible for ensuring the safety of the patients:

a) Operating Suite — The surgeon in charge of each case.

b) ACU — The covering anesthesiologist is responsible to coordinate care with the nursing personnel.

c) Hemodialysis — The Nurse Manager or designee and physician will direct activities of the personnel.

d) Obtain equipment and services required for completion of the procedure.

e) Keep list of anticipated supplies and prepare to procure additional supplies as needed.

f) Patients on ventilators—when central O_2 is turned off, switch ventilator to room air and/or obtain portable O_2 tanks. If no power and/or patients shall be moved, patients shall be bagged.

g) Patients with IVs, arterial lines and Swan-Ganz — Disconnect transducer from patient cable-take pressure bag with patient. Saline lock all non-critical IV lines.

12.2.2 Intensive Care Units (ICU)

a) The Nurse Manager or designee shall evaluate the ICU patients with the house officer to

determinepossible transfers and/or discharge.

b) Transfer as many patients as possible to medical surgical or step down units, if safe to do so.

c) Use gurneys/wheeled stretchers, beds and evacuation equipment to move patients to refuge areas.

d) Collaborate with house officer and respiratory therapists to evaluate appropriate shutoff of oxygen,ventilation equipment and other gases to preserve resources.

12.2.3 Labour and delivery, family centred care and maternity units

The Nurse Manager or designee shall direct the unit personnel to:

a) Obtain wheelchairs, gurneys, incubators, instruments and supplies needed to complete Labor andDelivery procedures.

b) Transport infants in their mother's arms, if appropriate.

c) Place multiple infants into a single crib, incubator or evacuation vest for transport by a nurse, ifneeded.

d) Transport labouring patients via bed, gurney or evacuation equipment, if safe to do so.

12.2.4 Neonatal intensive care unit, pediatric intensive care unit and pediatrics

The Nurse Manager or designee shall direct the unit personnel to:

a) Transport infants in cribs/incubators/specialized evacuation equipment with a nurse in attendanceduring the evacuation

b) If necessary multiple infants may be placed into a single crib or incubator for transport by a nurse

c) Older non-ambulatory paediatric patients may be transported by bed, gurney, wheelchair, carried or rolled in a blanket (do not use sheets; they are not strong enough) and dragged to a safe location asneeded.

d) Ambulatory paediatric patients may be evacuated together by forming a chain, holding hands, andalternating the older and younger children in the line as time and circumstances permit.

12.3 Evacuation of non-patient care areas

Overall, the evacuation of non-patient care areas will follow the same general guidelines.

a) Remain calm.

a) Recognize local threat or receive evacuation instructions from the Command Center or authorizedpersonnel according to facility plan and move personnel to the pre-identified assembly point.

b) Persons in immediate danger should evacuate first.

c) In areas where there are visitors, escort the visitors to your department's assembly point.

d) Unless otherwise indicated, evacuation should proceed from offices farthest from the evacuationroute to closest.

e) If time allows, as each room is cleared, lights should be turned off, nonessential electrical equipment should be turned off and unplugged.

f) Each room should be marked as evacuated

g) If an individual requires additional evacuation support than is immediately available, the door shouldbe marked so that returning responders know which room to evacuate.

> NOTE   Each healthcare facility should pre-determined how this will be designated.

h) The department head should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. and marked as clear.

> NOTE   Each healthcare facility should pre-determined how this will be designated.

i) Personnel/visitors with disabilities may require assistance. Each department head shall identify which of their personnel may have difficulty during an evacuation and pre-plan the best way to aid their movement to a safe location.

j) Visitors should remain at the assembly point until the Command Center declares an "all clear" or other directions are given.

k) Account for personnel at assembly point (conduct roll call). If you have time, conduct roll call prior to evacuation, and again at the assembly point.

l) Initiate continuity of operations plan actions.

m) Update the Command Center on your operational status and impact on personnel and visitors. Receive and implement instructions from the Command Center. Notify the Command Center if thereare additional individuals that need evacuating or if the area is all clear, and if you need additional staffing, supplies, or other resources. Send personnel to the labor pool is requested.

n) Ensure personnel and visitors are aware of the situation.

12.4 Complete evacuation — Personnel responsibilities

Since all areas will be affected, all clinical personnel will assist with patient care and evacuation of current patients from their units, and perform follow up care at the assembly point.

Nonclinical personnel – all functions will cease, and personnel will evacuate to their designated assemblypoint, and assign personnel to the labor pool for further instructions.

12.5 Vertical/complete evacuation transport devices

12.5.1 If there is a need to relocate patients horizontally, patients shall be moved using normal patient transportation equipment and routes of travel.

The following resources can be used in patient evacuation:

a) Wheelchairs can be used to move ambulatory, minimally ambulatory patients and non-ambulatory patients. Mostly used to get to the stairwell, and if able to carry the wheelchair down the stairwell, then itcan be used to move the patient/resident/personnel to the assembly point.

b) Beds/wheeled stretchers: can be used to move non-ambulatory patients, but very difficult for verticalmovement.

c) Improvised equipment is only to be used when normal transportation equipment is not available. Blanket drags, multi-person carries, and utilization of other equipment not ordinarily used for transportation may be needed.

12.5.2 Additional resources may be needed during evacuation flashlights, spotlights, electrical cords, water stations, personal protective equipment, work gloves, portable ventilators, and other non-patient related equipment may be needed.

12.5.3 Specialized evacuation transport devices (chairs, stair stretchers, sleds, infant carry slings, motorized gurneys, blankets) are located within the facility and are intended for use in vertical and complete evacuations.

13. Evacuation assembly points

In the event of a complete or total evacuation, patients/residents, personnel and visitors will evacuate to external assembly points. Each department is pre-identified to evacuate to a specific assembly point.

13.1 Determining assembly points

Assembly points are assigned based on the care provided in the department. Departments with the most acute patients will assemble together near the emergency department where additional resources and ground transportation will be the most available. Departments without patients will evacuate to the remotest locations.

Non-department based assembly points are identified for the Command Center, Labor Pool, Communications post, and Personnel First Aid.

13.2   Assembly point key activities

a)   Roll call of all patients/residents, personnel and visitors

b)   Patient assessment and care

13.3   Assembly point resource needs

Resources may be brought with personnel as they evacuate. Other resource needs shall be filled by the Command Center from external disaster caches:

a)   Food and water;

b)   Communication devices for personnel to keep updated;

c)   Environmental protection (tents, umbrellas, blankets, sheets, etc.);

d)   Chairs, flashlights/light sticks, basic first aid kits;

e)   Medical supplies - depending on the care provided.

14.   Patient/resident transfer to alternate facilities

14.1   Internal coordination

Internal organization of patients/residents should be implemented concurrently with the External Coordination procedures.

14.1.1 Organizing patients/residents

14.1.1.1   Categorize and physically organize patients/residents as follows:

a)   Those who have their own transportation and are being discharged to home;

b)   Those who need to be evacuated to an alternate acute care facility;

c)   Those who need to be evacuated to a skilled nursing facility;

d)   Those who are being discharged home but require transportation;

14.1.1.2   Once the patient's/resident's evacuation status has been determined, it should be noted on a sign, sticker, or other mechanism and placed prominently on the patient/resident. This tag should remain on

the patient/resident at all times until the evacuation destination is reached.

14.1.2 Patient/resident information

As each patient/resident is placed in their appropriate category, their medical record (which should have accompanied them) should be reviewed to collect information necessary to track and discharge / transfer the patient/resident.

14.1.3   Patient/resident tracking

a) Patient tracking information is to be maintained in the area with copies forwarded to the CommandCentre and kept with the Patient Tracking Manager.

b) Standard inter-facility transfer forms are to be completed on each patient/resident sent to an alternate care site, along with a copy of the medication administration record, and other pertinent medical record information.

c) Patients/residents discharged to home should be provided with standard discharge instructions.

d) If home health follow-up is necessary, send pertinent medical information home with the patient as well.

e) Patient Tracking Manager and/or deputies will contact alternate care sites to ensure patient arrival until all patients have been verified.

14.1.4 Personnel tracking

a) Establish processes to coordinate personnel who may accompany patients/residents being transferred toalternate care sites.

b) If personnel are to remain at these sites, then implement the mutual aid agreements established withthese facilities.
c) A record should be maintained of the name, title, and the facility that they were assigned to.

14.2   External Coordination

a) If patients need to be transferred to another facility for ongoing medical care, identify available beds bythe following procedures:

b) Coordinate with other facilities in the same healthcare system.

c) Hospitals: If the above resources are unavailable or inadequate, request assistance from the Local EMS   Agency. Provide the number of patients by type of bed (critical care, medical/surgical, pediatrics, etc) that require evacuation.

d) Skilled Nursing Facilities: If the above resources are unavailable or inadequate, request assistance fromaccredited facilities.

e) Obtain transportation resources by contacting your contracted ambulance providers.

f) Transferred patients should have medical records and medications sent with them:

    i) At a minimum, use a triage tag or Patient Evacuation Tracking form to be included.

    ii) Maintain a log of transferred patients. Can use a combination of Patient EvacuationTracking form in Annex E and Master Patient Evacuation Tracking Form in Annex F.

14.3 Transportation resource needs matrix

Estimate the type and quantity of transportation resources needed using the tool in Annex D. Use thisinformation when requesting assistance through your usual transportation provider:

a) Access needed transportation through the hospital based Incident Command process, recognizingthat this will most likely be organized regionally using available local and regional assets,

b) Be aware of any Memorandums of Understanding (MOU) for transportation,

c) Be aware of the hospital based transportation resource inventory (vehicles, vans, receiving dockvehicles, ambulances etc.),

d) Use relay system (stationing staff at intervals along the evacuation route) if regular transport bedsare used,

e) Take chart records and maintain with patients or the local EMS Agency.

14.4 Evacuation triaging and transportation tag

14.4.1 An evacuation transportation tag system shall be used to track patients who are evacuated from the facility.

a) Clinical personnel are responsible for patient assessment/triage which will dictate mode oftransportation based on acuity and care needs.

b) The assessment/triage process and transportation tag will be completed prior to movement ofpatients from the facility.

c) The tags should be updated and reviewed during triage and transportation to the assembly pointsand/or other healthcare facilities.

14.4.2 Patient tracking manager will be responsible for:

a) Maintaining a supply of the evacuation tags at each patient care unit.

b) Coordinating the distribution of evacuation tags during the incident.

c)   Tracking patients who are evacuated from the facility.

15.   Closure of a portion or all of the facility following evacuation

15.1   Introduction

15.1.1   The decision to close all or a portion of the facility is made by the Incident Commander. Closure of the facility (all or in part) is indicated if:

15.1.1.1   The facility ceases the operational capability to provide safe and adequate care.

15.1.1.2   The environment of care is no longer capable of supporting safe and adequate care.

15.1.1.3   Closure has been directed by an external agency having legal authority to do so.

15.1.2   Facility operations during an evacuation will be under the direction of the Infrastructure Branch Director. This position will coordinate all facility control operations as needed during an evacuation. The first step in this process is to have the current status of all facility systems evaluated and documented. From this status report, the Infrastructure Branch Director may call for additional support (e.g., local utilities companies/vendors).

NOTE   Each healthcare facility should pre-determined how this will be designated

15.2   General guidelines

a)   Whenever possible, operationally capable areas should continue to provide care, treatment, andservice as long as possible.

b)   Affected / hazardous areas should be closed first. Once cleared, these areas should be locked andutilities to the area shut down.

c)   Nonessential areas should be closed next. Once cleared, these areas should be locked and utilitiesto the area shut down.

d)   Patient care areas should be closed based on operational and environmental conditions. Closure should proceed from the most at risk to the least at risk areas. Once cleared, these areas should be locked and utilities to the area shut down.

e)   If time and circumstance permit, patient care areas should be scavenged for available supplies, equipment, medication, beds, transport devices, etc. These material resources should be brought to appropriate assembly points or as otherwise directed by the Command Center.

f)   Information Services should conduct a full backup of all information systems prior to shutting down mainframe computers and network systems. Individual proprietary systems should be backed up to external hard drives for removal from the facility.

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g) If time and circumstances permit, medical records should be boxed and removed and transported to an offsite storage location. Records should be removed if possible, from most recent admissions going backward.

h) If time and circumstances permit, personnel records should be boxed and removed from human resources and transported to an off-site storage location.

i) Unless safety issues are present, utilities should be maintained until the affected areas are fully cleared and ready for closure. At that point, Engineering should implement standard and/or emergency shutdown procedures as warranted. Once utilities are shut down, they should be locked out / tagged out and the area secured as able.

j) Controlled substances are secured at all times except during administration. If the facility were to close, these items would be secured by default.

k) If medications are to be moved or evacuated with patients, they shall be secured with licensed personnel.

l) Process to secure diagnostic radiology areas / medications / isotopes in accordance with state law.

15.3 Securing the facility

Usual procedures to secure the facility will be implemented. Focus areas include:

a) Maintaining general security, especially during prolong incidents or when resources are scarce;

b) Establishing a perimeter around the facility, especially patient care areas OR establishing aperimeter around affected high risk area areas within the facility;

c) Controlling access and movement in and between facilities;

d) Maintaining traffic control on campus;

e) Ensuring only authorized persons re-enter the facility after evacuation;

f) Coordination with local public safety, as needed.

15.4 Stay team

If the facility has been evacuated, but personnel need to remain to stabilize the incident and restorefunctionality, designate a Stay Team. This may include members of the Incident Management Team including the Safety Officer, emergency management personnel, facilities/engineering, risk management, human resources, etc.

16. Recovery: Restoring the facility after evacuation

16.1   Introduction

Ensure that restoration and reimbursement issues and planning for facility start up are addressed through the facility continuity of operations plan or business continuity plan.

> NOTE   Each healthcare facility should pre-determined how this will be designated

16.2   General Guidelines

a)   Facilities are determined to be structurally sound and safe, and systems are not compromised, for occupancy. If not safe, may require repairs/retrofits/replacements that need to be approved by relevant authorities/authority having jurisdiction.

b)   Prioritize which departments and personnel to repatriate.

c)   Restoration and testing of infrastructure – water, electricity, Heating Ventilation and Air Conditioning system, medical gases.

d)   All items within the facility that can be affected by spoilage due to loss of power and/or high temperatures are tested and repaired/replaced/quarantined, as needed (e.g., food, medications, radioactive supplies and equipment, computerized diagnostics, etc.).

e)   Procedures to assess the need for and implementing cleaning and decontamination.

f)   Certification by local authorities.

g)   Essential functions and supplies/supply chains (pharmacy, supplies, laundry, etc.) are re-established.

h) Notification of reopening to other hospitals/healthcare facilities, EMS Agency, patient families, media.

i) Procedures for repatriation of patients including:

  i) Approval from relevant authority.

  ii) Patient transportation coordination with sending hospital/healthcare facility.

  iii)   Medical records management.

  iv)   Transportation coordination.

  v)   Patient care assignments.

  vi)   Room assignments.

        vii)   Patient re-registration.

j)   For additional resources, see:

        i)   Incident Management Team Recovery Responsibilities - Annex F.

        ii)   Hierarchy of Repopulation Approval(s) - Annex G.

        iii)   General All-Hazards Hospital Repopulation Factors / Steps - Annex H.

17. Training

17.1 General

Determine the extent of hospital based employee training when designing training. If the hospital does notinclude training in the following topics, then add:

a) Importance of wearing hospital identification during an emergency.

b) Importance of assuring that non-clinical staff and non-clinical volunteers are wearing proper identification; and clinical staff is credentialed through a hospital process

c) 'All Hazards Planning' to include Incident Command/HICS, hierarchy of roles and chain of command topics.

d) Training staff on Hazard Vulnerability Analysis (HVA)

e) HICS training for managers and needs awareness training for staff to include where and when to report to hospital if off site when emergency occurs.

f) Training/education regarding designated parking locations, hospital entrances, labor pool site and check-in process during disasters.

g) Enhancement of call tree to sort by staff address and proximity to hospital (see Annex J).

h) Plan to include staff participation in hospital drills so that facility evacuation specific challenges are included.

i) A discussion of the possibility of two types of evacuations—an initial evacuation to a safe place, within the hospital or at a local hospital then a secondary transfer to care at an appropriate facility:

    j) Alternate communication modes available to staff (radios, walkie-talkies, satellite phones, in house wireless communication devices, cell phones [hospital or personal], voice over internet etc.).

i) Provide regular training on all modes of communication (i.e., know how to use radios, walkie-talkies, in house wireless devices etc.).

ii)Train staff to use the appropriate radio frequencies designated for hospital disaster use.

iii)   Know hospital dead zones for cell phones, radios, and walkie-talkies, in house wirelessdevices.

iv)   Use clear language – avoid code and industry specific nomenclature.

k)Recommendation that staff plan for at least four days (96 hours) of personal supplies (clothing/toiletries/and medications if applicable).

17.2   Facility evacuation training

Include the following in facility evacuation training:

a)   Options and methods to identify unit-based leaders during an evacuation or incident to include use of hats, large ID tags, vests/ shirts/sashes—whichever method is chosen should be consistent throughout hospital and be utilized for every drill. This is especially important when non-clinical staff or volunteers are included in an evacuation and who do not know the leaders by name or by reputation].

b)   Evacuation routes from unit to safe Area and outside hospital (destination to be determined whenscope of the evacuation is identified).

c)   Review of evacuation bag contents and storage locations.

d)   Review method of designating when a patient care room is empty/cleared.

NOTE Each healthcare facility should pre-determined how this will be designated.

e) Use of unit Team Leader Job Action sheets, Patient Evacuation Tracking Form in Annex E and Incident Message Form in Annex K. Include in evacuation bags and in departmental disaster plans or charge nurse resource binder pick the forms and delete the website.

f) Method to document patient tracking and family notification/family reunification based on hospital emergency management plan.

g) Method used to categorize patients for evacuation based on hospital emergency management plan.

h) A communication directory to the command center and other important contact phone/pager numbers to be maintained in departmental disaster plan.

i) Knowledge of hospital specific communication/pager dead zones and planning for alternate forms of written or verbal communication via runners.

j) Reporting of pertinent drill findings and available after-action reports.

k) Adding a coaching component to hospital drills.

18.   Family notification

a) Notify family as soon as possible

b) Assign family liaison position to keep families appraised of patient transfer status and location. Note: it is important to coordinate this information with the Public Information Officer (PIO).

c) If applicable or necessary, have ready access to all pertinent transfer consent forms

19.   Supplies

a)   Identify patients in multiple ways as follows:

i) Consider both standard ID bands/ID stickers on attached medical equipment, as well as direct patient marking. Utilize a surgical marking pen or waterproof marker to write on a transparentdressing that is then applied to the skin of the patient.

ii)The preferred location for this transparent dressing is the abdomen, with other skin sites considered when the abdomen is not intact and there is an alternative site on the patient's body thatcan accommodate the dressing.

b)   The transparent dressing (as described above) that is placed directly on the patient should ideally contain the same information as the ID band/ID sticker: the name of the patient (Mother's name inneonates), the date of birth and hospital identification number.

c)   Determine whether evacuation boxes or bags/backpacks are the most appropriate transport methodbased on unit storage capability and previous hospital planning.

d)   Place content stickers in and on evacuation boxes/bags and in policy and secure with breakawaylock or closures.

e)   Assure that all bags can accommodate even very low birth weight infants (under 1000 g).

f)   Have one supply bag/box per patient per room (supply amount should be enough for a minimum of4-6 hours).

g)   Move all available supplies and medications with the patient; be cognizant that the receiving hospital/staging area may not have the needed supplies or medications immediately available.

h)   Plan for unit based evacuation bags with supplies for all patients.

i)   Store supplies in a low position for easy access and in a safe room to avoid contamination.

j)   Consider how to transport dietary needs for patients.

k)   Take existing and available medications along with Med Boxes if available

i)   Bring Hats/Blankets/Thermoregulatory Methods.

20.   Equipment

a) Recognize that there are multiple types of evacuation equipment made specifically for different patients.

b) Purchase and drill with evacuation supplies and equipment so that staff become familiar with their use.

c) Utilize Patient Evacuation Tracking Form in Annex E to document all equipment transported with the neonate.

d) Know battery life/promote extension of battery life by plugging in electrical equipment.

e) Charge all equipment in emergency outlets if power is available while preparing for evacuation.

f) Consider bed batteries as back up.

g) Consider purchase of back up batteries for equipment and a method to assure charging capabilities and testing based on recommendations of manufacturer or hospital based Biomedical/Clinical Engineering.

h) Syringe pumps.

i) Drug box/transport bag/organized supply kit.

j) Airway bag and supplies.

k)Oxygen source and supplies.

l) Portable suction equipment.

m)   Consider taking a crash cart if going to a non-clinical safe Area on a horizontal move.

n)   Consider additional hospital locations of units crash carts that could easily be moved to the designated safe area (i.e., additional unit crash cart maintained in an outpatient setting or emergency department).

21.   Operational structure/standard operating procedures

Consider surge capacity of a facility as well as surge capability of the receiving facility based on number and acuity of patients and transport route, including how many patients can be transported in one trip.

22.   Receiving Hospital

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a)   Receive patient into facility. Transfer of plan of care via communication hand-off.

b)   Assign a family liaison position to notify next of kin as soon as possible regarding condition of thepatient and arrival at their facility. Instruct family on communication and visitation process.

> NOTE   it is important to coordinate this information with the Public Information Officer (PIO).
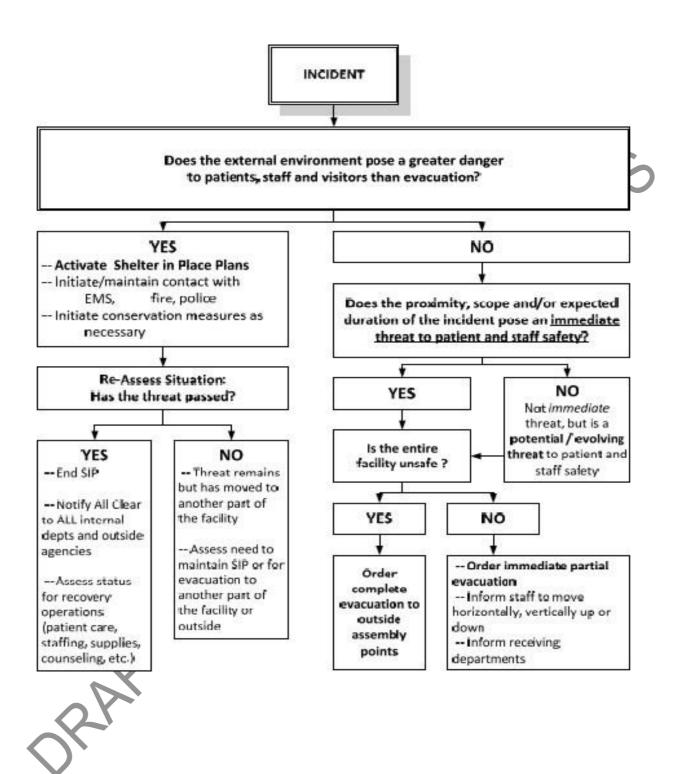
Annex A

(normative)

Decision Tree

When the decision is made to activate, the magnitude of the emergency response shall be determined. The Incident Commander will utilize the Decision Tree to determine what type and level of response is needed.

INCIDENT

Does the external environment pose a greater danger to patients, staff and visitors than evacuation?

YES
-- **Activate Shelter in Place Plans**
-- Initiate/maintain contact with EMS, fire, police
-- Initiate conservation measures as necessary

NO

Does the proximity, scope and/or expected duration of the incident pose an __immediate threat to patient and staff safety?__

Re-Assess Situation: Has the threat passed?

YES
-- End SIP
-- Notify All Clear to ALL internal depts and outside agencies
-- Assess status for recovery operations (patient care, staffing, supplies, counseling, etc.)

NO
-- Threat remains but has moved to another part of the facility
-- Assess need to maintain SIP or for evacuation to another part of the facility or outside

YES

Is the entire facility unsafe ?

NO
Not *immediate* threat, but is a **potential / evolving** threat to patient and staff safety

YES

Order complete evacuation to outside assembly points

NO
-- Order immediate partial evacuation
-- Inform staff to move horizontally, vertically up or down
-- Inform receiving departments

Annex B

(normative)

Decision Matrix

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When the decision is made to activate, the magnitude of the emergency response shall be determined. The Incident Commander will utilize the Decision Matrix to determine what type and level or response is needed. (Planning note: This chart can be personalized to your facility by adding meaningful triggers.)

Incident requiring facility to consider whether an evacuation plan or shelter in place plan should be activated.	
SCENARIO #1 **The external environment* would pose a greater danger to patients, personnel, and visitors than evacuation.** * External may mean inside - but outside of the affected area; or external - outside the facility	**YES** • **Activate Shelter in Place Plans** • Initiate/maintain contact with EMS, or local fire, local police • Initiate conservation measures as necessary
Assess situation: Threat has passed.	**YES** • End SIP • Notify All Clear to ALL internal depts & outside agencies • Assess status for recovery operations (patient care, supplies, counseling, staffing, etc.)
	NO Threat remains but has moved to another part of the facility. Assess need to maintain SIP or for evacuation to another part of the facility or outside.
SCENARIO #2 **The proximity, scope and/or expected duration of the incident pose an immediate threat to patient/resident and personnel safety.**	**YES** • **Order immediate partial evacuation** • Inform personnel to move horizontally, vertically up or down • Internal Relocation: Inform receiving departments • **OR Order complete evacuation to pre-identified assembly points**
	NO – not immediate threat, but threat exists, follow steps for Scenario #3
SCENARIO #3 **Potential / evolving threat to patient and personnel safety**	**YES** Decision to make: Partial or Total Evacuation?
Assess situation: Is the entire facility unsafe for patients/residents or personnel?	**YES** • Activate Complete Evacuation Plan • Determine evacuation sequence of departments
	NO Activate Partial Evacuation or Relocation Plan • Inform personnel to move horizontally, vertically up or down • Internal Relocation: Inform receiving departments

Annex C
(normative)

Incident assessment worksheet

Use this worksheet to assess the impact that the incident will have on the facility. Sources of this information may come from affected departments, liaison officers, other community responsible partners ,etc.

INCIDENT CHARACTERISTICS	
Arrival	
Note: The amount of time until the event combined with the anticipated time to evacuate determines how long an evacuation decision can be deferred	
When is the incident expected to impact the facility?	
How variable is the impact timeframe?	
Magnitude	
Note: The magnitude of the event predicts potential damage to a facility and utilities, which could cut off the supply of key resources, or otherwise limit the ability to shelter-in-place and care for patients.	
What are the expected effects on the facility?	
What are the expected effects on the community?	
How likely is the event to be more or less severe than predicted – what are the impacts?	
Area Impacted	
Note: Competition for resources needed to evacuate patients (especially vehicles) increases when more facilities evacuate simultaneously.	
How large is the geographic area affected?	
How many vulnerable healthcare facilities are in this geographic area (LTC, hospitals, others)?	
Duration	
Note: The duration of the incident affects how long facilities have to operate on backup, alternative, or less predictable resources.	
How long is the incident expected to last?	
How variable is the expected duration?	
ANTICIPATED EFFECT OF THE INCIDENT ON KEY RESOURCES	
Water	
Note: Water loss of unknown duration (more than 1-2 days) is almost always cause for evacuation.	
Is the facility or main city water supply in jeopardy? Already non-functional?	
Is there a backup water supply (well, nearby building with intact water mains)?	
If not, how soon will city water return?	
Heat / Air Conditioning	
Note: Loss of heat especially during a northern winter, or loss of air conditioning in summer, is often a cause for evacuation—often within 12 hours.	

Is the HVAC system in jeopardy (steam, water for boilers, etc.)? Already non-functional?	
Is there a backup (intact nearby building that still has power/HVAC)?	
If not, will the building be too cold/hot for patient safety before adequate temperature stabilizes?	

Electricity

Note: Loss of electricity endangers ventilated patients, among others, and may affect the sequence in which patients are evacuated.

Is power at risk? Just for the facility or a wider area?	
Are backup generators functional?	
How long can they run without refueling?	
Is refueling possible given the situation?	
Can some sections/wings be shut down to reduce fuel consumption and stretch fuel supplies?	

Facility Structural Integrity

Notes: Structural damage may cause rooftop water tanks to fail, flooding the building. Safety/integrity may not be obvious to untrained occupants.

Is the building obviously/visibly unsafe? All of it or only portions (e.g., can people be consolidated in safer sections)?	
Is there a water tank on the roof, and is it intact?	
Is a structural engineer needed to make an assessment?	

ANTICIPATED EFFECT OF THE INCIDENT ON THE COMMUNITY

Road Conditions

Notes: There may be a limited window of opportunity to carry out a ground-based evacuation. Increased use of helicopters to evacuate patients may be required. Personnel may not be able to get to the facility to relieve existing personnel or assist in the evacuation.

Are any major routes from the hospital to potential receiving care sites closed or threatened?	
Will evacuation traffic clog major routes from the hospital to potential receiving care sites?	
Are access routes to the hospital cut off or threatened?	

Community/Building Security

Note: If patient and personnel safety cannot be assured, the decision needs to be made whether sheltering in place is safer or if evacuation will be necessary.

Have any nearby areas experienced increases in civil disorder or looting?	
Are local law enforcement agencies understaffed due to self-evacuations or significant additional responsibilities?	
Are additional private security officers available to secure the hospital?	
Evacuation Status of Other Nearby Health Care Facilities	
Notes: If other healthcare facilities are evacuating: the competition for ambulances, wheelchair vans, and buses may be substantially increased; you may be asked to accept additional patient; patients may have to be relocated to facilities further away than anticipated.	
Are other healthcare facilities already evacuating or planning to evacuate, or have they decided to shelter-in-place?	
State/County/Local Evacuation Order	
Note: You may have no choice but to evacuate.	
Have evacuation orders been issued in areas closer to the incident?	
Have any public or private statements been issued regarding the possibility of an evacuation order?	
Have any other incidents occurred that increase the likelihood that an evacuation order will be issued?	
Availability of Local Emergency Response Agencies	
Unavailability of local fire agencies increases the risk of sheltering-in-place.	
Are local emergency response agencies understaffed or less available due to other responsibilities?	

DRAFT

Annex D

(normative)

Transportation resource needs matrix

Use this tool to determine transportation needs when requesting assistance through your usual transportation providers

Emergency Department Census and Transportation Needs		
	Use your total ED census (including waiting room)	
	# of Pt	Calculation:
Discharge within 3 hours		Multiply your total ED census by
Total ED Patients needing transport		Multiply your total ED census by
Type of Transportation Resource	# of Pt	Calculation:
Critical Care Transport		Multiply Total ED Patients Needing Transport by
ALS Transport		Multiply Total ED Patients Needing Transport by
BLS Transport		Multiply Total ED Patients Needing Transport by
Van/Bus Transport		Multiply Total ED Patients Needing Transport by

Inpatient Census and Transportation Needs		
	# of Pt	Calculation:
Discharge within 3 hours		Multiply your total inpatient census by
Inpatients Needing Transport		Multiply your total ED census by
Type of Transportation Resource	# of Pt	Calculation:
NICU Transport		Multiply Total Inpatients Needing Transport by
Critical Care Transport		Multiply Total Inpatients Needing Transport by
ALS Transport		Multiply Total Inpatients Needing Transport by
BLS Transport		Multiply Total Inpatients Needing Transport by
Van/Bus Transport		Multiply Total Inpatients Needing Transport by

Annex E

(normative)

Patient evacuation tracking form

Completed by the nurse providing care. The patient tracking manager should maintain a transfer summary form, or this form to track all patients that are transferred to an alternate care site or discharged.

PATIENT NAME			DATE OF BIRTH		SEX
MEDICAL RECORD NUMBER		**DISPOSITION** (circle) Discharged or Transferred			
EMERGENCY CONTACT		**TELEPHONE NUMBER**		**NOTIFIED OF TRANSFER** (circle) Yes No	
ATTENDING PHYSICIAN		**NOTIFIED OF TRANSFER** (circle) Yes No			
RECEIVING CARE SITE		**METHOD OF TRANSPORT**		**TRANSPORTING AGENCY**	
DATE TRANSFERRED	**TIME TRANSPORT INITIATED**		**TIME OF ARRIVAL** **AT RECEIVING FACILITY**		
ORIGINAL CHART OR INFO SHEET **SENT WITH PATIENT** (circle) Yes No		**ADVANCED DIRECTIVE** (circle) Yes No		**COPY SENT WITH PATIENT** (circle) Yes No	
PRIMARY DIAGNOSIS		**SECONDARY DIAGNOSES**			
EQUIPMENT OWNED BY SENDING FACILITY **ACCOMPANYING PATIENT DURING TRANSPORT**			**MEDICATION SENT WITH PATIENT** (circle) Yes No *If yes, describe below:*		
BELONGINGS SENT WITH PATIENT (circle) Yes No *If no, describe below:*			**COMMENTS**		
NAME AND TITLE OF PERSONNEL MEMBER(S) **ACCOMPANYING PATIENT TO ALTERNATE CARE SITE**					

Annex F

(normative)

Master patient evacuation tracking form

- Master Patient Evacuation Tracking Form

MASTER PATIENT EVACUATION TRACKING FORM

1. INCIDENT NAME		2. DATE/TIME PREPARED	3. PATIENT TRACKING MANAGER

4. PATIENT EVACUATION INFORMATION

Patient Name	Medical Record#	Disposition	Evacuation Triage Category	Accepting Hospital	Time Hospital Contacted & Report given
			Immed Delayed Minor Expired		
		Home or Transfer			
Transfer Initiated (Time/Transport Co.)	Med Record Sent Yes No	Medication Sent Yes No	Family Notified Yes No	Arrival Confirmed Yes No	Admit Location Floor ICU ER	Expired (time)

Patient Name	Medical Record#	Disposition	Evacuation Triage Category	Accepting Hospital	Time Hospital Contacted & Report given
			Immed Delayed Minor Expired		
		Home or Transfer			
Transfer Initiated (Time/Transport Co.)	Med Record Sent Yes No	Medication Sent Yes No	Family Notified Yes No	Arrival Confirmed Yes No	Admit Location Floor ICU ER	Expired (time)

Patient Name	Medical Record#	Disposition	Evacuation Triage Category	Accepting Hospital	Time Hospital Contacted & Report given
			Immed Delayed Minor Expired		
		Home or Transfer			
Transfer Initiated (Time/Transport Co.)	Med Record Sent Yes No	Medication Sent Yes No	Family Notified Yes No	Arrival Confirmed Yes No	Admit Location Floor ICU ER	Expired (time)

Patient Name	Medical Record#	Disposition	Evacuation Triage Category	Accepting Hospital	Time Hospital Contacted & Report given
			Immed Delayed Minor Expired		
		Home or Transfer			
Transfer Initiated (Time/Transport Co.)	Med Record Sent Yes No	Medication Sent Yes No	Family Notified Yes No	Arrival Confirmed Yes No	Admit Location Floor ICU ER	Expired (time)

Patient Name	Medical Record#	Disposition	Evacuation Triage Category	Accepting Hospital	Time Hospital Contacted & Report given
			Immed Delayed Minor Expired		
		Home or Transfer			
Transfer Initiated (Time/Transport Co.)	Med Record Sent Yes No	Medication Sent Yes No	Family Notified Yes No	Arrival Confirmed Yes No	Admit Location Floor ICU ER	Expired (time)

5. SUBMITTED BY	6. AREA ASSIGNED TO	7. DATE/TIME SUBMITTED

8. FACILITY NAME

Purpose: Record information concerning patient disposition during a hospital/facility evacuation   Origination: Patient Tracking Manager
Copies to: Planning Section Chief and Documentation Unit Leader

Annex G

(normative)

Incident management team recovery responsibilities

G.1 Command

G.1.1 Incident Commander

G.1.1.1 Assess if criteria for partial or complete reopening of the facility is met, and order reopening and repatriation of patients

G.1.1.2 Oversee restoration of normal hospital operations.

G.1.2 PIO

Conduct final media briefing providing situation status, appropriate patient information and termination of the incident.

G.1.3 Liaison Officer

Notify local emergency management, fire, EMS and Licensing and Certification of termination of the incident and reopening of the facility.

G.1.4 Safety Officer

Oversee the safe return to normal operations and repatriation of patients.

G.2 Operations

G.2.1 Restore patient care and management activities.

G.3

G.3.1 Repatriate evacuated patients.

G.3.2 Re-establish visitation and non-essential services.

G.4 Planning

G.4.1 Finalize the Incident Action Plan and demobilization plan.

G.4.2 Compile a final report of the incident and hospital response and recovery operations.

G.4.3 Ensure appropriate archiving of incident documentation.

G.4.4 Write after-action report and corrective action plan to include the following:

G.4.4.1 Summary of actions taken.

G.4.4.2 Summary of the incident.

G.4.4.3 Actions that went well.

G.3.4.5 Area for improvement.

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G.3.4.6 Recommendations for future response actions.

G.4 Logistics

G.4.1 Implement and confirm facility cleaning and restoration, including:

G.4.2 Structure.

G.4.3 Medical equipment certification.

G.4.4 Provide debriefing and mental health support services for personnel and patients.

G.4.5 Inventory supplies, equipment, food, and water, and return to normal levels.

G.5 finance/administration

G.5.1 Compile final response and recovery cost and expenditure and estimated lost revenues summary and submit to the Incident Commander for approval.

G.5.2 Contact insurance carriers to assist in documentation of structural and infrastructure damage and initiate.

Annex H

(normative)

Hierarchy of Repopulation Approval(s)

Dependent upon circumstances, the following sequential steps should be expected prior to the repopulation of evacuated hospital facilities.

Steps	Date Completed
A. Local government agencies have removed restrictions, if any, related to the environmental quality in the area or facility for the types of patients to be moved back into the facility.	
B. Local fire department and/or law enforcement agency representative allows re-entry to the specific evacuated neighborhood in which the facility is located and/or allows re-entry to evacuated facilities, as applicable.	
C. If structural integrity or any major building system is compromised, OSHPD inspects and repopulation cannot occur until any red and yellow building tags are removed from the impacted building by OSHPD.	
D. If required, due to prolonged loss of power and refrigeration or breach of pharmaceutical security, State Pharmacy Board may conduct a site visit to approve measures taken to restore Pharmacy capacity and safety.	
E. The CEO/IC oversees an assessment of environmental safety, facilities, operations and resources, including the factors identified in the General All Hazards Repopulation Factors checklist below, and prepare the facility for repopulation.	
F. The CEO/IC maintains communication with the Licensing & Certification (L&C) District Office regarding facility status, progress and estimated timeframes for reopening of facility (ies). Depending upon the circumstances, L&C may schedule a reportable event visit.	
G. Once the CEO/IC makes a determination, based on best judgment, that the facility is ready to repopulate, L&C is notified and: 1. If necessary, an L&C repopulation inspection is scheduled, or 2. Repopulation is initiated.	
H. If an L&C repopulation visit is required: 1. If necessary, additional actions or agency reviews may be requested by L&C; and/or 2. The determination is made that hospital facilities are safe for patients, personnel and visitors, programs and services can be resumed, and repopulation can be initiated.	

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Annex J

(normative)

General all-hazards hospital re-population factors / steps

The following factors / steps should be considered as appropriate to the type of evacuation

Factors / Steps	Status/Date
A. Facilities are determined to be structurally sound and safe, and systems are not compromised, for occupancy. If not safe, may require repairs/retrofits/replacements that need to be approved by OSHPD, fire marshal and Licensing & Certification (L&C).	
B. Air particulate exposure levels (e.g., smoke, chemicals) in buildings are documented to be reduced to acceptable/safe levels as defined by Cal/OSHA permissible exposure limits (PELS) and local Air Quality Management District standards using available methods (e.g., air scrubbers, open windows, blowers, HAZWOPER response, etc), if needed. Only test equipment appropriate to the hazard should be used to determine safe levels of habitability and may require an outside testing laboratory service.	
C. Hospital shall have a plan to prepare for and implement repopulation.	
D. All interior and exterior surfaces/areas are clean and free of debris (e.g., counters, walls, drawers, closets, roof, parking facilities, etc).	
E. All filters in the facility, HVAC systems, and generators, etc. should be cleaned/replaced, if needed.	
F. Replace or clean linens, drapes, and upholstery, if needed.	
G. All items within the facility that can be affected by spoilage due to loss of power and/or high temperatures are tested and repaired/replaced/ quarantined, as needed (e.g., food, medications, radioactive supplies and equipment, computerized diagnostics, etc.).	
H. Essential functions and supplies/supply chains (pharmacy, supplies, laundry, etc.) are returned to operational status. The facility's ability to provide essential services should be sustainable for the long term. Program Flex may be an option subject to L&C District Office approval.	
I. Vandalism and/or looting damage, if applicable, is repaired and alleviated.	
J. Full and non-abbreviated generator and smoke detector tests are completed, if needed.	
K. HVAC systems are tested and operational, if needed.	
L. Utilities are tested and operational (electricity, water supply and quality, plumbing, etc.).	
M. Dietary services are operational and sustainable for the long term; in the case of damage to kitchens/equipment, program flex approval from L&C may be requested for contract services during repairs.	
N. Determine if the laboratory evacuation plan was followed. If the laboratory evacuation plan was not adhered to, or found to have limitations, a mitigation response is necessary.	

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Annex K

(normative)

SAMPLE ICU EVACUATION CALL TREE

{INSERT HOSPITAL NAME OR LOGO}

DEPARTMENT CALL TREE

ICU Management Staff

NAME	TITLE	CONTACT NUMBERS	CONTACT STATUS		ARRIVAL STATUS	HAS FAMILY PLAN YES/NO	NEEDS FAMILY CARE		INCIDENT ASSIGNMENT
			Received message	Left message			Y/N	How many	
		H: C: W:							
		H: C: W:							
		H: C: W:							

Department staff residing within 30 MINUTES of hospital

NAME	TITLE	CONTACT NUMBERS	CONTACT STATUS		ARRIVAL STATUS	HAS FAMILY PLAN YES/NO	NEEDS FAMILY CARE		INCIDENT ASSIGNMENT
			Received message	Left message			Y/N	How many	
		H: C: W:							
		H: C: W:							

Sample ICU evacuation call tree

{INSERT HOSPITAL NAME OR LOGO} (CONT.)

Department staff residing within 60 MINUTES of hospital

NAME	TITLE	CONTACT NUMBERS	CONTACT STATUS		ARRIVAL STATUS	HAS FAMILY PLAN YES/NO	NEEDS FAMILY CARE		INCIDENT ASSIGNMENT
			Received message	Left message			Y/N	How many	
		H: C: W:							
		H: C: W:							

Department staff residing more than 60 MINUTES from hospital

NAME	TITLE	CONTACT NUMBERS	CONTACT STATUS		ARRIVAL STATUS	HAS HOME FAMILY PLAN YES/NO	NEEDS FAMILY CARE		INCIDENT ASSIGNMENT
			Received message	Left message			Y/N	How many	
		H: C: W:							
		H: C: W:							

Annex L

(normative)

Incident message form

– INCIDENT MESSAGE FORM			
1. FROM (Sender):			**2. TO (Receiver):**
3. DATE RECEIVED	**4. TIME RECEIVED**	**5. RECEIVED VIA**	**6. REPLY REQUESTED:**
		☐ Phone ☐ Radio	☐ Yes ☐ No
		☐ Other	If Yes, REPLY TO (if different from Sender):

7. PRIORITY ☐ Urgent - **High** ☐ Non Urgent – **Medium** ☐ Informational - **Low**

8. MESSAGE *(KEEP ALL MESSAGES / REQUESTS BRIEF, TO THE POINT, AND VERY SPECIFIC)*:

9. ACTION TAKEN *(if any)*:

Received by:	Time Received:	Forward to:
Comments:		

Received by:	Time Received:	Forward to:
Comments:		

10. FACILITY NAME

Purpose: Provide standardized method for recording messages received by phone or radio   **Origination:** All Positions
Original to receiver. **Copies to:** Documentation Unit Leader and Message Taker