XXXX Emergency Sheltering, Relocation, and Evacuation Plan

Revised 03/13/12

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Emergency Relocation Plan

Plan Overview and Assumptions

The purpose of this plan is to assist in activating sheltering, patient relocation, or partial or full evacuation of X Medical Center. The responsible individual for content and implementation of this plan is the X Manager of Emergency Preparedness. This plan has been reviewed and approved by members of the X Emergency Preparedness Committee and X Executive Leadership Team.

This plan informs actions taken to shelter, relocate (within the facility) or evacuate (external to the facility) patients and personnel. These actions may be driven by many incidents and situations. The overall management of the incident and recovery are the responsibility of the incident commander. Reimbursement tracking, restoration, business continuity, and recovery activities must be conducted in concert with patient protection and movement and are not included in this plan.

X will maintain procedures in order to manage internal and/or external situations which pose a threat to the environment of care or present a life safety threat. Additional personnel may be required to conduct these operations. X will assign personnel to this task including internal staff and external according pre-existing agreements with other facilities (compacts), local First Responder agencies and/or other entities (medical reserve corps, etc.) with resources.

This plan was developed in conjunction with the Metro Region Healthcare System Preparedness Program and the Metro Hospital Compact to ensure a consistent approach across the region. Plans have been cross-walked against applicable Joint Commission, Occupational Safety and Health Administration (OSHA), Center for Medicare and Medicaid Services (CMS), and other regulations to assure compliance.

1.2 Objective

The objective of this plan is to;

- Define key terms
- Identify the direction and control systems for the coordination of an evacuation or protective actions.
- Provide algorithms for decision-making
- Describe key communications components
- Identify the steps of the facility evacuation process
- Identify responsibilities of outside agencies and their activation

1.3 Hazard Vulnerability Assessment

X has tailored this plan according to the latest facility Hazard Vulnerability Assessment (HVA)in respect to the hazards which would likely impact the environment of care. The potential hazards which are most likely to impact the facility and force sheltering, patient relocation, and/or evacuation are:

- Weather emergencies – tornado
- Hazardous materials events
- Community based major utilities or systems failures
- Flooding – internal or external
- Structural damage
- Institutional Hazards and Vulnerabilities*
    - Special vulnerabilities
        - *Critical Care; NBICU,PICU, Burn Unit, SICU, MICU, Surgery,*
        - *In-patient psychiatric units, Crisis Center*
        - *Pediatric Unit and nursery*
    - Water (potable and non-potable)
    - Steam
    - Electricity
    - Gas
    - Boilers / chillers
    - Powered life support equipment
    - Information technology / communications
    - Security
    - Emergency Medical Services & EMS Communication Center
    - Location of the facility in relation to receiving hospitals with appropriate capacity/capability (e.g. NICU capability)

Pre-event Mitigation actions have been undertaken to help minimize the impact of each of these types of emergencies on the facility systems. The X Hazard Vulnerability Assessment and Pre-Disaster assessment as well as information about mitigation actions are available upon request to X, *Manager of Emergency Preparedness.*

* Facilities should identify and mitigate hazards to the degree possible. May wish to use the AHRQ assessment (pg. 13 Table 4 - http://www.ahrq.gov/prep/hospevacguide/hospevactab4.htm) and/or the HICS pre-incident checklist for internal scenario #2 – Evacuation available at http://www.hicscenter.org/docs/206.swf in planning

1.4 Possible Actions and Definitions

1.4.1 - Factors influencing actions: The *needs, and the time and resources* **available to meet the needs –** incident command staff will have to balance these to determine which of the following strategies is appropriate.

1.4.2 - Action Timing:

1. Pre-event actions – occur in advance of the event (for example, staged evacuation in advance of flooding, sheltering in place)

2. Post-event actions – occurs after an event. Post-event actions may be:

a. Emergent – Undertaken immediately and with limited ability to stage patients, transfer records, etc.

b. Urgent – Undertaken after assessment of an evolving threat or after considerations of risk posed by the impact of the event – usually within 4-8 hours after an event occurs.

1.4.3 - Action Types:

1.Shelter In Place (SIP) - Shelter In Place assures the maximal safety of individuals in their present location when the dangers of movement exceed the relative risk from the threat or movement cannot be safely completed in a reasonable timeframe. Shelter in place decisions must be made in relation to the risk to the patient – a patient undergoing cardiac surgery at the time of the threat would be moved only in the most dire situation. Similarly, intensive care unit patients should be moved only in extreme circumstances, but outpatient clinics may be easily evacuated. SIP decisions are not, therefore, necessarily applied to the entire facility though in situations where the external environment is the threat (chemical cloud, weather) protective actions may be taken to protect the facility at large.

2. Internal Patient Relocation – movement of patients to an area of relative safety in response to a given threat or movement to staging areas within the institution in preparation for evacuation.

a. Horizontal – movement to a safe location on the same floor, preferably nearer to an emergency exit. For example, movement to the next smoke compartment during a fire situation.

b. Vertical - movement of individuals to a safe location on a different floor when a horizontal evacuation cannot meet the service or safety needs of the patients (for example, ICU patients) or is unsafe

3. Evacuation – movement of patients out of the affected facility when the facility cannot maintain a safe environment of care. Evacuations may be emergent (fire or other immediate life safety threat) or non-emergent (delayed life-safety threat or anticipated evacuation)

a. Partial evacuation – Evacuation of a subset of facility patients – this may involve patients requiring specialized care that can no longer be safety delivered at the affected facility (intensive care, dialysis)

b. Complete evacuation – complete evacuation of a facility due to an unsafe environment of care – usually will involve facility shutdown actions

1.5 Direction and Control

All personnel are authorized to take immediate patient relocation or sheltering actions in response to a life safety emergency.

All non-emergent patient movement or evacuation decisions should be made by the incident commander after initial situation assessment (see algorithm) according to the facility Emergency Operations Plan (EOP) and personnel appointed under the Hospital Incident Command System (HICS)(Evacuation Decision Team).

A jurisdiction may issue an evacuation order that may supersede the Facility's Administrator authority. X will cooperate with the evacuation orders of the local officials and assist in the coordination of the facilities evacuation to the degree safely possible - though this may *not* necessarily involve a complete evacuation depending on the timeframe and risk of the threat compared to the risk to the patients.

The incident commander will determine the HICS structure for the incident using the HICS Evacuation and Shelter in Place Response Guide:

- Evacuation ***is*** the incident at the facility (anticipated evacuation for flooding): Operations Chief may supervise evacuation activities.

- Evacuation is due to ***another*** incident at the facility: Evacuation Branch Director should be appointed to supervise (see example below for a partial HICS chart reflecting a fire requiring evacuation).

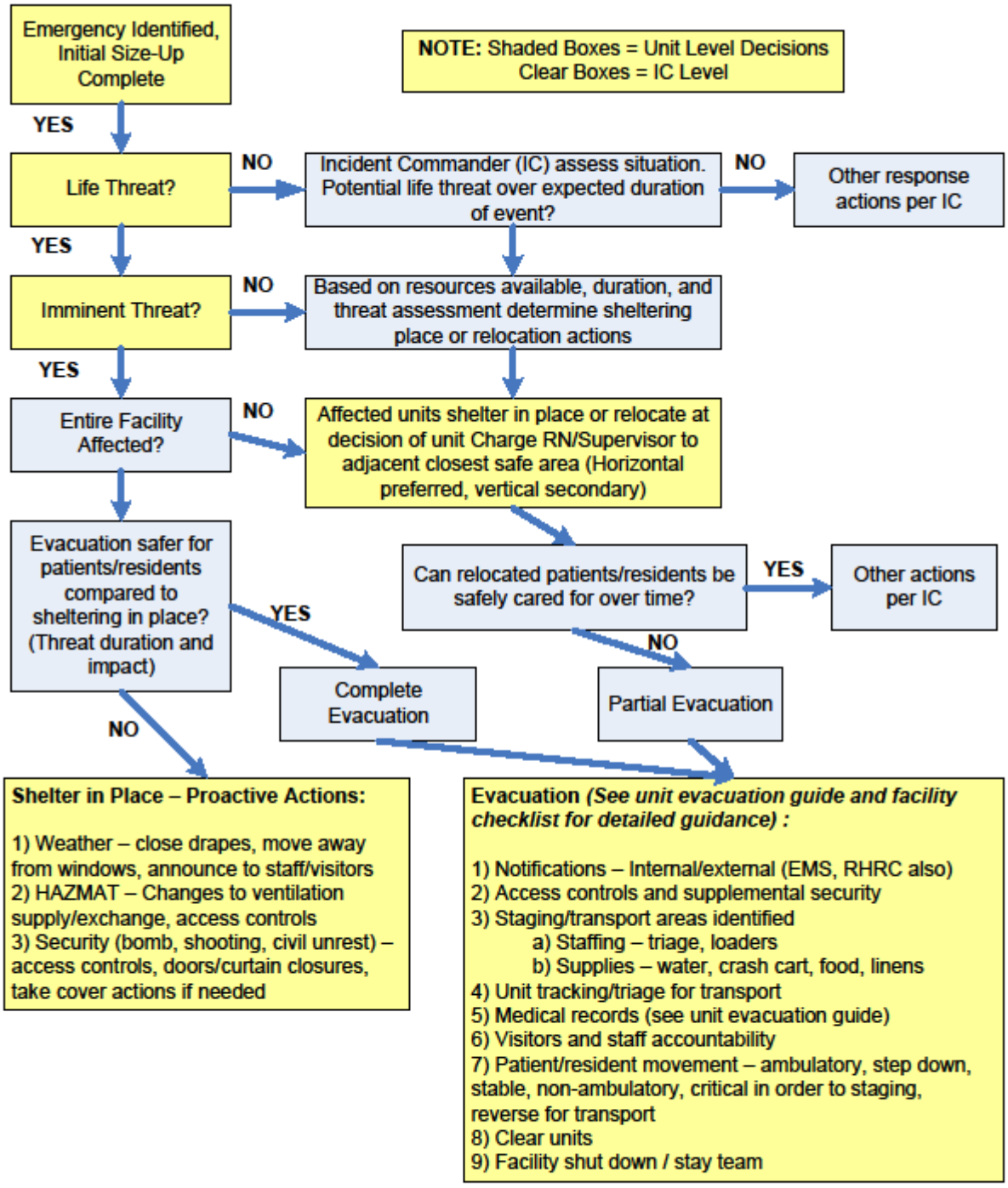
- Each facility may wish to map out these division and unit assignments prior to an event as they will be consistent regardless of whether a Evacuation Branch Director is used

Job check lists for incident command positions associated with evacuation operations are located in the attachments, along with evacuation-specific forms - (HICS) 254, 255, 259, 260, etc.):

- Operations / Medical Care Branch Director
- Planning Section Chief / Resources Unit Supervisor
- Unit Leader Job Aid (for charge nurses on patient care units and outpatient / support services)
- Staging Manager / Officer(s)
- Triage Officer(s)
- Transport Officer(s)

The decision tree below can be used to assist in decision making regarding sheltering, relocation, and evacuation, though this is not meant to account for all circumstances.

Sheltering, Relocation, and Evacuation Decision Tree



1.6 Communications

Internal notification and partner communications should be conducted according to the Emergency Operations Plan. Key considerations in hospital evacuations include, but are not limited to:

- Staff: Notification to internal and external staff 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.
- Patient Families: Notification of patient families of patient evacuation destinations
- Patient Medical Providers – Notification of evacuation destinations
- 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)
- Media: Public information reflecting the capabilities of the facility

1.7 Coordination with external agencies

Coordination with external agencies is critical to planning what to do as things change rapidly. Healthcare facilities must continue to update their decisions based upon information provided by other agencies - for example, knowing the duration of the chemical cloud, or a power outage is crucial to continued decision-making about sheltering vs. evacuation.

a. Shelter in place and internal patient movement: Facility Incident command must establish communication links; appoint liaisons as needed to assure a common operating picture, and adequate situational awareness to facilitate ongoing decision-making (fresh air intake, access controls, etc.)

b. Evacuation: incident command must establish coordination with:

i. Security / public safety – to provide appropriate traffic controls

ii. Transportation –EMS Resource Control Center (XXX-XXX-XXXX) if operational at X – X is back-up at XXX-XXX-XXXX should be contacted and appropriate liaisons established to assure that adequate transportation capacity (buses, WC vans, ambulances) can be delivered

iii. Regional Healthcare Preparedness Coordinator (RHPC) should be notified in any actual or anticipated case of evacuation involving more than a few patients (X security XXX-XXXX has call list)

iv. Destination coordination – The evacuating facility is responsible for assuring transportation to a receiving facility that is capable of providing the necessary, on-going patient care. Except in cases of movement of a few specialized patients, the Regional Healthcare Preparedness Coordinator (RHPC) may be called on to assist (as above) and will work with the facilities in the region (and if needed, with the Minnesota Department of Health (MDH) – Office of Emergency Preparedness (OEP)) to assist destination mapping for evacuated patients. Evacuating facility shall work with EMS to assure coordination of information / patient tracking.

2.0 Sheltering and Relocation

2.0.1 Sheltering – when the threat does not permit safe relocation or evacuation, the following actions may be taken. **Patient care and administrative units are authorized to initiate these actions** upon recognition/notification of threat (in conjunction with notification of supervisors or other actions under emergency operations plan):

- Weather – wind, hail, or tornado threat – move patients and staff away from windows as possible. Close drapes and exterior doors/windows. Assure staff and visitors also advised of weather situation.

- Security emergency – bomb threat, individual posing security threat, external civil unrest – Implement department-specific access controls. Close smoke compartment doors, patient room and office doors and perform other take cover measures as needed. Assure staff and visitors are aware of situation.

- HAZMAT incident – sheltering usually relevant to external plume of chemical, facilities will shut down air intake into ventilation system, security to implement access controls as needed. Assure visitors and staff aware of threat.

2.0.2 Re-location – Units may have to re-locate patients and staff in relation to a threat. Primary and secondary locations are listed in summary below. More complete information is available in the individual unit evacuation plans. (***See Appendix 1*** for example template).

Unit supervisors and charge nurses are authorized to initiate patient re-location in response to an imminent threat. Re-location does not involve formal gathering of medical records or triaging of patients. Ambulatory patients should be assisted to the new location and non-ambulatory patients moved on beds, carts, or via canvas / blanket carries.

Once patients / residents are in a place of safety, the facility plan should be instituted and further movement would be delegated by roles designated in the facility plan. Movement to staging area is authorized only with orders from Incident Commander or appropriate section chief and should be conducted according to evacuation plans/section below (see table next page):

X - Internal Re-location in Response to Unit-based Threat Note: This reference is being revised 8/9/11

(Based on bed availability and location of incident)

X Unit Name & Beds	Occupied Beds	Specialized equipment/needs e.g. 1:1, ventilators etc.	HAZMAT / medical gases	Locked unit?	Preferred relocation to:	Secondary relocation to:	Preferred Staging area for evacuation
MICU (X)				NA	0	0	
SICU (X)				NA	0	0	
Burn (X)				NA	0	0	
intermediate (X)				NA	0	0	
Trauma/surgical (X)				NA	0	0	OB
Stepdown (X)				NA	0	0	
Med (X)				NA	0	0	
Ortho (X)				NA	0	0	
PICU (X)				NA	0	0	
Pediatrics (X)				NA	0	0	
L&D / MW (X)				NA	0	0	
OB (X)				NA	0	0	
Nursery (X)				NA	0	0	
NBICU (X)				NA	0	0	Nursery
Psych (X)				Yes	0	0	
Psych 1 (X)				Yes	0	0	
Psych 2 (X)				Yes	0	0	
Psych 3 (X)				Yes	0	0	
Psych 4 (X)				Yes	0	0	
Psych 5 (X)				Yes	0	0	
Rehab (X)					0	0	
Observation (X)				NA	0	0	
ED (X)				NA	0	0	
Crisis Center (x)				Yes	0	0	
OR/PACU (X)				NA	0	0	

2.1 Evacuation

Incident commander must authorize evacuation when specific patient units or the facility are unsafe for continued occupancy due to compromised structure or services. Evacuations may include:

- **Partial** – initiated for a subset of facility patients whose needs cannot be met by the facility or in anticipation of flood or other threat to that unit/area. Often, a partial evacuation is for patients with specialized needs (ICU).
- **Complete** – a threat poses a major danger to all occupants and complete evacuation is required to assure patient and staff safety (fire, flooding, structural damage)

Unit specific checklists should be developed to assist in the operation of evacuation. ***See Appendix 2-4*** for template samples. This is not an all-inclusive list as additional items may be added. The following summarizes core responsibilities during an evacuation. (Units that have an imminent threat to patient / resident safety must first move patents / residents to a place of safety according to facility plan and then contact supervisors per facility EOP.)

2.1.1 Incident Command Actions – (see also Check List: Operations/Medical Care Branch for checklist)

1. Analyze threat and determine that evacuation is required for patient/staff safety
2. Activate any appropriate facility response plan alerts
3. Notify facilities, safety/security and appoint Safety Officer, Infrastructure Branch Director if not already appointed. Depending on facility size and incident impact, consider an Evacuation Branch Manager (less applicable when the evacuation is the IC focus, more applicable when the incident is the IC focus – for example, fire at the facility)
4. Appoint Staging Manager (see Staging Manager Job Aid)
5. Notify affected units (or entire facility) of need to triage and move patients to staging areas
6. Notify local EMS agencies and patient transportation resources according to need (see table below)
7. Notify RHPC and local hospitals (RHPC via X security XXX-XXX-XXXX or XXX-XXX-XXXX, hospitals may be reached via RHPC or directly on 800mhz system on HOSP-CALL)
8. Appoint Transportation Manager (see Transportation Manager Job Aid) – transportation manager to identify vehicle staging area, assure adequate transport resources requested, assure outgoing patients, equipment, and staff recorded (Transportation Manager appoints transport officer 1/staging area if more than one)
9. Task Planning Section Chief with identifying destinations for patients and tracking departure and arrivals as well as assuring medical record transfer
10. Monitor patient movement and staging / transportation actions and arrangements for transfer
11. Assure Public Information Officer appointed to convey facility status and inform staff, patient families, and medical providers of the situation
12. Recognize that staff should be prepared for the possibility of accompanying patients/residents to receiving facilities. In some instances it may be necessary for staff to stay with patients/residents at the receiving facility since receiving facility may have enough beds but not enough staff.

2.1.2 Ambulatory Care Actions

1. Recognize unit-based threat or receive evacuation instructions from incident commander and move patients/residents and staff from area to rally point.
2. Account for staff, assure patients/residents have transport home / back to point of origin.
3. Sweep area for remaining persons, closing doors and placing sticker / tape on each door across the door and jamb indicating ‘room clear’
4. Report unit clear to Medical Care Branch Director / Incident Command

2.1.3 Inpatient Care Actions

1. Recognize unit-based threat or receive evacuation instructions from incident commander or authorized personnel according to facility plan and move patients/residents and staff from area to re-location point (horizontal first, then vertical per unit plan) or to staging according to threat/instructions
2. Assure belongings and appropriate records accompany patient (see below) depending on immediacy of threat
3. Account for patients at staging / re-location point
4. Account for staff at rally point after patients transferred
5. Sweep unit for remaining persons, closing doors and placing sticker on each door across the door and jamb indicating ‘room clear’
6. Report unit clear to Medical Care Branch Director / Incident Command

2.1.4 Non-Patient Care Area Actions

1. Recognize unit-based threat or receive evacuation instructions from incident commander or authorized personnel according to facility plan and move staff from area to rally point.
2. Account for staff at rally/muster point
3. Initiate continuity of operations plan actions
4. Sweep area for remaining persons, closing doors and placing sticker on each door across the door and jamb indicating 'room clear'
5. Report unit clear to Infrastructure Branch Director / Incident Command

2.1.5 – Evacuation of Staff with Disabilities – ***See Appendix 5***

In the event of an evacuation, staff members/visitors with disabilities may require assistance. Each department head must identify which of their employees may have difficulty during an evacuation and pre-plan the best way to aid their movement to a safe location.

2.2 Staging Areas

Staging areas - are locations to which patients are moved pending evacuation or discharge. Note that during an emergency evacuation when the facility is in a dangerous condition, these plans may have to be modified and staging may occur external to the building.

Staging areas for X are: (***See Appendix 1 Table 1)***

- ***North Lobby***
- ***South Lobby***
- ***East Lobby***

The Staging Manager will assure that each staging area(s) have a transport officer, triage officer, and a staging officer. The functions at the staging area are:

- calling units to evacuate sequentially depending on resources available for transport and threat environment
- Provide space for patients including chairs for ambulatory patients
- Receive and organize patients arriving from inpatient units
- Assure patients are tagged and triaged for transportation loading
- Briefly assess each patient medically and assure stability and/or assess new complaints or conditions arising during evacuation process (Triage Officer)
- Assure that medical records and belongings accompany the patient
- Move patients to appropriate vehicle loading areas (Transportation Officer)
- Track patients loaded into vehicles and their destination (Transportation Officer)

For additional information, see Staging Manager check list (***Appendix 6***)

Supplies required at each staging area include acute medical care, oxygen, water, snacks, personal care items, and basic medications (***See Appendix 8*** for details)

2.3 External Transportation

In the event of evacuation, Planning Section Chief / Transportation Officer should arrange adequate transport capacity utilizing the resources below and those obtained from partner agencies.

Planning Section Chief / Transportation Officer should poll units to determine ambulance (Basic Life Support - BLS, Advanced Life Support - ALS, Aeromedical), wheelchair, and sitting (bus) requirements and communicate this to ERCC (XXX-XXX-XXXX). See sample worksheet to be completed below for which defaults can be assigned to allow rough predictive calculations of needs for post-event evacuation and actual numbers used for pre-event evacuation. For each unit, may assume (roughly – this is based on averaged information from prior evacuations – but there is great variability between hospitals – these assumptions should be checked against actual acuity levels):

- ICU patients – ALS ambulance 1/unit (assuming ICU patients are critically ill
- Step-down units – 25% ALS, 25% BLS, 25% wheelchair, 25% bus
- Med / surg – 10% ALS, 30% BLS, 30% wheelchair, 30% bus
- Specialty units per facility estimates (NICU requires specialized transport teams, etc)

Transportation Resource Table

Service / Resource	Contact information (supervisor, phone, other)	Distance	Resources available	Notes
Local EMS	X EMS – Dispatch XXX-XXX-XXXX	On Site	Communications, Ambulances, Mutual Aid and Ambulance Strike Team activation	
Wheelchair and scheduled stretcher providers	Via ERCC XXX-XXX-XXXX (co-located with X dispatch)			
Local charter or other bus company	Via ERCC as above			
Local Mass Transit	Via ERCC as above - Metro Transit,			
Specialized mass casualty bus	XFD – 911 or XXX-XXX-XXXX (airport) fire	<5 miles	X Fire Department –X patient bus	
Other transportation resources	X patient transportation (?)			

Example of External Transportation Resources Table:

This is a sample of how you can distribute the patients. The % used here is just an assumption, the patients requiring ALS/ BLS might be lesser in the specific units depending on the patient's medical condition & the availability of the resources.

Unit	Unit operating beds	Unit current census	Discharge/Left	ALS	BLS	Wheelchair	Passenger Bus	Specialized transport (NICU, Aero Medical)	Notes (1:1,
MICU	28	15	0	100%= 15					
SICU	20	12	0	100%= 12					
Burn	17	5	0	10%= 0	30%= 2	30%=1	30%=5		
intermed	12	6	1	10%=0	30%=2	30%=2	30%=2		
Surgery	44	20	10	20%=4	30%=6	25%=5	25%=5		
stepdown	37	23	8	10%=2	40%=10	25%=5	25%=6		
Med	56	30	10	10%= 3	20%= 6	30%= 9	40%= 12		

External Transportation Resources Table (note; use Ambulance Strike Team transport calculator)

Unit	Unit operating beds	Unit current census	Discharge/Left	ALS	BLS	Wheelchair	Passenger Bus	Specialized transport (NICU, Aero Medical)	Notes (1:1,
MICU	28								
SICU	20								
Burn	17								
intermed	12								
surgery	44								
stepdown	37								
Med	56								
ortho	37								
PICU	7								
Pediatrics	21								
L&D/MW	24								
OB	24								
Nursery	44								
NBICU	21							NICU	

Psych	102								Escorts
rehab	18								
obs	15								
ED	70								
crisis									Escorts
PACU/OR									
TOTAL				ALS	BLS	WC	BUS		

Patient Triage, Tagging, Documentation and Movement

2.4.1 Triage & Prioritization

KEY CONCEPT: *Triage assigns the color for patient transportation from staging to the receiving facility NOT for priority of transport to the staging area – which is often the reverse*

Triage Level	Priority for Evacuation off nursing unit –**REVERSED START PRIORITY**	Priority for Transfer from the transport staging area to another healthcare facility – TRADITIONAL START PRIORITY
RED – STOP	These patients require maximum assistance to move. In an evacuation these patients move LAST from the inpatient unit. These patients may require 2-3 staff members to transport	These patients require maximum support to sustain life in an evacuation. These patients move FIRST as transfers from your facility to another healthcare facility.
YELLOW – CAUTION	These patients require some assistance and should be moved SECOND in priority from the inpatient unit. Patients may require wheelchairs or stretchers and 1-2 staff members to transport	These patients will be moved SECOND in priority as transfers from your facility to another healthcare facility
GREEN – GO	These patients require minimal assistance and can be moved FIRST from the unit. Patients are ambulatory and 1 staff member can safely lead several patients who fall into this category to the staging area.	These patients will be moved LAST as transfers from your facility to another healthcare facility.

Adapted from Continuum Health Partners – Evacuation Planning for Hospitals (2006)

2.4.2 Patient Tagging and Documentation

Every patient must be tagged, tracked and documented during an evacuation.

Tagging: Disaster Management System (DMS) patient evacuation tags will be used to identify each patient and their belongings. Location of tags noted on unit evacuation templates.

Tracking: Each patient will be recorded on the appropriate tracking sheet (***See Appendix 7*** HICS 255)

Documentation:

1. Emergency Evacuation – the following information must accompany the patient. Further information should be accessed and forwarded to the receiving facility (EPIC Snapshot)
    a. Name, age
    b. Allergies
    c. Medications
    d. Problem list
    e. Advance directives
    f. Commitment orders
    g. Isolation precautions (if any)
    h. Emergency contact (if unable to provide)

2. Non-emergency evacuation should include the above AND
    a. Copy of Medication Administration Record (MAR)
    b. Copy of most recent discharge or care summary
    c. Copies of latest lab reports
    d. Primary care physician information

2.4.3 Patient Movement Methods

1. Hand-holding (consider use of waist belt if available)
2. Carts/Beds/Wheelchairs/Isolettes
3. Carries – blanket, canvas, stretcher
4. Blanket / Sled Drag
5. Critical patients – must move with Bag Valve Mask (BVM) or portable ventilator, “D” cylinder oxygen, possibly cardiac monitor or pumps – see Intensive Care Unit (ICU) evacuation template for further information. Patients should not be moved to staging until transportation is available unless imminent threat dictates immediate movement.

2.5 Safety and Security

Security of the facility during an evacuation will be under the direction of the Security Branch Director. The Security Department will have a representative at the Hospital Command Center (X Conf Room). The following actions may need to take place in the event on an evacuation:

- Access Control - Ensure the security of the facility and personnel by monitoring individuals entering and exiting the building.
- Crowd Control - Maintain scene safety and ensure crowd control.
- Traffic Control - Organize and enforce vehicular traffic security for facility.-
- Search Unit - Coordinate the search and rescue of missing staff, patients, and family members.
- Law Enforcement Interface - Coordinate security of facility with outside law enforcement agencies.

Other community resources that may be utilized to assist in the securing of the facility are;
Insert local community resources. Hennepin County Sheriff’s Office, etc.

A request for additional security resources can be made to the regional hospital resource centre (RHRC) for additional security services & personnel.

All agencies involved in security operations at the facility will be coordinated through the facilities Incident Command System (consider unified command with other responding agencies).

The Safety Officer is accountable for assuring facility safety and operational safety (including use of PPE) during any relocation / evacuation incident

2.6 Facility Operations, Shut-Down, Recovery, and Stay Team

Facility operations during an evacuation will be under the direction of the Infrastructure Branch Director / IC. 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 using the*”HICS- 251 Facility System Status Report”*. From this status report, the Infrastructure Branch Director / IC may call for additional support (e.g. Local utilities companies/vendors).

If possible, basic utility needs will be restored as soon as possible with the goal of preventing the need for an evacuation.

If the evacuation dictates, the following utilities/services will be evaluated for the possibility of shutting down and securing:

- Power
- Water/Sewer

- Lighting
- Heating Ventilation and Air Conditioning (HVAC)
- Building and Grounds Damage
- Medical Gases
- Medical Devices and Radiological Isotopes
- Environmental Services
- Food Services

Refer to Appendix 10 for a planning checklist for Facility Operations, Shut Down, Recovery and Stay Team

Recovery - Assure that restoration and reimbursement issues and planning for facility start-up are addressed through the facility continuity of operations plan.

Facility Approvals:

This Plan is Appendix B of the X Emergency Operation Plan. The signatures for approving the Emergency Operation Plan and all other appendixes can be found in X Administration and the Emergency Preparedness Department.

Revision Date:
7/11/11

Appendix 1: Relocation of Patient / Residents

Table 1:

Note: Table 1 is designed to illustrate the facility in a block diagram. Facilities Management will help configure for X, with shading to indicate function of the area and arrows to illustrate primary horizontal and vertical evacuation directions. The block diagram reflects a vertical picture of the facility unless otherwise indicated.

Hospital Example

(indicator preferred staging area for and ambulance loading areas)

Medicine 3 →↓	**Pediatrics ←→**	**Surg / Ortho ←↓**	**Intensive Care →↓**	**Stepdown ←**
Medicine 2 ↑↓	**Surgery →**	**Day Surgery ←↓**	**Psychiatry →↓**	**Outpatient ↓**
Emergency →	**Emergency ←→**	**Lobby (staging)**	**Outpatient ←**	**Administration ←**

Key

Patient Care Area
Critical Care Patient Area
Non Patient Care Area
Vacant

Note: This table is under revision.

Appendix 2
Shelter-in-place, Relocation, and Evacuation Actions
X INPATIENT UNITS

Department/Station Name: _____Date Revised: _____

Reference: Web Homepage, Emergency Preparedness - X Procedures for Sheltering, Relocation, and Evacuation

Emergency Reporting Security Operation Center - 911
X Hospital Command Center: X-XXXX

Manager/ Head of Department Phone: _____ Department Charge Nurse/Supervisor Phone: _____

Mode of contact to inform all the staff (e.g. Vocera, Pager, Cell): **_____**

Relocation: *Horizontal (First Option):*	***Green – (Amb PT's):***	**Yellow/Red (non- Amb PT's):**
Vertical (second option):	***Green – (Amb PT's):***	**Yellow/Red (non- Amb PT's):**
Evacuation Staging Area : (This is where you will account for staff & patients; to ensure everyone is safe)	***Green (Ambulatory Pts): TBD.*** **Yellow/Red Pts (Non-Amb./critical):**	
Unit Equipment location: *Equipment such as evac chairs, wheelchairs, back-boards, patient slides, and extra flashlights should be requested through the Hospital Command Center.*	**Note where these items are stored on unit if available:** **Wheelchair locations**_____ **Gurney locations** _____ **Evac Chair locations** _____ (or contact command centre for them) **Other:** _____	

Review procedures outlined on the Emergency Preparedness Guide – flip chart

Shelter-in-place: Protects the patients on the current unit when relocation or evacuation is not practical due to the type of threat or timeline

- Weather – (wind/tornado) – close drapes and room doors, move patients away from windows as practical, move and alert visitors and staff to threat.
- Security Alert – internal threat - close room doors for internal threat, close doors in hallways, other actions per security/incident commander. Brief visitors and staff to situation

- HAZMAT – follow instructions per safety/security/incident command

Relocation: Protect patients by moving them to a safer area of care within the facility, usually the adjacent smoke compartment but sometimes vertically or to other non-adjacent units.

- ***Anyone*** recognizing an imminent danger to patients or others shall take immediate steps to safeguard those in danger including patient movement. Patients in imminent danger should be moved first, ambulatory patients and visitors second and non-ambulatory patients third. See box above for unit-specific preferred destination and equipment location.

- Relocation may also be used to adapt to a unit-specific problem such as a water pipe burst, electrical outage, etc. Unit charge nurse should coordinate with the incident commander.

Evacuation: Movement of patients from the facility to another institution. This may be a partial evacuation (certain units or specialized patients) or a complete facility evacuation and is undertaken as a last resort.

Charge Nurse Responsibilities upon notice of evacuation decision (Unit manager and or supervisor may be available to fulfill or assist with these duties):

1. **Notify unit staff and reassign staff as needed.**
   - Compile a list of patients in your area, and your staff currently working (see worksheet with equipment)
   - Confirm evacuation staging destination. (See * below)
   - Direct staff and patients to remain at staging until all persons are accounted for.
   - Assess acuity and resource needs for moving non-ambulatory patients. For patient
   - Movement personnel should be organized into 3 groups:
     i. **Loader** will help patient onto carts, wheelchairs or blankets
     ii. **Mover** will push or pull these patients to the next smoke compartment, stairwell or elevator(when directed to do so)
     iii. **Carrier** will carry the non-ambulatory person down the stairs or down the elevator(when directed to do so)

**** Whenever possible, patients should be held in a safe area (i.e. defend in place) until called for by the Staging Area Manager. As EMS rigs and alternate transportation is available, the Staging Manager will be working with EMS to match the correct patient needs with the ambulance rating (ALS, BLS, Bus etc) and destination.***

2. **Triage patients for movement / transport using evacuation tags (with equipment)**
   - Tag color reflects priority for *transport to the staging area or away from immediate danger as follows:*
     - *Green*
     - *Yellow*
     - *Red*
   - Triage color reflects priority for transport to the receiving facility as follows:
     - *Red*
     - *Yellow*
     - *Green*

*****Remember: Green = patients are ambulatory, Yellow = non-ambulatory, Red = unstable critical care***

   - Tag all patients and attach tear-off band from tag to belongings
   - Determine ambulatory status of patients and assign staff to move them. All patients capable of ambulating should form a chain by holding hands (if capable) and be lead to the new location by staff member(s).

3. **Assess acuity and resources needed**:
   - To LOAD, MOVE, and CARRY non-ambulatory patients will depend on elevator status, etc. *You may need to request assistance from the Hospital Command Center for additional staff, Evac-chairs, Wheelchairs, gurneys, carrying canvas etc.*

- In non-emergency situation assure that staging is ready for yellow/red patients prior to moving.

4. Assign person(s) to check all rooms to assure:

- No occupants remain and no safety issues
- Doors have been closed after room has been vacated
- Once each room has been evacuated, the staff person checking the room will close the door and place the "Room Clear" sticker across the door jam.
- If time and resources allow, assign person(s) to transport your area's medications.

5. Documentation:

- Emergency – *Take patient summary sheet with demographics, allergies, medications, problem list,*
- *Emergency contact information. Bring full chart if possible*.
- Non-emergency – *Above plus medication administration record and facility chart.*
- Upon arriving at staging, complete patient and staff head count. Staff shall remain at safe location until reassigned or dismissed. Patients shall be directed to remain at staging location until further instructions are given for discharge or transportation

Special Considerations:

1. Patients on ventilators: When central O2 is turned off, switch ventilator to room air and/or obtain portable O2 tanks. If no power and/or patients must be moved, patients must be bagged.

Note*:* It may be necessary to request personnel resources from the Labor Pool to travel with the patient if there are significant medical needs to maintain the patient's life support.

2. Patients with IV's, arterial lines and Swan-Ganz:

i. Disconnect transducer from patient cable-take pressure bag with patient.
ii. Saline lock all non-critical IV lines

3. Equipment: O2 tanks, bag-valve-mask, wheelchairs, defibrillator or monitors, transport monitor, evacuation mattress, slide board

4. Medications:

i. **In-**house "patient relocation" (horizontal or vertical): *Medications required by the receiving station or unit may be retrieved from OmniCell "Emergency Over-ride", or by using the medications located in the crash carts, until the patient's OmniCell location has been updated to the new station.*

ii. **Off-**site "Evacuation": *When any evacuation of a portion of the hospital or a complete evacuation is necessary the Operations Section Chief and Staging Manager will request at least one pharmacist to work within the Red/Yellow Staging area to assist with medication needs for all patients requiring life support medication while in route.*

5. Procedures:

i. The physician will assess if invasive procedure(s) can be stopped
ii. The physician will stop any other procedures in progress at a safe point, and the patient(s) will be prepared to move.

Equipment (see location in box at top page 1)

- Evacuation tags
- Headlamps or flash lights if needed (4)
- Blankets and sheets used to protect for cold weather travel and as carrying or sliding sheets
- Carrying canvas / med sled / backboard (X)
- Evacuation chair

Appendix 3
Shelter-in-place, Relocation, and Evacuation Actions

X EVACUATION MISSION CRITICAL UNITS

Department Name: _____ **Date Revised:**_____

Reference: Web X Homepage, Emergency Preparedness - X Procedures for Sheltering, Relocation, and Evacuation

Emergency Reporting Security Operation Center - 911
X Hospital Command Center: X-XXXX

Department Manager***/Supervisor Phone:*** _____

Job positions responsible for Evacuation procedures: Primary: _____Secondary: _____

Staging Area for Shelter-in place:_____
Staging Area for Relocation:_____
(This is where you will account for staff; to ensure everyone is safe)

Review procedures outlined on the Emergency Preparedness Guide – flip chart

Shelter-in-place: Protects the current unit when relocation or evacuation is not practical due to the type of threat or timeline

- Weather – (wind/tornado) – close drapes and room doors, move patients away from windows as practical, move and alert visitors and staff to threat.
- Security Alert Yellow – internal threat - close room doors for internal threat, close doors in hallways, other actions per security/incident commander. Alert visitors and staff to situation
- HAZMAT – follow instructions per safety/security/incident command

Relocation: Protect everyone by moving them to a safer area of care within the facility, usually the adjacent smoke compartment but sometimes vertically or to other non-adjacent units.

- ***Anyone*** recognizing an imminent danger to patients or others shall take immediate steps to safeguard those in danger including patient movement. Patients in imminent danger should be moved first, ambulatory patients and visitors second and non-ambulatory patients third.

- Relocation may also be used to adapt to a unit-specific problem such as a water pipe burst, electrical outage, etc. department manager or supervisor should coordinate with the incident commander.

Evacuation: Movement of patients to a staging area to send them home or refer to another off-site clinic or transfer to inpatient facility. This may be a partial evacuation (certain units or specialized patients) or a complete facility evacuation is undertaken as a last resort.

Job positions identified above are responsible for evacuation decisions and procedures:

1. **Notify unit staff and reassign staff as needed.**
    - Contact your manager/supervisor
    - Compile a list of your staff currently working
    - Confirm evacuation staging destination. Direct staff and patients to remain at staging until all persons are accounted for.

Note: If situation warrants, staff, patients or customers may need to form a chain by holding hands and proceed to the new location.

**** Staff from business unit/departments may be requested to assist with patient relocation and or evacuation. Whenever possible, patients should shelter-in-place until called for by the Staging Area Manager. As EMS rigs or alternate transportation is available, the Staging Manager will be working with EMS to match the correct patient needs with the ambulance rating (ALS, BLS, Bus etc) and destination.***

2. Assign person(s) to check all rooms to assure:

- No occupants remain and no safety issues
- Doors have been closed after room has been vacated
- **Once each room has been evacuated, the staff person checking the room will close the door and place a "Room Clear: sticker across the door jam**

Unit personnel may be requested to assist evacuation of patient / visitors from In-patient Units.

1. Triage patients for movement / transport (with equipment)

Green Pt.: *Ambulatory*
Yellow Pt.: *Non- Ambulatory (need assistance)*
Red Pt.: *Unstable / Critical (need life support)*

- Determine ambulatory status of patients and assign staff to move / escort them.
- Acute injuries from the incident should be evaluated in the Emergency Department

2. Assess acuity and resources needed:

- To LOAD, MOVE, and CARRY non-ambulatory patients will depend on elevator status, etc
- Contact Hospital Command Center for additional staff, Evac-chairs, Wheelchairs, carrying canvas gurneys, etc.
- In non-emergency situation assure that staging is ready for yellow/red patients prior to moving.

3. Door Closure procedure is same for all the departments; you may be asked to assist the same for in-patient units.

Special Considerations:

Based on the unique services this business area provides, procedures should be written with the goals of preventing injury to staff, and assisting with the safe and orderly evacuation of all occupants.

Note: *The potential to assist with patient evacuation is dependent on each individual's ability, and based on which areas need to be evacuated.*

Equipment

The Evacuation Manual/Kit contains

- Department Specific Evacuation Plan
- flashlights
- Room Clear Stickers
- other

Appendix 4
Shelter-in-place, Relocation, and Evacuation Actions

X BUSINESS AREA UNITS

Department Name: _____ **Date Revised:**_____

Reference: Web Homepage, Emergency Preparedness - X Procedures for Sheltering, Relocation, and Evacuation

Emergency Reporting Security Operation Center - 911
X Hospital Command Center: X-XXXX

Department Manager***/Supervisor Phone:*** _____

Job positions responsible for Evacuation procedures: Primary: _____Secondary: _____

Staging Area for Shelter-in place:_____
Staging Area for Relocation:_____
(This is where you will account for staff; to ensure everyone is safe)

Review procedures outlined on the Emergency Preparedness Guide – flip chart

Shelter-in-place: Protects the current unit when relocation or evacuation is not practical due to the type of threat or timeline

- Weather – (wind/tornado) – close drapes and room doors, move patients away from windows as practical, move and alert visitors and staff to threat.
- Security Alert Yellow – internal threat - close room doors for internal threat, close doors in hallways, other actions per security/incident commander. Alert visitors and staff to situation
- HAZMAT – follow instructions per safety/security/incident command

Relocation: Protect everyone by moving them to a safer area of care within the facility, usually the adjacent smoke compartment but sometimes vertically or to other non-adjacent units.

- ***Anyone*** recognizing an imminent danger to patients or others shall take immediate steps to safeguard those in danger including patient movement. Patients in imminent danger should be moved first, ambulatory patients and visitors second and non-ambulatory patients third.

- Relocation may also be used to adapt to a unit-specific problem such as a water pipe burst, electrical outage, etc. department manager or supervisor should coordinate with the incident commander.

Evacuation: Movement of patients to a staging area to send them home or refer to another off-site clinic or transfer to inpatient facility. This may be a partial evacuation (certain units or specialized patients) or a complete facility evacuation is undertaken as a last resort.

Job positions identified above are responsible for evacuation decisions and procedures:

3. **Notify unit staff and reassign staff as needed.**
    - Contact your manager/supervisor
    - Compile a list of your staff currently working

- Confirm evacuation staging destination. Direct staff and patients to remain at staging until all persons are accounted for.

Note: If situation warrants, staff, patients or customers may need to form a chain by holding hands and proceed to the new location.

**** Staff from business unit/departments may be requested to assist with patient relocation and or evacuation. Whenever possible, patients should shelter-in-place until called for by the Staging Area Manager. As EMS rigs or alternate transportation is available, the Staging Manager will be working with EMS to match the correct patient needs with the ambulance rating (ALS, BLS, Bus etc) and destination.***

4. Assign person(s) to check all rooms to assure:

- No occupants remain and no safety issues
- Doors have been closed after room has been vacated
- **Once each room has been evacuated, the staff person checking the room will close the door and place a "Room Clear: sticker across the door jam**

Unit personnel may be requested to assist evacuation of patient / visitors from In-patient Units.

2. Triage patients for movement / transport (with equipment)

Green Pt.: *Ambulatory*
Yellow Pt.: *Non- Ambulatory (need assistance)*
Red Pt.: *Unstable / Critical (need life support)*

- Determine ambulatory status of patients and assign staff to move / escort them.
- Acute injuries from the incident should be evaluated in the Emergency Department

2. Assess acuity and resources needed:

- To LOAD, MOVE, and CARRY non-ambulatory patients will depend on elevator status, etc
- Contact Hospital Command Center for additional staff, Evac-chairs, Wheelchairs, carrying canvas gurneys, etc.
- In non-emergency situation assure that staging is ready for yellow/red patients prior to moving.

3. Door Closure procedure is same for all the departments; you may be asked to assist the same for in-patient units.

Special Considerations:

Based on the unique services this business area provides, procedures should be written with the goals of preventing injury to staff, and assisting with the safe and orderly evacuation of all occupants.

Note: *The potential to assist with patient evacuation is dependent on each individual's ability, and based on which areas need to be evacuated.*

Equipment

The Evacuation Manual/Kit contains

- Department Specific Evacuation Plan
- flashlights
- Room Clear Stickers
- ????other

Appendix 5
Shelter-in-place, Relocation, and Evacuation Actions

X AMBULATORY / OUTPATIENT UNITS

Clinic Name: _____ **Date Revised:**_____

Reference: Webpage Home, Emergency Preparedness - X Procedures for Sheltering, Relocation, and Evacuation

Emergency Reporting Off-site clinics call 911 (community public safety) and then call X-XXXX (Security Operation Center) and report your emergency incident.

X Hospital Command Center: X-XXXX

Head clerical employee Phone Number: _____
Department Charge Nurse/Supervisor Phone: _____
(*These phone no.'s shold be of someone who is always present in the clinic during clinic hours)*

Job positions responsible for Evacuation procedures: Primary:_____ Secondary: _____
(one of the job positions who is always there during clinic hours)

Relocation: *Horizontal (First Option):*	***Green – (Amb PT's):***	**Yellow/Red (non- Amb PT's):**
Vertical (second option):	***Green – (Amb PT's):***	**Yellow/Red (non- Amb PT's):**
Evacuation Staging Area for staff & Patients (This is where you will account for staff & patients; to ensure everyone is safe)	***Green (Ambulatory Pts):*** *(enter your location)* **Yellow/Red Pts (Non-Ambulatory/critical):** *(enter your location)*	
Rescheduling / Referring: (Coordinate with Contact Center)	*designated clinic/ hospital :* _____ ***Pt. Currently in Clinic:*** ***-Send them home*** ***-Refer to designated clinic*** ***Pt. with appointments contact them:*** ***- Reschedule appointment*** ***-Refer to designated clinic*** ***-Cancel appointment***	
Unit Equipment location:	**Evacuation Manual/Kit** _____ **Wheelchair locations**_____ **Gurney/Stretcher locations** _____ **Evac. Chair locations?** (to be evaluated)_____ **Other:** _____	

Review procedures outlined on the Emergency Preparedness Guide – flip chart
Shelter-in-place: Protects the patients on the current unit when relocation or evacuation is not practical due to the type of threat or timeline

- Weather – (wind/tornado) – close drapes and room doors, move patients away from windows as practical, move and alert visitors and staff to threat.

- Security Alert Yellow – internal threat - close room doors for internal threat, close doors in hallways, other actions per security/incident commander. Alert visitors and staff to situation
- HAZMAT – follow instructions per safety/security/incident command

Relocation: Protect everyone by moving them to a safer area of care within the facility, usually the adjacent smoke compartment but sometimes vertically or to other non-adjacent units.

- ***Anyone*** recognizing an imminent danger to patients or others shall take immediate steps to safeguard those in danger including patient movement. Patients in imminent danger should be moved first, ambulatory patients and visitors second and non-ambulatory patients third. See box on page one for unit-specific preferred destination and equipment location.

- Relocation may also be used to adapt to a unit-specific problem such as a water pipe burst, electrical outage, etc. clinic manager or supervisor should coordinate with the incident commander.

Evacuation: Movement of patients to a staging area to send them home or refer to another off-site clinic or transfer to inpatient facility. This may be a partial evacuation (certain units or specialized patients) or a complete facility evacuation is undertaken as a last resort. Follow the Instruction on box on page 1 for rescheduling/referring patients.

Job positions identified on page one who are responsible for evacuation decisions and procedures:

5. **Notify unit staff and reassign staff as needed.**
    - Confirm evacuation staging destination. Direct staff and patients to remain at staging until all persons are accounted for.
    - Compile a list of remaining patients in your area, and your staff currently working (see worksheet with equipment)
    - Inform patients of situation and if safe, discharge from facility home via safe egress – document discharges

**** Whenever possible, patients should shelter-in-place until called for by the Staging Area Manager. As EMS rigs or alternate transportation is available, the Staging Manager will be working with EMS to match the correct patient needs with the ambulance rating (ALS, BLS, Bus etc) and destination.***

6. Triage patients for movement / transport (with equipment)

Green Pt.: *Ambulatory*
Yellow Pt.: *Non- Ambulatory (need assistance)*
Red Pt.: *Unstable / Critical (need life support)*

- Determine ambulatory status of patients and assign staff to move / escort them. Consider having patients form a chain by holding hands (if capable) to facilitate staff leading them to the new location.
- Acute injuries from the incident should be evaluated in the Emergency Department
  Assess acuity and resource needed to LOAD, MOVE, and CARRY non-ambulatory patients (will depend on status of elevators etc.).

7. **Assess acuity and resources needed**:
    - To LOAD, MOVE, and CARRY non-ambulatory patients will depend on elevator status, etc. You may need to request assistance from the Hospital Command Center for additional staff, Evac-chairs, Wheelchairs, carrying canvas gurneys, etc.
    - In non-emergency situation assure that staging is ready for yellow/red patients prior to moving.

4. Assign person(s) to check all rooms to assure:
- No occupants remain and no safety issues
- Doors have been closed after room has been vacated
- **Once each room has been evacuated, the staff person checking the room will close the door and place a "Room Clear: sticker across the door jam**
- If time and resources allow, assign person(s) to transport your area's medications.

5. Documentation:

- Emergency – Take patient summary sheet with demographics, allergies, medications, problem list, emergency contact information. Bring full chart if possible.
- Non-emergency – Above plus medication administration record and facility chart.
- Upon arriving at staging, complete patient and staff head count. Staff shall remain at safe location until reassigned or dismissed. Patients shall be directed to remain at staging location until further instructions are given for discharge or transportation

Special Considerations:

1. **Patients on life support:**
    a. Assure that the patient is shifted to another care/unit or handed over to EMS transportation.
2. **Special Equipment:** wheelchairs, transport monitor, slide board, canvas carriers
3. **Medications:**
    a. When any evacuation of a portion of the hospital or a complete evacuation is necessary the Operations Section Chief and Staging Manager will request at least one pharmacist to work within the Red/Yellow Staging area to assist with medication needs for all patients requiring life support medication while in route.
4. **Procedures:** Terminate procedures as determined by the physician based on the threat. No new procedures will be started.

Equipment (see location in box on page 1)

- The Evacuation Manual/Kit contains
    - Evacuation Guide / Manual
    - Headlamps or flashlights if needed
    - Room Clear Stickers
    - Blankets/ Clinic Linen
- Evacuation chair?
- Patient nutrition & hydration Kit

Appendix 6 – Disabilities

Types of Disabilities in the Workplace and Guidelines for Evacuation

Addressing the needs of staff with disabilities ahead of time will alleviate unneeded stress and anxiety during an actual event. The needs of staff with disabilities is no different than anyone else, however the

method of relocation may need to be altered. For that reason, exercises and drills should include persons with disabilities as a normal part of exercises. This also means asking their input on how best to assist them with relocation, identify what they may need, and addressing necessary equipment they use.

Ambulatory - Limited Mobility

- Ensure that staff with disabilities are accounted for. Many individuals with limited mobility do not need assistance on a daily basis and the fact they may require it in an emergency can be overlooked.
- Allow people to evacuation with other employees as possible. Alternatively, if they need to evacuate after others, establish a process that is comfortable with the effected staff during drills and exercises.
- Appoint staff to assist them as needed

Non-Ambulatory – (lift and assist methods should be determined prior to evacuation – for example, staff in wheelchairs requiring vertical evacuation)

- If the situation allows for it, use the Shelter in Place strategy. Ensure non-ambulatory patients have moved to a safe location and await further instruction.
- If elevators are unavailable, assist staff down the stairs in their wheelchair or in a special 'stair-chair.' If they must be carried, ask what lift will be most comfortable for them and be sure another person brings their wheelchair down as soon as possible (carrying battery-operated wheelchairs may not be possible). A non-ambulatory person feels secure, and is most independent, in their own wheelchair.

Hearing Impaired

- Ensure the hearing impaired employee understands exactly what is happening. If alarms have been triggered it is important they know the reason. An alarm's strobe light will only signal there is an incident.
- Provide clear, concise instruction. Speak slowly or communicate in writing if possible.
- If the employee will assist patients in an evacuation, have them work in tandem with another so they receive situation updates and direction.

Non-English Speaking Individuals

- Accommodate non-English speaking individuals as much as possible during an evacuation. The use of hand signals may be the primary means to provide direction to those individuals.

Visually Impaired

- Ensure visually impaired employees are able to navigate to the emergency exits, as the work area may change during an evacuation, leading to confusion.
- Provide assistance as hallways can quickly become crowded with people, beds and supplies.

Cognitively Impaired

- Prior to an incident, provide repetitive training on evacuation from their work area.
- Assign staff to escort them to safety, if necessary.

Service Animals

- Insure that the service animals of staff with disabilities are also accounted for and needs planned for during exercises and drills.

Apendix7: Unit Evacuation Leader Job Action Sheet

UNIT EVACUATION LEADER

Mission: Shelter-in place, Relocate, and/or Evacuate patients.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Incident Commander Signature:

Unit Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Nursing Administrative Supervisor or Evacuation Supervisor. Obtain Job action sheet and other required forms from Evacuation Kit.		
Read all of the immediate steps on this Job Action Sheet and put on vest for position identification. When time permits read entire Job Action Sheet.		
Keep updating your Evacuation Supervisor about the updates in your Unit.		
In an Emergency or Unplanned Evacuation do the following three steps:		
Assess, if the situation is an imminent life threat, use decision flow chart, on the cover of evacuation manual, in Evacuation kit, or refer Emergency Preparedness Flip Chart present in your unit.		
If the situation is of imminent life threat, move non-ambulatory patients using Mega Movers (carrier with handles), located in Unit store room, or designated area. Move patients to the designated Re-location area on your Unit Plan, or to the next closest area that is safe.		
If possible take patient summary sheet with demographic details, emergency contact medication list, etc. with the patient.		
Execute the following steps in a planned evacuation and/or after emergency relocation:		
Compile a list of patients and staff currently working in your area, including support staff.		
Reassign staff to patients if needed, to make sure each patient has staff responsible for tracking their movement from unit up to being evacuated from the hospital.		
Brief unit staff on current situation; outline unit action plan and designate time for next briefing.		
Hand out Evacuation Tags and Evacuation Tracking forms to each nurse, and guide them on how to use them.		
Brief staff nurses to triage patients for movement using evacuation tags. Refer Evacuation plan for details of reverse triaging (priority of patient movement off the unit).		
Brief staff to take patient summary, other important documents and medications with patients.		
Confirm Evacuation Staging area and Relocation area (If, needed).		
Assess the resources needed for moving Non-ambulatory patients.		
Confirm the availability of the resources/ Equipment needed, mentioned on the Unit Evacuation plan.		
Obtain the resources from the designated area to the unit needed.		
Contact Evacuation Supervisor of your department, if you need more than available resources for your designated area.		
Give the second briefing to the staff on the designated time, and give updates on time to move patients.		
Make sure all the patients are triaged, and ready to be moved, and co-ordinate where help needed.		

Immediate (Operational Period 0-2 Hours)	Time	Initial
Refer Unit Evacuation plan for direction on how to group movement personnel, in Loaders Mover & Carriers, or the same person can do all three when needed.		
You may request additional personnel from Evacuation Supervisor.		
Confirm patients are moved in reverse triage priority, i.e. Green/ Ambulatory move first, Yellow/ need minimal assistance patients move second, Red/ need most assistance move last.		
Patients with spine injury or other severe injuries which need professional help to move, co-ordinate with Evacuation Supervisor to request for EMS help, to see if that is possible.		
Refer to special Considerations on your Unit Evacuation plan, if you have patients on ventilators, IV's equipment, and medications.		
Once patients are triaged, give the order to start moving them to the designated staging area, with reverse triage priority.		
Brief staff nurses of their responsibilities in the staging area, he/she shall complete the patient tracking details if any of them were unknown earlier, like where is the patient moved. Completed patient tracking form shall be handed over the staging area manager.		
Stickers are provided with the evacuation Kit/ Manual.		
Assign person(s) to check all rooms to assure, no occupants remain or safety issues. Doors should be closed after rooms have been vacated.		
After checking each room, person(s), should put room clear stickers on the doors, across the door jam (as shown in the picture in the kit/manual).		
After all the patients have been evacuated and the rooms have been checked, please report to your Evacuation Supervisor for further Instructions.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Unless assigned by Evacuation Supervisor, to assist in other areas; report to staging area and complete staff head count.		
Assist in the staging area; with the patient care and preparation for disposition		
Address issues related to ongoing patient care: • Patient transfers • Patient tracking • Staff health and safety • Mental health for patients, families, staff, incident management personnel • Fatality management • Staffing • Staff prophylaxis • Medications • Medical equipment and supplies • Documentation		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor In-patient unit's staff and support staff's ability to meet workload demands, staff health and safety, resource needs and documentation practices.		
Conduct regular situation briefings with Evacuation Supervisor.		
Address issues related to ongoing patient care: • Patient transfers • Patient tracking • Staff health and safety		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
• Mental health for patients, families, staff, incident management personnel • Fatality management • Staffing • Staff prophylaxis • Medications • Medical equipment and supplies • Documentation		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well-Being Unit. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Evacuation Supervisor on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214/ Unit Log) are submitted to the Documentation Unit.		
Submit comments to the Evacuation Supervisor for discussion and possible inclusion in an after-action report; topics include: • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Appendix 8 – Check Lists

Command Staff Check List

Shelter / Relocation / Evacuation

Does not replace HICS Job Action Sheet – Use as Hazard-Specific Supplement

Task	Assigned	Complete
Initial assessment		
Review threat intensity and likely duration		
Review any unit-based relocations that are occurring and anticipate needs in those areas		
Determine, based on the unit-based impacts the need for sheltering vs. relocation of displaced patients vs. partial or full evacuation to other institutions (see relevant sections below)		
Assure damage and utilities impact assessment being conducted by Infrastructure Branch Director		
Shelter in place		
Instruct Infrastructure Branch Director to shut down air intakes if plume threat or internal ventilation if internal HAZMAT spill		
Implement necessary access controls and monitoring in response to threats (Security Branch Director)		
Communicate protective actions (door and drape closings, etc) to affected units as well as any event specifics		
Relocation		
Determine affected units and actions taken, notify affected units		
Determine facility capacity for relocated patients – if insufficient see evacuation, below		
Assure resources (staff and supplies) transferred to units absorbing relocated patients		
Assure all patients accounted for and information transferred to receiving units		
Determine timeframe to recover affected units and any effects on patient admissions, scheduling (e.g. surgeries) and flow		
Evacuation		
Determine scope of evacuation (partial for subset of patients / areas – for example ICU patients, complete for total facility evacuation) based on threat		
Consider appointment of Evacuation Branch Director under Operations if Operations has multiple other issues (fire, etc) to address		
Activate any appropriate facility response plan alerts		
Announce evacuation order to affected units / institution		
Determine whether usual staging area(s) can be used and announce alternatives if needed		
Assign Staging Manager and Transportation Officer (HICS positions) to coordinate patient and vehicle staging according to evacuation plans		
Initiate coordination between Planning Chief and Resource Unit on transportation (see table in EOP Evacuation Annex) and facilities to accept patients/residents and report back to IC		
Contact RHPC (insert phone number) for coordination assistance		
Place alert on MnTrac or appropriate electronic communication tool regarding scope of evacuation and any EMS diversion actions		
Notify local EMS agency of situation and activate any mutual aid plans, summon necessary public safety assistance		
Security to implement appropriate access controls – no family or visitors inside during evacuation		
Security coordinates with local law enforcement regarding traffic controls external to facility		
Logistics Chief to assure pharmaceuticals and supplies to staging areas		
Distribute staff and resources to affected areas to facilitate patient / staff movement to staging areas		
PIO to communicate facility status to media and families		
Assure matching of patients to appropriate transfer facility		

Assure patient tracking by transportation officer at time of loading		
Assure prioritized movement of patients to and through staging (in non-emergency evacuation Staging Manager should call units to sequentially evacuate them)		
In case of complete evacuation – appoint Stay Team Unit Leader		

Triage Officer Checklist - Evacuation

Does not replace HICS Job Action Sheet – Use as Hazard-Specific Supplement

Task	Assigned	Complete
Initial tasks		
Assure basic medications and any needed IV fluids or patient care supplies are available or requested via Staging Manager		
Assist with identifying and clearing space for Green/Yellow/Red patients		

Assess patients arriving to staging for:
• Discharge home – (depending on situation may be held for discharge or transferred to another safer location nearby for discharge)
• Transfer to other facility:
  ○ Green – ambulatory, low acuity (bus, etc.)
  ○ Yellow – non-ambulatory, non-critical care (WC or BLS vehicle)
  ○ Red – critical care (ALS / critical care)		

Assure evacuation tag applied and reflects priority for transfer accurately		
Subsequent tasks		
Group patients for transport loading by acuity		
Direct staff to provide necessary patient cares during staging period		
Coordinate with Staging Manager (or Officer, if several staging sites) and Transport Officer regarding supplies, patient loading priority, appropriate vehicle for transport, and flow issues		

Evacuation Staging Manager – Checklist

Task	Assigned	Complete
Immediate (Operational Period 0-2 Hours)		
Receive appointment and briefing from the Operations Section Chief. Obtain Staging Unit Job Action Sheets		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Determine need for and appropriately appoint Evacuation Staging Team Leaders, distribute any corresponding Job Action Sheets and position identification. Complete the Branch Assignment List (HICS Form 204).		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief the Evacuation Staging Team Leaders on current situation; outline branch action plan and designate time for next briefing.		
Identify appropriate area(s) to serve as Staging Area(s) based on patient acuity for the preparation of transporting patients and their equipment from facility to an accepting facility.		
Coordinate staging needs of all patients and their equipment and all evacuation staging team members. Requesting additional or rotation of staff to evacuation staging areas in coordination with Labor Pool & Credentialing Unit and Transportation Unit Leader		
Regularly report Evacuation Staging Area(s) status to Operation Section Chief.		
Assess problems and needs; coordinate with Operations Section Chief.		
Instruct all Evacuation Staging Team Leaders to evaluate situation, including patients, equipment, supplies, and medication inventories and staff needs in collaboration with Logistics Section Supply Unit Leader; report status to Operations Section Chief and Supply Unit.		
Meet with the Operations Section Chief and Logistics Section Chief, as appropriate to discuss plan of action and staffing in all activities.		
Continue coordinating transport of patients and their equipment from staging to the transport area, working with the Transport Manager as needed.		
Ensure prioritization of problems when multiple issues are presented.		
Develop and submit an Evacuation Staging Area action plan to the Operations Section Chief when requested.		
Ensure documentation is completed correctly and collected.		
Make notification and advise the Operations Section Chief immediately of any problems encountered or operational issue(s) you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Extended (Operational Period Beyond 12 Hours)		
Continue to monitor the Evacuation Staging Team's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Coordinate assignment and orientation of personnel sent to assist patient/resident		
Rotate staff on a regular basis.		
Document actions and decisions on a continual basis.		
Continue to provide the Operations Section Chief with periodic situation updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well-Being Unit Leader. Provide for staff rest periods and relief.		

Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		
Demobilization/System Recovery		
As needs for Evacuation Staging Area decrease, return staff to their normal jobs or release and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader.		
Assist the Operations Section Chief and Branch Directors with restoring facility resources to normal operating condition.		
Ensure the retrieval/return of equipment/supplies		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Operations Section Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and Evacuation Staging Unit Operational Logs (HICS Form 214) are submitted to the Operations Section Chief.		
Submit comments to the Operations Section Chief for discussion and possible inclusion in the after-action report; topics include: • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Evacuation Staging Team Member Check List

Does not replace HICS Job Action Sheet – Use as Hazard-Specific Supplement

Task	Assigned	Complete
Initial tasks		
Receive patients/residents into Staging area and confirm hand off information is accurate (Evacuation tag and Patient Evacuation tracking form HICS 260)		
Assure patient/residents comfort and medical needs are met (personnel, medication, water, blankets)		
Communicate any personnel/supply needs to Staging Team Leader		
Subsequent tasks		
Group patients for transport loading by acuity or destination (dependent upon size of event and number of staging locations)		
At the end of shift brief Evacuation Staging Team Leader on any current problems or any outstanding issues		
Complete and submit any documentation to Evacuation Staging Team Leader		
Demobilization		
Ensure equipment and supplies are retrieved/returned		
Upon deactivation of your position brief Evacuation Staging Team Leader on any current problems or any outstanding issues		
Complete and submit any documentation to Evacuation Staging Team Leader		

Appendix 9 – HICS Forms

HICS 251 FACILITY SYSTEM STATUS REPORT

HICS 254 DISASTER VICTIM/PATIENT TRACKING FORM

HICS 255 MASTER PATIENT EVACUATION TRACKING FORM

HICS 259 HOSPITAL CASUALTY/FATALITY REPORT

HICS 260 PATIENT EVACUATION TRACKING FORM

HICS 251 – FACILITY SYSTEM STATUS REPORT			
1. Operational Period Date/Time	**2. Date Prepared**	**3. Time Prepared**	**4. Building Name:**

5. SYSTEM STATUS CHECKLIST		
COMMUNICATION SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Fax	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Information Technology System (email/registration/patient records/time card system/intranet, etc.)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Nurse Call System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Paging - Public Address	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Radio Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Satellite System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, External	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, Proprietary	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Video-Television-Internet-Cable	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
INFRASTRUCTURE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Campus Roadways	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Fire Detection/Suppression System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

Food Preparation Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ice Machines	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Laundry/Linen Service Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Structural Components (building integrity)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
PATIENT CARE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Decontamination System (including containment)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Digital Radiography System (e.g., PACS) and Nuclear medicine	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ethylene Oxide (EtO)/Sterilizers	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Isolation Rooms (positive/negative air)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
SECURITY SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Door Lockdown Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Surveillance Cameras	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
UTILITIES, EXTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*

Electrical Power-Primary Service	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sanitation Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Natural Gas	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
UTILITIES, INTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Air Compressor	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Electrical Power, Backup Generator	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Fuel status)
Elevators/Escalators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Hazardous Waste Containment System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Heating, Ventilation, and Air Conditioning (HVAC)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Medical Gases, Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Oxygen	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Pneumatic Tube	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Steam Boiler	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sump Pump	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Well Water System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

Vacuum (for patient use)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water Heater and Circulators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
6. CERTIFYING OFFICER		
7. FACILITY NAME		

HICS 254 – DISASTER VICTIM/PATIENT TRACKING FORM

1. INCIDENT NAME	2. DATE/TIME PREPARED	3. OPERATIONAL PERIOD DATE/TIME

4. TRIAGE AREAS (Immediate, Delayed, Expectant, Minor, Morgue)

MR#/ Triage #	Name	Sex	DOB/ Age	Area Triaged to	Location/Time of Diagnostic Procedures (x-ray, angio, CT, etc.)	Time sent to Surgery	Disposition (home, admit, morgue, transfer)	Time of Disposition

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

8. FACILITY NAME

HICS 255 - MASTER PATIENT EVACUATION TRACKING FORM

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

4. PATIENT EVACUATION INFORMATION

i) Patient Name / Patient Sticker	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Red Yellow Green		Accepting Hospital Name	Time Hospital Contacted & Report given
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)
ii) Patient Name / Patient Sticker	**Medical Record#**	**Disposition** Home or Transfer	**Evacuation Triage Category** Red Yellow Green		**Accepting Hospital Name**	**Time Hospital Contacted & Report given**
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)
iii) Patient Name / Patient Sticker	**Medical Record#**	**Disposition** Home or Transfer	**Evacuation Triage Category** Red Yellow Green		**Accepting Hospital Name**	**Time Hospital Contacted & Report given**
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)
iv) Patient Name / Patient Sticker	**Medical Record#**	**Disposition** Home or Transfer	**Evacuation Triage Category** Red Yellow Green		**Accepting Hospital Name**	**Time Hospital Contacted & Report given**
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

HICS 259 – HOSPITAL CASUALTY/FATALITY REPORT

1. INCIDENT NAME	2. DATE	3. TIME	4. OPERATIONAL PERIOD DATE/TIME

5. NUMBER OF CASUALTIES/FATALITIES

	Adult	Pediatric *(<18 years old)*	Total	Comments
Patients seen				
Waiting to be seen				
Admitted				
Critical care bed				
Medical/surgical bed				
Pediatric bed				
Discharged				
Transferred				
Expired				

6. PREPARED BY (Patient Tracking Manager):	*7. FACILITY NAME*

Appendix 9 – Evacuation Time Assessment Tool (Pre-Event)

Evacuation Time Assessment (Pre-event)

Resource	Response Yes/No	Implication
Staff • If a mandatory community evacuation order is issued, what percentage of your staff is likely to leave (and not report for work)? • Have additional trained staff been identified / located to assist, if necessary, with the evacuation?		• Higher percentage = increased risk to patients and longer evacuation time • If no, increased evacuation time. If yes, does the community event also place demands on that group?
Census / patient mix • How many patients are in the ICU (including adult, pediatric, and neonatal intensive care units) and other units (e.g., burn units) with special evacuation needs (e.g., patient must be accompanied by two health care professionals)? • Typical census of adult and pediatric patients? • Typical census of patients with special evacuation needs (e.g., psychiatric patients, bariatric patients, patients from correctional facilities)?		• The more specialty patients, the more limited and distant the receiving facilities and the less specialized transport platforms available
Transportation Needs • What percentage of patients could self-evacuate (e.g., be taken home or evacuated by family/friends)? • What percentage of patients are ambulatory (e.g., could be evacuated in a bus)? • What percentage can sit up but not walk (e.g., could be evacuated in wheelchair vans)? • What percentage requires medical attention at the BLS level during transport? • What percentage requires life support equipment (e.g., could only be evacuated in an ALS ambulance or via helicopter)?		• See worksheet for generation of specific numbers (in text of MDH template) • Higher percentage of specialized transportation resources = more difficult to meet the needs
Transportation Available		

• Does the hospital have an *exclusive* contract with transportation providers to supply vehicles, or is it dependent on public/private vehicles serving others? • Is there a regional mechanism for sharing transportation resources? • How many different access roads reach the hospital, and how many loading zones where there are ramp exits for moving patients? • How long would it take to get all of the patients out of the hospital and on the road to another location (assuming the hospital is full, roads are not damaged/blocked, and appropriate vehicles and staff are available)? • Does the hospital plan specify an off-site "assembly point" where patients could be moved without vehicles, and from which transportation/loading into vehicles would be faster? • How long would this two-stage evacuation take? Hours = time until evacuation • How quickly could all the patients be moved out of the building in an emergency?		• No exclusive contract = more vulnerable • No = more vulnerable • Limited = vulnerable • No off-site "assembly point"= more vulnerable • Longer time = higher risk to stay
Closest receiving facility • How close is the nearest care site that could provide appropriate care for: - NICU patients - PICU patients - CICU patients - Other adult ICU patients - Psych patients - Other ventilator-dependent patients - Other patients with special/advanced medical needs		• Longer distance = increased transport times and higher overall risk

PRE-EVENT EVACUATION DECISION TOOL

Factor	Issues to Consider	Implications
Event Characteristics		
Arrival	• When is the event expected to impact the hospital? The region? • How variable is the impact timeframe?	The amount of time until the event combined with the anticipated time to evacuate determines how long an evacuation decision can be deferred.
Magnitude	• What are the expected effects on the facility and community? • How likely is the event to be more or less severe than predicted – what are the impacts?	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.
Area Impacted	• How large is the geographic area affected? • How many vulnerable health care facilities are in this geographic area (LTC, hospitals, others)?	Competition for resources needed to evacuate patients (especially vehicles) increases when more facilities evacuate simultaneously.
Duration	• How long is the event expected to last? • How variable is the expected duration?	The duration of the event affects how long hospitals have to operate on backup, alternative, or less predictable resources.
Anticipated Effect of the Event on Key Resources		
Water	• 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?	Water loss of unknown duration (more than 1-2 days) is almost always cause for evacuation.
Heat	• Is the heat source in jeopardy (steam, water for boilers, etc.)? Already non-functional? • Is there a backup (intact nearby building that still has power/heat)? • If not, will the building be too cold for patient safety before adequate heat returns?	Loss of heat, especially during a northern winter, is almost always a cause for evacuation—often within 12 hours.
Electricity	• Is power at risk? Just for the hospital 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	Loss of electricity endangers ventilated patients, among others, and may affect the sequence in which patients are evacuated.

	consumption and stretch fuel supplies?	
Facility Structural Integrity	• 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?	• Structural damage may cause rooftop water tanks to fail, flooding the building. • Safety/integrity may not be obvious to untrained occupants.
Anticipated Effect of the Event on the Community		
Road Conditions	• 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?	• 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. • Staff may not be able to get to the hospital to relieve existing staff or assist in the evacuation.
Community/Building Security	• Have any nearby areas experienced increases in 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?	If patient and staff safety cannot be assured, evacuation will be necessary.
Evacuation Status of Other Nearby Health Care Facilities	Are other hospitals or other health care facilities already evacuating or planning to evacuate, or have they decided to shelter-in-place?	If other hospitals or health care facilities are evacuating: – the competition for ambulances, wheelchair vans, and buses may be substantially increased. – the hospital may be asked to accept additional patients. – patients may have to be relocated to facilities further away than anticipated.
State/County/Local Evacuation Order	• Have evacuation orders been issued in areas closer to the event? • 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?	You may have no choice but to evacuate.

Availability of Local Emergency Response Agencies	Are local emergency response agencies understaffed or less available due to other responsibilities?	Unavailability of local fire agencies increases the risk of sheltering-in-place.

Appendix 10 – Supplies

Unit Supplies (per inpatient unit, see other unit-specific information at institution set up kits for X units/departments)

- DMS evacuation tags – sufficient for Unit
- Flashlights / headlamps (4)
- Blankets / carrying canvas
- 'Room Clear' labels (pink fluorescent, 2x4 inches)
- Permanent medium markers
- Large rubber bands
- Large envelopes for records
- Unit patient tracking form
- Unit staff/visitor tracking form
- Unit evacuation template (extra copies to posted)
- Extra footies

Pharmacy Evacuation Cache (Under Revision – 3/13/12)

Medication	Strength / concentration	Quantity
Acetaminophen	375mg tab	500
ASA	81mg chewable	30
Albuterol	MDI	5
Furosemide (lasix)	40mg injectable	5
Furosemide (lasix)	40mg tab	20
Oxycodone elixir	10mg/5ml tubs	20
Ibuprofen	200mg tabs	100
Acetaminophen	160mg / 5ml	1 bottle
Diphenhydramine	50mg / 2ml injectable	10
Diphenhydramine	25mg tab	50
Enoxaparin	100mg / syringe	15
Droperidol	5mg / 2ml	15
Haloperidol	10mg tab	25
Olanzapine	10mg tab	25
Lorazepam	2mg/2ml injectable	15
Ativan	1mg po	25
Insulin	Regular	2 bottles
Insulin	70/30	2 bottles
Marcaine	0.25% with epi	2 bottles
Hydromorphone	1mg/2ml	20
Saline lock	5ml	50
Syringe tuberculin with needle		20
Syringe 12ml	Luer lock	20
Syringe	3ml with 1 inch 23 ga. needle	20
Needle	18 ga. 1.5 inch	20
Needle	25 ga. 1.5 inch	10

Staging Supplies

Item	Location it is coming from	Notes
Administrative Items		
Permanent Markers		
Rubber Bands for Medical Records		
Sheet Protectors for Transfer Documentation to Accompany Patient		
Extra Forms – HICS FORMS		
DMS evacuation tags		
Additional 'room clear' labels (100)		
Food Items		
Bottled water (2 bottles per patient)		
Energy bars (2 per patient)		
Medical Items		
IV Solutions		
• D5 0.45NS – x bags		
• NS – x bags		
Medications per table (in addition to crash cart supplies)		
Crash / Code Cart		
Wheel Chairs (WC)		
Walkers		
Crutches		
Gloves, exam M, L		
Crash cart		
Portable oxygen cylinders (D type)		
Personal Items		
Sani-wipes		
Hand sanitizer		
Chux		
Diapers Adult		
Sheets		
Blankets		
Emesis bags		
Non-Skid Socks for Ambulatory Patients without Shoes		
Facial tissues		
Janitorial Items		
Paper towels		
Garbage bags, plastic		
Zip close plastic bag – gallon		
Flashlight		
Fluorescent Vest		

Appendix 11 - Considerations for Facility Shut Down and "Stay Team" Activities

Task	Assigned	Complete
Change facility status to closed or other MnTrac status/notification as per regional plan		
Identify the lockdown plan and how to harden exterior & critical infrastructure		
Identify the alternate sites for a media center and staging (labor and equipment) for going to alternate site		
Define departmental procedures for securing and shutting down equipment and identifying staff assigned to perform shutdown functions: (critical operations responsibilities)		
Lab		
Finance		
Records		
Central Sterile Supply		
Imaging (CT, MRI, Radiology, Ultrasound, Nuclear medicine – including securing of isotopes)		
Pharmacy (defined procedures for security and/or management of controlled substances)		
Dietary & Food Services		
Medical Equipment (Bio-Electronics) (securing of high value medical equipment (crash carts)		
Information Technology (IT, Telecommunications, Radio Communications, Computing Facility)		
Morgue		
Defined procedures for securing utilities		
Medical gases		
Fuel		
Water/sewer		
Electricity (shut down or activate generators		
HVAC		
Steam		
Medical Gas system		
Fire alarm/sprinkler system		
Hazardous Materials and Hazardous Waste to include:		
Hazardous Waste (satellite and waste sites)		
Hazardous Materials Storage Locations		
Identification of personnel assigned to secure utilities		
Procedure to account for safe evacuation of assigned "stay team" personnel		
Defined procedures for coordinating local public safety to determine inner and outer perimeters		

Task	**Assigned**	**Complete**
Heliport (notify Airport Commission of closure of heliport		
Defined procedures for establishing staging areas to include coordination with local response partners		
Defined procedures for identifying safe areas outside the building for accountability of patients, staff, visitors, and physicians		

Facility recovery and 'start-up' procedures are beyond the scope of this document. For detailed information and assessment sheets see AHRQ publication 10-0081 'Hospital Assessment and Recovery Guide' (May 2010) available at: *Hospital Evacuation Decision Guide*

Acronym List

BVM	Bag Valve Mask
CMS	Centers for Medicare and Medicaid Services
DMS	Disaster Medical System
EMS	Emergency Medical Services
EOP	Emergency Operations Plan
EOC	Emergency Operations Center
HICS	Hospital Incident Command System
HVA	Hazard Vulnerability Analysis
HVAC	Heating, Ventilation, and Air Conditioning
IC	Incident Command
ICS	Incident Command System
JC	Joint Commission
MAR	Medical Administration Record
MDH	Minnesota Department of Health
MRC	Medical Reserve Corp
OEP	Office of Emergency Preparedness
OSHA	Occupational Safety and Health Administration
PPE	Personal Protective Equipment
RHPC	Regional Healthcare Preparedness Coordinator
SIP	Shelter in Place
WC	Wheel Chair

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