

Emergency Sheltering, Relocation and Evacuation Plan for [Company]

TEMPLATE FROM MDH—VERSION 5

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Contents

Purpose	4
Scope	4
Objectives.....	4
Hazard Vulnerability Assessment	4
Possible Actions and Definitions.....	5
Factors Influencing Actions.....	5
Action Timing	5
Action Types.....	6
Direction and Control.....	6
HICS Forms	9
Job Checklists	9
Communications	9
Coordination with External Agencies.....	9
Sheltering in Place (SIP)	10
Relocation	10
Evacuation.....	11
Incident Command Actions.....	11
Ambulatory Care Actions	12
Inpatient Care Actions	12
Non-Patient Care Area Actions	13
Evacuation of Staff with Disabilities	13
Staging Areas.....	13
External Transportation	13
Patient Triage, Tagging, Documentation, and Movement	14
Triage and Prioritization.....	14
Patient Tagging and Documentation	15
Patient Movement Methods	16
Safety and Security	16
Facility Operations, Shut Down, Recovery and Stay Team.....	17
Review, Authorities, References.....	17
Appendix 1: In-Patient Unit Specific Actions	18

Appendix 2: Support and Administration Specific Actions	20
Appendix 3: Evacuation Considerations—Disabilities	22
Appendix 4: Command Staff Check List	24
Appendix 5: Triage Officer Checklist—Evacuation	27
Appendix 6: Evacuation Staging Manager Checklist.....	28
Appendix 7: Evacuating Staging Team Member Checklist.....	31
Appendix 8: Evacuation Pre-Event Time Assessment and Decision Tool	32
Pre-Event Evacuation Time Assessment	32
Pre-Event Evacuation Decision Tool	35
Appendix 9: Supplies	39
Unit Supplies	39
Pharmacy Evacuation Cache	39
Staging Supplies	40
Appendix 10: Considerations for Facility Shut Down and “Stay Team” Activities.....	42
Acronym List	43
References	43
Acknowledgements.....	44

Purpose

The purpose of this plan is to assist in activating sheltering, patient relocation, or partial or full evacuation of [Company]. The responsible individual for content and implementation of this plan is the Chief Executive Officer and/or designee for [Company].

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.

[Company] 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. [Company] 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 [Choose an item](#). 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.

Scope

This plan is a supplement to, not a replacement for, the response actions and resources described in the facility Emergency Operations Plan (EOP) and provides additional details relevant to an incident that involves facility sheltering, relocation, or evacuation.

Objectives

The objectives 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, and
- Identify responsibilities of outside agencies and their activation.

Hazard Vulnerability Assessment

[Company] 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
- [Company] Hazards and Vulnerabilities
 - Special Vulnerabilities According to Specialty Functions
 - Click or tap here to enter text.
 - Click or tap here to enter text.
 - Click or tap here to enter text.
 - Water (potable and non-potable)
 - Steam
 - Electricity
 - Gas
 - Boilers/chillers
 - Powered life support equipment
 - Information technology/communications
 - Security
 - 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 [Company] HVA and Pre-Disaster assessment as well as information about mitigation actions are available upon request.

Possible Actions and Definitions

Factors Influencing Actions

Incident Command staff will have to balance the needs, and the time and resources available to meet the needs to determine which of the following strategies is appropriate.

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

Action Types

1. **SHELTER IN PLACE (SIP):** Shelter in place assures the maximal safety of individuals in the 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 the direst 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. However, in situations where the external environment is the threat (e.g. chemical cloud) 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.
 - 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 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 or non-emergent.
 - a. **Partial evacuation**—Evacuation of a subset of facility patients. This may involve patients requiring specialized care that can no longer be safely delivered at the affected facility.
 - b. **Complete evacuation**—Complete evacuation of a facility due to an unsafe environment of care. Usually, this will involve facility shutdown actions.

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 below) according to the facility EOP and personnel appointed under the Hospital Incident Command System (HICS).

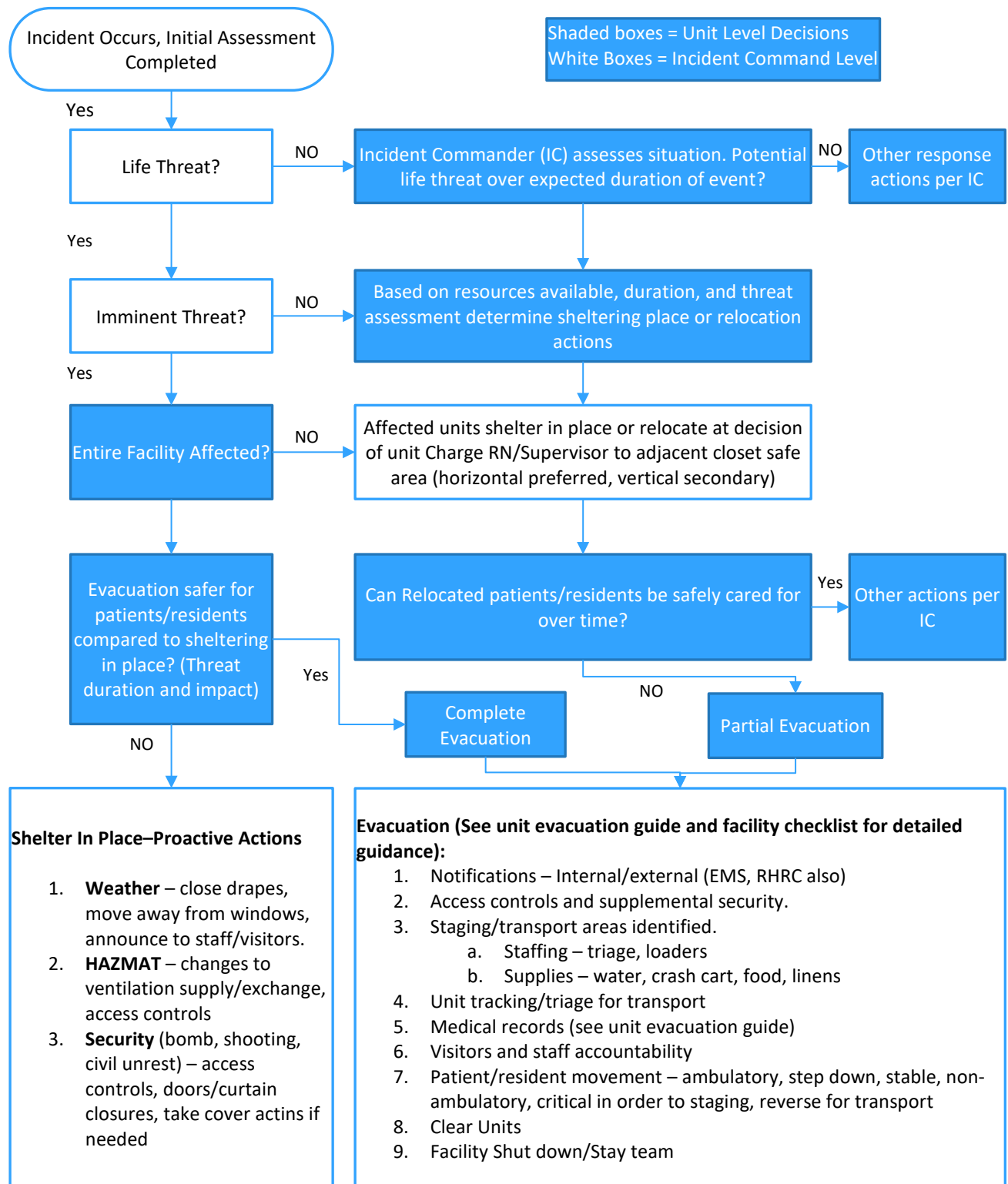
If an evacuation is suggested by local authorities, [Company] will collaborate with local officials and assist in the coordination of the facilities evacuation to the degree safely possible - though this may *not* necessarily involve a complete evacuation depending on the timeframe and risk of the threat compared to the risk to the patients.

The incident commander will determine the HICS structure for the incident:

- If evacuation **is** the incident at the facility (anticipated evacuation for flooding): Operations Chief may supervise evacuation activities.
- If 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 the division and unit assignments prior to an event as they will be consistent regardless of whether an Evacuation Branch Director is used.

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.

Figure 1: Sheltering, Relocation, and Evacuation Decision Tree

HICS Forms

HICS Forms are located online through the Center for HICS Education and Training at: <http://hicscenter.org/SitePages/HICS%20Forms.aspx>. The HICS 255 Form—Master Patient Evacuation Tracking—is recommended during an evacuation response in addition to contacting the **Choose an item.** to activate the regional Patient Tracking Plan.

Job Checklists

Job checklists for incident command positions associated with evacuation operations are located in the appendices.

Communications

Internal notification and partner communications should be conducted according to the EOP. 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.
- **Medical Providers:** Notification to medical providers their patients are being evacuated and their destination facility.
- **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.

Coordination with External Agencies

Coordination with external agencies is critical to planning what to do as things change rapidly. Health care 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.

1. **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.)
2. **Evacuation:** Facility Incident Command must establish coordination with:
 - a. Security/public safety – to provide appropriate traffic controls.
 - b. Transportation – EMS regional coordination entity or local EMS dispatch should be contacted and appropriate liaisons established to assure that adequate transportation capacity (buses, WC vans, ambulances) can be delivered.
 - c. The **Choose an item.** should be notified in any actual or anticipated case of evacuation involving more than a few patients.

- d. 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 Choose an item. may be called on to assist and will work with the facilities in the region. If needed, the Choose an item. can contact the Minnesota Department of Health (MDH), Center for Emergency Preparedness and Response (CEPR) to assist destination mapping for evacuated patients. Evacuating facility will work with EMS and the Choose an item. to assure coordination of information/patient tracking.

Sheltering in Place (SIP)

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 the EOP. Situations where SIP may be appropriate include:

- Weather—wind, hail, or tornado threat
 - Move patients and staff away from windows
 - Close drapes and exterior doors/windows
 - Assure staff and visitors also advised of weather situation
- Security emergency—bomb threat, active shooter, external civil unrest
 - Implement department specific access controls
 - Close smoke compartment doors, patient room doors, and office doors
 - Implement take cover measures as necessary
 - Assure staff and visitors are aware of situation
- HAZMAT incident—sheltering usually relevant to external plume of chemical
 - Shut down air intake into the ventilation system
 - Security to implement access controls as needed
 - Assure visitors and staff aware of threat

If SIP is for an extended period of time, to ensure adequate staffing, it may be necessary to have staff and their families housed at the facility. Additional resources and staffing may need to be reassigned to this area as well. This is mentioned as a consideration as it may allow for additional staff to be present and not worry about their family situation.

Relocation

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.

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 carry.

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.

Table 1: Relocation and Evacuation Areas per Facility Unit

<i>Unit Name</i>	Beds	Unit Locked	Specialized Equipment	Primary Relocation	Secondary Relocation	Staging Area for Evacuation
<i>Med-Surge</i>						
<i>Adult ICU</i>						
<i>PICU</i>						
<i>NICU</i>						
<i>Emergency</i>						
<i>Psych</i>						
<i>Pharmacy</i>						
<i>Lab</i>						
<i>Administration</i>						

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. These checklists are not 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 patients/residents to a place of safety according to facility plan and then contact supervisors per facility EOP.)

Incident Command Actions

Also See Checklist: Operations/Medical Care Branch

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 the [Choose an item](#) and local hospitals according to compact or other agreements.
8. Appoint Transportation Manager (see Transportation Manager Job Aid) – to identify vehicle staging area, assure adequate transport resources requested, assure outgoing patients, equipment, and staff recorded.
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 (PIO) 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.

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.

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.

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 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.

Evacuation of Staff with Disabilities

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.

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 [Company] are:

The Staging Manager will assure that the staging area(s) have a transport officer, triage officer, and, if multiple staging areas, 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 Evacuation Staging Manager Checklist (Appendix 6).

Supplies required at each staging area include acute medical care, oxygen, water, snacks, personal care items, and basic medications.

External Transportation

In the event of evacuation, the Planning Section Chief/Transportation Officer should arrange adequate transport capacity utilizing [Company] resources (see Table 2) and those obtained from partner agencies. Contact the Choose an item. for resource requests.

The 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. In general, the below averages can be used for a rough estimate for transportation needs:

- ICU: Assuming ICU patients are critically ill, ALS ambulance 1 per every 1-2 patients
- Step-down units: 25% ALS, 25% BLS, 25% wheelchair, 25% bus
- Medical/Surgical units: 10% ALS, 30% BLS, 30% wheelchair, 30% bus
- Specialty units:
 - Click or tap here to enter text.
 - Click or tap here to enter text.
 - Click or tap here to enter text.

Table 2: Transportation Resources

SERVICE OR RESOURCE	CONTACT INFORMATION	DISTANCE	RESOURCES AVAILABLE
CLICK OR TAP HERE TO ENTER TEXT.			
CLICK OR TAP HERE TO ENTER TEXT.			
CLICK OR TAP HERE TO ENTER TEXT.			
SPECIALIZED MASS CASUALTY BUS	Minnesota Duty Officer (651) 649-5451 or 1-800-422-0798	Located in Metro Region and Fargo/Moorehead.	18 patient MAC 22 bus with driver

Patient Triage, Tagging, Documentation, and Movement

Triage and 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.

Table 3: Triage and Prioritization¹

¹ Adapted from Continuum Health Partners—Evacuation Planning for Hospitals (2006)

Triage Level	Priority for Evacuation from Nursing Unit to Staging Area Reversed START Priority	Priority for Transfer from the Staging Area to another Health Care Facility Traditional START Priority
Red	▪ Last ▪ Require maximum assistance ▪ Need stretchers ▪ Require 2-3 staff members to move	▪ First ▪ Require maximum support to sustain life
Yellow	▪ Second ▪ Require some assistance ▪ May need wheelchairs or stretchers ▪ May require 1-2 staff members to move	▪ Second
Green	▪ First ▪ Require minimal assistance ▪ Ambulatory ▪ 1 staff member can safely lead several to the staging area	▪ Last

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. HICS 255-Master Patient Evacuation Tracking.

Documentation:

- Emergency Evacuation – the following information must accompany the patient. Further information should be accessed and forwarded to the receiving facility
 - Name, age
 - Allergies
 - Medications
 - Problem list
 - Advance directives
 - Commitment orders
 - Isolation precautions (if any)
 - Emergency contact (if unable to provide)
- Non-emergency evacuation should include the above AND
 - Copy of Medication Administration Record (MAR)
 - Copy of most recent discharge or care summary
 - Copies of latest lab reports
 - Primary care physician information

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.

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 facility Emergency Operation Center (EOC). 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:

- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.

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.

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.

Review, Authorities, References

Approval date:	
Modification date(s):	
Authorizing signature:	

Appendix 1: In-Patient Unit Specific Actions

Click or tap here to enter text.

Facility Emergency Reporting Phone: Click or tap here to enter text.

Command Center Phone: Click or tap here to enter text.

Supervisor: Click or tap here to enter text.

Relocation: Horizontal (first option): Click or tap here to enter text.

Vertical (second option): Click or tap here to enter text.

Evacuation staging location: Click or tap here to enter text.

Unit equipment location: Click or tap here to enter text.

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 – 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 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/Administrator Supervisor Responsibilities upon notice of evacuation decision:

6. Notify unit staff and reassign staff as needed.
7. Compile a list of patients in your area, and your staff currently working.
8. Staging Area is: Click or tap here to enter text. . Confirm staging destination. Direct staff and patients to remain at staging until all persons are accounted for.
9. Assign staff member to print or compile required documentation.
 - a. *Emergency:* Take patient summary sheet with demographics, allergies, medications, problem list, and emergency contact information. Bring full chart if possible.
 - b. *Non-emergency:* Above plus medication administration record and facility chart.
10. Triage patients for movement/transport using evacuation tags.

- a. Tag color reflects priority for *transport to the receiving facility NOT movement to staging* thus green patients are ambulatory, yellow non-ambulatory, red unstable/critical care.
 - b. Tag all patients and attach tear-off band from tag to belongings
11. Begin Evacuation to Staging Area with Green/Ambulatory Patients.
 - a. Assign staff to move them. All patients capable of ambulating should form a chain by holding hands (if capable) and be lead to the staging area by staff member(s).
12. Assess acuity and resource needed to LOAD, MOVE, and CARRY non-ambulatory patients. Will depend on elevator status, etc. In non-emergency situation assure that staging is ready for yellow/red patients prior to moving.
13. Assign person(s) to check all rooms to assure:
 - a. No occupants remain and no safety issues.
 - b. Doors have been closed after room has been vacated.
 - c. Closed rooms are marked with ROOM CLEAR sticker across door and jamb.
14. If time and resources allow, assign person(s) to transport your area's medications.
15. 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.
2. **Patients with IV's, arterial lines and Swan-Ganz:** Disconnect transducer from patient cable-take pressure bag with patient. 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:** Designate an individual to take the drug box from the crash cart and the Narcotic boxes with sign-out sheets. Backpack with needleless syringes with adapters for vials and IV's, alcohol swabs, saline, gloves, tubexes and carpulets.

Procedures:

The physician will assess if invasive procedure(s) can be stopped.

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
- Room clear stickers
- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.

Appendix 2: Support and Administration Specific Actions

Click or tap here to enter text.

Facility Emergency Reporting Phone: Click or tap here to enter text.

Command Center Phone: Click or tap here to enter text.

Supervisor: Click or tap here to enter text.

Relocation: Horizontal (first option): Click or tap here to enter text.

Vertical (second option): Click or tap here to enter text.

Evacuation staging location: Click or tap here to enter text.

Unit equipment location: Click or tap here to enter text.

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

- Weather – (wind/tornado) – close drapes and room doors, move away from windows as practical, alert visitors and staff to threat.
- Security – 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: Relocation of staff / functions to a safer area within the facility, usually the adjacent smoke compartment but sometimes vertically or to other non-adjacent units.

- **Anyone** recognizing an imminent danger shall take immediate steps to safeguard those in danger including staff/visitor movement. 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 coordinator should coordinate with the incident commander. For re-establishment of functions at alternate site in building see unit/area Continuity of Operations Plan

Evacuation: Movement of staff to a staging area to assist with evacuation of the facility and potentially clearing/closing of the unit. This may be a partial evacuation (certain units or specialized patients) or a complete facility evacuation and is undertaken as a last resort.

Supervisor Responsibilities upon notice of evacuation decision:

1. Notify unit staff and reassign staff as needed.
2. Inform staff of situation and actions to be taken.
3. Compile a list of staff in your area, currently working.
4. Staging Area is: Click or tap here to enter text. . Confirm staging destination. Direct staff and patients to remain at staging until all persons are accounted for.
5. Prior to leaving work area secure any hazardous chemicals, safes, and other potential hazards.
6. Take any 'go-kits' or continuity supplies for your unit.
7. Assign person(s) to check all rooms to assure:

- a. No occupants remain and no new/correctable safety issues to report.
 - b. Closed doors after room has been vacated.
 - c. Closed rooms are marked with ROOM CLEAR sticker across door and jamb.
8. Upon arriving at staging, complete staff head count. Staff shall remain at safe location until reassigned or dismissed.

Equipment (see location in box at top page 1)

- Room clear stickers
- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.

Appendix 3: Evacuation Considerations—Disabilities

Addressing the needs of staff, patients, and visitors 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 evacuate 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. 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.

Click or tap here to enter text.

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.

Appendix 4: Command Staff Check List

Does not replace HICS JAS 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		

Task	Assigned	Complete
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)		

EMERGENCY SHELTERING, RELOCATION AND EVACUATION PLAN FOR [COMPANY]

Task	Assigned	Complete
Determine if any staff need to accompany patients/residents to receiving facilities		
In case of complete evacuation – appoint Stay Team Unit Leader		

Appendix 5: 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		

Appendix 6: Evacuation Staging Manager Checklist

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

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.		

Task	Assigned	Complete
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.		

Task	Assigned	Complete
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.		

Appendix 7: Evacuating Staging Team Member Checklist

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 8: Evacuation Pre-Event Time Assessment and Decision Tool

Pre-Event Evacuation Time Assessment

Resource	Response	Implication
STAFF		
If a mandatory community evacuation order is issued, what percentage of your staff is likely to leave (and not report to work)?		Higher percentage of absenteeism equals increased risk to patients and longer evacuation time
Have additional trained staff been identified/located to assist, if necessary, with evacuation?		If not, expect an 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) and other units (e.g. burn units) with special evacuation needs (e.g. patient must be accompanied by two health care professionals)?		The more specialty patients, the more staff required, the more limited and distant the receiving facilities and the less specialized transport platforms available.
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)?		
TRANSPORTATION NEEDS		
What percentage of patients could self-evacuation (e.g. be		See worksheet above (Table 1, pg. 9)

Resource	Response	Implication
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 require life support equipment (e.g. could only be evacuated in an ALS ambulance or via helicopter)?		Higher percentage of specialized transportation resources equals more difficult to meet the needs
TRANSPORTATION AVAILABLE		
Does the hospital have an <i>exclusive</i> contract with transportation providers to supply vehicles, or is it dependent on public/private vehicles serving others?		No exclusive contract leaves the facility more vulnerable
Is there a regional mechanism for sharing transportation resources?		If not, the facility is more vulnerable
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		Limited means more vulnerable

Resource	Response	Implication
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?		No off-site “assembly point” equals more vulnerable
How long would this two-stage evacuation take? Hours = time until evacuation.		Longer the time the higher risk to stay
How quickly could all the patients be moved out of the building in an emergency?		
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 - Psychiatric patients - Other ventilator-dependent patients - Other patients with special/advanced medical needs		Longer distance equals increased transport times and higher overall risk

Pre-Event Evacuation Decision Tool

	Factor	Issues to Consider	Implication
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.

	Factor	Issues to Consider	Implication
	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 consumption and stretch fuel supplies?	Loss of electricity endangers ventilated patients, among others, and may affect the sequence in which patients are evacuated.
	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	Road Conditions	Are any major routes from the hospital to potential receiving care sites closed or threatened?	There may be a limited window of opportunity to carry out a ground-based evacuation.

	Factor	Issues to Consider	Implication
		- Will evacuation traffic clog major routes from the hospital to potential receiving care sites? - Are access routes to the hospital cut off or threatened?	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 there may be: 1) competition for ambulances, 2) wheelchair vans, and buses may be substantially increased, 3) the hospital may be asked to accept additional patients, 4) 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	You may have no choice but to evacuate.

	Factor	Issues to Consider	Implication
		the possibility of an evacuation order? ▪ Have any other incidents occurred that increase the likelihood that an evacuation order will be issued?	
	Availability of Local Emergency Response Agencies	▪ 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 9: Supplies

Unit Supplies

Per inpatient unit. See other unit-specific information at institution.

- DMS evacuation tags for Unit
- Flashlights / headlamps (4)
- Blankets / carrying canvas
- 'Room Clear' labels
- 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

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

Staging Supplies

Item	Where to Get It (Location)	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)		
Wheel Chairs (WC)		
Walkers		
Crutches		
Gloves, exam M, L		
Crash/Code 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		

EMERGENCY SHELTERING, RELOCATION AND EVACUATION PLAN FOR [COMPANY]

Item	Where to Get It (Location)	Notes
Garbage bags, plastic		
Zip close plastic bag – gallon		
Flashlight		
Fluorescent Vest		

Appendix 10: 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 <u>departmental</u> 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		
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		

Acronym List

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

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