



Los Angeles County Emergency Medical Services Agency

Evacuation and Shelter in Place Guidance
for Healthcare Facilities

Part II: Plan Template

April 17, 2012

**Los Angeles County Emergency Medical Services Agency
Evacuation and Shelter in Place Guidance for Healthcare Facilities: Plan Template**

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Overview

Purpose:

The purpose of this plan is:

- To direct the activities required to implement sheltering-in-place, partial evacuation/internal relocation or full evacuation
- To outline the responsibilities of individuals and departments during shelter-in-place, partial evacuation/relocation, and full evacuation
- To prioritize response requirements and establish an orderly shelter, relocation, or evacuation process using the Incident Command System (ICS)

General Plan/Policy Guidelines:

- Sheltering-in-place, relocation, and evacuation activities:
 - May occur as standalone response or may be implemented in a progression, if necessary, as the incident evolves
 - May be implemented in a proactive response to impending hazards
 - May be implemented in response to an acute incident
- The following are examples of factors that could lead to activation of the shelter-in-place / relocation / evacuation plan: *OR insert results of your HVA*
 - Loss of environmental support services including heating, water, air conditioning, sterilization, electrical power, and medical gases.
 - Internal emergencies such as fire, smoke, hazardous materials release, or active shooter or threat.
 - External emergencies including natural and man-made disasters such as earthquake, urban and wildfires, flood, power outage, civil disturbance, terrorism, hazardous materials spills, contaminated victims/toxic agents, radiation exposure, explosions and police actions.
- The evacuation of the facility shall only be initiated as a last resort in response to disruption of services caused by an internal or external disaster.
- The responsible individual for the activation and implementation of this plan is the *[insert position, e.g., Incident Commander, Administrator on Duty, Chief Executive Officer and/or designee, etc.]*.

Supporting Plans

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

- Emergency operations plan (EOP)
- Command center operations
- Department-specific evacuation plans
- Lockdown procedures
- Active shooter/threat
- Facility closure, restoration and start up
- Business continuity

Operational Definitions

Shelter in Place: A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP.

- When SIP is done in an active shooter or active threat situation, it can be called Defend in Place. Refer to Active Shooter/Threat Plan (*if you have one*) or Appendix, page xx

Evacuation: The movement of patients, personnel and visitors from a dangerous location to one of relative safety.

- **Partial Evacuation or Relocation:** Movement within the facility.
- **Horizontal Evacuation:** Evacuation on the same floor, often to the other side of a set of fire barrier doors.
- **Vertical Evacuation:** Evacuation to a safe place on another floor, can be upward or downward.
- **Total or Complete Evacuation:** The full evacuation of a facility to an outside area which may also require transfer of patients (and possibly personnel) to another healthcare facility or alternate site.

Emergent Evacuation: An evacuation that is conducted in quick response to an acute emergency.

Planned or Phased Evacuation: An evacuation that is conducted in a planned or phased manner in response to an impending emergency such as wildfire or flood.

Refuge Area: A location within a building that is identified as having relative safety. May be used in SIP situations or partial evacuation/relocation.

Assembly Point or Collection Area: A pre-identified area outside of the building where departments will assemble upon evacuation from the facility.

Plan Activation

The responsible individual for the activation and implementation of this plan is the [insert position, e.g., Incident Commander, Administrator on Duty, Chief Executive Officer and/or designee, etc].

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

- Decision Tree - Appendix, page 23
- Decision Matrix - Appendix, page 24
- Incident Assessment Worksheet, page 32

Incident Management

Establish Command and Control

- The overall management of incident response and recovery is the responsibility of the Incident Commander as designated in the Emergency Management Plan.
 - All personnel are authorized to take immediate patient/resident relocation or sheltering actions in response to a life safety emergency.
 - Every department is responsible for implementing their activities within the evacuation plan.
- The Incident Commander will notify and activate:
 - Activate Code [*internal, etc*].
 - Activate ICS Incident Management Team members as needed by the incident.
 - The HICS Incident Response Guide for Evacuation may serve as a guide
 - Activate the Command Center. If the primary location is not available, notification must include the new alternate location.
- ICS and Command Center operations shall be guided by:
 - This plan, and other plans activated in support of this incident.
 - ICS Job Action Sheets.
 - HICS Forms, including the following evacuation related forms:
 - 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
- All information related to the incident shall be coordinated and released through the Command Center.
- The Command Center will coordinate with outside agencies, other healthcare facilities and facility administration regarding facility status, evolving situational needs, and overall status of the evacuation/shelter in place process.

Roles and Responsibilities

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

- Initial Critical Action Sheet for an Emergency Evacuation - Appendix, page 25
- Initial Critical Action Sheet for Emergent Shelter in Place - Appendix, page 26
- Defend in Place for Active Threat/Shooter - Appendix, page 27
- Command Personnel Checklist for Shelter, Relocation, & Evacuation - Appendix, page 30
- HICS Evacuation Incident Response Guide

Incident Commander

- Has the full authority and responsibility for the decision-making processes for this response.

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Public Information Officer

- Coordinate media communications regarding the status of the facility, including the need to evacuate.
- Establish a family information center to notify and respond to queries from family members regarding the status and location of patients who have been evacuated. Utilize the tracking information provided to the Command Center by the Planning Section Chief.
- Assign personnel to notify the patients/residents emergency contact person.

Liaison Officer

- Notify local agencies to notify that you are experiencing an adverse incident that requires sheltering or evacuation and update your operational status (capabilities, resources needs, etc).
- Hospitals:
 - Los Angeles County Department of Health Services Emergency Medical Services (EMS) Agency: use ReddiNet, call the Medical Alert Center (MAC): 866-940-4401, or use the HEAR radio
 - Ensure the facility is placed on ambulance diversion via ReddiNet
- All Facilities: Notify Licensing and Certification: 800-228-1019
- Notify community response partners, including:
 - Local fire department (may be able to assist with evacuation; provide information on the incident, etc)
 - Local police department (may be able to assist with securing the facility / area; provide information on the incident, etc)
 - If you rent space, notify your landlord

Safety Officer

- Oversee the immediate stabilization of the facility
- Recommend areas for immediate evacuation to protect life
- Ensure the safe evacuation of patients, staff and visitors
- Conduct initial and ongoing analysis of existing evacuation practices for health and safety issues related to personnel, patients, and facility, and implement corrective actions to address

Operations Section Chief

- Coordinate the processes necessary to safely evacuate a portion or all of the facility.
- Identify appropriate staging areas for the receipt and movement of patients/residents, personnel and visitors.
- Work with the Medical Care Branch Director to identify (number and acuity levels), prioritize, and evacuate patients in a systematic and orderly manner.
- Communicate with the Infrastructure Branch Director to determine the need for — and orderly implementation of — the operational reliability and/or shut down of utilities and structural support systems.

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- Coordinate with the Infrastructure Branch Director to determine and supply necessary utilities and medical gases to the sheltering or evacuation assembly points.
- Coordinate with the Liaison Officer to determine the number and type of transportation vehicles that will be necessary to evacuate patients to alternate care sites.
- Work with the Security Branch Director to establish access and control of key areas of the facility and campus during the evacuation.
- Interface with the Business Continuity Branch Director to assure that the security and availability of vital patient/resident health record, and other key information is maintained.

Planning Section Chief

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

Logistics Section Chief

- Work with the Operations Section Chief to provide the necessary medical equipment, beds, medications, and supplies to safely relocate patients to alternate locations. Caches of equipment, supplies, and medications pre-positioned to manage an influx of casualties can be used if they are not required for their intended purpose.
- Assure an adequate supply of personnel and other human resources to safely evacuate patients/residents and visitors to alternate locations.
- Ensure that potable water and basic food supplies are brought to the sheltering area or assembly points.
- Collaborate with the Operations and Planning Section Chiefs to identify and address both internal and external transportation needs.
- Establishing a family information center to notify and respond to queries from family members of personnel regarding the status and location of personnel who have been evacuated.

All Personnel

- All personnel are authorized to take immediate patient/resident relocation or sheltering actions in response to a life safety emergency.
- Assist patients/residents with sheltering or evacuating as indicated

Communication

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

- **Personnel, on duty:** Notification of potentially unsafe situation(s) at the facility. If evacuation activities are possible, an 'evacuation standby' notification should be made

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as soon as possible so that units may begin accessing appropriate supplies and collecting belongings and records.

- **Personnel, off duty:** Notification of potentially unsafe situation(s) at the facility. Provide guidance on whether personnel should report to duty as usual or not.
- **Patient families:** Notification of patient/resident families of evacuation destinations
- **Medical providers:** Notification of evacuation destinations
- **Personnel families:** Notification of incident status and 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

Initial Notification Chart

See Appendix, page 43.

Estimate How Many Will Need to Be Evacuated or Need Sheltering Resources

See Appendix, page 44, to estimate the number of people that will need to be evacuated or relocated, or will require resources if they are sheltering in place.

Sheltering in Place Procedures

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

- *Weather* – wind, hail, or other weather threat
 - Remain calm.
 - Move patients/residents and personnel away from windows as possible.
 - Close drapes/blinds and exterior doors/windows.
 - Ensure personnel and visitors also advised of weather situation.
 - Update incident command on your operational status and impact on patients/residents, personnel, and visitors.
 - Personnel will remain with patients/residents.
- *Security emergency – bomb threat, individual posing security threat, external civil unrest*
 - Remain calm.
 - Refer to Active Shooter/Bomb Threat policy.
 - Implement department-specific access controls.
 - Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed.
 - Ensure personnel and visitors are aware of the situation.

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- Update incident command on your operational status and impact on patients/residents, personnel, and visitors.
- Personnel will remain with patients/residents.

- *Hazardous materials (HAZMAT) incident*
 - Remain calm.
 - If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
 - Ensure visitors and personnel aware of threat – location and actions to take.
 - Update incident command on your operational status and impact on patients/residents, personnel, and visitors.
 - Personnel will remain with patients/residents.

Evacuation - General Guidelines

Authority and Decision Making

- All personnel are authorized to take immediate patient/resident relocation actions in response to an immediate life safety emergency.
- Initiation of a vertical or complete evacuation, with the exception of persons in immediate danger, will be coordinated by the Incident Commander/Command Center.

Evacuation Priorities

In an emergency:

1. Persons in immediate danger
 - If persons are not in immediate danger, personnel shall WAIT for evacuation orders.
2. Ambulatory persons
3. Non-ambulatory persons
4. Critical patients will be moved last when the maximum number of personnel and equipment is available.
5. Personnel will remain with patients/residents.
6. Evacuation shall be completed in a calm and orderly fashion.

Evacuation Routes

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

- Evacuation shall be completed in a calm and orderly fashion.
- When possible, horizontal evacuation is preferred over vertical evacuation.
- Departments should have pre-identified evacuation routes.
- Incident specific evacuation routes may be necessary and must be communicated by the Command Center quickly to affected areas.

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- Only when absolutely necessary should evacuation result in patient/resident leaving the interior of the facility.
- Visitors, personnel, and ambulatory patients should walk to the designated assembly point. If vertical evacuation is necessary, stairs — not elevators — should be used for these individuals. Personnel should be assigned at key points along the evacuation route to direct individuals to the assembly points.
- Elevators — if operational — are reserved for transporting non-ambulatory patients. Engineering / maintenance personnel should be assigned to take operational control of the elevators using the bypass key to take elevators directly to / from the affected areas. Do not use elevators in a fire or earthquake.
- If elevators are non-operational, and vertical evacuation is required, non-ambulatory patients will be carried down stairwells using assist devices, blanket carry, or two-man carry techniques.
- Human Chain - can be used if you have large numbers of ambulatory patients. Two personnel members are needed, one in the front and one in the rear. Have the first patient put his/her hand on the shoulder of the first personnel member, and everyone else do the same to the person in front. The last person in the chain should be the second personnel member.

Return to Facility

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

- Assisting with evacuation of patients/residents, visitors or other personnel/equipment
- Authorized by the Incident Commander/Command Center
- An order to repopulate / reopen the facility has been approved by Licensing and Certification

Moving to a Safe Refuge - Horizontal Evacuation

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

Procedures

1. Remain calm.
2. Follow instructions of the area supervisor.
3. Identify the next functional smoke compartment (i.e., beyond the next set of double fire doors).
4. Movement shall be completed in a calm and orderly fashion.
5. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
6. Move patients/residents, personnel and visitors who are closest to the hazard to the next functional smoke compartment or identified refuge area. If you are moving patients to another floor, follow instructions for vertical evacuation.

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7. Ambulatory patients should be assisted to the new location, and non-ambulatory patients moved on beds, carts, wheelchairs, or via blanket carry.
8. If possible, take with you the necessary patient/resident care equipment and supplies from the hazardous area.
9. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
10. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
11. Each room should be marked as evacuated (*Planning Note: you should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
12. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. (*Planning Note: you should pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etc.*)
13. The area supervisor should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear (*Planning Note: you facility should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
14. Relocation does not involve formal gathering of medical records, unless this relocation is part of a phased evacuation, then gather patient records.
15. Continue to care for all patients/residents during transport and relocation.
16. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.
17. Update the Command Center on your operational status and impact on patients/residents, personnel, and visitors, and if any additional individuals need to be evacuated or if the area is all clear. Receive and implement instructions from the Command Center.
18. Ensure personnel and visitors are aware of the situation.
19. Personnel will remain with patients/residents.

Safe Refuge Areas and Horizontal Evacuation Area Chart - see Appendix, page 41

Horizontal Evacuation: Personnel Responsibilities

- Affected area personnel – assist with patient care and evacuation of current patients/residents from their area
- Unaffected clinical area personnel – minimal numbers of clinicians will remain with current patients/residents, additional personnel will report to unit being evacuated to assist – utilize internal stairwells
- Non-clinical personnel – all non-critical functions will cease and personnel will report to unit being evacuated to assist – utilize internal stairwells

Vertical Evacuation Procedures

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

Procedures

1. Remain calm.
2. Follow instructions of the area supervisor or fire department.
3. Identify evacuation route and relocation area.
4. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
5. Evacuation shall be completed in a calm and orderly fashion.
6. Evacuate patients/residents, personnel and visitors from the hazard
7. Visitors, personnel, and ambulatory patients should walk to the designated area. Personnel should be assigned at key points along the evacuation route to direct individuals to the area.
8. Elevators — if operational — are reserved for transporting non-ambulatory patients.
 - o Do not use elevators in a fire or earthquake.
 - o If elevators are non-operational, and vertical evacuation is required, non-ambulatory patients will be carried down stairwells using specialized evacuation equipment (if available), blanket carry, or two-man carry techniques.
9. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
10. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
11. Each room should be marked as evacuated (*Planning Note: you should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
12. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. (*Planning Note: you should pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etc*).
13. The area supervisor should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear (*Planning Note: you should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
14. Continue care for all patients/residents during transport and at the assembly point.
15. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location. HICS Form 255 may be used.
16. Keep patient/resident files and records with the patient.
17. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location.
18. Update the Command Center on your operational status and impact on patients/residents, personnel, and visitors, and if any additional individuals need to be evacuated

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or if the area is all clear. Receive and implement instructions from the Command Center.

19. Ensure personnel and visitors are aware of the situation.
20. Personnel will remain with patients/residents.

Vertical Evacuation Route Chart - see Appendix, page 48

Vertical Evacuation: Personnel Responsibilities

- Affected area personnel – assist with patient/resident care and evacuation of current patients/residents from their area
- Unaffected clinical area personnel – minimal numbers of clinicians will remain with current patients/residents, additional personnel will report to unit being evacuated to assist – utilize internal stairwells
- Non-clinical personnel – all non-critical functions will cease and personnel will report to unit being evacuated to assist – utilize internal stairwells

Complete Evacuation Procedures

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

Procedures

1. Remain calm.
2. Follow instructions of the area supervisor or fire department.
3. Identify evacuation route and external assembly point.
4. Assign personnel to clear obstructions from corridors and control fire/smoke doors and other exits as required.
5. Evacuation shall be completed in a calm and orderly fashion.
6. Each patient who is evacuated should have the following accompany them:
 - Their medical record – which should remain in their possession during the entire evacuation process
 - Necessary medications along with their medication administration record
 - Their addressograph plate or name labels
 - Personal belongings (if time permits)
 - Ideally, these items should be placed in a large plastic belongings bag and the bag marked with the patient's name and medical record number with indelible ink.
7. Evacuate patients/residents, personnel and visitors from the hazard
8. Visitors, personnel, and ambulatory patients should walk to the designated area. Personnel should be assigned at key points along the evacuation route to direct individuals to the area.
9. Elevators — if operational — are reserved for transporting non-ambulatory patients.
 - Do not use elevators in a fire or earthquake.

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- If elevators are non-operational, and vertical evacuation is required, non-ambulatory patients will be carried down stairwells using specialized evacuation equipment (if available), blanket carry, or two-man carry techniques.
- 10. Unless otherwise indicated, evacuation should proceed from patient/resident rooms farthest from the evacuation route to closest.
- 11. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
- 12. Each room should be marked as evacuated (*Planning Note: you should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
- 13. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. (*Planning Note: you should pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etc*).
- 14. The area supervisor should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear (*Planning Note: you should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
- 15. Continue care for all patients/residents during transport and at the assembly point.
- 16. Account for all patients/residents and personnel. Check off the names of patients/residents as they are evacuated, and as they arrive in the new location. HICS Form 255 may be used.
- 17. Keep patient/resident files and records with the patient.
- 18. Update the Command Center on your operational status and impact on patients/residents, personnel, and visitors. Receive and implement instructions from the Command Center. Notify the Command Center if there are additional individuals that need evacuating or if the area is all clear, and if you need additional staffing, supplies, or other resources to manage your patients/residents.
- 19. Ensure personnel and visitors are aware of the situation.
- 20. Personnel will remain with patients/residents.

Guidelines for Evacuating Specific Patient Care Areas

OR, PACU & Hemodialysis

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

- Operating Suite - the surgeon in charge of each case.
- PACU - The covering anesthesiologist is responsible to coordinate care with the nursing personnel.
- Hemodialysis - The Nurse Manager or designee and physician will direct activities of the personnel.
- Obtain equipment and services required for completion of the procedure.
- Keep list of anticipated supplies and prepare to procure additional supplies as needed.

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

Intensive Care Units (ICU)

- The Nurse Manager or designee shall evaluate the ICU patients with the house officer to determine possible transfers and/or discharge.
- Transfer as many patients as possible to medical surgical or step down units, if safe to do so.
- Use gurneys, beds and evacuation equipment to move patients to refuge areas.
- Collaborate with house officer and respiratory therapists to evaluate appropriate shut-off of oxygen, ventilation equipment and other gases to preserve resources.

Labor and Delivery, Family Centered Care and Maternity Units

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

- Obtain wheelchairs, gurneys, incubators, instruments and supplies needed to complete Labor and Delivery procedures.
- Transport infants in their mother's arms, if appropriate.
- Place multiple infants into a single crib, incubator or evacuation vest for transport by a nurse, if needed.
- Transport laboring patients via bed, gurney or evacuation equipment, if safe to do so.

NICU, PICU and Pediatrics

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

- Transport infants in cribs/bassinets/incubators/specialized evacuation equipment with a nurse in attendance during the evacuation
- If necessary multiple infants may be placed into a single crib or incubator for transport by a nurse
- Older non-ambulatory pediatric patients may be transported by bed, gurney, wheelchair, carried or rolled in a blanket (do not use sheets; they are not strong enough) and dragged to a safe location as needed.
- Ambulatory pediatric patients may be evacuated together by forming a chain, holding hands, and alternating the older and younger children in the line as time and circumstances permit.

Evacuation of Non-Patient Care Areas

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

1. Remain calm.
2. Recognize local threat or receive evacuation instructions from the Command Center or authorized personnel according to facility plan and move personnel to the pre-identified assembly point.

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3. Persons in immediate danger should evacuate first.
4. In areas where there are visitors, escort the visitors to your department's assembly point.
5. Unless otherwise indicated, evacuation should proceed from offices farthest from the evacuation route to closest.
6. If time allows, as each room is cleared, lights should be turned off, non-essential electrical equipment should be turned off and unplugged.
7. Each room should be marked as evacuated (*your facility should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator*).
8. If an individual requires additional evacuation support than is immediately available, the door should be marked so that returning responders know which room to evacuate. *(Planning Note: you should pre-determine how this will be designated, e.g., a closed door with something white outside like a pillow, sheet, etc).*
9. The department head should identify a single individual to sweep the area for remaining persons, ensuring to check all patient rooms, offices, storage areas, restrooms, etc. And marked as clear *(Planning Note: you should pre-determine how this will be designated, e.g., a closed door, an "X" marked prominently on the door, or other indicator)*.
10. Personnel/visitors with disabilities may require assistance. Each department head must identify which of their personnel may have difficulty during an evacuation and pre-plan the best way to aid their movement to a safe location.
11. Visitors should remain at the assembly point until the Command Center declares an "all clear" or other directions are given.
12. Account for personnel at assembly point (conduct roll call). If you have time, conduct roll call prior to evacuation, and again at the assembly point.
13. Initiate continuity of operations plan actions.
14. Update the Command Center on your operational status and impact on personnel and visitors. Receive and implement instructions from the Command Center. Notify the Command Center if there are additional individuals that need evacuating or if the area is all clear, and if you need additional staffing, supplies, or other resources. Send personnel to the labor pool if requested.
15. Ensure personnel and visitors are aware of the situation.

Complete Evacuation: Personnel Responsibilities

- Since all areas will be affected, all clinical personnel will assist with patient care and evacuation of current patients from their units, and perform follow up care at the assembly point.
- Non-clinical personnel – all functions will cease, and personnel will evacuate to their designated assembly point, and assign personnel to the labor pool for further instructions.

Vertical/Complete Evacuation Transport Devices

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

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The following resources can be used in patient evacuation:

- Wheelchairs can be used to move ambulatory, minimally ambulatory patients and non-ambulatory patients. Mostly used to get to the stairwell, and if able to carry the wheelchair down the stairwell, then it can be used to move the patient/resident/personnel to the assembly point.
- Beds/gurneys: can be used to move non-ambulatory patients, but very difficult for vertical movement.
- Improvised equipment is only to be used when normal transportation equipment is not available. Blanket drags, multi-person carries, and utilization of other equipment not ordinarily used for transportation may be needed.

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

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

See Appendix, page 50, for a complete list of devices and location.

Evacuation Assembly Points

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

Determining Assembly Points

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

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

Assembly Point Key Activities

- Roll call of all patients/residents, personnel and visitors
- Patient assessment and care

Assembly Point Resource Needs

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

- Food and water
- Communication devices for personnel to keep updated
- Environmental protection (tents, umbrellas, blankets, sheets, etc.)
- Chairs, flashlights/light sticks, basic first aid kits
- Medical supplies - depending on the care provided

Evacuation Assembly Point Chart - see Appendix, page 49

Patient/Resident Transfer to Alternate Facilities

Internal Coordination

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

Organizing Patients/Residents

Categorize and physically organize patients/residents as follows:

- Those who have their own transportation and are being discharged to home
- Those who need to be evacuated to an alternate acute care facility
- Those who need to be evacuated to a skilled nursing facility
- Those who are being discharged home but require transportation

Once the patient's/resident's evacuation status has been determined, it should be noted on a sign, sticker, or other mechanism and placed prominently on the patient/resident. This tag should remain on the patient/resident at all times until the evacuation destination is reached.

Patient/Resident Information

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

See Appendix, page 54 and 55, for forms.

Patient/Resident Tracking

- Patient tracking information is to be maintained in the area with copies forwarded to the Command Center and kept with the Patient Tracking Manager.
- Standard inter-facility transfer forms are to be completed on each patient/resident sent to an alternate care site, along with a copy of the medication administration record, and other pertinent medical record information.
- Patients/residents discharged to home should be provided with standard discharge instructions.

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- If home health follow-up is necessary, send pertinent medical information home with the patient as well.
- Patient Tracking Manager and/or deputies will contact alternate care sites to ensure patient arrival until all patients have been verified as arriving and HICS form 255 is completed.

Personnel Tracking

- Establish processes to coordinate personnel who may accompany patients/residents being transferred to alternate care sites.
- If personnel are to remain at these sites, then implement the mutual aid agreements established with these facilities.
- A record should be maintained of the name, title, and the facility that they were assigned to.

External Coordination

- If patients need to be transferred to another facility for ongoing medical care, **identify available beds** by the following procedures:
 1. Coordinate with other facilities in the same healthcare system
 2. Hospitals: If the above resources are unavailable or inadequate, request assistance from the LA County EMS Agency:
 - Contact the Medical Alert Center (MAC): 866-940-4401, Press 1
 - Provide the number of patients by type of bed (critical care, medical/surgical, pediatrics, etc) that require evacuation
 3. Skilled Nursing Facilities: If the above resources are unavailable or inadequate, request assistance from Licensing and Certification:
 - Contact Licensing and Certification: 800-228-1019
 - Provide the number of residents by type of acuity that require evacuation
- **Obtain transportation resources** by contacting your contracted ambulance providers
 - If not feasible or additional resources are needed from the County, contact the EMS Agency
- Transferred patients should have **medical records and medications** sent with them.
 - At a minimum, use a triage tag or HICS Form 260 Patient Evacuation Tracking
 - Maintain a log of transferred patients. Can use a combination of HICS Form 260 and HICS Form 255 Master Patient Evacuation Tracking Form
- See Appendix, page 54 and 55, for forms.

Transportation Resource Needs Matrix

Estimate the type and quantity of transportation resources needed using the tool in Appendix, page 53. Use this information when requesting assistance through your usual transportation providers or the LA County EMS Agency.

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Evacuation Triage and Transportation Tag

An Evacuation Transportation Tag System shall be used to track patients who are evacuated from the facility.

- Clinical personnel are responsible for patient assessment/triage which will dictate mode of transportation based on acuity and care needs.
- The assessment/triage process and transportation tag will be completed prior to movement of patients from the facility.
- The tags should be updated and reviewed during triage and transportation to the assembly points and/or other healthcare facilities.

See Appendix, page 46, for the evacuation triage system color code.

Patient Tracking Manager will be responsible for:

- Maintaining a supply of the evacuation tags at each patient care unit.
- Coordinating the distribution of evacuation tags during the incident.
- Tracking patients who are evacuated from the facility.

Closure of a Portion or All of the Facility Following Evacuation

The decision to close all or a portion of the facility is made by the Incident Commander in collaboration with senior Command Center personnel. Closure of the facility (all or in part) is indicated if:

- The facility ceases the operational capability to provide safe and adequate care.
- The environment of care is no longer capable of supporting safe and adequate care.
- Closure has been directed by an external agency having legal authority to do so.

Facility operations during an evacuation will be under the direction of the Infrastructure Branch Director. This position will coordinate all facility control operations as needed during an evacuation. The first step in this process is to have the current status of all facility systems evaluated and documented using the HICS 251 Facility System Status Report. From this status report, the Infrastructure Branch Director may call for additional support (e.g., local utilities companies/vendors).

(Planning note: Your facility should have a plan in place for how it will conduct a facility closure, utility shutdown procedures, etc, however guidance is included below. You can include this in your evacuation plan or refer to your plan that deals with these specific issues.)

General Guidelines

- Whenever possible, operationally capable areas should continue to provide care, treatment, and service as long as possible.
- Affected / hazardous areas should be closed first. Once cleared, these areas should be locked and utilities to the area shut down.

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- Non-essential areas should be closed next. Once cleared, these areas should be locked and utilities to the area shut down.
- Patient care areas should be closed based on operational and environmental conditions. Closure should proceed from the most at-risk to the least at-risk areas. Once cleared, these areas should be locked and utilities to the area shut down.
- If time and circumstance permit, patient care areas should be scavenged for available supplies, equipment, medication, beds, transport devices, etc. These material resources should be brought to appropriate assembly points or as otherwise directed by the Command Center.
- Information Services should conduct a full backup of all information systems prior to shutting down mainframe computers and network systems. Individual proprietary systems should be backed up to external hard drives for removal from the facility.
- If time and circumstances permit, medical records should be boxed and removed and transported to an off-site storage location. Records should be removed — if possible — from most recent admissions going backward.
- If time and circumstances permit, personnel records should be boxed and removed from human resources and transported to an off-site storage location.
- Unless safety issues are present, utilities should be maintained until the affected areas are fully cleared and ready for closure. At that point, Engineering should implement standard and/or emergency shut-down procedures as warranted. Once utilities are shut down, they should be locked out / tagged out and the area secured as able.
- Controlled substances are secured at all times except during administration. If the facility were to close, these items would be secured by default.
 - If medications are to be moved or evacuated with patients, they must be secured with licensed personnel.
- Process to secure diagnostic radiology areas / medications / isotopes in accordance with state law.

Securing the Facility

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

- Maintaining general security, especially during prolonged incidents or when resources are scarce
- Establishing a perimeter around the facility, especially patient care areas OR establishing a perimeter around affected high risk areas within the facility
- Controlling access and movement in and between facilities
- Maintaining traffic control on campus
- Ensuring only authorized persons re-enter the facility after evacuation
- Coordination with local public safety, as needed

Stay Team

If the facility has been evacuated, but personnel need to remain to stabilize the incident and restore functionality, designate a Stay Team. This may include members of the Incident

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Management Team including the Safety Officer, emergency management personnel, facilities/engineering, risk management, human resources, etc.

See Facility Shut Down and “Stay Team” Member Check List - Appendix, page 62.

Recovery: Restoring the Facility after Evacuation

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

(Planning note: Your facility should have a plan in place for how it will conduct a facility restoration, however guidance is included below. You can include this in your evacuation plan or refer to your plan that deals with these specific issues.)

General Guidelines

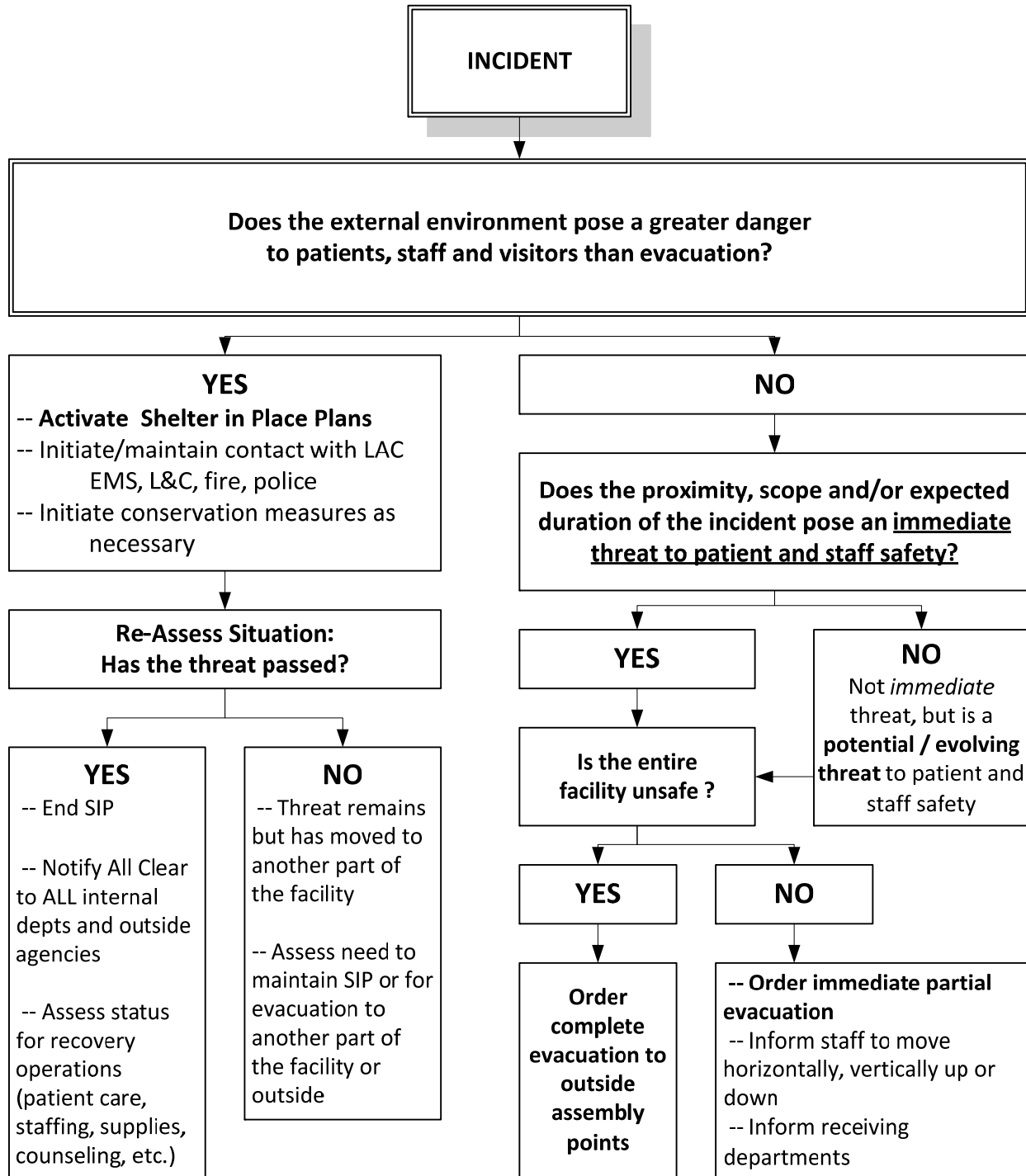
- Facilities are determined to be structurally sound and safe, and systems are not compromised, for occupancy. If not safe, may require repairs/retrofits/replacements that need to be approved by OSHPD, fire marshal and Licensing & Certification.
- Prioritize which departments and personnel to repatriate
- Restoration and testing of infrastructure – water, electricity, HVAC, medical gases
- All items within the facility that can be affected by spoilage due to loss of power and/or high temperatures are tested and repaired/replaced/quarantined, as needed (e.g., food, medications, radioactive supplies and equipment, computerized diagnostics, etc.).
- Procedures to assess the need for and implementing cleaning and decontamination
- Certification by local authorities (i.e., Licensing & Certification, OSHPD, local fire marshal, State Pharmacy Board, LAC Dept of Public Health, etc)
- Essential functions and supplies/supply chains (pharmacy, supplies, laundry, etc.) are reestablished
- Notification of reopening to other hospitals/healthcare facilities, LAC EMS Agency, patient families, media
- Procedures for repatriation of patients including:
 - Approval from Licensing & Certification
 - Patient transportation coordination with sending hospital/healthcare facility
 - Medical records management
 - Transportation coordination
 - Attending assignments
 - Room assignments
 - Patient re-registration

For additional resources, see

- Incident Management Team Recovery Responsibilities - Appendix, page 63
- Hierarchy of Repopulation Approval(s) - Appendix, page 64
- General All-Hazards Hospital Re-Population Factors / Steps - Appendix, page 65

Appendix: Decision Tree

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



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Appendix: Decision Matrix

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

Incident requiring facility to consider whether an evacuation plan <u>or</u> shelter in place plan should be activated.	
SCENARIO #1 The external environment* would pose a greater danger to patients, personnel, and visitors than evacuation. * External may mean inside - but outside of the affected area; or external - outside the facility	YES <ul style="list-style-type: none"> • Activate Shelter in Place Plans • Initiate/maintain contact with LAC EMS, or L&C, local fire, local police • Initiate conservation measures as necessary
Assess situation: Threat has passed.	YES <ul style="list-style-type: none"> • End SIP • Notify All Clear to ALL internal depts & outside agencies • Assess status for recovery operations (patient care, supplies, counseling, staffing, etc.)
	NO Threat remains but has moved to another part of the facility. Assess need to maintain SIP or for evacuation to another part of the facility or outside.
SCENARIO #2 The proximity, scope and/or expected duration of the incident pose an immediate threat to patient/resident and personnel safety.	YES <ul style="list-style-type: none"> • Order immediate partial evacuation • Inform personnel to move horizontally, vertically up or down • Internal Relocation: Inform receiving departments • OR Order complete evacuation to pre-identified assembly points
	NO – not immediate threat, but threat exists, follow steps for Scenario #3
SCENARIO #3 Potential / evolving threat to patient and personnel safety	YES Decision to make: Partial or Total Evacuation?
Assess situation: Is the entire facility unsafe for patients/residents or personnel?	YES <ul style="list-style-type: none"> • Activate Complete Evacuation Plan • Determine evacuation sequence of departments
	NO Activate Partial Evacuation or Relocation Plan <ul style="list-style-type: none"> • Inform personnel to move horizontally, vertically up or down • Internal Relocation: Inform receiving departments

Appendix: Initial Critical Action Sheet for an Emergent Evacuation

Below are the initial critical action steps that can be taken by the house supervisor or initial Incident Commander.

Upon initial notification that an incident has occurred:

- ❑ Assess information from affected department
- ❑ If persons are in immediate danger, instruct personnel to move them out of harm's way
- ❑ Notify the Administrator on Duty and summarize incident including potential impacts

If the decision is made by the AOD to evacuate:

- ❑ Activate the Evacuation Plan
- ❑ Contact the operator to overhead page "Code xx"
- ❑ Notify and activate the ICS Incident Management Team
- ❑ Activate the Command Center (primary or alternate, depending on incident)
- ❑ Develop and implement an Incident Action Plan (goals, objectives, and strategies for an operational period)
- ❑ Determine type of evacuation needed: vertical, horizontal, complete
 - Will patients and personnel stay in the building, or will they need to evacuate to the outside?
- ❑ Order the organized and timely evacuation of the facility
 - Prioritize departments to be evacuated, based on:
 - Danger / risk level - high danger, evacuate first
 - Ease of movement - more ambulatory, evacuate first
 - Instruct departments to gather as much medical information, medications, medical supplies and equipment as possible
 - Instruct departments to follow the designated evacuation route
 - Instruct department to evacuate to their designated assembly point and conduct roll call of personnel, patients, and visitors
- ❑ Notify fire, EMS, L&C, and law enforcement, local emergency management agency
 - Establish Unified Command with first responder agency, if applicable
- ❑ Establish the external Command Center, if doing a complete evacuation
- ❑ Have Operations / Infrastructure Branch assess the status of the facility
 - Try to maintain life support operations (power, water, communications) until all are evacuated
 - Determine if any of the assembly point areas are unsafe
- ❑ Have Operations / Medical Care Branch assess if patient care is being compromised and if transfer will be required
- ❑ Have Logistics establish a Labor Pool
- ❑ Have Logistics deploy the evacuation disaster supplies cache
 - Deploy radios to assembly points
- ❑ Have Operations / Security Branch secure the facility and restrict visitors and entry of non-essential personnel

Appendix: Initial Critical Action Sheet for Emergent Shelter in Place

Below are the initial critical action steps that can be taken by the house supervisor or initial Incident Commander.

Upon initial notification that an incident has occurred:

- ❑ Assess information from affected department
- ❑ If persons are in immediate danger, instruct personnel to move them out of harm's way
- ❑ For an active threat, contact law enforcement immediately
 - Upon arrival, establish Unified Command with first responder agency
- ❑ Notify the Administrator on Duty and summarize incident including potential impacts

If the decision is made by the AOD to shelter in place:

- ❑ Activate the Shelter in Place Plan
- ❑ Contact the operator to overhead page "Code xx" or page instructions (sample message: "May I have your attention, please. Authorities have advised us of an emergency nearby. For your safety, everyone is requested to stay inside and shelter in place until we are notified that the emergency is over.")
- ❑ Notify and activate the ICS Incident Management Team
- ❑ Activate the Command Center (primary or alternate, depending on incident)
- ❑ Develop and implement an Incident Action Plan (goals, objectives, and strategies for an operational period)
- ❑ Order the organized and timely shelter in place of the affected area
 - HazMat or severe weather instructions for the affected area
 - Shelter in a location with few windows and doors, and with access to restrooms and drinking water
 - Close and lock windows. Secure doors; lock if possible
 - Seal cracks around doors and windows (and any vents that do not close) with damp towels, duct tape, plastic sheeting, etc.
 - Active threat (e.g., shooter) instructions for the affected area
 - Hide out of the active shooter/threat's view
 - Lock the door and blockade with heavy furniture
 - Silence cell phones and pagers
 - Turn off any source of noise (e.g., biomedical equipment, radios, TVs)
 - Hide behind large items
 - Remain quiet
 - If have access to a phone, call security. If you cannot speak, leave the line open allow security to listen
- ❑ Notify fire, EMS, and L&C
- ❑ HazMat: Have Operations / Infrastructure Branch assess the status of the facility
 - Shut off heating, air conditioning or other ventilation system so outside air is not drawn indoors, or prevent circulation throughout the facility if the source is internal
- ❑ Have Operations / Security Branch secure the facility and restrict visitors and entry of non-essential personnel

Appendix: Defend in Place for Active Threat/Shooter

Characteristics of an Active Threat/Shooter Situation

- An active threat/shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area
- Typically use firearms, but may also use knives, or other weapons
- Most commonly, victims are selected at random, however a disgruntled patient/family member or staff member may target their victim
- Unpredictable and evolve quickly
- Law enforcement is usually required to end an active shooter situation
- Because active threat/shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active threat/shooter situation

How to Respond When an Active Threat/Shooter is in Your Vicinity

Quickly determine the most reasonable way to protect your own life. Remember that patients are likely to follow the lead of employees and managers during an active threat/shooter situation.

Option 1. Evacuate

If there is an accessible escape path, attempt to evacuate the premises. Be sure to:

- Remain calm
- Have an escape route and plan in mind
- Evacuate regardless of whether others agree to follow
- Leave your belongings behind
- Help others escape, if possible
- Prevent individuals from entering an area where the active threat may be
- Keep your hands visible
- Follow the instructions of any police officers
- Do not attempt to move wounded people
- Call 911 when you are safe

Option 2. Hide out or Defend in Place

If evacuation is not possible, find a place to hide where the active threat is less likely to find you. Your hiding place should:

- Be out of the active threat's view
- Provide protection if shots are fired in your direction (i.e., a room or office with a closed and locked door)
- Not trap you or restrict your options for movement
- To prevent an active threat from entering your hiding place:
 - Lock the door
 - Blockade the door with heavy furniture
 - Call 911 when safe to do so

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- If the active threat is nearby:
 - Lock the door
 - Silence your cell phone and/or pager
 - Turn off any source of noise (i.e., biomedical equipment, radios, televisions)
 - Hide behind large items (i.e., cabinets, desks)
 - Remain quiet

Option 3. If evacuation and hiding out are not possible

- Remain calm
- Dial 911, if possible, to alert police to the active threat's location
- If you cannot speak, leave the line open and allow the dispatcher to listen

Option 4. Take action against the active shooter

As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

- Act as aggressively as possible against him/her
- Throw items and improvising weapons
- Yell
- Commit to your actions

How to Respond When Law Enforcement Arrives

Law enforcement's purpose is to stop the active shooter as soon as possible.

What to Expect from Officers' Actions

- Officers will proceed directly to the area in which the last shots were heard or threat is identified to be
- Officers usually arrive in teams of four (4)
- Officers may wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment
- Officers may be armed with rifles, shotguns, and/or handguns
- Officers may use pepper spray or tear gas to control the situation
- Officers may shout commands, and may push individuals to the ground for their safety

How to React When Law Enforcement Arrives

- Remain calm, and follow officers' instructions
- Put down any items in your hands (i.e., bags, jackets)
- Immediately raise hands and spread fingers
- Keep hands visible at all times
- Avoid making quick movements toward officers such as holding on to them for safety
- Avoid pointing, screaming and/or yelling
- Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which officers are entering the premises
- The first officers to arrive to the scene will not stop to help injured persons

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- Expect rescue teams comprised of additional officers and emergency medical personnel to follow the initial officers. These rescue teams will treat and remove any injured persons. They may also call upon able-bodied individuals to assist in removing the wounded from the premises. Once you have reached a safe location or an assembly point, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave until law enforcement authorities have instructed you to do so.

Information to Provide to Law Enforcement or 911 Operator

- Location of the active shooter/threat
- Number of shooters, if more than one
- Physical description of person making the threat
- Number and type of weapons held by the person making the threat
- Number of potential victims at the location

Managing the Consequences of an Active Threat/Shooter Situation

After the active shooter has been incapacitated and is no longer a threat, facility Incident Command should engage in post-incident assessments and activities, including:

- Account for all individuals at a designated assembly point to determine who, if anyone, is missing and potentially injured
- Determine a method for notifying families of individuals affected by the active threat/shooter, including notification of any casualties
- Assess the psychological state of individuals at the scene, and refer them to health care specialists accordingly
- Identify and fill any critical personnel or operational gaps left in the organization as a result of the active threat/shooter

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Appendix: Command Personnel Checklist for Shelter, Relocation, & Evacuation

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

The Incident Commander can use this checklist to assign tasks to Command and General Personnel.

Task	Assigned	Complete
Initial assessment		
Review threat intensity and likely duration		
Review any department-based relocations that are occurring and anticipate needs in those areas		
Determine, based on the department-based impacts, the need for sheltering vs. relocation of displaced patients vs. partial or full evacuation to other institutions (<i>see relevant sections below</i>)		
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 there is a plume threat or shut down internal ventilation		
Implement necessary access controls and monitoring in response to threats (Security Branch Director)		
Communicate protective actions (door and drape closings, etc) to affected departments as well as any incident details		
Relocation - Movement within the Facility		
Determine affected departments and actions taken		
Determine facility capacity for relocated patients – if insufficient see evacuation, below		
Assure resources (personnel and supplies) transferred to departments absorbing relocated patients		
Assure all patients accounted for and information transferred to receiving departments		
Determine timeframe to recover affected departments 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 / facility		

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Task	Assigned	Complete
Determine whether usual assembly points 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 and facilities to accept patients/residents and report back to IC		
Contact LA County EMS Agency for coordination assistance; use ReddiNet, call the Medical Alert Center (MAC): 866-940-4401, or use the HEAR radio		
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 personnel and resources to affected areas to facilitate patient / personnel 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)		
Determine if any personnel need to accompany patients/residents to receiving facilities		
In case of complete evacuation – appoint Stay Team Unit Leader		

Appendix: Incident Assessment Worksheet

Use this worksheet to assess the impact that the incident will have on the facility. Sources of this information may come from the affected departments, Liaison Officer, other community response partners / ReddiNet, facilities/ or engineering department, news media, etc.

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

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Is the HVAC system in jeopardy (steam, water for boilers, etc.)? Already non-functional?	
Is there a backup (intact nearby building that still has power/HVAC)?	
If not, will the building be too cold/hot for patient safety before adequate temperature stabilizes?	
Electricity	
<i>Note: Loss of electricity endangers ventilated patients, among others, and may affect the sequence in which patients are evacuated.</i>	
Is power at risk? Just for the facility or a wider area?	
Are backup generators functional?	
How long can they run without refueling?	
Is refueling possible given the situation?	
Can some sections/wings be shut down to reduce fuel consumption and stretch fuel supplies?	
Facility Structural Integrity	
<i>Notes: Structural damage may cause rooftop water tanks to fail, flooding the building. Safety/integrity may not be obvious to untrained occupants.</i>	
Is the building obviously/visibly unsafe? All of it or only portions (e.g., can people be consolidated in safer sections)?	
Is there a water tank on the roof, and is it intact?	
Is a structural engineer needed to make an assessment?	
ANTICIPATED EFFECT OF THE INCIDENT ON THE COMMUNITY	
Road Conditions	
<i>Notes: There may be a limited window of opportunity to carry out a ground-based evacuation. Increased use of helicopters to evacuate patients may be required. Personnel may not be able to get to the facility to relieve existing personnel or assist in the evacuation.</i>	
Are any major routes from the hospital to potential receiving care sites closed or threatened?	
Will evacuation traffic clog major routes from the hospital to potential receiving care sites?	
Are access routes to the hospital cut off or threatened?	
Community/Building Security	
<i>Note: If patient and personnel safety cannot be assured, the decision needs to be made whether sheltering in place is safer or if evacuation will be necessary.</i>	

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

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Appendix: Triage Officer Checklist - Evacuation

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

Mission: To ensure that patients/residents are properly triaged to determine their most appropriate disposition for the most optimal care, and prepare for transfer if applicable.

Task	Assigned	Complete
Initial tasks		
Ensure basic medications, any needed IV fluids or patient care supplies are available or requested via the Staging Manager		
Assist in identifying and clearing space for Green/Yellow/Red patients/residents		
Assess patients arriving to the Staging Area for: <ul style="list-style-type: none"> • Discharge home – (depending on situation may be held for discharge or transferred to another safer location nearby for discharge) • Transfer to other facility: <ul style="list-style-type: none"> ○ 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 personnel to provide necessary patient care 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		
Demobilization		
Ensure equipment and supplies are retrieved/returned		

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Appendix: Evacuation Staging Manager Checklist

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

Mission: To ensure that patients/residents are properly organized in the Staging Area in order to perform an efficient and safe evacuation to another care site.

Task	Assigned	Complete
Immediate (Operational Period 0-2 Hours)		
Determine need for and appropriately appoint Evacuation Staging Team Leaders, distribute any corresponding Job Action Sheets and position identification.		
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 personnel to evacuation staging areas in coordination with Labor Pool & Credentialing Unit and Transportation Unit Leader		
Instruct all Evacuation Staging Team Leaders to evaluate situation, including patients, equipment, supplies, and medication inventories and personnel needs in collaboration with Logistics Section Supply Unit Leader; report status to Operations Section Chief and Supply Unit.		
Continue coordinating transport of patients and their equipment from staging to the transport area, working with the Transport Manager as needed.		
Extended (Operational Period Beyond 12 Hours)		
Continue to monitor the Evacuation Staging Team’s ability to meet workload demands, personnel health and safety, resource needs, and documentation practices.		
Coordinate assignment and orientation of personnel sent to assist patient/resident		
Rotate personnel on a regular basis.		
Demobilization/System Recovery		
As needs for Evacuation Staging Area decrease, return personnel to their normal jobs or release and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader.		

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Appendix: Evacuation Staging Team Member Checklist

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

Mission: To ensure that patients/residents are properly organized in the Staging Area in order to perform an efficient and safe evacuation to another care site.

Task	Assigned To	Completed
Initial tasks		
Receive patients/residents into Staging Area and		
Confirm transfer information is complete and accurate for each patient/resident (including: evacuation tag, Patient Medical Information Form, and Patient Evacuation Tracking Form HICS 260)		
Assure patient/resident comfort and medical needs are met (personnel, medication, water, blankets)		
Communicate any patient care needs to Staging Team Leader		
Communicate any resource needs to Staging Team Leader		
Subsequent tasks		
Group patients/residents 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: Clinical / Patient Department Shelter in Place and Evacuation Plan Template

Each department should assess and create their own plan.

Relocation: Horizontal (first option) to:	
Vertical (second option) to:	
Vertical evacuation route/path:	
Evacuation assembly point:	
Department shelter in place supplies/equipment location:	
Department evacuation supplies/equipment location:	
Estimated number of patients/residents at peak:	
Estimated number of personnel at peak:	
Estimated number of visitors at peak:	

Shelter in Place: A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP. When SIP is done in an active shooter or active threat situation, it is called **Defend in Place**. Procedures:

- Remain calm.
- *Weather* – wind, hail, or other weather threat
 - Move patients/residents and personnel away from windows as possible.
 - Close drapes/blinds and exterior doors/windows.
- *Security emergency – bomb threat, individual posing security threat, external civil unrest*
 - Refer to Active Shooter/Bomb Threat policy.
 - Implement department-specific access controls.
 - Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed.
- *Hazardous materials (HAZMAT) incident*
 - If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
- Ensure personnel and visitors also advised of situation.
- Update incident command on your operational status and impact on patients/residents, personnel, and visitors.
- Personnel will remain with patients/residents.

Evacuation: The movement of patients, personnel and visitors from a dangerous location to one of relative safety. Movement may be within the facility, such a relocation to adapt to a specific problem such as a water pipe burst, electrical outage, etc. It may result in movement from the facility to another institution. Complete facility evacuation is undertaken as a last resort. Each department has an Assembly Point, a pre-identified area outside of the building where departments will assemble upon evacuation from the facility.

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Anyone recognizing an imminent danger to patients or others shall take immediate steps to safeguard those in danger including patient movement.

Charge Nurse/Administrator Responsibilities upon notice of evacuation decision:

- Remain calm.
- Receive instruction from the Command Center.
- Notify department personnel and reassign personnel as needed.
- Compile a list of patients and all facility personnel currently working in your area.
- Patient/residents, personnel, and visitors in imminent danger should be moved first, ambulatory patients and visitors second and non-ambulatory patients third.
- Confirm assembly point destination is available
- Triage patients for movement / transport using evacuation tags (with equipment)
 - Tag color reflects priority: green patients are ambulatory (move first), yellow non-ambulatory, red unstable/critical care (move last)
 - Tag all patients and attach tear-off band from tag to belongings
 - Determine ambulatory status of patients and assign personnel 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 personnel member(s).
 - 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.
- Assign a person to check all rooms to assure:
 - No occupants remain and no safety issues
 - Evacuated rooms are marked with (*pre-determined room clear indicator*)
- If time and resources allow, assign person(s) to transport your area's medications.
- 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 assembly point, complete patient and personnel head count. Personnel 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:
 - 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.
 - Patients with IVs, arterial lines and Swan-Ganz:
 - Disconnect transducer from patient cable-take pressure bag with patient.
 - Saline lock all non-critical IV lines
 - Disconnect chest tubes from wall suction and leave to water seal. DO NOT CLAMP.

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- Invasive monitoring lines (arterial lines, CVP lines, ICP monitors, etc.) should be clamped securely and/or disconnected and removed if possible.
- Nasogastric or gastrostomy tubes should be disconnected from suction, or collection system and kept open to drain by gravity.
- Evacuate tracheostomy patients with an obturator and a spare tracheal tube, as well as a bulb syringe for suction.
- Clamp peritoneal dialysis tubing, disconnect from solution, and cap the tubing end. (Do not evacuate bottles, bags, or octopus attachments).
- Remove cardiac monitors, leaving leads in place.
- Disconnect oxygen prior to evacuation.
- If time and resources allow, bring patient needed equipment: O2 tanks, bag-valve-mask, defibrillator or monitors, transport monitor, etc
- Procedures in progress:
 - 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.

Shelter In Place Supplies and Equipment Stored in this Department	
Resource	Purpose

Evacuation Supplies and Equipment Stored in this Department	
Resource	Purpose

Appendix: Support and Administrative Department Shelter in Place and Evacuation Plan Template

Each department should assess and create their own plan.

Relocation: Horizontal (first option) to:	
Vertical (second option) to:	
Vertical evacuation route/path:	
Evacuation assembly point:	
Department shelter in place supplies/equipment location:	
Department evacuation supplies/equipment location:	
Estimated number of patients/residents at peak:	
Estimated number of personnel at peak:	
Estimated number of visitors at peak:	

Shelter in Place: A procedure used to take immediate shelter in a current location or refuge area. Abbreviated as SIP. When SIP is done in an active shooter or active threat situation, it is called **Defend in Place**. Procedures:

- Remain calm.
- *Weather* – wind, hail, or other weather threat
 - Move patients/residents and personnel away from windows as possible.
 - Close drapes/blinds and exterior doors/windows.
- *Security emergency – bomb threat, individual posing security threat, external civil unrest*
 - Refer to Active Shooter/Bomb Threat policy.
 - Implement department-specific access controls.
 - Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed.
- *Hazardous materials (HAZMAT) incident*
 - If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
- Ensure personnel and visitors also advised of situation.
- Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
- Personnel will not leave patients/residents unattended at any time for any reason.

Evacuation: The movement of patients, personnel and visitors from a dangerous location to one of relative safety. Movement may be within the facility, such a relocation to adapt to a specific problem such as a water pipe burst, electrical outage, etc. It may result in movement from the facility to another institution. Complete facility evacuation is undertaken as a last resort. Each department has an Assembly Point, a pre-identified area outside of the building where departments will assemble upon evacuation from the facility.

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Anyone recognizing an imminent danger to patients or others shall take immediate steps to safeguard those in danger including patient movement.

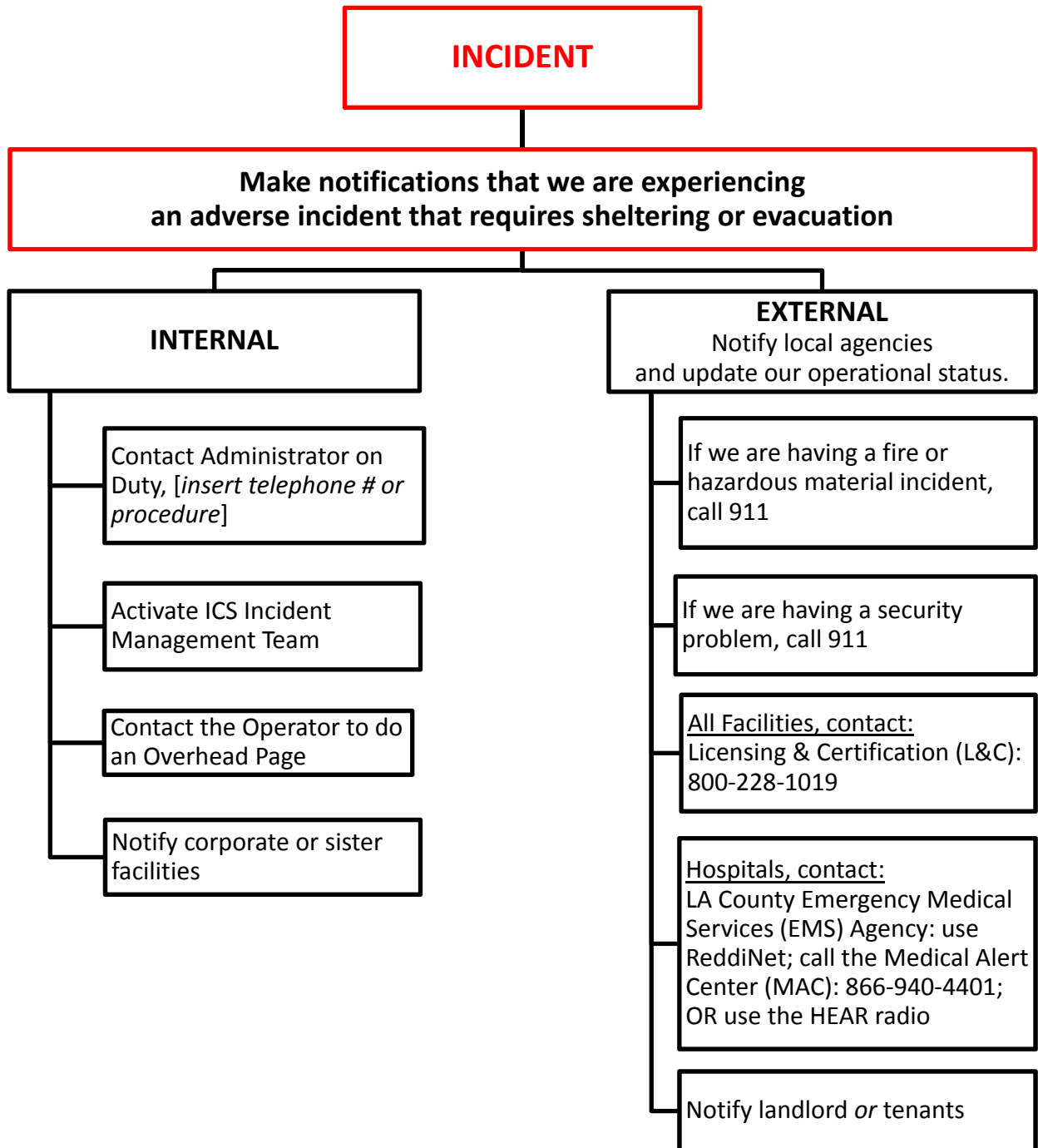
Supervisor Responsibilities upon notice of evacuation decision:

- Remain calm.
- Receive instruction from the Command Center.
- Notify department personnel and reassign personnel as needed.
- Compile a list of all facility personnel currently working in your area.
- Patient/residents, personnel, and visitors in imminent danger should be moved first, ambulatory persons second and non-ambulatory persons third.
- Confirm assembly point destination is available.
- Prior to leaving work area secure any hazardous chemicals, safes, and other potential hazards.
- Take any 'go-kits' or continuity supplies for your unit.
- Assign a person to check all rooms to assure:
 - No occupants remain and no safety issues
 - Evacuated rooms are marked with (*pre-determined room clear indicator*)
- Upon arriving at assembly point, complete head count. Personnel shall remain at safe location until reassigned or dismissed.

Shelter In Place Supplies and Equipment Stored in this Department	
Resource	Purpose

Evacuation Supplies and Equipment Stored in this Department	
Resource	Purpose

Appendix: Initial Notification Chart



Appendix: Estimate of How Many Will Need to Be Evacuated or Need Sheltering Resources

Use this table to estimate the number of people that will need to be evacuated or relocated, or will require resources if they are sheltering in place.

(Planning note: Add rows as needed to reflect the number of departments or areas in your facility. This may also be transcribed into an Excel file to assist in calculating totals.)

Personnel, Patient/Resident and Visitor Census at Its Highest					
Day of the Week:			Time of Day:		
Department or Area	Location (Floor, etc.)	# of All Personnel*	# of Ambulatory Pts/Residents	# of Non-ambulatory Pts/Residents	# of Visitors

* Includes clinical and non-clinical personnel. This may further be broken down by ambulatory and non-ambulatory.

Appendix: Evacuation Triage and Transportation Tag

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

- Clinical personnel are responsible for patient assessment/triage which will dictate priority and mode of transportation based on acuity and care needs.
- The assessment/triage process and transportation tag will be completed prior to movement of patients from the facility.
- The tags should be updated and reviewed during triage and transportation to the assembly points and/or other healthcare facilities.

Patient Tracking Manager will be responsible for:

- Maintaining a supply of and coordinating the distribution the evacuation tags at each patient care department.
 - If tags are not available or you run out, use any piece of paper and write the triage color: RED, YELLOW or GREEN.
- Tracking patients who are evacuated from the facility.

EVACUATION TRIAGE LEVEL	PRIORITY FOR EVACUATION FROM PATIENT CARE UNIT (Reversed START Triage)	PRIORITY FOR TRANSFER FROM THE TRANSPORT STAGING AREA TO ANOTHER HEALTHCARE FACILITY (Traditional START Triage)
RED	<ul style="list-style-type: none"> • These patients are evacuated LAST from the unit because they require maximum assistance to move. • These patients may require 2-3 personnel members to transport 	<ul style="list-style-type: none"> • These patients are transported FIRST as transfers from your staging area to an alternate healthcare site. • These patients require maximum support to sustain life in an evacuation.
YELLOW	<ul style="list-style-type: none"> • These patients require some assistance and should be evacuated SECOND in priority. • Patients may require wheelchairs or stretchers and 1-2 personnel members to transport. 	<ul style="list-style-type: none"> • These patients will be transported SECOND in priority as transfers from your staging area to an alternate healthcare site.
GREEN	<ul style="list-style-type: none"> • These patients require minimal assistance and can be evacuated FIRST from the unit. • Patients are ambulatory and 1 personnel member can safely lead several patients who fall into this category to the assembly point. 	<ul style="list-style-type: none"> • These patients will be transported LAST as transfers from your staging area to an alternate healthcare site or released to home.

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Appendix: Safe Refuge Areas and Horizontal Evacuation Area Chart

(Planning notes: Complete this chart during the planning process. Evacuation areas may be identified by a location name or number.)



Department	Floor	Primary Horizontal Evacuation Area	Secondary Horizontal Evacuation Area

Appendix: Carry Evacuation Techniques

Below are emergency carry techniques for evacuation of non-ambulatory patients/residents, personnel or visitors. These techniques would be used as a last resort.

PACK STRAP CARRY – One Rescuer	
<ul style="list-style-type: none"> • This method should be used when the patient can stand, but not walk, and limited personnel are available. • Have the patient stand at the side of the bed directly behind you. • Have them place their arms over your shoulders and cross them in front. • Grasp the opposite arm, bend your knees, lean forward and lift. • This method can be used for short distances, or if the patient is very light. 	
ONE-PERSON ARM CARRY – One Rescuer	
<ul style="list-style-type: none"> • Hold the patient around the patient’s back and under the knees. • This method can be used for short distances, or if the patient is very light. 	
BLANKET DRAG – One Rescuer	
<ul style="list-style-type: none"> • Lower the bed as much as possible, and put blanket along the side of the bed, make sure some of the blanket is under the bed. Leaving two to three feet extra at the top. • Kneel on your left knee, and put your left arm under the their shoulders. Place your right arm under their knees, and pull their legs and hips off the bed, allowing the head and torso to follow. • Use your left arm to support, not hold, the head and shoulders as you lower them to your left knee. Then gently lower the head and shoulders to the blanket. • Grasp the end of the blanket above the patient's head, roll it up a few inches, and drag the patient to safety. 	
REAR APPROACH ASSIST – One Rescuer	
<ul style="list-style-type: none"> • Used for an ambulatory patient who may be confused. • Approach from the rear, put both arms between the patient's arms and body, and grasp their wrists. • Gently guide them to safety, tuck your head into their shoulder to protect you should they move their head to one side. 	
SIDE BY SIDE ASSIST – One Rescuer	
<ul style="list-style-type: none"> • This carry is for patients who can stand and walk with support. • Put the patient's left (right) arm over your shoulder, and grasp it with your left (right) arm. • Place your right arm around their waist, and support them as you walk to safety. 	

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TWO PERSON SLING CARRY – Two Rescuers	
<ul style="list-style-type: none"> • Use when the patient can sit up in bed, but not walk unaided. • Each rescuer positions themselves on either side of the patient. • Have the patient put his/her arms over each rescuers shoulders, and hold on. • The rescuers should then grasp each other’s arms under the patient's knees and back, lifting like a sling. • Two people can carry non-ambulatory patients for long distances using this method. • Lean the patient against a wall when you want to unload the patient. • Bend the knee closest to the wall to control descent, letting patient’s feet touch the floor, and gently lowering their body. • (Not recommended for patients with back or cervical problems.) 	
EXTREMITY CARRY – Two Rescuers	
<ul style="list-style-type: none"> • Can be used as long as the patient can sit up in bed. • The first rescuer sits behind the patient, has them fold their hands in front of their body, and grasps the patient's forearms with their own. • The second rescuer sits between the patients legs, and cradles each leg with their arms. • Stand in unison using good body mechanics. • (Not recommended for patients with back or cervical problems.) 	
CHAIR CARRY – Two Rescuers	
<ul style="list-style-type: none"> • Place the patient in a sturdy, non-swivel chair. • Tilt the chair backwards as rescuers lift the patient. • If possible, secure the victim to the chair. • If the rescuers need to carry the patient over uneven surfaces or stairs, the rescuers must face each other. 	
BLANKET CARRY – Four to Six Rescuers	
<ul style="list-style-type: none"> • Do not use sheets for this procedure, they will not provide sufficient support. • Can be used if the patient is very heavy. • Can be used to carry IVs, oxygen tubing, etc. • Three rescuers are needed to roll the patient to their side, lift in unison, and place them on a blanket, along with IVs, etc. • The rescuers crouch on each side, roll up the blanket until their hands touch the patient, and then lift in unison. 	

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Appendix: Transportation Resource Needs Matrix

Use this tool to determine transportation needs when requesting assistance through your usual transportation providers or the LA County EMS Agency (contact via ReddiNet, MAC 866-940-4401, or HEAR).

Emergency Department Census and Transportation Needs		
	<i>Use your total ED census (including waiting room)</i>	
	# of Pt	Calculation:
Discharge within 3 hours		Multiply your total ED census by 40%
Total ED Patients needing transport		Multiply your total ED census by 60%
Type of Transportation Resource		
	# of Pt	Calculation:
Critical Care Transport		Multiply Total ED Patients Needing Transport by 4%
ALS Transport		Multiply Total ED Patients Needing Transport by 16%
BLS Transport		Multiply Total ED Patients Needing Transport by 26%
Van/Bus Transport		Multiply Total ED Patients Needing Transport by 54%

Inpatient Census and Transportation Needs		
	# of Pt	Calculation:
Discharge within 3 hours		Multiply your total inpatient census by 20%
Inpatients Needing Transport		Multiply your total ED census by 80%
Type of Transportation Resource		
	# of Pt	Calculation:
NICU Transport		Multiply Total Inpatients Needing Transport by 6%
Critical Care Transport		Multiply Total Inpatients Needing Transport by 6%
ALS Transport		Multiply Total Inpatients Needing Transport by 7%
BLS Transport		Multiply Total Inpatients Needing Transport by 50%
Van/Bus Transport		Multiply Total Inpatients Needing Transport by 31%

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Appendix: Evacuation Patient Medical Information Form

Completed by the nurse providing care. The following information is the minimum provided when transporting a patient/resident to another care site. A copy of the medical record and advanced directives should be included, if possible. A copy of this form should be maintained by the Patient Tracking Manager.

SENDING FACILITY		DATE		
PATIENT NAME		DATE OF BIRTH		SEX
MEDICAL RECORD NUMBER		ADMISSION DATE	CONSENT OBTAINED FOR TRANSFER (circle) Yes No Unable to Obtain	
EMERGENCY CONTACT		TELEPHONE NUMBER		NOTIFIED OF TRANSFER (circle) Yes No
PATIENT ACUITY		ATTENDING PHYSICIAN		NOTIFIED OF TRANSFER (circle) Yes No
ORIGINAL CHART SENT WITH PATIENT (circle) Yes No		ADVANCED DIRECTIVE (circle) Yes No		COPY SENT WITH PATIENT (circle) Yes No
PRIMARY DIAGNOSIS		SECONDARY DIAGNOSES		ALLERGIES
PRIMARY LANGUAGE: ENGLISH (circle) Yes No		IF NO, PRIMARY LANGUAGE:		IF NO, DOES PATIENT UNDERSTAND ENGLISH: Yes No
VITALS AT TIME OF TRANSFER	TEMPERTURE	PULSE	RESPIRATIONS	BLOOD PRESSURE
ISOLATION STATUS (circle) None Contact Droplet Airborne Other		PRECAUTIONS (circle) Aspiration Seizure Fall Elopement Other:		
OXYGEN (circle) Mask Cannula Other: _____ Oxygen Requirement:		DIET (circle) NPO Tube Feeding: Yes No Enteral Parenteral Formula: _____ Type: Regular Low Salt Diabetic Bland Consistency: Regular Ground Puréed Thickened Liquids Other:		
INTRAVASCULAR DEVICE (circle) Central Line PICC Line Arterial Line Saline Lock Medication Drip Other:		MENTAL STATUS (circle) Oriented Alert Lethargic Mildly Confused Severely Confused BEHAVIOR (circle) Cooperative Disruptive Belligerent Combative Wanders Withdrawn		
FOLEY (circle) Yes No				
INCONTINENT (circle) Yes No If yes, (circle) Bowel Bladder		MEDICATION(S) SENT WITH PATIENT (circle) Yes No <i>If yes, describe below:</i>		
ASSISTIVE DEVICES (circle all that apply) None Cane Walker Wheelchair Glasses Dentures: Upper Lower Hearing Aid Prosthesis, Type:		MEDICATION(S) MOSTLY RECENT ADMINISTERED		
EQUIPMENT OWNED BY SENDING FACILITY ACCOMPANYING PATIENT DURING TRANSPORT		COMMENTS		
RECEIVING CARE SITE		METHOD OF TRANSPORT		TRANSPORTING AGENCY
DATE TRANSFERRED	TIME TRANSPORT INITIATED		TIME OF ARRIVAL AT RECEIVING FACILITY	
NAME OF PERSON COMPLETING THIS FORM		CREDENTIAL AND TITLE		

Note: Additional information can be written on back if needed and/or time permits.

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Appendix: Patient Evacuation Tracking Form

Completed by the nurse providing care. The Patient Tracking Manager should maintain a HICS 255, Transfer Summary Form, or this form to track all patients that are transferred to an alternate care site or discharged.

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

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Appendix: HICS 255 - Master Patient Evacuation Tracking Form

HICS 255 - MASTER PATIENT EVACUATION TRACKING FORM						
1. INCIDENT NAME		2. DATE/TIME PREPARED			3. PATIENT TRACKING MANAGER	
4. PATIENT EVACUATION INFORMATION						
Patient Name	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Immed Delayed Minor Expired		Accepting Hospital	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)
Patient Name	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Immed Delayed Minor Expired		Accepting Hospital	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)
Patient Name	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Immed Delayed Minor Expired		Accepting Hospital	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)
Patient Name	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Immed Delayed Minor Expired		Accepting Hospital	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)
Patient Name	Medical Record#	Disposition Home or Transfer	Evacuation Triage Category Immed Delayed Minor Expired		Accepting Hospital	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						

Purpose: Record information concerning patient disposition during a hospital/facility evacuation **Origination:** Patient Tracking Manager

Copies to: Planning Section Chief and Documentation Unit Leader

HICS 255

Appendix: Patient Care Department Supplies

Patient Care Department Evacuation Supplies

The following items are stored in each patient care department: (*below is a sample; update to reflect your supplies*)

Resource	Storage Location	Purpose
Evacuation triage tags		
Permanent medium markers		
Labels and ball point pens		
'Room Clear' labels (pink fluorescent, 2x4 inches)		To identify areas that have been checked and evacuated
Flashlights / headlamps (4)		
Blankets / carrying canvas		
Large envelopes		For records / transfer documentation to accompany patient
Rubber Bands		For medical records information
Clipboard		
Patient Evacuation Tracking Form (HICS 260)		
Master Patient Evacuation Tracking Tools (HICS 263)		
Unit personnel/visitor tracking form		
Extra footies		For ambulatory patients without shoes
Fluorescent vest		For department / evacuation lead
List of department supplies to be 'grabbed' if time allows		

Patient Care Department Shelter in Place Supplies

The following items are stored in each patient care department: (*below is a sample; update to reflect your supplies*)

Resource	Storage Location	Purpose
Bottled water		
Food		
Radio		

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Appendix: Pharmacy Evacuation Cache

(Below is a sample; update to reflect your supplies)

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

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Appendix: Assembly Point Supplies

(Below is a sample; update to reflect your supplies)

Item	Storage Location	Destination	Deployment Method (e.g., automatic upon evac, upon instruction from the IC, etc.)
Administrative Items			
Permanent markers			
Rubber bands for medical records			
Sheet protectors for transfer documentation to accompany patient			
HICS Forms			
Evacuation tags			
Additional 'room clear' labels (100)			
Chart pads			
Food Items			
Bottled water			
Energy bars			
Medical Items			
IV Solutions			
D5 0.45NS – x bags			
NS – x bags			
Crash / Code Cart			
Wheel Chairs (WC)			
Walkers			
Crutches			
Gloves, exam M, L			
Crash cart			
Portable oxygen cylinders (D type)			
First aid kits			
Personal Items			
Sani-wipes			
Hand sanitizer			
Diapers, adult			
Sheets			

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Item	Storage Location	Destination	Deployment Method (e.g., automatic upon evac, upon instruction from the IC, etc.)
Blankets			
Emesis bags			
Non-skid socks for ambulatory patients without shoes			
Facial tissues			
Janitorial Items			
Paper towels			
Flashlight			
Garbage bags, plastic			
Zip close plastic bags, gallon			
“Infrastructure”			
Tents			
Chairs			
Generators			

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Appendix: Facility Shut Down and “Stay Team” Member Checklist

Task	Assigned To	Complete
Change facility status to closed	Liaison Officer	
Identify the lockdown plan and how to harden exterior & critical infrastructure	Operations/Security Branch Director	
Define procedures for coordinating local public safety to determine inner and outer perimeters	Operations/Security Branch Director	
Heliport (notify closure of heliport)	Liaison Officer	
Procedure to account for safe evacuation of assigned “stay team” personnel	Logistics Section	
Define <u>departmental</u> procedures for securing and shutting down equipment and identifying personnel assigned to perform shutdown functions: (critical operations responsibilities)		
Bio-medical equipment		
Central / sterile supply		
Dietary & foodservices		
Hazardous waste (satellite and waste sites)	Safety Officer	
Hazardous materials storage locations	Safety Officer	
Imaging (CT, MRI, radiology, ultrasound, nuclear medicine – including securing isotopes)		
Information Technology (IT, telecomm, radio)		
Finance		
Lab		
Morgue		
Pharmacy (defined procedures for security and/or management of controlled substances)		
Records		
Utilities (see next chart for procedures)		

Utility Shutdown Procedures

Utility	Location of Shut Off	Responsible Party Performing Shut Off	Procedure
Electricity			
HVAC			
Medical Gas - Oxygen			
Medical Gas – Nitrous Oxide			
Medical Vacuum			
Natural Gas			
Sewer			
Steam			
Telephone			
Water – Potable			
Water – Fire Sprinkler			

Appendix: Incident Management Team Recovery Responsibilities

COMMAND

- ❑ Incident Commander
 - Assess if criteria for partial or complete reopening of the facility is met, and order reopening and repatriation of patients
 - Oversee restoration of normal hospital operations
- ❑ PIO: Conduct final media briefing providing situation status, appropriate patient information and termination of the incident
- ❑ Liaison Officer: Notify local emergency management, fire, EMS and Licensing & Certification of termination of the incident and reopening of the facility
- ❑ Safety Officer: Oversee the safe return to normal operations and repatriation of patients

OPERATIONS

- ❑ Restore patient care and management activities
- ❑ Repatriate evacuated patients
- ❑ Re-establish visitation and non-essential services

PLANNING

- ❑ Finalize the Incident Action Plan and demobilization plan
- ❑ Compile a final report of the incident and hospital response and recovery operations
- ❑ Ensure appropriate archiving of incident documentation
- ❑ Write after-action report and corrective action plan to include the following:
 - Summary of actions taken
 - Summary of the incident
 - Actions that went well
 - Area for improvement
 - Recommendations for future response actions

LOGISTICS

- ❑ Implement and confirm facility cleaning and restoration, including:
 - Structure
 - Medical equipment certification
- ❑ Provide debriefing and mental health support services for personnel and patients
- ❑ Inventory supplies, equipment, food, and water, and return to normal levels

FINANCE/ADMINISTRATION

- ❑ Compile final response and recovery cost and expenditure and estimated lost revenues summary and submit to the Incident Commander for approval
- ❑ Contact insurance carriers to assist in documentation of structural and infrastructure damage and initiate

Appendix: Hierarchy of Repopulation Approval(s)

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

Steps	Date Completed
A. Local government agencies have removed restrictions, if any, related to the environmental quality in the area or facility for the types of patients to be moved back into the facility.	
B. Local fire department and/or law enforcement agency representative allows re-entry to the specific evacuated neighborhood in which the facility is located and/or allows re-entry to evacuated facilities, as applicable.	
C. If structural integrity or any major building system is compromised, OSHPD inspects and repopulation cannot occur until any red and yellow building tags are removed from the impacted building by OSHPD.	
D. If required, due to prolonged loss of power and refrigeration or breach of pharmaceutical security, State Pharmacy Board may conduct a site visit to approve measures taken to restore Pharmacy capacity and safety.	
E. The CEO/IC oversees an assessment of environmental safety, facilities, operations and resources, including the factors identified in the General All Hazards Repopulation Factors checklist below, and prepare the facility for repopulation.	
F. The CEO/IC maintains communication with the Licensing & Certification (L&C) District Office regarding facility status, progress and estimated timeframes for reopening of facility (ies). Depending upon the circumstances, L&C may schedule a reportable event visit.	
G. Once the CEO/IC makes a determination, based on best judgment, that the facility is ready to repopulate, L&C is notified and: <ol style="list-style-type: none"> 1. If necessary, an L&C repopulation inspection is scheduled, or 2. Repopulation is initiated. 	
H. If an L&C repopulation visit is required: <ol style="list-style-type: none"> 1. If necessary, additional actions or agency reviews may be requested by L&C; and/or 2. The determination is made that hospital facilities are safe for patients, personnel and visitors, programs and services can be resumed, and repopulation can be initiated. 	

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Appendix: General All-Hazards Hospital Re-Population Factors / Steps

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

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