MDPH HOSPITAL EVACUATION TOOLKIT
June 30, 2012

Dear Hospital Representative,

The Massachusetts Department of Public Health (MDPH) Hospital Evacuation Toolkit was developed by the Harvard School of Public Health Emergency Preparedness and Response Exercise Program (HSPH-EPREP) in collaboration with the MDPH Emergency Preparedness Bureau. The toolkit is meant to serve as a resource for hospitals to prepare their own comprehensive evacuation plans. The toolkit draws from the extensive literature review, review of hospital plans, interviews with hospitals that have had to evacuate and other activities that occurred in preparation for the MDPH statewide hospital evacuation exercise program and from lessons learned during the execution and evaluation of the exercise series. The Massachusetts General Hospital evacuation plan, in particular, was used as a reference for many of the specific tools and job action sheets in this toolkit. We gratefully acknowledge the outstanding hard work of many MGH leaders who contributed time and energy to create the plans and tools from which several of the toolkit items are adapted.

The MDPH Hospital Evacuation Toolkit and all related documents have been developed through a contract with the Emergency Preparedness Bureau at the Massachusetts Department of Public Health, with funding from the Office of Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program.

The views and opinions expressed as part of the MDPH Hospital Evacuation Toolkit and all related documents do not necessarily represent the views and opinions of the Office of Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program.

Sincerely,

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ACKNOWLEDGMENTS

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Purpose of Evacuation Toolkit

Although rarely required, hospital evacuations, full or partial, are extremely complicated and potentially dangerous events. Careful and detailed planning that supports the most orderly and safe evacuation operation possible must be included in any hospital emergency operations plan. There are a variety of potential reasons to need to evacuate and widely variable potential timelines within which a hospital must evacuate, thus hospitals are often challenged to create a common set of procedures and supporting documents that are useful among all of the envisioned evacuation scenarios. This toolkit is designed to assist hospitals with this planning by providing guidance and tools that are useful in the majority of anticipated scenarios.

This toolkit has been designed with the following assumptions and principles in mind:

- Evacuation may be immediately required following a no-notice event such as a tornado or fire,
- required in a delayed fashion following a structural or systems failure such as a loss of heat, or
- in anticipation of an event, such as for a hurricane.

- Hospitals may be required to partially or fully evacuate.
- Each care unit must be able to automatically and autonomously prepare their patients for evacuation in order to facilitate the evacuation efforts and to limit reliance on central communications.
- All patient care sites may potentially have to evacuate their units before transportation resources and/or receiving destinations are available. Hospitals should continue to encourage internal horizontal evacuation when possible, but, because horizontal safe sites may not be available, hospitals must also plan to have pre-designated assembly points on, or adjacent to, the hospital campus that can accommodate every care unit.
- Assembly point operations can rapidly become chaotic. Hospital evacuation plans must include structures that support administrative and medical leadership and care at their assembly points that will minimize the chaos and risk to patients.
- The process of matching evacuating patients with receiving facilities is a complicated endeavor that requires close collaboration with public health authorities, EMS, and neighboring health care institutions. Hospitals must centralize their team that arranges for transport destinations of their evacuating patients to minimize confusion and streamline communications.
- Receipt of evacuated patients can be taxing on hospitals and emergency departments. Hospitals should consider activating their emergency operations plans and plan for common challenges when receiving multiple evacuated patients.

Using the Evacuation Toolkit

This toolkit is designed to assist hospitals as they review and update their plans annually for partial or full evacuation. The first document, the Hospital Evacuation Guide, describes planning for the evacuation process from start to finish. It discusses best practices to facilitate communications between the Incident Command and clinical staff, to optimize patient movement and tracking, and to coordinate setup and operations of the Assembly Point. In addition, it describes the rationale behind many specifics of the recommended evacuation processes.

Supplementing the main guidance document are several other tools designed to clarify roles and specific responsibilities and assist with evacuation planning. For example, there is a guide to help hospitals roughly estimate how long an evacuation will take, based upon accounting for both operational and non-operational elevators. There is also a checklist of items to consider when reviewing the complete hospital evacuation plan. These guides provide job action sheets, tools, and spreadsheets that can be adapted and easily incorporated into any hospital evacuation plan. Any
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tools that are adapted should be read thoroughly and edited to reflect the specifics of the individual hospital, patient population, and surrounding environment.
II. HOSPITAL EVACUATION PLANNING GUIDE
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The Hospital Evacuation Planning Guide is meant to provide planning assistance and assist a hospital in refining and augmenting its efforts to prepare for the possible evacuation of part or all of the facility. This guidance is meant to complement and integrate with the institution's Emergency Operations Plan (EOP), and not replace, duplicate, or conflict with the structures, roles or guidance offered by the EOP.

Not all portions of the guidance will necessarily be appropriate for all hospitals. Hospitals are encouraged to review this document and adapt and incorporate those sections and tools they deem useful and appropriate to their needs.

Current Scope of Planning Guidance

While this guidance contains principles and procedures applicable to all healthcare facility evacuations, the specific tools in this document address evacuation procedures for inpatient care units only. Hospitals must, of course, consider all spaces within their campus such as outpatient care sites, procedural suites, public spaces, research programs, and others in their EOPs and in their evacuation planning.

Assumptions

The general assumptions upon which this toolkit is based are listed in the Introduction. For this guidance, it is assumed that the systems, structures and tools within this guidance will always be used after the hospital's EOP has been activated. It is therefore also assumed that the Incident Command System (ICS) will be used throughout the duration of a hospital's evacuation response. Because each hospital may have its own unique ICS structure specified within its EOP, this planning guidance does not replace or alter the institution's fundamental ICS structure, but rather proposes to add additional specific functional components that may be activated during a hospital evacuation when needed. Whenever relevant, this planning guidance will show where a proposed function specific to evacuation may fit within a general incident command system (ICS).

As also mentioned in the Introduction, there are a large variety of potential reasons to need to evacuate and potential timelines within which a hospital must evacuate. Because some emergency planners may feel more comfortable specifying a timeline within which evacuation must occur in a "basic" evacuation planning scenario, the core planning assumption in this guidance is that full evacuation of the hospital must be completed within 4-6 hours. This planning guidance is nonetheless relevant for other evacuation scenarios as well. In a gradual evacuation, the same steps are followed but with more time to complete them. In an immediate evacuation, while there is no time for anticipation of the incident, the efforts a hospital makes to adapt the guidance and tools within this document are anticipated to help staff better know what to do without needing specific direction and where to go to protect their patients and themselves.
PREFACE

Purpose

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GUIDING PRINCIPLES

Moving all patients, visitors and staff out of dangerous and/or damaged facilities as safely as possible is always the goal of an evacuation. It is important to recognize that care and processes will not be optimal in an evacuation scenario. To that end, understanding key principles will help staff make good decisions during a chaotic event.

- Full evacuation of a hospital should generally be considered as a last resort when mitigation or other emergency response efforts are not expected to maintain a safe care environment.
- Safety is always the primary concern.
- Simplicity is key; the staff will need a simple plan to follow in an emergency.
- Flexibility is vital because the procedures must be able to be adapted to a variety of situations.
- Self-sufficiency at the unit level is important because timely communication from hospital leaders may be difficult or even impossible, requiring employees at every level to know immediately what to do in their area.
- It may be necessary to evacuate patient care sites before transportation resources and/or receiving destinations are available. Because horizontal safe sites may not always be available, hospitals must also identify and designate Assembly Points located away from the main clinical areas for every patient care unit that will accommodate essential patient care functions while patient transport is being arranged.
- Individual patient care units should stay together at the Assembly Points whenever possible (instead of dividing their patients into separate groups by ambulatory status). This is because the unit teams familiar with their patients will be better able to manage them in a chaotic situation away from the care unit.
- EMS and other external patient transporters should generally not be asked to come into the hospital to load patients because of the risks, time delays, and inefficiency in this process when large numbers of patients are involved. Instead, evacuating patients should be brought to meet their transporting ambulances and other vehicles in rapid-throughput staging areas.
- When difficult choices must be made, leaders and staff must focus on the “greatest good for the greatest number.”
PROCESS OVERVIEW

The process of evacuation of a hospital can be divided into several key components. Each component is described in detail in this guidance. As detailed in the AHRQ Hospital Evacuation Decision Guide, the decision to evacuate is a difficult one that is likely to be made by a team of leaders in the hospital after carefully assessing the safety threats and all possible alternatives. Once the decision to evacuate has been made, however, the processes of hospital evacuation are fairly linear. Below is an example schematic of the core stages in a hospital evacuation process:

Clinical Unit Preparation is managed by a “Unit Leader” on each care unit (typically a resource nurse or other site leader). This stage includes preparation of medical records, medications, and equipment needed to accompany each patient during transport and ends when patients are ready for transport from the unit. The Unit Leader is also responsible for working with responsible clinicians to identify which patients may be safely discharged from the hospital immediately and not require transfer to another unit or hospital.

Internal Patient Transport is arranged by a “Floor Coordinator” who works with the Unit Leader to ensure all patients are transported off the unit to the Discharge Area, Assembly Point or Staging Area via stairs or elevator, as appropriate. On the ground level, “Transport Coordinators” ensure patients are transported to the pre-designated Assembly Point or Discharge Site.

Assembly Point Operations leaders ensure that supplies, equipment and staff are available and organized to care for patients in the Assembly Point. The Assembly Point takes responsibility when patients “check-in” and manages patient care until patients are ready to be transferred to another facility.

Discharge Site Operations staff take charge of care for patients who, following the evacuation order, have been deemed appropriate for safe, rapid discharge from the hospital. Discharge site leaders ensure that supplies and staff are ready and organized to supervise patients while they wait for transport to their home or another appropriate location. The Discharge Site takes responsibility for patients when they “check-in” and provides support until they leave the hospital.
**Staging and External Transport** staff manage patients as they “check-out” from the Assembly Point and load into ambulances and other transport vehicles to be taken to other hospitals. Leaders ensure that the patients’ travel needs are met (records, equipment, staff supervision if necessary), confirm patient identity and transfer destination, and document that the patients have left the hospital.

**Patient Tracking** staff are responsible for tracking and reporting on the location of patients throughout the evacuation process to provide continual accountability.

**Family Notification** unit members are responsible for attempting to notify family members and other related and responsible parties about patient transfer destinations, answering calls and responding to questions from family members about patient welfare and location.

**Patient Destination Team** staff begins work as soon as the evacuation plan is activated to match evacuating patients with appropriate available beds in other facilities. Because of the complexity of this process, the Team should include representation from the Chief Medical Officer, senior nurses, admitting office representatives, and case managers. The Team works closely with public health and EMS officials to identify available beds and ambulances for patient transfers.
PLAN ACTIVATION

Authority to Order Evacuation

An appropriate and available official must be vested with the authority to order partial or full evacuation of the hospital. This authority may generally rest with the CEO, the Administrator On-Call (AOC), and/or the Incident Commander in an activation of the hospital EOP. In all circumstances, however, hospital plans must vest an on-site leader with the authority to act in an extreme situation that requires an immediate response 24 hours a day, 7 days per week.

In many cases, however, the decision to evacuate is, in fact, not immediately obvious and may require input from a variety of clinical and non-clinical leaders. When time permits, hospitals may wish to consider creating an Evacuation Decision Team with representation from nursing, physicians, safety, facilities maintenance, security, and others who can quickly weigh the risks of evacuation against the risks of staying in place.

Making the Decision

In most emergencies, a full evacuation will not be required. Due to the complex needs and unstable nature of many hospital patients, evacuation is generally considered as a last resort. Evacuation should be ordered only when absolutely necessary, and when there is an imminent or potential, unmitigated threat to patient/staff safety.

For further information regarding the decision making process, please review the AHRQ Hospital Evacuation Decision Guide (www.ahrq.gov/prep/hospevacguide/hospevac.pdf). Excerpted from that guide below is a partial list of situations that may warrant evacuation:

- Fire and smoke
- Facility or structural damage
- Potential exposure to hazardous materials
- Terrorism or violent, armed visitor(s)
- Credible bomb threat

It is important to remember that the decision to evacuate is not necessarily an “all or none” action. In many instances, when more time is needed and available to assess the danger posed by the event, hospitals should consider issuing a “Prepare Only” order. Under such an order, hospital staff should begin preparations for evacuation (packing patients, moving supplies to Assembly Point, etc.) that will greatly speed the process if a full evacuation becomes necessary, but they will not actually remove patients from their care units. If the hospital needs to subsequently evacuate, it will have saved valuable time and limited chaos and risks to patients. If the hospital does not need to evacuate, no patients will have been placed at risk in transit and the preparatory work will have served as excellent practice for staff.

Once the decision is made, the full institution should be notified of the evacuation. An automated Emergency Notification System that contacts all hospital leaders and managers should be utilized if available. Overhead pages, emails, text messages, notification of news outlets and other means of contacting employees and staff should be considered as appropriate.

Notification of External Agencies

As should be described in the Hospital EOP, all appropriate agencies must be immediately notified of any plans to evacuate the facility. At a minimum, MDPH, local public health, local EMS, local fire, local police, and regional CMED representatives should be notified of this decision.
Key Decisions for the Incident Commander

Once the decision to evacuate has been made, there are several additional key decisions that must be made quickly and communicated.

1. Level of Evacuation
2. Type of Evacuation
3. Evacuation Time Frame (Immediacy of Evacuation)
4. Patient Prioritization
5. Assembly Point and Discharge Site Locations
6. Labor Pool Activation
7. Evacuation Coordinator Assignment
8. Patient Destination Team Activation

1. Level of Evacuation

The scope of any evacuation can change over time depending on the nature and course of the event. Below is the full list of options for evacuation in order of increasing scope and severity:

- Shelter in Place
- Horizontal Evacuation
- Vertical Evacuation
- Total or Full Evacuation

Shelter in Place: This level requires cessation of all routine activities in preparation for an impending threat, such as a hurricane or toxic cloud. Specific preparations should be made to mitigate against the anticipated threat. In general, patients, visitors and staff remain where they are until they receive further instructions. In most cases, the safest place for the patient is in his/her room. Closing doors/windows provides initial protection from fire and smoke. When possible, preparations should also be made to enable immediate evacuation of patients, should evacuation become necessary.

Horizontal Evacuation: This level involves moving patients in immediate danger away from the threat, but keeping the patients on the same floor of the hospital as the one they are evacuating. Horizontal evacuation typically involves moving patients to an area of refuge in an adjacent smoke/fire zone or in some cases, at the opposite side of the building. Most evacuations of single departments or patient care units can be done horizontally, which is the fastest option and facilitates the simplest re-entry process. Evacuation of an entire building may even be accomplished horizontally if every floor of the evacuated building connects to another building.

Vertical Evacuation: This level refers to the complete evacuation of a specific floor in a building. In general, patients and staff evacuate vertically towards ground level whenever possible to prepare for evacuation outside, should it become necessary. For most localized incidents, vertically evacuated patients and staff are sent to an area of refuge elsewhere in the hospital typically at least two floors away from the incident floor.

Total or Full Evacuation: This level involves a complete evacuation of the facility, and is used only as a last resort.

2. Type of Evacuation

In addition to determining the level of an evacuation, the hospital Incident Commander needs to determine the priority for moving groups of patients based on the conditions of the event. Generally, a hospital evacuation will be conducted in one or a combination of three previously described Response...
Models based on the amount of time available for a given evacuation and the other resources (especially transport resources) available:

**Geographic Model:** This systematic evacuation focuses on the evacuation of areas at greatest risk within the hospital or selects individual care units to evacuate sequentially as entire units. This may occur when a hospital has significant advance notice and/or has the required time to evacuate based on the geographic location of patient units.

**Pro(s):** Allows for partial evacuation that will not disrupt the entire hospital and allows units to stay together throughout the evacuation process enhancing consistency of medical care.

**Con(s):** Requires considerable evacuation time.

**Resource Model:** This evacuation focuses on utilizing resources in the most efficient manner possible. Evacuation would occur vertically (top to bottom if elevators are available, or reversed if not) while identifying evacuees that require scarce resources. Therefore, patient prioritization would be directly linked to resource availability (e.g. ICU patients would be evacuated in a way that makes the best use of ambulances equipped to handle ICU patients).

**Pro(s):** Utilizes available resources effectively; effectively streamlines evacuation process in a top-down or bottom-up method.

**Con(s):** Requires significant real-time planning and logistical management to best allocate scarce resources at a time of crisis.

**Acuity Model:** This evacuation process attempts to account for patient acuity in the prioritization of patients during the evacuation operation. In this model, evacuation is conducted in the same top-down or bottom-up method as described in the Resource Model. However, the most medically fragile patients may be evacuated last to ensure that they are not removed from ventilators and other life support equipment until absolutely necessary.

**Pro(s):** Evacuates the most mobile patients first to ensure the greatest good for the greatest number of patients. Partial evacuation can be accomplished in the shortest amount of time of all three models.

**Con(s):** Does not account for the allocation of scarce resources so could induce a situation where ICU patients would have to wait a long time for the appropriate transport vehicles.

Emergency Evacuation Procedures and leaders often utilize portions of all three of these models depending on the patient acuity, time available for evacuation, and type of event prompting the evacuation. Further details describing the decision making process for hospital evacuation can be found in the document titled “Hospital Evacuation Checklist” in the MDPH toolkit.

3. **Evacuation Time Frames**

The time frame for evacuation may be different depending on the nature of the threat and how much time can be taken to prepare for moving patients. See the chart below for specific hospital orders that may be used:

**Example Evacuation Orders**

| Immediate: | No time for preparation – evacuate immediately |
| Rapid:     | Limited time for preparation (1-2 hours) – everyone out in 4-6 hours |
| Gradual:   | Extended time for preparation – evacuation to occur over many hours or even days |
| Prepare Only: | Do not move patients, but begin preparation for evacuation |

HOSPITAL EVACUATION PLANNING GUIDE
4. Patient Prioritization

Prioritizing patients for the limited physical resources available for evacuation, such as personnel, elevators, stairwells, transport sleds, etc., is among the most logistically and ethically challenging tasks required in hospital evacuation. There is no single priority model that will work equally well for all hospitals and all circumstances. Nonetheless, it is worthwhile for hospital leaders to consider how they may prioritize patients in certain example scenarios in their particular facility. Listed below are some general potential priorities of evacuation in selected scenarios. Because of the physical locations of different units within a given hospital, the elevator and stairwell locations, and other factors, these priority lists may or may not be appropriate for that hospital. Hospital leaders should use these scenarios to discuss patient prioritization on their own as part of their planning efforts.

In any evacuation that is severely time-sensitive, where there are immediate and broad threats to life safety, the priority must be to get as many patients out as possible. Therefore, the acuity model may be adopted requiring patients needing the most assistance to be the last to move. The default priority in these situations may be:

- Patients in immediate danger
- Ambulatory patients
- Patients on general care units requiring transport assistance
- Patients on intensive care units

If time is critical and an acuity model is adopted, ICU patients may be moved after all the general care units have been evacuated. In addition to maximizing patients evacuated in the least amount of time, this plan model ensures critical care patients have access to medical gases, suction, and monitoring for as long as possible. (If a resource model evacuation is possible, ICU patients should be evacuated as transport resources become available.) Although ICU patients may be the last to leave the hospital, they should be the first to leave the Assembly Point, as they are the highest priority for transfer to other hospitals.

In a rapid (but not immediate) evacuation, the default transport plan for evacuation should be based on an orderly, rapid process where entire patient care units are moved sequentially. Units of different acuity (i.e. a general medical/surgical unit and an ICU) may be evacuated in parallel when possible to avoid uneven demand on EMS resources (i.e. avoid heavy use of ALS ambulances only at the beginning or end of the evacuation). There is controversy about the order of floor evacuations, but one recommended plan is to evacuate from the top of the building to the bottom if elevators are available, or from the bottom of the building to the top if only stairs are available.

In a gradual evacuation, hospitals may not require the use of assembly points, but rather may choose to send patients directly from their units to waiting EMS assets in the staging area. In such a circumstance, communication between the staging area and the floors is critical to ensure that the flow of patients out of the units anticipates available EMS units and prevents logjams of ambulances waiting at the curb for arriving patients to transport.

5. Assembly Point(s) and Discharge Site Locations

The hospital should identify several locations surrounding the hospital that could be used as either an Assembly Point or a Discharge Site.

The Assembly Point is the place, or set of places, where patient care units gather (outside the main clinical buildings of the hospital) to receive basic care and await transfer, or re-entry back into the
hospital. *The Assembly Point(s) should not be a comprehensive field hospital. The Assembly Point(s) should be designed as a holding area with only essential care resources.*

The **Discharge Site** is the place where patients who are being discharged home wait for family or friends to pick them up. Ideally, the Discharge Site is located at some distance away from the Assembly Point to minimize traffic congestion and competition for roadways.

It is important to consider proximity and size when determining suitable Assembly Point and Discharge Sites. While an Assembly Point in close proximity to the hospital can aid in the effort to relocate fragile patients during an evacuation, it also can be of concern for any event involving an explosive device, chemical hazards, or other potentially expansive threat. Ideally, both the Assembly Point and Discharge Site will permit sheltering indoors. It is also important to remember economies of scale, however, when choosing assembly points and discharge sites, since it is much more difficult for clinical support services, like Pharmacy, to support patient care in many separated locations.

*Several nearby sites should be identified, and their willingness to help in the event of an emergency should be confirmed upon the incorporation of this guidance into hospital plans. In the event of an emergency, these sites should be contacted immediately.* For capacity and capabilities of other Assembly Point/Discharge Site options, reference the Assembly Point Guide in the MDPH Toolkit.

### 6. Labor Pool Activation

Evacuation is a severely labor-intensive process. Using the hospital EOP, the Labor Pool should be activated immediately to identify and assign staff to support the evacuation. The Labor Pool may need to call in staff from home for any evacuation, but is much more likely to need to do so if an evacuation happens on the evening shift, the night shift, or during a weekend.

The following chart identifies the functions and supervisors that may be required to effectively evacuate a hospital. Space has been left to calculate the estimated resources needed for the key functional areas involved. These numbers will be highly dependent upon the normal patient demographics of the hospital that requires evacuation. Note that many of these resources can be re-deployed as the evacuation progresses. *(For example, some of the staff transporting patients out of the main campus buildings can be re-assigned as runners at the Assembly Point once the majority of patients have been evacuated.)* *(Note: AP = Assembly Point).*
Example of Labor Pool Staffing Chart

<table>
<thead>
<tr>
<th>Function</th>
<th>Estimated Staff Needed</th>
<th>Supervised By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare/pack patients on inpatient care units (# clinicians and # administrative staff per unit – (Identify those only needed for night shift events as well)</td>
<td>Fill in staff requirements</td>
<td>Inpatient Unit Leaders</td>
</tr>
<tr>
<td>Transport to Assembly Point (with elevators working)</td>
<td>Fill in staff requirements</td>
<td>Transport Unit Leader</td>
</tr>
<tr>
<td>Transport to Assembly Point (without elevators working)</td>
<td>Fill in staff requirements</td>
<td>Transport Unit Leader</td>
</tr>
<tr>
<td>Monitor/assess patients at Assembly Point</td>
<td>Fill in staff requirements</td>
<td>Assembly Point Transport Supervisor</td>
</tr>
<tr>
<td>Patient assessment at Assembly Point (one clinician/patient care unit) as supplemental staffing until all the inpatient unit nurses and clinicians have arrived at the Assembly Point</td>
<td>Fill in staff requirements</td>
<td>Assembly Point Section Leaders</td>
</tr>
<tr>
<td>Care for patients/support nurses with vitals, feedings, etc. at Assembly Point (# staff members per unit)</td>
<td>Fill in staff requirements</td>
<td>Inpatient Unit Leaders</td>
</tr>
<tr>
<td>Relay information and/or transport supplies and medications between Assembly Point and main hospital (# runners per AP)</td>
<td>Fill in staff requirements</td>
<td>Assembly Point Section Leaders</td>
</tr>
<tr>
<td>Load patients into vehicles and ensure readiness to travel</td>
<td>Fill in staff requirements</td>
<td>Staging and External Transport Unit Leader</td>
</tr>
<tr>
<td>Care/assist patients at Discharge Site</td>
<td>Fill in staff requirements</td>
<td>Discharge Site Leader</td>
</tr>
<tr>
<td>Answer calls from families in Phone Bank</td>
<td>Fill in staff requirements</td>
<td>Social Services</td>
</tr>
</tbody>
</table>

7. Evacuation Coordinator Assignment

The key link between Incident Command and the patient care units during evacuation are the Evacuation Coordinators. (See job action sheet in Appendix 4.) Staff serving in this role are responsible for communicating with each unit and monitoring their progress to ensure they are safely evacuated. Ideally, following the ICS principle of span of control, each Evacuation Coordinator would have approximately 5, and not more than 7, patient care units to manage. Hospitals should consider the total number of patients in each unit, the acuity of patients in each unit, and the size and layout of the hospital when deciding how many Evacuation Coordinators they believe they should have.
The Incident Commander should designate sufficient Evacuation Coordinators to be able to monitor the progress of the units as they evacuate, but not dedicate so many staff to this position that they compete with the rest of the IC structure for responsibilities or staffing.

As mentioned previously, each care unit should specifically designate a “Unit Leader”. Upon receiving the order to evacuate or prepare for evacuation, the Unit Leader should be prepared to discuss the following questions with their Evacuation Coordinator to help the hospital effectively prepare for evacuation.

1. **Time for units to prepare**: How much time is available to pack patients before transport begins?

2. **Assembly Point location**: Should the unit move to its default AP, or is there modification based on the scenario?

3. **Discharge Site location**: Should the unit send discharged patients to the default site, or is there modification based on the scenario?

4. **Priority sequence for evacuation**: In what order will units be evacuated?

5. **Elevator assignment**: Per plan in Appendix 5, or is there modification based on the scenario?

6. **Stairwell assignment**: Per plan in Appendix 5, or is there modification based on the scenario?

7. **Non-unit staff**: should any hospital staff currently on the unit, but not based on that care unit (such as physical therapy or respiratory therapy) return to their home department or stay on the patient care unit and help evacuate patients?

8. **Staff recycling back into building**: Transporters and security staff may re-enter the building when needed, but what about other unit staff? Should nurses escort patients to the Assembly Point and then return for another group of patients or not?

9. **Labor Pool staging area/phone**: Where should extra staff report for assignment?

10. **Family Support Center location/phone**: Where should families be directed for support?

### 8. Activation of the Patient Destination Team

If it seems likely that re-entry (into the hospital) will not be possible in a timely manner, the Chief Medical Officer should activate this team immediately. The team is activated to match evacuating patients with appropriate available beds in other facilities. Because of the complexity of this process, the Team should include representation from the Chief Medical Officer, senior nurses, admitting office representatives, and case managers. The Team works closely with public health and EMS officials to identify available beds and ambulances for patient transfers.

The Team should have a designated location around the hospital that has sufficient computer, telephone, and meeting space resources to permit it to function efficiently. All physicians, physician assistants, and nurse practitioners must be notified that the Patient Destination Team has been activated and is working with public health authorities to arrange appropriate destinations for all patients. It is vitally important to the success of the Team that individual physicians not compete with the Patient Destination Team and attempt to arrange transfer beds on their own. This creates the potential for significant confusion and introduces potential errors into the process.
The following is a summary of example key evacuation responsibilities by department in a hospital. Depending on the administrative structure of each hospital, these responsibilities may fit into the department listed, or they may be better assumed by another department. For smaller hospitals, many of these responsibilities may need to be combined under one department or ICS function. All of the responsibilities listed are in addition to the general responsibilities that will be otherwise listed in the hospital EOP.

<table>
<thead>
<tr>
<th>Department</th>
<th>Responsibilities</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitting</td>
<td>Patient Tracking</td>
<td>Social Services may also need a list of patients by unit with “next of kin” information including contact phone numbers</td>
</tr>
<tr>
<td></td>
<td>• AP Check-in and Discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discharge Site Check-In and Discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide data to Social Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assist Patient Destination Team</td>
<td></td>
</tr>
<tr>
<td>Biomedical Engineering</td>
<td>• Identify all available equipment for internal and external patient transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transport appropriate medical equipment to AP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Troubleshoot malfunctioning equipment during evacuation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Track any equipment that leaves facility</td>
<td></td>
</tr>
<tr>
<td>Blood Bank</td>
<td>• Inventory available blood products</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identify coolers and other resources available to support blood transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transport blood products to AP</td>
<td></td>
</tr>
<tr>
<td>Facilities Maintenance</td>
<td>• Activate emergency systems to commandeer elevator banks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor system utilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assist with AP site setup</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assist with patient transport as needed</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>• Assist with Patient Destination Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identify non-acute care transfers (on unit) that may be discharged to skilled nursing facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Staff the Discharge Site as needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support Family Assistance Center as needed</td>
<td></td>
</tr>
<tr>
<td>Department</td>
<td>Responsibilities</td>
<td>Notes</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>• Staff emergency resuscitation and stabilization area at the AP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Respond to injuries/illness during evacuation as requested</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide staff to support loading teams</td>
<td></td>
</tr>
<tr>
<td>Environmental Services</td>
<td>• Set up AP and Discharge Site</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide staff for patient transport</td>
<td></td>
</tr>
<tr>
<td>Food/Nutrition Services</td>
<td>• Transport emergency supplies to AP and Discharge Site and distribute as needed</td>
<td>Includes standard TPN bags</td>
</tr>
<tr>
<td>Health Information Systems</td>
<td>• Retrieve or track medical records before patient transfer to other facility</td>
<td>Or print/email abstracts</td>
</tr>
<tr>
<td></td>
<td>• Assist receiving institutions with obtaining medical record data</td>
<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td>• Provide Labor Pool resources</td>
<td>Clinical staff may be needed for transport</td>
</tr>
<tr>
<td></td>
<td>• Assign AP Labor Pool representative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Track staff who travel to other facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor emergency challenges to labor agreements</td>
<td></td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>• Provide interpreter staff at the AP and Discharge Site</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assist with the translation in the Family Assistance Center</td>
<td></td>
</tr>
<tr>
<td>Materials Management</td>
<td>• Manage patient transport process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transport medical supplies, linens, other needed items to AP, Discharge Site</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>• Transport medication “cache” and IV fluids to AP and dispense as needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support Discharge Site with needed medications and dispensing as possible</td>
<td></td>
</tr>
<tr>
<td>Security</td>
<td>• Communicate with outside agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lockdown facility and secure roads</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unlock all stairwell doors</td>
<td></td>
</tr>
<tr>
<td>Department</td>
<td>Responsibilities</td>
<td>Notes</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>• Manage access to/from secure units</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clear evacuation route</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Manage routes/checkpoints</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Check units after closing (if possible)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support care units and Family Waiting Areas at the AP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assist with psychiatric patient transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide staff to manage ambulance flow</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>• Deploy staff to critical care units for internal and external transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transport respiratory equipment to AP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide emergency care as needed in the resuscitation and stabilization area at the AP</td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td>• Manage family call center</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Manage family support/waiting areas</td>
<td></td>
</tr>
<tr>
<td>Telecommunications</td>
<td>• Use overhead paging system to communicate information as appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Setup phone bank at AP, Discharge Site, family support center</td>
<td></td>
</tr>
</tbody>
</table>
PATIENT TRACKING

During an evacuation emergency, a functional internal patient tracking system, even if simple and paper-based, is crucial to provide clinicians, families and leaders with situational awareness of the appropriate location and status of all patients throughout the event. A system that reports selected “check-in” and “check-out” data for patients at various touch-points in the process is ideal. Those touch-points include:

- Leaving the patient care unit
- Arriving at the AP or Discharge Site
- Leaving the AP or Discharge Site
- Arriving at the Staging Area
- Leaving the Staging Area
- Arriving at the receiving hospital

The Admitting Department may be best tasked with the responsibility for the Patient Tracking function. Their role may include the following responsibilities:

- Checking-in patients to both the Assembly Point and the Discharge Site
- Discharging patients from both the Assembly Point and the Discharge Site
- Updating patient location information in electronic information systems and/or using manual paper logs as backup
- Providing routine patient tracking reports for the hospital EOC
- Participating in the Patient Destination Process
- Providing reports with contact information for Social Service staff manning the phone bank
- Contacting receiving facilities to confirm patient arrivals
- Obtaining location and contact information data from the receiving hospitals for sending to clinicians and patient families

Sample Guidelines for Patient Tracking:

1. Admitting will create a detailed inpatient census at the time of the evacuation order to provide accountability for all inpatients in the facility at the time of the order.

2. Patients will be tracked upon arrival at either the Assembly Point or the Discharge Site. In addition, each Unit Leader will use their Patient Tracking Log (see the Patient Tracking Guide in the MDPH Hospital Evacuation Toolkit) to verify that all of their patients arrived at the Assembly Point. Admitting will be notified if any patients are missing, and will, in turn, notify the appropriate supervisor in the ICS.

3. Admitting will need to notify the Patient Destination Team of patients who eloped without notifying staff, left the hospital against medical advice (AMA) prior to transfer, or were discharged directly from the units. Admitting will track all such patients to be able to reconcile the final transfer, and discharge lists with the inpatient census at the time of discharge.

4. At the Assembly Point, Admitting will periodically verify the census to ensure accuracy of Patient Tracking information. Admitting will provide regular reports on the status of tracking information to the EOC.

5. Admitting will track all patients who leave the hospital campus at the Discharge Site and Staging Area.
6. Admitting will attempt to contact all receiving hospitals to verify the arrival of the transferred patient and will obtain location and contact information data from the receiving hospitals for sending to clinicians and patient families.
PATIENT DESTINATION TEAM

The Incident Commander will need to mobilize a Patient Destination Team as soon as it becomes clear that timely re-entry to the facility will not be possible. This team will match all patients in need of transfer with appropriate beds at other facilities.

The Team may report to the Chief Medical Officer, nursing supervisor or the admitting office in a hospital’s EOP. The Team will work with the EMS liaison from the community, public health officials, and any other coordinators or organizations involved such as a regional organization of hospitals, etc. The hospital staff below should be included in the Patient Destination Team. Clinicians providing care to special inpatient populations (such as pediatrics, obstetrics, specialty surgical, psychiatric, or others) should work with the Team to help coordinate unique bed needs and care networks (such as Level III nurseries, burn centers, specialty ICUs, inpatient psychiatric facilities, etc.).

- Inpatient Clinical Supervisor(s)
- Admitting
- Case Management
- Physician Leader (CMO or designee)
  - Specialty physician representation

It is important to determine the site where this group will gather with sufficient computer, telephone, and meeting space resources to permit it to function efficiently. There must be a plan for backup sites and support in case the first area is not available and/or safe. All physicians, physician assistants, and nurse practitioners must be notified that the Patient Destination Team has been activated and is working with public health authorities to arrange appropriate destinations for all patients. It is vitally important to the success of the Team that individual physicians not compete with the Patient Destination Team and attempt to arrange transfer beds on their own. This creates significant confusion and introduces potential errors into the process.
PHYSICIAN ROLES
Staff Physicians, House Staff (if applicable) and Physician Extenders

In the event of an emergency that requires preparation for possible evacuation or actual evacuation of the facility, all responsible and responding clinicians (i.e. MDs, PAs, NPs) with patients in the hospital must be notified of the event immediately by an electronic notification system or other mechanism. All Chiefs of each hospital service should also be notified. Clinicians should follow the direction of their immediate supervisor or Department Chief, as specified within the Hospital Incident Command System (HICS). Clinicians should not attempt to contact the Incident Commander or other institutions directly during the evacuation process.

The first responsibility of clinicians with active responsibility for inpatients is to prepare their inpatients for evacuation. This involves:

1. Reassessment of each patient’s clinical status.
2. Reviewing all active medications and clinical interventions (i.e. supplemental oxygen, monitoring, etc.).
3. Minimizing all medications and clinical interventions. Continue only those that will be essential until the patient is successfully evacuated and arrives at another hospital.
4. Writing/printing a summary of the patient’s inpatient course and treatment plan to assist clinicians at the receiving hospital in assuming safe care of the patient. Clinicians should be sure to include their own contact information in this documentation.
5. Giving report to receiving clinicians at the receiving hospital (when possible).

If a clinician has patients on multiple units, he/she should prioritize the most critical patients – specifically, any patients who will not be able to move without clinician input and/or assistance.

Key Points/Issues:

- Commonly, physicians are not aware of their roles during an evacuation. Evacuation plans should ensure the communication of job roles and functions for physicians.
- Clinicians without active inpatient responsibilities, or clinicians who can be safely relieved of those responsibilities, may be asked to assist with other functions. Some clinicians will be sent to the Assembly Point to receive and care for patients evacuated from their floors.
- Clinicians should still retain primary responsibility for their patients at the Assembly Point. Discharge or transfer notes should be written if possible before patients leave the Assembly Point, though this may not be possible in all cases.
- **Clinicians SHOULD NOT attempt to arrange transfer destinations for their inpatients.** This function should be performed by the Patient Destination Team, a centralized team of physicians, nurses, and admitting staff who will work with public health and public safety authorities to identify available beds and optimize the patient transfer process.
CLINICAL UNIT PREPARATION

In order to prepare patients for the safest possible evacuation, a number of steps must be taken to ensure the appropriate staff, equipment, medications, medical records, and other necessary items accompany the patient during the process. A complete “tool” for inpatient care units has been developed to guide staff in preparing individual floors or units for evacuation. This tool provides structured mechanisms to gather and report data on the patients and their needs, on available resources, and to help package patients for safe transfer. (Please see Evacuation Floor Guide for related and expanded documents, including step-by-step instructions for Unit Leaders.) This general guidance has been designed to support either a rapid or gradual evacuation. In an immediate evacuation, however, many of the preplanning efforts and patient tracking forms in this section may be impossible to complete given a lack of time.

If patients are clinically stable, they may be discharged from the unit at the time of the evacuation order to minimize transfer needs. Because it may be difficult to contact patient families to arrange to have the patient picked up and/or it may be dangerous to let families into the facility, it is generally preferable to have a centralized discharge site away from the main buildings of the hospital and away from the Assembly Point(s). All patients from a given clinical unit should be sent to either the Discharge Site or Assembly Point. Any patients who leave the hospital without notifying staff or who leave against medical advice should be clearly tracked and reported to the Tracking team.

Sample Procedure for Clinical Unit Preparation:

1. Staff will receive the order to evacuate or prepare for evacuation. Each clinical unit will designate a “Unit Leader” according to a specified procedure. A designated “Floor Coordinator” may provide logistical support to the Unit Leader.

2. The Unit Leader will open and use the Evacuation Floor Guide and associated tools.

3. Nursing and other staff will complete the tools in the Floor Guide. The Unit leader will send unit-level patient and resource reports to the EOC per hospital protocol.

4. Patients will be individually “packaged” for transport with their necessary medical equipment, records, medications, and assistive/adaptive devices to maintain independence.

5. Patients “off the unit” for testing or treatment at the time of evacuation may not return to the unit. Instead, they may be transported to the Assembly Point, and will rejoin the unit there, depending on the required urgency of the evacuation. Clinical staff caring for the patient “off-unit” will contact the Unit Leader to confirm this transport request and location. If patients do not return to the unit, clinical staff on the unit will bring a completed tracking form, and any necessary medical equipment, records, medications, and assistive/adaptive devices to maintain independence to meet the patient at the AP.

6. Visitors may stay with the patient, or be directed to leave, per the direction of the Unit Leader.

7. Ambulatory patients and visitors may take the stairs. Non-ambulatory patients will wait for their turn on the elevators, or the med-sled stair route.

8. Discharges may be made directly from the unit, at the assembly point or at a separate designated discharge site.

9. The Unit Leader should communicate with the Evacuation Coordinator and Transport Coordinator to learn the order of unit evacuations and ensure that all patients are safely
transported to the Assembly Point or Discharge Site. Floor Coordinators will assist the Unit Leader with tracking and communications.
TRANSPORT PROCESS

Prioritizing patients for the limited transport resources available for evacuation, such as personnel, elevators, stairwells, transport sleds, etc., is among the most logistically and ethically challenging tasks required in hospital evacuation. There is no single priority model that will work equally well for all hospitals and all circumstances. Considering the physical locations of different units within a given hospital, the elevator and stairwell locations, and other factors, hospitals should create a patient transport evacuation plan that supports an orderly, rapid process where entire patient care units are moved one after the other. Units of different acuity (i.e. a general medical/surgical unit and an ICU) may be evacuated in parallel when possible to avoid uneven demand on EMS resources (i.e. avoid heavy use of ALS ambulances only at the beginning or end of the evacuation). There is controversy about the order of floor evacuations, but one recommended plan is to evacuate from the top of the building to the bottom if elevators are available, or from the bottom of the building to the top if only stairs are available.

If time is critical, evacuation of ICUs and other critical care units should be coordinated based on the resource model to maximize efficiency in transportation resources. In addition to maximizing the number of patients evacuated, an evacuation plan should endeavor to ensure critical care patients have access to central medical gases for as long as possible to minimize demand on portable tanks.

Patients/visitors who are able to travel down stairs on foot should not have to wait for their unit’s turn on the elevators. Once the Assembly Point has been opened with minimal staffing, patients should be escorted by unit staff when possible, and guided along the evacuation route to the Assembly Point by staff manning checkpoints throughout the hospital.

Hospitals with several vertical floors may wish to explore purchasing transport sleds to assist with transporting non-ambulatory patients down stairwells if elevators cannot be used. While the experience of California hospitals with four or fewer stories that have evacuated after earthquakes suggests such devices may not be necessary, hospitals with more stories may find staff availability and fatigue to be a factor when repeatedly carrying patients down multiple floors during the evacuation. No specific product or procedure is endorsed by this guidance, however.

In general, patients may require internal transportation in two stages: 1) from the unit to the Assembly Point (or Discharge Site) and 2) from the Assembly Point to the Staging and External Transport Area(s). It may be useful to have separate ALS (and/or critical care transportation) and BLS transport areas at different staging points to speed loading of those patients requiring different types of ambulance transport and limit bottlenecks.

Sample Procedure for ELEVATOR Transport Process:

1. Start at the top patient care unit in each building, with critical care units being prioritized based on the external transport and receiving destination resources available.

2. Transport stretchers and wheelchairs should be dropped off immediately on the top floors early in the process to speed patient loading. As soon as sufficient stretchers and wheelchairs are delivered, staff should begin delivering stretchers and wheelchairs to the next units to evacuate to permit them to begin to package their patients.

3. Floor Coordinators should assist unit staff with elevator loading and provide direction to the elevator operators.

4. Patients are loaded onto elevators and taken to the Assembly Point in the order in which they become ready for internal transport. A clinical staff member will accompany the first
transported patient(s) to ensure that the Assembly Point has at least one medical worker who can begin to care for the unit.

5. Other clinical staff members will accompany patients in transport as needed for medical monitoring and care. When the last patient leaves the unit, the Unit Leader and Floor Coordinator will travel to the Assembly Point to oversee care in the Assembly Point area.

6. Transport staff may need to re-enter the building to transport more patients to the Assembly Point(s) and Discharge Site. There should be separate, designated routes for transporters to re-enter and re-ascent the floors so that they do not interfere with patient evacuation processes.

7. As patients arrive in the Assembly Point, it may be necessary to take them off of the transport stretchers and wheelchairs in order to retrieve additional patients from the hospital. Transporters should work with clinical staff to identify which patients can be removed from the stretchers and chairs and assist with patient movement as appropriate when directed by clinical staff.

**Sample Procedure STAIRS-ONLY Transport Process:**

1. Immediately gather any designated equipment for stairs-only transport process and identify vendors or other partners that can be contacted for required manpower and equipment. Specialty transport sleds or other devices will need to be dropped on the units early in the process. Ideally, there will be enough sleds so that while one unit is evacuating into the stairwells, the next unit already has sleds and is packing patients and lining up for their turn.

2. Fire department and other public safety staff may be required for lifting and moving of patients and to help with obtaining specialty equipment such as backboards, scoop stretchers, stair chairs, etc. Staff unfamiliar with such equipment or with procedures for carrying patients in stairwells should not carry patients except in cases of immediate life threatening emergencies.

3. Start at the bottom patient care unit in each building, with critical care units being prioritized based on the external transport and receiving destination resources available. Separate stairwells should be designated for ambulatory and non-ambulatory patients if possible.

4. Floor Coordinators should assist with distributing transport sleds and other transportation equipment and staging of patients for transport via stairwells.

5. The stairwell teams should manage transport sleds and transport patients to the ground floor. Then the transport team should move patients to stretchers/wheelchairs and transport to the AP.

6. Patients are taken down the stairs and taken to the Assembly Point in the order in which they become ready for internal transport. A clinical staff member will accompany the first transported patient(s) to ensure that the Assembly Point has at least one medical worker who can begin to care for the unit.

7. Transport staff may need to re-enter the building to transport more patients to the Assembly Point(s) and Discharge Site. There should be separate, designated routes for transporters to re-enter and re-ascent the floors so that they do not interfere with patient evacuation processes.
8. Other clinical staff members will accompany patients in transport as needed for medical monitoring and care. When the last patient leaves the unit, the Unit Leader and Floor Coordinator will travel to the Assembly Point to oversee care in the Assembly Point area.

Evacuation Routes

Patients, visitors, and transporters from all areas should be directed to take specific, pre-specified routes to the Assembly Point(s) and the Discharge Site (or other locations if necessary). Security and other designated hospital staff should make sure the route is clear and monitor the route for problems or bottlenecks. Manned checkpoints should be created at selected locations along these routes where staff can give directions and provide help. A reference map should be outlined containing this information in the hospital’s written evacuation protocols.
ASSEMBLY POINT ORGANIZATION

Because it may be necessary to evacuate patient care sites before transportation resources and/or receiving destinations are available, hospitals must also identify and designate Assembly Points located away from the main clinical areas for every patient care unit that will accommodate essential patient care functions while patient transport is being arranged. Individual patient care units should stay together at the Assembly Points whenever possible (instead of dividing their patients into separate groups by ambulatory status). This is because the unit teams familiar with their patients will be better able to manage them in a chaotic situation away from the care unit. The Assembly Point(s) should not attempt to serve as a comprehensive field hospital. The Assembly Point(s) should be designed as a holding area with only essential care resources.

Each hospital unit should identify a primary and secondary Assembly Point based on proximity to the primary hospital facility. This ensures that one can be reached rapidly during the most time sensitive emergencies that only affect the hospital facility and that the other can be utilized if an Assembly Point that is a further distance from the hospital if required.

An “Assembly Point Director” is responsible for the overall operations at the Assembly Point. The hospital Incident Commander or Operations Chief will designate an Assembly Point Director, who, in turn will designate a Clinical Supervisor and a Staging and External Transport Supervisor (each with a job action sheet listed in the Staffing Configurations Guide in the MDPH Toolkit). All of these supervisory positions will report to the AP Director. The Clinical Supervisor will oversee the individual patient care Unit Leaders at the Assembly Point. If there are too many units at a single Assembly Point for the Clinical Supervisor to manage, s/he may create Section Leaders to oversee groups of clinical units. The number of supervisory positions required will depend on the size of the AP, the number and acuity of the units located there, and the specifics of the physical space.

Sample Organizational Chart of the Assembly Point Positions

1. All of the Patient Care Units at the AP are managed by a “Unit Leader”. The Unit Leaders report to a “Clinical Supervisor” in the Assembly Point.

2. The Emergency Medical Stabilization Area should be created, staffed, and led by the Emergency Department. This area should stabilize patients who decompensate during transport, and treat injuries suffered during the evacuation process. In addition, one or two
mobile ED physician/nurse teams should be available to respond to care needs along the evacuation route.

Assembly Point Area Map

An Assembly Point Map should be developed as part of the Evacuation Procedures that details the use of space utilized for Assembly Point operations. The map should detail the Occupancy Plan for the Assembly Point including: a patient check-in area, specific sites for each clinical care unit’s patients, a location of common basic medical supplies, a biomedical equipment holding area, and an Emergency Medical Stabilization Area. It may also include routes to the Staging and External Transport Area.

Additionally, key departments should have designated locations in the Assembly Point that can be designated on the Assembly Point Map. The following departments may require detailed information:

- Where the Pharmacy will dispense medications from their satellite location.
- Where Food and Nutrition Services will distribute basic foods.
- Where Materials Management will stage and distribute from the various supply/linen areas already distributed throughout the facility.
- Where Environmental Services will locate and empty biomedical and routine waste containers.

Pathways should be marked in the map. Traffic coordinators should guide transporters who are entering with patients, or bringing them down for discharge. The locations of Traffic coordinators should also be identified in the map. Upon receiving his/her assignment, the first responsibility of the Assembly Point Director should be ensuring the AP is set-up appropriately in accordance with the AP map.
ASSEMBLY POINT CARE

Ideally, assembly point care should be conducted for only as long as it takes to arrange for appropriate transfer resources and destinations for all evacuated patients, or until it is safe to re-enter the building. Once patients arrive at the Assembly Point, only the minimum required care interventions should be continued as directed by the patient’s providers. During their time at the Assembly Point, some additional patients may be deemed appropriate for discharge. A sample process flow for patients being cared for in the AP is below.

Sample Process Flow for Assembly Point Care

Sample Guidelines for Assembly Point Care

1. The hospital Operations Chief will designate an Assembly Point Director, who, in turn, will designate a Clinical Supervisor and a Staging and External Transport Supervisor.

2. The Clinical Supervisor will oversee the individual patient care Unit Leaders at the Assembly Point. If there are too many units at a single Assembly Point for the Clinical Supervisor to manage, s/he may create Section Leaders to oversee groups of clinical units.

3. Every patient care unit should have a designated space in the Assembly Point. Similar units should be grouped together whenever possible.
4. All the critical supplies needed at the Assembly Point should have been pre-determined (see Assembly Point Guide in this Toolkit) and should be transported to the AP by the responsible department. In addition, patient care units should have pre-planned lists of special supplies/equipment that they will need to bring with them to support essential care. In some rare scenarios, it may be necessary to hold patients in the Assembly Point(s) for up to 24 hours. While hospitals may not plan to bring 24 hours of supplies to the Assembly Point initially, they should have plans for resupply of the Area(s) if patients remain in these areas after supplies begin to run out.

5. Oxygen conservation will be a critical issue if patients on oxygen cannot be transferred to other facilities quickly. Oxygen concentrators should be aggressively utilized if available.

6. In general, patients on contact and droplet infection control precautions should not be coholed in one area. Patients should remain with their units to maintain the integrity of their diagnosis/infection as much as possible but still adhere to the type of precautions required as possible. This approach enhances the staff’s ability to identify and manage the specific infection control needs. However, patients on airborne precautions may be segregated or coholed by the Unit with patients with the same diagnosis (e.g. TB with TB, Varicella with Varicella), in a separate location or at some distance from others if possible.
DISCHARGE SITE ORGANIZATION/CARE

Discharge Site Operations staff take charge of care for patients who, following the evacuation order, have been deemed appropriate for safe, rapid discharge from the hospital. Discharge Site leaders ensure that supplies and staff are ready and organized to supervise patients while they wait for transport to their home or other appropriate location. The Discharge Site takes responsibility for patients when they “check-in” and provides support until they leave the hospital.

DECISION AND PROCESS FOR OPENING DISCHARGE SITE

Upon issuing the order to evacuate, the hospital Incident Commander (or designee) may decide to open a dedicated discharge site to facilitate rapid and safe discharge of inpatients who would otherwise need to be transferred away from the hospital to other institutions.

SAMPLE PATIENT CRITERIA

- Patients whose ongoing medical diagnostic and/or treatment needs do not require inpatient hospitalization
- Patients who can be safely cared for at home.
- Transportation to home/family will occur within a 4-6 hour timeframe.
- Patients able to tolerate sitting up for 4-6 hours.

SAMPLE STAFFING REQUIREMENTS

- Leadership: one physician or nursing leader who is responsible for Discharge Site operations
- Registered nurses: one RN for approximately every 6-8 patients
- Clinical support staff: one nursing assistant for approximately every 12-16 patients
- Administrative support staff: one clerical staff and two volunteers for approximately every 20 patients
- Case manager: two case managers for approximately every 30 patients
- Pharmacy: one pharmacist per Discharge Site
- Medical staff: one physician, PA or NP per Discharge Site
- Medical records: one representative per Discharge Site
- Patient tracking/admitting: one person per Discharge Site
- Security: one officer per Discharge Site

DISCHARGE SITE SUPPLIES

General supply needs for the Discharge Site may include:
- Desk space for staff with computers, printers and phones
- Chairs/recliners/couches
- General medical supplies
- Paper supplies (progress note paper, medication sheets, blank computer paper)
- Linens (blankets, towels)
- Dietary supplies (snacks and meals)
- Toileting facilities/supplies
- Medical supplies (snacks and meals)
- Code cart
- Medical record processing (discharge chart management)

The care units should send the patients with all medications that may be needed for a 4-6 hour stay at the Discharge Site. However, if additional medications are needed while at the Discharge Site, a pharmacist should be responsible for obtaining those medications.
SAMPLE PROCESS FOR TRANSFERING PATIENTS TO AND FROM THE DISCHARGE SITE

The following steps should be taken to transfer patients to the Discharge Site:

1. Each patient’s clinician (MD, NP, or PA) determines, based upon the patient’s clinical situation, that the patient is suitable for discharge from the hospital.

2. The clinician documents a brief summary of all of the items below in the patient’s chart, or will communicate this information to the patient’s nurse. *If the patient’s responsible or responding clinician is not immediately available, the patient should be transported to the Assembly Point.*
   a. The patient is suitable for discharge and a discharge order is written
   b. All necessary prescriptions are written
   c. All treatments required following discharge are specified
   d. The patient’s follow up plan following discharge is clarified
   e. Any pertinent signs or symptoms the patient may need to watch for following discharge

3. Family members should be contacted about discharge and pick-up location if time allows. Information regarding who and how patient will be transported home should be noted on the Patient Evacuation Form. (If time does not allow, this step can be completed at the Discharge Site.)

4. All patients should have an identification bracelet documented to be in place before transfer to the Discharge Site.

5. Staff nurses who are preparing patients for transfer to the Discharge Site should provide the following information:
   a. Completed Patient Evacuation Form summarizing key information
   b. A short nursing discharge note

6. All personal items and relevant medical data should travel with the patient including:
   a. Medical record
   b. Medications and treatment supplies
   c. Belongings
   d. Place Card

7. Patient may then be transported to the Discharge Site, accompanied by staff or volunteer if possible.

8. The patient’s name and medical record information should be added to the tracking sheet upon arrival at the Discharge Site.

9. Patients will be discharged from the Discharge Site when family or other appropriate individuals arrive to transport the patient. The patient’s name and medical record information should be documented with the time of discharge. Patient tracking staff should routinely report the number of discharged patients to the hospital EOC.
STAGING AND EXTERNAL TRANSPORT

Staging and external transport staff manage patients as they “check-out” from the Assembly Point and load into ambulances and other transport vehicles to be taken to other hospitals. Leaders ensure that the patients’ travel needs are met (records, equipment, staff supervision if necessary), confirm patient identity and transfer destination, and document that the patients have left the hospital.

The process of managing patient flow out of the Assembly Point(s) and into the Staging area, in addition to managing waiting ambulances and other vehicles can rapidly become disorganized and/or create bottlenecks if the appropriate vehicles, equipment and staff are not available in a very timely manner. The Site is managed by a Staging and External Transport Supervisor, who is, in turn, supported by an Ambulance Flow Leader and a Loading Team Leader.

The Staging and External Transport Supervisor is responsible for the overall flow and accuracy of loading patients onto transport vehicles. S/he must maintain close communications with the Patient Destination Team to obtain continual updates on the destinations of the evacuating patients and ensure that all patients are sent to the correct facility and receiving unit. The Supervisor should try to keep the flow of patients into the Staging Area constant, calling for patients from the Assembly Point in anticipation of arriving ambulances so that traffic through the loading area remains brisk and efficient.

The Ambulance Flow Leader monitors the flow and rate of arriving ambulances and other transport vehicles, ensuring that ALS, BLS, chair car and other necessary vehicles are continually arriving to transfer patients to their evacuation destinations. S/he should work with the local EMS liaison to discuss transport vehicle needs or problems. S/he should also work closely with hospital security officials and the local police liaison to ensure smooth traffic flow into and out of the Staging Area. The hospital may choose to designate separate arrival and loading sites for ALS and BLS ambulances in the evacuation procedures to minimize confusion about the capabilities of the arriving crews, and to speed throughput of lower acuity patients.

The Loading Team Leader is responsible for the final matching of patients with their transporting vehicle and crew. S/he will maintain a log of which patients have left the hospital, noting the specific vehicle transporting them, the time they left, and what hospital equipment and/or personnel traveled with the patients.
Patients should be loaded onto the first available vehicle with the appropriate clinical capabilities to get them safely to their transfer destination. Ambulances without higher clinical capabilities (such as BLS ambulances) can be permitted to take higher acuity patients if hospital nurses or physicians travel with the patients with all necessary additional equipment and medications (including syringes and pumps). The Staging and External Transport team should identify cases where transport of hospital staff, supplies, and equipment may be necessary and request the needed supplies, medications and equipment as early as possible in the process to minimize loading and transfer delays.
FAMILY NOTIFICATION PROCESS

Family Notification unit members are responsible for attempting to notify family members and other related and responsible parties about patient transfer destinations, answering calls and responding to questions from family members about patient welfare and location. The Social Services Department, or similar functioning department, should take the responsibility for keeping families informed about the locations of the patients and their condition (when known). The Unit’s role includes:

- Contacting patients’ families to notify them about the impending evacuation.
- Managing a phone bank that will answer calls from families looking for information.
- Rounding at the Assembly Point to support patients, gathering information about their condition, and updating families as possible.
- Managing and determining locations for the primary and secondary family waiting areas for families that are on-site during the evacuation if they will not or cannot leave.

Key Points/Issues:

- Given the understandable anxiety that may surround a hospital evacuation, preparing evacuation risk communication messages ahead of time may help considerably in the family notification process. Quickly and accurately disseminating a reassuring message to families that also describes the process for obtaining further information about the status of their loved one may help prevent family members from arriving onsite, potentially threatening everyone’s safety, and degrading an already chaotic situation.
- Social Services may need to gather support from the Labor Pool to help staff the phone bank. They should consider what other staff within the hospital may best be suited to this task. They may also need runners to help relay information to and from the social workers on the floors.

Sample Guidelines for Family Notification

1. Many patients will want to call their families when the evacuation process begins. When time allows, nursing staff should encourage patients to place these calls while waiting for transport. Pre-templated “talking points” may be given to patients as they contact their families to help support the hospital response (i.e. “the hospital has a plan for this event”, “please do not come to the hospital”, “please call the following hotline for more information”, “please do not call the main hospital number”, etc.)

2. Public Affairs should encourage families to stay home until the patient has been transferred to a new facility (or until the hospital buildings are safe to re-enter).

3. A primary and secondary location should be designated that can handle and place calls to and from families during an evacuation.

4. Admitting will need to provide the Family Notification Unit with current lists of patients by unit with “next of kin” information for the phone bank.
SPECIAL PATIENT POPULATIONS

Although much of evacuation planning for the different individual care units can be generalized across the entire hospital, there are, of course, special populations within hospitals that need special planning and procedures. Below is an overview of guidance that may be given when planning for some of the special populations within a hospital.

Emergency Department Patients

All Emergency Department patients who have received a medical screening exam and do not have an emergency medical condition should be discharged. All others must be transferred to another facility, along with the hospital’s inpatient population. Overall, patients in the ED should be handled based on acuity, with the highest acuity patients transferred out first. Critical care patients may be grouped with the ICUs, depending on hospital plans.

Infants and Pediatric Patients

Ensuring that children are kept safe is a special consideration in evacuation planning. Infants and children should stay with their parent at all times, unless their parent is not on-site at the time of the evacuation. Before leaving the patient care unit, staff should band parents with their child’s information. Name bands should also be created for parents who aren’t present, so they can be banded at the time of reunification. Hospital staff must continuously accompany any children without parents to the Assembly Point.

All the pediatric patient care units should be kept together at the Assembly Point. The location of the pediatric units within the Assembly Point should be chosen for its safe perimeter (i.e. limited number of monitorable access points and child-safe outlets and fixtures). Door monitors should be assigned to make sure ambulatory children don’t wander. In addition, the Unit Leaders for each of the pediatric units should ensure that all other necessary equipment for the essential care for children are available at the Assembly Point (i.e. code carts, IV supplies, medications and pumps, etc.).

For verbal children without parents present, staff may use a form to ask questions and document answers (for example, what is your pet’s name?). This form can be used later for family reunification. If a parent is not present at the time of transfer to another facility, this form should travel with the child. If possible, photos should be taken of children before they are transported to another facility.

If parents do present to the Assembly Point, social work staff and security should work with pediatric staff to confirm identities and reunite the family.

Obstetric Patients

Patients in active labor, or who appear to be approaching active labor should generally not be transferred prior to delivery, except as directed by the obstetrics clinician. If a woman in labor needs to be transferred to another facility, the hospital should use its standard protocols for staffing and care of the patient. Such patients should be prioritized for immediate transfer.

Psychiatric Patients

For a variety of reasons, evacuating inpatient psychiatric patients will be challenging. The event will certainly exacerbate anxiety levels and other mental health issues for some patients. Further, there
are real safety concerns when moving secured patients out of the secure environment. Evacuating psychiatric patients requires close collaboration with psychiatric clinicians and with hospital security. In general, security staff should be in place before patients begin to move. The Unit Leader of a psychiatric unit should identify the different types of psychiatric patients for which separate transportation may need to be considered and relay this information to the Evacuation Coordinator and others in the hospital ICS. Patients who are violent or have extreme behavioral issues should bypass the Assembly Point. They should instead travel with a clinician and security and have secure transport arranged to a receiving facility. Patients who are not violent or medically complicated could be evacuated directly to a nearby psychiatric facility or other hospital via shuttle bus. They should be accompanied by both nursing and security staff during transport.

**Bariatric Patients**

Bariatric patients may need specialized equipment and additional staff for transport. Ideally, the hospital should have access to bariatric stretchers, wheelchairs, and transportation sleds for evacuation and staff trained to use these devices in an emergency. If these items are not available, the hospital evacuation protocols should indicate where they can be found in the event of an emergency evacuation.
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Purpose of Evacuation Floor Guide

This Guide has been developed to assist individual patient care units in both the pre-planning and the response phases of evacuation. Enclosed in this Guide are documents and tools that, when combined together, form a floor-level "Toolkit" for evacuation. Once adapted to meet the needs of the individual hospital and individual unit, the toolkit may be placed on every patient care unit ahead of time to speed and structure hospital evacuation. Staff on each unit should regularly review its contents and routinely conduct exercises using the specific tools to ensure familiarity with its contents.

Upon receiving the order to evacuate or to prepare to evacuate, nurses and others on the individual care units should open the toolkit and complete the appropriate checklist.
INTRODUCTION

Purpose of Evacuation Floor Guide
This Guide has been developed to assist individual patient care units in both the pre-planning and the response phases of evacuation. Enclosed in this Guide are documents and tools that, when combined together, form a floor-level “Toolkit” for evacuation. Once adapted to meet the needs of the individual hospital and individual unit, the toolkit may be placed on every patient care unit ahead of time to speed and structure hospital evacuation. Staff on each unit should regularly review its contents and routinely conduct exercises using the specific tools to ensure familiarity with its contents.

Upon receiving the order to evacuate or to prepare to evacuate, nurses and others on the individual care units should open the toolkit and complete the appropriate checklist.
UNIT EVACUATION PROCESS CHECKLIST

Complete all steps on this checklist upon receiving the order to evacuate or to prepare to evacuate

☐ The senior nurse on the unit (or other appropriate designee) should assume the role of “Unit Leader.” That individual should read and follow the “Unit Leader Job Action Sheet” in this toolkit.

☐ The Unit Leader should receive a briefing from the hospital “Evacuation Coordinator” or other senior leader in the hospital. If communications with leadership have been disrupted because of the emergency event, continue to begin to prepare the unit for possible evacuation by following the steps below.

☐ All unit staff should gather to briefly discuss the situation and communicate the response and evacuation plan (if known).

☐ Visitors may stay with the patient, or be directed to leave per the direction of the Unit Leader.

☐ The patients’ responsible and responding clinicians should respond to the unit to:
  o Reassess each patient’s clinical status.
  o Review and minimize all active medications and clinical interventions (i.e. supplemental oxygen, monitoring, etc.) Only those medications and interventions that will be essential until the patient is successfully evacuated and arrives at another hospital should be continued.
  o Write a brief summary of the patient’s inpatient course and treatment plan to assist clinicians at the receiving hospital in assuming safe care of the patient. Clinicians should be sure to include their own contact information in this documentation.
  o Give report to receiving clinicians at the receiving hospital (when possible).

☐ All nurses should complete one individual Patient Evacuation Form per patient that they are caring for. One copy of this form will travel with the patient when they leave the unit, the other copy stays with the unit for recordkeeping.
  o If the Unit Leader has patient assignments at this point, s/he should assign those patients to someone else to complete the forms and prepare the patients for evacuation.
  o Patients “off the unit” for testing or treatment at the time of evacuation may not return to the unit. Instead, they may be transported to the Assembly Point, and will rejoin the unit there, depending on the required urgency of the evacuation. Clinical staff caring for the patient “off-unit” will contact the Unit Leader to confirm this transport request and location. If patients do not return to the unit, nurses on the unit will bring a completed tracking form, and any necessary medical equipment, records, and medications to meet the patient at the Assembly Point.

☐ The Unit Leader will work with all staff on the unit to complete the Evacuation Tracking Log to ensure every patient is accounted for.
  o Once completed, this log must be faxed (or delivered) to the hospital Emergency Operations Center (EOC) so that hospital leaders have an accurate patient census and can begin arranging for beds to transfer evacuating patients.

☐ Determine if there are additional staff or transport equipment needs for evacuation after reviewing the Patient Evacuation Forms. Note these needs on the enclosed Request Form and fax (or deliver) to the EOC.
The Unit Leader should direct the staff nurses to begin to package patients for transport, including their medications, essential belongings, and needed medical equipment and supplies during transport. Assume that patients may be in transit for as long as 12 hours.

When notified by the hospital Evacuation Coordinator or Transport Coordinator, begin to send patients and staff to the Assembly Point and Discharge Site.

- All patients who will be evacuated away from the hospital should be taken to the unit's Assembly Point. Your unit's default Assembly Point is: ______________________
- All patients who will be discharged from the hospital should be taken to the hospital Discharge Site. The hospital's default Discharge Site is: ______________________

The Unit Leader should communicate with the Evacuation Coordinator and Transport Coordinator to learn the order of unit evacuations and ensure that all patients are safely transported to the Assembly Point or Discharge Site. Floor Coordinators will assist the Unit Leader with tracking and communications.

Patients are loaded onto elevators and taken to the Assembly Point in the order in which they become ready for internal transport. A clinical staff member will accompany the first transported patient(s) to ensure that the Assembly Point has at least one medical worker who can begin to care for the unit.

Other clinical staff members will accompany patients in transport as needed for medical monitoring and care. When the last patient leaves the unit, the Unit Leader and Floor Coordinator will travel to the Assembly Point to oversee care in the Assembly Point area.

As patients arrive in the Assembly Point, it may be necessary to take them off of the transport stretchers and wheelchairs in order to retrieve additional patients from the hospital. Transporters will work with clinical staff to identify which patients can be removed from the stretchers and chairs and assist with patient movement as appropriate when directed by clinical staff.

Once patients arrive at the Assembly Point, only the minimum required care interventions should be continued as directed by the patient's providers. All the critical supplies needed at the Assembly Point will be transported to the AP by the responsible department. In addition, patient care units should have pre-planned lists of special supplies/equipment that they will need to bring with them to support essential care.

In general, patients on contact and droplet infection control precautions should not be cohorted in one area in the Assembly Point. Patients should remain with their units to maintain the integrity of their diagnosis/infection but still adhere to the type of precautions required as possible. This approach enhances the staff’s ability to identify and manage the specific infection control needs. However, patients on airborne precautions may be segregated or cohorted by the Unit with patients with the same diagnosis (e.g. TB with TB, Varicella with Varicella), in a separate location or at some distance from others if possible.

Patients will be taken from the Assembly Point to a Staging Area for loading and transportation when EMS resources and a receiving institution bed becomes available. In the Staging Area, patients should be loaded onto the first available vehicle with the appropriate clinical capabilities to safely get them to their transfer destination. Ambulances without higher clinical capabilities (such as BLS ambulances) can be permitted to take higher acuity patients if hospital nurses or physicians travel with the patients with all necessary additional equipment and medications (including syringes and pumps).
UNIT LEADER JOB ACTION SHEET

YOU REPORT TO AN
EVACUATION COORDINATOR: Name: ___________________ Contact Number: ________________

Your Evacuation Coordinator should brief you on the following:
- Time available to prepare for leaving the unit: __________________________
- Assembly Point Assignment (where to gather after leaving the building): __________________________
- Discharge Site Location: (where discharged patients wait for rides) __________________________
- Elevator Assignment: __________________________ Stairwell Assignment: __________________________
- Directions for Non-Unit Staff: Stay and help / Report back to home unit
- Sequence of Evacuation: __________________________
- Staff Recycling: (Can clinicians return to unit after leaving?) Yes / No
- Labor Pool: Directions for staff at home who can come in to help _________________________
- Family Support Center Phone Number: ___________________________________

You should notify your Evacuation Coordinator about the following:
- Any critical patients who will be at high risk if evacuated/moved
- Any physical damage or other immediate threats to the building/systems in your area

1. Find the Unit Evacuation Process Checklist. Review the document, then read this entire document before you begin. You will be responsible for completing the Checklist in its entirety.

2. Find the Unit Leader vest in the Evacuation Toolkit and put it on so you can be easily identified.

3. Gather all staff on the unit and communicate the following:
   - Amount of time available to prepare for transport, and how transport will occur
   - Location of the Assembly Point and the Discharge Site
   - The elevator and/or stair assignments for your unit
   - Whether non-unit staff should stay and help, or report back to their home departments

4. Assign staff to the roles below, and distribute the Role Description Sheet and name tag to each.
   - Assign an administrative assistant or coordinator to:
     - Print the medical record of the patient’s current hospitalization (if electronic)
     - Print each patient’s active orders
     - Print patient identification labels and label bags for packing of the patients’ active medications
     - Deliver the printed orders and the patients’ med sheets with the patients’ charts to patient rooms
   - Assign an administrative assistant or coordinator to:
     - Man the phones and/or radio, fielding calls and responding appropriately

5. With staff, review the location and status of each patient and quickly record decisions on the Tracking Log. Be sure EVERY patient is accounted for, even those who are off the unit for testing.
   - Any patient who is off the unit will go straight to the Assembly Point and rejoin your unit there.
   - Fax copy of the tracking log (per instructions on form) so the process of bed-finding at another facility can begin.

6. Complete the Request Form and send per instructions on form.
Make a quick estimate of any additional staff needed to safely evacuate patients.
Determine any transport needs beyond wheelchairs and stretchers (oxygen, monitors, etc).
If no extra resources are needed, check the appropriate box on the form and send.

7. Ask staff nurses to complete individual Patient Evacuation Forms and begin preparing patients to travel.
   • Critical medications (and supplies to administer) need to be packed with the patient.
   • For any patients off the unit, nurses should still complete the form and pack meds.
   • Special needs, assistive/adaptive devices required.

8. If medical staff are available and there is time to process the discharge, patients may be discharged directly from the unit. Send patient directly to the Discharge Site to wait for their ride.
   • Patients who leave AMA should sign the routine form.

9. Locate the Unit-Specific Packing List in the Evacuation Toolkit and assign someone to gather and transport those items to the Assembly Point.

10. Ambulatory patients who can manage the stairs will leave the unit first.
    • If possible, send an experienced nurse with this first group of patients.
    • This person will be in charge of the unit at the Assembly Point until you get there.
    • There will also be some extra clinical staff at the Assembly Point to help receive patients.

11. Work with staff to move patients to stretchers or wheelchairs as appropriate.
    • The Internal Transportation Director will automatically bring more wheelchairs/stretchers to each floor as their turn for transport approaches.
    • There will be a Transport Coordinator who will work with you to help get patients ready to board the elevators and/or enter the stairwells.

12. Ensure all staff and patients leave the unit safely.
    • Have the last nurse on the unit quickly pack any extra meds, syringes, etc. from the med room.

13. Contact your Evacuation Coordinator when the unit is empty and ready for closing.

14. After closing, rejoin unit at the Assembly Point.
    • Notify “Patient Tracking” if any of your patients are missing.
COMMUNICATIONS JOB ACTION SHEET

1. Read this entire sheet before you begin.

2. Find Communications name tag in the Evacuation Tool Kit and put it on. It is important for everyone with an official role to be identified.

3. Each Unit Leader will report to an Evacuation Coordinator. Note his/her name and contact information below for quick reference.

   Our Unit Reports to: _________________________ Phone: _____________________

4. If phones are working, field calls and respond or triage as needed.

   Calls from hospital leaders should be handled appropriately.
   - Respond to questions and provide information as requested.
   - Relay instructions immediately to your Unit Leader.
   - Consult with your Unit Leader for any decisions that must be made.

   Calls from staff should be handled as directed by your Unit Leader. Typically, staff responding to an emergency will report to a central Labor Pool.

   Fill In Specific Instructions Here (i.e. where to report, where to call, etc.)

   Calls from patient families should be answered as quickly and completely as possible. Give whatever information you are able to provide, including where the patient will be going. If they need additional information, refer them to the Family Support Center.

   Family Support Center Phone: ________________

5. If phones are NOT working, communication will take place via cell phone or hand held radios.
   - Locate at least 2 cell phones that work on the unit. Fill in Cell Phone Numbers Here:

   ______________________________ ______________________________

6. After the unit has been evacuated, check with your Unit Leader for further instruction.
   - When directed to do so, contact an/the Evacuation Coordinator to report the unit is empty.
   - Leave the unit and rejoin staff at the designated Assembly Point.
PATIENT RECORD PREPARATION JOB ACTION SHEET

1. Read this entire sheet before you begin.

2. Find Patient Record Preparation name tag in the Evacuation Tool Kit and put it on. It is important for everyone with an official role to be identified.

3. Before starting record preparation, you need to create individual medication bags for patients. Find the plastic bags in the Evacuation Toolkit and stick a patient label on each bag.
   - Create a bag for every patient, even those who are “off the floor” or who may be discharged.
   - Leave labeled bags in the med room/area for nurses to fill.

4. Print orders and med sheet for each patient from the computer.
   - Print orders and med sheet for every patient, even those who are “off the floor” or who may be discharged.

5. Find the chart(s) for each patient and insert the printed orders in the front of the chart.
   - Include extra labels in the front of each chart if possible.
   - Provide orders for patients who are “off the floor” to your Unit Leader.

6. Bring the charts and orders to each patient in his/her room.

7. Check with your Unit Leader for further instruction.
**SAMPLE PATIENT EVACUATION TRACKING LOG**

**Directions for Unit Leader:**

1. Review patients with staff and record information. 
   - Unit Name: _________________________________
   - Unit Leader: _________________________________

2. As soon as form is completed, **FAX** to hospital Emergency Operations Center.
   - Pager/Cell Phone: _________________________________

---

<table>
<thead>
<tr>
<th>Patients (Use Labels)</th>
<th>Visitors?</th>
<th>Status</th>
<th>Acuity Category</th>
<th>Equipment Needs</th>
<th>Mode of Transport</th>
<th>Destination</th>
<th>Time Pt Left</th>
<th>Has Meds?</th>
<th>Pt Arrived</th>
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<td>Discharge Site</td>
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<td>Monitor</td>
<td>Stretcher</td>
<td>Other</td>
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</table>
REQUEST FORM

Completed By: Unit Leader or Dept Head
Fax To: Emergency Operations Center

Directions for Unit Leader:

1. Review patients with staff and record information.

2. As soon as form is completed, FAX to hospital Emergency Operations Center.

Requestor Information

Unit/Dept Name: _________________________________

Building/Floor: _________________________________

Your Name: _________________________________

Contact Number: _______________________________

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<tr>
<th>Type of Staff (Role)</th>
<th>Number Requested</th>
<th>Comments</th>
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<th>Equipment</th>
<th>Number Requested</th>
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<tbody>
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<td></td>
</tr>
</tbody>
</table>

Please be specific when making your request!
INPATIENT PREPARATION FOR EVACUATION
Information Sheet for Staff

Assembly Points
- Patient Care Units will stay together at the Assembly Point.
- There should be a few clinicians available at the Assembly Point to receive and help care for your patients.
- If time allows for discharge, appropriate patients may go straight to the Discharge Site.

Medications
- Pack 2 doses of each CRITICAL med in a bag that can accompany your patient.
- You should also pack any necessary IV fluids and/or tube feeds with your patient. (Standard tube feeds should also be available at the Assembly Point.)
- Additional meds (including narcotics) and blood products should be available at the Assembly Point.

Supplies
- Any supplies readily available in patient rooms can be packed with the patient.
- General medical supplies will be available at the Assembly Point, so do not take time to pack from the supply room.
- Unit-specific supplies and/or equipment (see back of this page) will be transported to the Assembly Point by the person assigned by your Unit Leader.

Patients on Oxygen
- Any patient currently on oxygen should remain on oxygen during transport if possible.
- Patients should stay on room oxygen as long as possible to preserve portable oxygen resources.

Patients on Ventilators
- During an evacuation, respiratory therapists will be dispatched to the units to assist you.
- If a travel ventilator isn’t available, the patient will be bagged during transport. The ventilator should accompany the patient and be reconnected if possible at the Assembly Point.

Patients on Monitors
- Only patients who have a potentially life-threatening indication will travel with portable monitors.

Patients “Off the Unit”
- Patients who are off the unit will go straight to the Assembly Point, and will re-join your unit there.
- Do not take time to pack their belongings but do make sure their critical meds, assistive devices, and Evacuation Form go to the Assembly Point.

Don’t Forget About You
- Take your purse/keys/etc. with you before you leave the unit.
Completed By: Staff Nurses

PATIENT EVACUATION FORM

Main Diagnosis: ________________
Allergies: ____________________
Attending/Team: ____________________
Family Notified: No Yes (who)
Patient’s Language: ____________________

<table>
<thead>
<tr>
<th>Precaution Status</th>
<th>None</th>
<th>Contact</th>
<th>Airborne</th>
<th>Droplet</th>
<th>Neutropenic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Status</td>
<td>Oriented</td>
<td>Lethargic</td>
<td>Confused</td>
<td>Suicide Precautions</td>
<td></td>
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<tr>
<td>Acuity Category</td>
<td>General Care</td>
<td>Step Down</td>
<td>ICU</td>
<td>Wig for Subacute</td>
<td></td>
</tr>
</tbody>
</table>

Priority Issues/Safety Concerns: ____________________

Critical Meds: ____________________ Include all needed to maintain patient stability

CLINICAL REQUIREMENTS (check boxes that apply)

- IV (List Med): [ ] Saline Lock [ ] Continuous Infusion [ ] None
- Oxygen: [ ] Need for Travel [ ] Need at Assembly Point [ ] None
- Monitoring: [ ] Need for Travel [ ] Need at Assembly Point [ ] None
- Vent/Respirator: [ ] Yes [ ] No
- Suction: [ ] Need for Travel [ ] Need at Assembly Point [ ] None
- Diet: [ ] NPO [ ] Tube Feeding [ ] (list) __________
- Transport Mode: [ ] Stretcher/ICU Bed [ ] Wheelchair [ ] Ambulatory
- Supervision During Transport: [ ] Needed — Clinical [ ] Needed — Non Clinical [ ] Not Needed

PACKING LIST (check for readiness to travel)

- [ ] Meds  [ ] MD Orders  [ ] ID Band  [ ] Pt Belongings  [ ] Mobility Device
- [ ] IV Fluids  [ ] Chart  [ ] Special Equipment/Supplies

COMMENTS/UNIT SPECIFIC INFORMATION

PATIENT DESTINATION

[ ] Assembly Point [ ] Discharge Site [ ] Home (Direct) [ ] AMA

Estimated Pickup Time: __________

CLINICIAN SIGNATURE: ____________________ [ ] Ready to Move

Directions: Original form stays with patient. Give carbon copy to your Unit Leader.
Each inpatient care unit will be required to identify specific items they will need when caring for their patient population at the Assembly Point. They must pack and transport these items to the Assembly Point to be used for care of their population if required.

Below is an example of such a list.

<table>
<thead>
<tr>
<th>UNIT XX ASSEMBLY POINT PACKING LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>#6, #7, and #8 Trachs (1 of each)</td>
</tr>
<tr>
<td>Ab Visor (patient specific)</td>
</tr>
<tr>
<td>Atrium closed drainage kits (2)</td>
</tr>
<tr>
<td>Battery Charging Strips for portable equipment</td>
</tr>
<tr>
<td>Bovie Machine (if present on the unit)</td>
</tr>
<tr>
<td>Bronchoscope</td>
</tr>
<tr>
<td>Central Line Insertion Kit</td>
</tr>
<tr>
<td>Chest Tubes/Chest Tube Drainage – these will be available at the AP</td>
</tr>
<tr>
<td>CO2 Detector</td>
</tr>
<tr>
<td>CVVH Machine with disposables and replacement fluids</td>
</tr>
<tr>
<td>Doppler</td>
</tr>
<tr>
<td>Fluid Warmer + Tubing (patient specific)</td>
</tr>
<tr>
<td>Internal Defibrillator Paddles</td>
</tr>
<tr>
<td>Internal paddles (1)</td>
</tr>
<tr>
<td>Kelly Clamps for chest tubes</td>
</tr>
<tr>
<td>Kerlix Bandage 4.5 in X 4.1 yd</td>
</tr>
<tr>
<td>Line Cart</td>
</tr>
<tr>
<td>Medtronic pacer box (4)</td>
</tr>
<tr>
<td>Monitor with pressure monitor capabilities</td>
</tr>
<tr>
<td>Open Chest Kit</td>
</tr>
<tr>
<td>Open chest tray (1)</td>
</tr>
<tr>
<td>PiCCO + Lines</td>
</tr>
<tr>
<td>Plastic Sheets (patient specific –hypothermia)</td>
</tr>
<tr>
<td>Pulmonary Artery Catheter</td>
</tr>
<tr>
<td>PVU, emergency batteries, hand pump, controller, with integrated reserve battery, wearable battery, charger and accessories</td>
</tr>
<tr>
<td>Resuscitation Fluid (patient specific –e.g. Lactated Ringers, Albumin)</td>
</tr>
<tr>
<td>Specific items for Thoratec and Levacor)</td>
</tr>
<tr>
<td>Temporary pacemaker wires, generators and magnets</td>
</tr>
<tr>
<td>Thoracentesis Kit</td>
</tr>
<tr>
<td>Trach Ties (3)</td>
</tr>
<tr>
<td>Transducer Set-ups</td>
</tr>
</tbody>
</table>
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**UNIT XX ASSEMBLY POINT PACKING LIST**

1. #6, #7, and #8 Trachs (1 of each)
2. Ab Visor (patient specific)
3. Atrium closed drainage kits (2)
4. Battery Charging Strips for portable equipment
5. Bovie Machine (if present on the unit)
6. Bronchoscope
7. Central Line Insertion Kit
8. Chest Tubes/Chest Tube Drainage
9. CO2 Detector
10. CVVH Machine with disposables and replacement fluids
11. Doppler
12. Fluid Warmer + Tubing (patient specific)
13. Internal Defibrillator Paddles
14. Internal paddles (1)
15. Kelly Clamps for chest tubes
16. Kerlix Bandage 4.5 in X 4.1 yd
17. Line Cart
18. Medtronic pacer box (4)
19. Monitor with pressure monitor capabilities
20. Open Chest Kit
21. Open chest tray (1)
22. PiCCO + Lines
23. Plastic Sheets (patient specific – hypothermia)
24. Pulmonary Artery Catheter
25. PVU, emergency batteries, hand pump, controller, with integrated reserve battery, wearable battery, charger and accessories
26. Resuscitation Fluid (patient specific – e.g. Lactated Ringers, Albumin)
27. Items for Thoratec and Levacor
28. Temporary pacemaker wires, generators and magnets
29. Thoracentesis Kit
30. Trach Ties (3)
31. Transducer Set

**MDPH HOSPITAL EVACUATION TOOLKIT**

**IV. EVACUATION STAFFING GUIDANCE**
# Table of Contents

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ASSEMBLY POINT CLINICAL SUPERVISOR JOB ACTION SHEET ................................. 74  
STAGING AND EXTERNAL TRANSPORT AREA SUPERVISOR JOB ACTION SHEET .......................... 75
Purpose of the Evacuation Staffing Guidance

The Evacuation Staffing Guidance describes selected specific job functions that may be needed in a hospital’s incident command structure to fill integral roles in the event of an evacuation and supplies sample Job Action Sheets (JAS) for those functions. These functions are meant to supplement, not replace, the usual hospital ICS positions. This Guidance also supplies a staffing checklist for the Incident Commander to help ensure that positions with the appropriate capabilities to support evacuation are filled. Hospitals will need to carefully review this guidance and decide which of these suggested roles and functions are useful within their own evacuation planning and adapt them as necessary to their local system and structures.
INTRODUCTION

Purpose of the Evacuation Staffing Guidance
The Evacuation Staffing Guidance describes selected specific job functions that may be needed in a hospital’s incident command structure to fill integral roles in the event of an evacuation and supplies sample Job Action Sheets (JAS) for those functions. These functions are meant to supplement, not replace, the usual hospital ICS positions. This Guidance also supplies a staffing checklist for the Incident Commander to help ensure that positions with the appropriate capabilities to support evacuation are filled. Hospitals will need to carefully review this guidance and decide which of these suggested roles and functions are useful within their own evacuation planning and adapt them as necessary to their local system and structures.
Make Specific Assignments for Evacuation (in addition to usual ICS assignments)

Assign one or more EVACUATION COORDINATORS:

Staff serving in this role are responsible for communicating with each unit and monitoring their progress as they prepare to evacuate and package their patients to ensure each unit is safely evacuated. Each Evacuation Coordinator should have approximately 5, and not more than 7, evacuating patient care units to manage. Use the form (Evacuation Tracking Sheet by Unit) in this toolkit to record which units are assigned to each coordinator.

Evacuation coordinators need to tell the units about these decisions:
- Can elevators be used (if so, which ones)? If not, which stairwells will be used?
- Are transport sleds or other specialty equipment available? (see plan for details)
- Should non-unit staff return to their departments or stay where they are and help evacuate patients?
- Can staff recycle back into main campus buildings after exiting with evacuated patients?
- Where should unassigned staff report for Labor Pool assignments?
- What is the anticipated order of unit evacuation?
Make Specific Assignments for Evacuation (continued)

- Assign one: INTERNAL TRANSPORTATION TEAM DIRECTOR:
  The position is responsible for deploying and managing staff who will transport patients from the individual care units to the Assembly Point(s), Discharge Site, and Staging Area(s). S/he will monitor available elevator and stairwell usage and will work with outside public safety representatives (i.e. fire, EMS, and police) to coordinate manpower and equipment use for transport.

- Assign one: PATIENT DESTINATION TEAM DIRECTOR:
  The destination team director will need to assemble and lead this team as soon as it is clear that building re-entry is not feasible.

- Assign one or more: ASSEMBLY POINT DIRECTOR(S):
  The position should be filled with a senior manager with excellent operational skills who will be in charge of each Assembly Point. The Assembly Point Director will designate a Clinical Supervisor and a Staging and External Transport Supervisor who will report to the AP Director. The Clinical Supervisor will oversee the individual patient care Unit Leaders at the Assembly Point.

  If there are too many units at a single Assembly Point for one Clinical Supervisor to manage, the Assembly Point Director may name Section Leaders to oversee groups of clinical Unit Leaders under the Clinical Supervisor.
Evacuation Coordinator Job Action Sheet

YOU REPORT TO THE
OPERATIONS CHIEF: Name: ___________________ Contact Number: _________________

YOUR ASSIGNED PATIENT CARE UNITS ARE: ______________________
You are responsible for:
  o Making sure your units have been notified about the evacuation, and have been given all necessary information
  o Providing guidance to each Unit Leader
  o Monitoring the pace of preparations for each unit’s evacuation
  o Troubleshooting any issues in preparation for evacuation
  o Coordinating with the Internal Transportation Director to obtain sufficient transportation resources to evacuate your assigned units
  o Knowing when each of your units has evacuated
  o Escalating issues as appropriate

You should notify the HICS Operations Chief immediately about the following:
  o Any units where patients/staff are in immediate danger
  o Any units where building/systems have significant damage
  o Any unmet needs for additional resources

1. Read this entire sheet before you begin.
2. Put on the vest/nametag labeled “Evacuation Coordinator” so you can be easily identified. Get a radio/phone for communication.
3. Contact each of your assigned patient care units and ask to speak with the Unit Leader.
   a. Confirm the evacuation order and amount of time they have to prepare to leave.
   b. Give the Unit Leader your contact number.
   c. Find out if anyone is in immediate danger, or if there is significant damage to the building/systems on that unit (If so, relay information back to HICS Operations Leader immediately).
   d. Direct staff to find and complete the Evacuation Toolkit.
4. After completing the first round of calls to each unit, call each unit again to provide more information including:
   a. Assembly Point location
   b. Discharge Site location
   c. Elevator and/or stairwell assignment
   d. Whether staff can re-enter building after leaving
   e. Family Support Center location and phone number (for families on-site, or those who need to call for information)
5. Direct the Unit Leader to gather staff and quickly complete the patient tracking log. This log must be faxed or delivered to the Admitting Office as soon as possible.
   a. Ask the Unit Leader about any fragile patients that may not survive a move.
   b. Work with Incident Command and the unit leader to make decisions about moving these patients.
6. Continually check-in with units often to answer questions and support staff. Units MUST contact you when they begin leaving the unit and when they have completed their evacuation.
   a. Ask the Unit Leader specifically: are all the patients gone?
   b. Ask the Unit Leader specifically: are all the staff gone?
7. Notify the Operations Chief as each unit evacuates. Communicate any problems as appropriate.
Internal Transportation Team Director Job Action Sheet

YOU REPORT TO THE OPERATIONS CHIEF: Name: ___________________ Contact Number: ___________________

You are responsible for:
• Identifying which elevators and stairwells may be used for evacuation.
• Communicating with the Operations Chief to determine the order of unit evacuation.
• Muster sufficient staff to transport all hospital patients to the Assembly Point(s), Discharge Area, and Staging Area(s).
• Identifying available and needed equipment for patient transportation (stretchers, wheelchairs, transportation sleds, stair chairs, etc.).
• Coordinating use of manpower and equipment with external public safety authorities (i.e. fire, EMS, police).
• Managing transportation assets to ensure the most efficient flow of patients out of the institution possible.
• Communicating with the Evacuation Coordinator(s) to inform them of the timing and availability of transportation assets to the individual units.
• Identifying and troubleshooting any bottlenecks in flow.

You should notify the OPERATIONS CHIEF about the following:
• Need for more staff or resources
• Obvious bottlenecks in flow

1. Read this entire sheet, including the attached diagram, before you begin.
2. Put on vest/nametag labeled “Internal Transportation Team Director” so you can be easily identified.
3. Muster staff to transport all hospital patients to the Assembly Point(s), Discharge Area, and Staging Area(s). Work with the Labor Pool as needed to obtain additional staff. Determine the training, fitness and physical capabilities of responding staff to lift and move patients.
4. Identify and gather available and needed equipment for patient transportation (stretchers, wheelchairs, transportation sleds, stair chairs, etc.).
5. Communicate with the Operations Chief and/or Security to identify which elevators and stairwells may be used for evacuation.
6. Communicate with the Operations Chief to determine the order of unit evacuation. Begin to deploy equipment and staff to the first units to evacuate.
7. Coordinate use of manpower and equipment with external public safety authorities (i.e. fire, EMS, police).
8. Manage transportation assets to ensure the most efficient flow of patients out of the institution possible. Monitor for bottlenecks to flow and troubleshoot those bottlenecks.
9. Routinely communicate with the Evacuation Coordinator(s) to inform them of the timing and availability of transportation assets to the individual units.
Patient Destination Team Leader Job Action Sheet

YOU REPORT TO THE OPERATIONS CHIEF: Name: ___________________ Contact Number: ________________

You are responsible for:
- Identifying all patients who require transfer to other hospitals
- Working with admitting, nursing, physician, case management and other hospital representatives to identify the destination and transportation needs of the evacuating patients
- Working with local and state public health authorities to ensure that the process of bed finding runs smoothly
- Identifying the timeline for bed availability at receiving hospitals and communicating that timeline to the Operations Chief and Incident Commander
- Ensuring that patient placement decisions are communicated to the Assembly Point and Staging Leaders
- Escalating issues as appropriate

You should notify the Operations Chief about the following:
- Any tracking logs from the patient care units that are missing
- Physicians who are circumventing the process
- Need for additional resources

1. Read this entire sheet before you begin.

2. Put on the vest/nametag labeled “Patient Destination Team Leader” so you can be easily identified.

3. Obtain a radio/phone for communication.
   a. Also, get a list of the Assembly Point and Staging Area Leaders so your team can communicate placement and transfer decisions

4. Assemble the team, making sure it includes the following role groups:
   a. Admitting
   b. Inpatient clinical supervisors
   c. Case management
   d. Inpatient physician representatives
   e. Specialty service representatives as appropriate

5. Quickly have team review the number and types of patients in-house to gain basic situational awareness of the evacuation needs.

6. Contact public health authorities to begin discussions on the numbers and types of patients that will require evacuation. Maintain continual contact with them in person or electronically during the process.

7. Review patient tracking logs from all patient care units as they are faxed or delivered.
   a. If logs are missing, inform Operations Chief ASAP

8. Determine which patients will be a priority for direct transfer to another facility.
   a. Patients requiring direct transfer to an OR or ICU (bypassing the Assembly Point)
   b. Patients requiring secure transfer (bypassing the Assembly Point)
9. Begin matching patients with appropriate beds and level of EMS transport required. Assign team members to be responsible for specific functions.
   a. Recording decisions
   b. Contacting other facilities and/or Department of Public Health (DPH) to confirm bed availability
   c. Contacting Assembly Point and Staging Leaders with decisions or requests for more information
   d. Contacting the “Evacuation Coordinators” to facilitate the timing for the direct, priority transfers

10. Every hour, provide a status update to the Operations Chief.
    a. Number of patients discharged home (or left AMA)
    b. Number of patients “matched” with another facility
    c. Number of patients left to match
    d. Estimated time remaining to match all patients

11. Escalate any problems or issues that need resolution.
Assembly Point Director Job Action Sheet

YOU REPORT TO THE OPERATIONS CHIEF: Name: ________________ Contact Number: ________________

You are responsible for:
- Making sure all of the key departments are present to set up the Assembly Point (AP)
- Ensure the AP is set-up correctly
- Appointing a Clinical Supervisor and a Staging and External Transportation Supervisor
- Ensuring appropriate signage is displayed at AP
- Monitoring the arrival of individual patients and units to the AP
- Monitoring the care of patients in the AP
- Responding to requests for information from the Incident Commander or Operations Chief
- Assessing Assembly Point operations and solving any problems or bottlenecks as they surface
- Ensuring any resource shortages are identified quickly and addressed
- Communicating with the Patient Destination Team and Staging Area leaders to ensure patients flow out of the AP as quickly as possible
- Escalating any other issues as appropriate

You should notify the Operations Chief about the following:
- Need for additional resources

1. Read this entire sheet before you begin.
2. Put on the vest/nametag labeled “Assembly Point Director” so you can be easily identified.
3. Get a radio/phone for communication.
4. Work with the Operations Chief to assign staff to the positions reporting to you at the Assembly Point (see organization chart on next page).
5. Give job action sheets/role descriptions to your reports, and provide additional direction as needed.
6. Ensure all relevant departments are present and working to set up support at the AP.
   a. ED (Emergency Medical Stabilization Area)
   b. Admitting (Patient Tracking)
   c. Environmental Services (Supply and Signage Setup)
   d. Buildings and Grounds (Power, Lighting, Heating/Cooling Setup)
   e. Social Services (Call Center and Family Waiting Areas)
   f. Pharmacy
   g. Materials Management
   h. Blood Bank (if needed)
   i. Food and Nutrition Services
   j. Security
7. Ensure signage is posted in lobby/entrance/key areas.
8. Communicate regularly with the Clinical Supervisor to monitor and assess activities for problems or bottlenecks. Address issues and resolve. Communicate issues as needed.
9. Work with leaders of the supply departments to ensure adequate resources are available.

10. Communicate with the Patient Destination Team and Staging Area leaders to ensure patients flow out of the AP as quickly as possible.

11. Monitor staff for signs of fatigue. Request replacement staff if needed.
Assembly Point Clinical Supervisor Job Action Sheet

YOU REPORT TO THE ASSEMBLY POINT DIRECTOR: Name: _________________ Contact Number: _________________

You are responsible for:
- Providing support and guidance to the Emergency Medical Stabilization Leader and the individual Unit Leaders
- If there are more than 5-7 Units to supervise, designating Section Leaders to supervise groups of approximately 5 Unit Leaders and report to you directly
- Ensuring a Rapid Response team is available for codes or acute medical emergencies
- Communicating with the Assembly Point Director to ensure that there are sufficient clinical staff and medical supplies present to support essential care
- Escalating issues as appropriate

You should notify the Assembly Point Director about the following:
- Issues that cannot be resolved
- Need for more staffing or resources

1. Read this entire sheet before you begin.
2. Put on the vest/nametag labeled “A.P. Clinical Supervisor” so you can be easily identified.
3. Get a radio/phone from the A.P. Director for communication.
4. If there are more than 5-7 Units to supervise, appoint sufficient Division/Group Supervisors to supervise groups of approximately 5 Unit Leaders (individual patient care units) and report to you directly.
5. Identify the Emergency Medical Stabilization Area and confirm that it is set up and able to provide care. Designate a physician/nurse team from this area who can respond to codes at the Assembly Point.
6. Periodically contact the Unit Leaders and the Emergency Medical Stabilization Leader for status updates. Ask them about resource needs and any problems.
7. Notify A.P. Director of any unresolved issues or concerns.
Staging and External Transport Area Supervisor Job Action Sheet

YOU REPORT TO THE
ASSEMBLY POINT DIRECTOR: Name: ______________     Contact Number: ________________

You are responsible for:
- Making sure appropriate EMS and other vehicles are requested for transport
- Making sure staff are in place for staging and loading of patients who are being transferred to other facilities
- Assessing the process, solving problems, and eliminating bottlenecks
- Providing direction to the loading teams
- Communicating regularly with the EMS liaison
- Communicating with Security and Police representatives to identify and resolve any traffic flow issues
- Escalating issues to Assembly Point Director when appropriate

You should notify the Assembly Point Director about the following:
- Need for additional staff
- Need for additional vehicles
- Any issues that need resolution

1. Read this entire sheet before you begin.
2. Put on the vest/nametag labeled ‘Staging and External Transport Supervisor’ so you can be easily identified.
3. Get a radio/phone from Assembly Point Director for communication.
4. Ensure pathways/areas for staging patients in the lobby are clearly identified and ready.
5. Ensure vehicles are requested, staged and ready to transport patients. EMS will have a liaison to assist with ambulance staging.
6. There should be at least two teams who will be responsible for loading patients into vehicles and ensuring they can travel safely to their destination. Each team will include a:
   a. Clinician (experienced ED clinician who can confirm that the appropriate staff, supplies and equipment needed are present)
   b. Biomedical engineer (to retrieve or track hospital equipment travelling with the patient)
   c. Loader (anyone strong who can help get patients into vehicles) must be supervised by EMS to ensure that they do not injure themselves or the patients with improper loading
   d. Patient tracking representative to document the specific vehicle used for transport and time of departure for each patient.
7. Ensure all relevant departments/staff are in place and ready to move, discharge and load patients.
8. Supervise process and ensure any bottlenecks are resolved. Periodically evaluate need for more loading teams, and more clinical staff in the travel pool.
9. Escalate any issues to the Assembly Point Director.
MDPH HOSPITAL EVACUATION TOOLKIT

V. ASSEMBLY POINT GUIDE
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# Table of Contents

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NUTRITIONAL DISASTER SUPPLY LIST FOR ASSEMBLY POINT ........................................ 85
Purpose of Assembly Point Guide

The hospital should identify several locations surrounding the hospital that could be used as Assembly Points in the event that a rapid evacuation must take place and patients will need to be immediately relocated to a safe location.

This Assembly Point can serve as the place where patients would gather (outside the hospital) to receive basic care and await transfer, or re-entry back into the hospital. The Assembly Point should not be a comprehensive field hospital. The Assembly Point should be designed as a holding area with limited care resources.

This guide provides the direction required to ensure that supplies, equipment and staff are ready and organized to care for patients. The Assembly Point should take responsibility when patients “check-in” and manages care until patients are ready to transfer to another facility or be discharged to home via the Discharge Site.
INTRODUCTION

Purpose of Assembly Point Guide
The hospital should identify several locations surrounding the hospital that could be used as Assembly Points in the event that a rapid evacuation must take place and patients will need to be immediately relocated to a safe location.

This Assembly Point can serve as the place where patients would gather (outside the hospital) to receive basic care and await transfer, or re-entry back into the hospital. The Assembly Point should not be a comprehensive field hospital. The Assembly Point should be designed as a holding area with limited care resources.

This guide provides the direction required to ensure that supplies, equipment and staff are ready and organized to care for patients. The Assembly Point should take responsibility when patients “check-in” and manages care until patients are ready to transfer to another facility or be discharged to home via the Discharge Site.
ASSEMBLY POINT SET-UP GUIDELINES

The Assembly Point Director should coordinate the work of the various departments involved in Assembly Point set-up. The following departments should have primary responsibility for getting the Assembly Point ready to receive patients:

**Environmental Services**: cleaning supplies; tables/chairs; trash cans/gloves/masks

**Facilities Maintenance**: electrical support; extra lighting, heating or cooling as needed

**Materials Management**: clean supply areas; medical equipment and oxygen, code carts

In addition, the departments below are responsible for setting-up appropriate areas so they can support patient care at the Assembly Point:

- Pharmacy
- Biomedical Engineering
- Food and Nutrition Services
- Respiratory Care
- Blood Bank
- Admitting (Patient Tracking areas)
- Clinical Labs
- Telecommunications (Phone Bank)
- Social Services (Family Waiting Areas)
- Security

**Entrance Area**

Basic supplies (trash cans, hand hygiene liquid, gloves/masks) will be needed throughout the entrance area.

Clear pathways and signage are critical for ensuring a high volume of patients can move quickly through Patient Tracking and into the patient care areas. Pathways to enter and exit the Assembly Point should be tested and documented.

**Emergency Medical Stabilization Area**

Medical supplies and equipment should be transported and organized by Emergency Department staff. However they may also need:

- Dirty Utility area (see list on next page)
- Oxygen tanks
- Electrical support
- Portable Lights (if needed)
- Portable Heat or Cooling (if needed)

**Patient Care Areas**

The Assembly Point Director should have primary responsibility for directing the set-up process. S/he should ensure signage is visible, and make decisions about where items are placed if there is a need to vary from the basic plan. Each care unit space should have:

- Clean supply station with basic medical supplies
- Dirty utility area
- 1 Code cart
- Oxygen tanks/oxygen concentrator
- Charging station for batteries
- Electrical support
- Portable lights (if needed)
- Portable heat or cooling (if needed)

<table>
<thead>
<tr>
<th>Clean Supplies</th>
<th>Dirty Utility Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linens – sheets, blankets, pillows, towels</td>
<td>Trash can</td>
</tr>
<tr>
<td>Infection Control – gloves, masks, disinfectant wipes</td>
<td>Sharps disposals</td>
</tr>
</tbody>
</table>
The Assembly Point Director should coordinate the work of the various departments involved in Assembly Point setup. The following departments should have primary responsibility for getting the Assembly Point ready to receive patients:

- **Environmental Services**: cleaning supplies; tables/chairs; trash cans/gloves/masks
- **Facilities Maintenance**: electrical support; extra lighting, heating or cooling as needed
- **Materials Management**: clean supply areas; medical equipment and oxygen, code carts

In addition, the departments below are responsible for setting up appropriate areas so they can support patient care at the Assembly Point:

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- **Biomedical Engineering**
- **Food and Nutrition Services**
- **Respiratory Care**
- **Blood Bank**
- **Admitting (Patient Tracking areas)**
- **Clinical Labs**
- **Telecommunications (Phone Bank)**
- **Social Services (Family Waiting Areas)**
- **Security Entrance Area**

Basic supplies (trash cans, hand hygiene liquid, gloves/masks) will be needed throughout the entrance area. Clear pathways and signage are critical for ensuring a high volume of patients can move quickly through Patient Tracking and into the patient care areas. Pathways to enter and exit the Assembly Point should be tested and documented.

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**Patient Care Areas**

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- Dirty utility area
- 1 Code cart
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- Charging station for batteries
- Electrical support
- Portable lights (if needed)
- Portable heat or cooling (if needed)

**Clean Supplies**

**Dirty Utility Supplies**

<table>
<thead>
<tr>
<th>Clean Supplies</th>
<th>Dirty Utility Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Supplies – per list</td>
<td>Linen hampers</td>
</tr>
<tr>
<td>Admin Supplies – forms, clipboards and pens</td>
<td></td>
</tr>
</tbody>
</table>

Most of the medical and general clean supplies should be kept in the centralized clean supply stations. However, as part of the set-up process, heavily used items (gloves, hand hygiene liquid, hooks for hanging IVs, etc) should be placed throughout the section.

It is essential to sketch out a diagram of the Assembly Point set up as it would appear in the designated location chosen for the Assembly Point before using the space in an emergency.
ASSEMBLY POINT SURVEY TOOL

In deciding where to designate your Assembly Point, it is important to survey internal and external facilities to find the most suitable location. Below is an example of a survey tool that a hospital may use to review the potential patient and resource capacity of available locations to determine if they would serve as an adequate assembly points.

<table>
<thead>
<tr>
<th>Location</th>
<th>Seated</th>
<th>Wheelchair</th>
<th>Stretcher</th>
<th>Power</th>
<th>Phone</th>
<th>Distance</th>
<th>Computer</th>
<th>Vehicle Access</th>
<th>Weather Limiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Procedural Suite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>500 ft</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ambulatory building 2nd floor conf. rooms</td>
<td>50</td>
<td>40</td>
<td>15</td>
<td>Yes</td>
<td>Yes</td>
<td>350 yds</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ambulatory building 4th floor conf. rooms</td>
<td>40</td>
<td>30</td>
<td>10</td>
<td>Yes</td>
<td>Yes</td>
<td>350 yds</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ambulatory building 4th OB/GYN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>350 yds</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Neighboring Hotel Function rooms</td>
<td>100+</td>
<td>50</td>
<td>58</td>
<td>Yes</td>
<td>Yes</td>
<td>700 yds</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Neighboring Church</td>
<td>150+</td>
<td>50</td>
<td>10 to 20</td>
<td>Yes</td>
<td>Yes</td>
<td>750 yds</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Adjacent Parking Garage</td>
<td>200</td>
<td>200</td>
<td>50</td>
<td>No</td>
<td>No</td>
<td>300 yds</td>
<td>No</td>
<td>Yes</td>
<td>Limited</td>
</tr>
<tr>
<td>Adjacent Health Club</td>
<td>100</td>
<td>100</td>
<td>25</td>
<td>Limited</td>
<td>No</td>
<td>.25 mile</td>
<td>No</td>
<td>Limited</td>
<td>Yes</td>
</tr>
<tr>
<td>Adjacent Soccer Field *</td>
<td>All</td>
<td>All</td>
<td>200+</td>
<td>No</td>
<td>No</td>
<td>1000 yds</td>
<td>No</td>
<td>Limited</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Ground conditions would hamper wheelchairs and stretchers – seats would need to be supplied to the area as well.

#Elevator is not large enough to transport hospital beds/stretchers unless they were disassembled.
NUTRITIONAL DISASTER SUPPLY LIST FOR ASSEMBLY POINT
(Supporting approximately 1,000 patients, staff and visitors for 24 hours)

<table>
<thead>
<tr>
<th>Non-Perishable Food Items</th>
<th>Quantity</th>
<th>Meal #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy Bars</td>
<td>25 cases/72 bars</td>
<td>Energy Bar</td>
</tr>
<tr>
<td>Tuna, can individual 3 oz</td>
<td>75 cases/12</td>
<td>Cold Cereal</td>
</tr>
<tr>
<td>Crackers, Saltine individual</td>
<td>6 cases/500</td>
<td>Milk</td>
</tr>
<tr>
<td>Mayonnaise, packet</td>
<td>4 cases/500</td>
<td>Juice</td>
</tr>
<tr>
<td>Applesauce/Peaches, individual</td>
<td>25 cases/72 each</td>
<td>Water</td>
</tr>
<tr>
<td>Milk, shelf stable</td>
<td>10 cases 12/32 oz</td>
<td></td>
</tr>
<tr>
<td>Cold Cereal, assorted individual boxes</td>
<td>13 cases/70 boxes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutritional Supplements</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Meal Replacement, 8 oz bottle</td>
<td>50 cases/24 bottles</td>
<td></td>
</tr>
<tr>
<td>Meal Replacement 8 oz bottle (Diabetics)</td>
<td>25 cases/24 bottles</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infant Formula</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enfamil 20 cal-ready to use 6 oz bottles</td>
<td>4 cases/24 bottles</td>
<td></td>
</tr>
<tr>
<td>Standard Nipples</td>
<td>1 case/240 each</td>
<td></td>
</tr>
<tr>
<td>Pedialyte-ready to use bottles 2 oz</td>
<td>4 cases/48 bottles</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tube Feedings</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Meal Replacement 1.0 Ready to Hang</td>
<td>5 cases/8 liters</td>
<td>Canned Tuna</td>
</tr>
<tr>
<td>Meal Replacement 1.0 Ready to Hang</td>
<td>1 case/8 liters</td>
<td>Crackers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mayonnaise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peaches</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meal Replacement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Water</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Water/Juices</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Juice, can 5.5 oz Apple/Cranberry</td>
<td>38 cases/48 cans</td>
<td></td>
</tr>
<tr>
<td>Water, Spring 16.9 oz bottle</td>
<td>165 cases/24 bottles</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paper Supplies</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowls, 12 oz</td>
<td>2 case/1000</td>
<td></td>
</tr>
<tr>
<td>Bag, brown 10#</td>
<td>6 bundles/500</td>
<td></td>
</tr>
<tr>
<td>Napkin, dinner</td>
<td>2 cases/3000</td>
<td></td>
</tr>
<tr>
<td>Spoon, Soup plastic</td>
<td>3 case/1000</td>
<td></td>
</tr>
<tr>
<td>Knife, plastic</td>
<td>1 case/1000</td>
<td></td>
</tr>
<tr>
<td>Cup, 7 oz plastic</td>
<td>3 cases/2500</td>
<td></td>
</tr>
</tbody>
</table>
MDPH HOSPITAL EVACUATION TOOLKIT

VI. EMERGENCY RECEIVER GUIDANCE
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EMERGENCY RECEIVER GUIDANCE ............................................................................... 91
INTRODUCTION

Purpose of the Emergency Receiver Guidance
If one hospital is forced to evacuate all or a significant portion of its inpatient population, the evacuation event will undoubtedly create significant challenges for the other hospitals in its Region. Whether from the Regional effects of a loss of an Emergency Department, thereby diverting ambulances and other walk-in patients towards other area Emergency Departments, or from the disruptions that to inpatient admissions caused by a major influx of transferred patients, a hospital evacuation is always a Regional emergency event that requires more than just the evacuating hospital to use its emergency plans to manage the incident well. This Emergency Receiver Guidance describes the possible actions that neighboring hospitals (“Emergency Receivers”) may take to help support the evacuating hospital and avoid creating a secondary disaster in their own institutions.
EMERGENCY RECEIVER GUIDANCE

Activation of the Hospital EOP
Upon learning that another hospital in the Region is evacuating, all neighboring hospitals should be encouraged to activate their hospital's EOP, at least in a limited fashion. Information from the evacuating hospital may be fluid and dynamic. Rapid responses to requests for assistance may be required. The leadership and communications structures activated within a hospital's EOP will facilitate smoother communications with the evacuating facility and better situational awareness in the receiving institution. In addition, should the receiving hospital accept large numbers of transferred patients from the evacuating institution, significant coordination of administrative and clinical efforts will be required to avoid major disruptions to the Emergency Department and inpatient care areas as transferred patients arrive.

Designation of a Receiving Area and/or Team(s)
Despite the best efforts of the sending institution to manage the evacuation process, evacuated patients may arrive at a receiving hospital with some deterioration in their clinical status, with incomplete clinical data, and/or have diagnoses or conditions that are different than expected. Many receiving hospitals may not be comfortable accepting rapidly transferred patients directly into specific inpatient care beds without an initial brief clinical evaluation, while others may do so but require an immediate evaluation by a clinical team to review the patient’s current status and diagnoses.

Receiving hospitals may be tempted to request that all evacuated patients be transferred to the Emergency Department for this clinical evaluation, but in general this should be discouraged. Hospital Emergency Departments are typically crowded on a daily basis, and an additional influx of transferred inpatients would severely exacerbate this crowding and limit the ability of the Emergency Department to care for new, ill patients. Further, since the evacuating hospital’s Emergency Department will be closed, it is likely that all neighboring hospital Emergency Departments will see increases in volume.

Receiving hospitals should instead designate an alternate clinical location in their institutions for the receipt of transferred patients, if those patients will not be transferred directly to inpatient beds. This alternate location should be able to support registration of new patients, conduct basic medical care and emergency resuscitation if needed, and be staffed with the appropriate personnel to speed patients into their ultimate inpatient locations.

Whether transferred patients are sent to a specially designated receiving area, or directly to their inpatient beds, hospitals should be encouraged to create and use rapid response teams of physicians and nurses who will meet patients immediately on arrival and begin the difficult process of reviewing the patient’s care to date and initiating further clinical interventions if needed. Because of occasional differences among hospitals in the services to which patients are admitted, this team should have immediate available access to specialty expertise, should questions or issues arise.
MDPH HOSPITAL EVACUATION TOOLKIT

VII. HOSPITAL EVACUATION PLAN CHECKLIST
Assessment of initial priorities
Following notification of a threat and/or disaster event, does your plan specify:

- How a threat assessment is being performed?
- Who is assessing critical infrastructure and key resources?
- How to automatically conduct & submit unit-level situation and/or damage reports to hospital leadership?
- The trigger for units to submit damage reports?
- Who is compiling the damage reports and how long it will take?
- How long it will take to perform an assessment of the hospital's operational capabilities?

Establishment of Incident Command Structure
Does your plan specify:

- How you will rapidly compile, verify and share information/reports?
- When you will need your first Incident Action Plan (IAP) to be completed?

Determination of evacuation trigger points and type of evacuation
Does your plan specify:

- Specific trigger points that you will use to decide whether to evacuate?
- Formalized "pre-evacuation" stages with defined actions?
- Any alternatives to evacuation that you can use?
- Distinct types of evacuation (Pre-evacuation staging, single unit, multi-unit, single/multiple buildings, entire campus)?
- How each evacuation stage is triggered?

Authority to make evacuation decisions
Does your plan specify:

- If the staff or any other designated personnel have the authority to completely vacate an adjacent (unaffected) unit in case of a possible immediate life threat (e.g. fire) if they perceive an impending threat?
- A predefined location to evacuate to?
- If multiple units are competing for the same location, how to resolve this?
- Someone on-site 24/7 who has the authority to order a partial or full evacuation?
- If the CEO/Board of Directors reserve the right to overrule operational decisions?
- What input/influence outside agencies will have on hospital decisions (MDPH, MEMA, CMED, EMS, local fire command)?
- How a dispute between the local fire department and hospital administration would be resolved if the hospital agreed with a specific portion of the evacuation order/recommendation?
### Hospital Evacuation Plan Checklist

#### INITIAL DECISION MAKING AND INCIDENT MANAGEMENT

**Assessment of initial priorities**  
Following notification of a threat and/or disaster event, does your plan specify:

- [ ] How a threat assessment is being performed?
- [ ] Who is assessing critical infrastructure and key resources?
- [ ] How to automatically conduct & submit unit-level situation and/or damage reports to hospital leadership?
- [ ] The trigger for units to submit damage reports?
- [ ] Who is compiling the damage reports and how long it will take?
- [ ] How long it will take to perform an assessment of the hospital’s operational capabilities?

**Establishment of Incident Command Structure**  
Does your plan specify:

- [ ] How you will rapidly compile, verify and share information/reports?
- [ ] When you will need your first Incident Action Plan (IAP) to be completed?

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Does your plan specify:

- [ ] Specific trigger points that you will use to decide whether to evacuate?
- [ ] Formalized “pre-evacuation” stages with defined actions?
- [ ] Any alternatives to evacuation that you can use?
- [ ] Distinct types of evacuation? (Pre-evacuation staging, single unit, multi-unit, single/multiple buildings, entire campus)
- [ ] How each evacuation stage is triggered?

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- [ ] If the staff or any other designated personnel have the authority to completely vacate an adjacent (unaffected) unit in case of a possible immediate life threat (e.g. fire) if they perceive an impending threat?
- [ ] A predefined location to evacuate to?
- [ ] If multiple units are competing for the same location, how to resolve this?
- [ ] Someone on-site 24/7 who has the authority to order a partial or full evacuation?
- [ ] If the CEO/Board of Directors reserve the right to overrule operational decisions?
- [ ] What input/influence outside agencies will have on hospital decisions (MDPH, MEMA, CMED, EMS, local fire command)?
- [ ] How a dispute between the local fire department and hospital administration would be resolved if the hospital disagreed with a specific portion of the evacuation order/recommendation?
<table>
<thead>
<tr>
<th><strong>Contact with the local public safety incident command system(s), surrounding communities &amp; other response partners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does your plan specify:</strong></td>
</tr>
<tr>
<td>☐ Mechanisms to use in sending/receiving information from local public safety and local public health representatives?</td>
</tr>
<tr>
<td>☐ Types of information you need from local public safety and local public health representatives?</td>
</tr>
<tr>
<td>☐ The type of information you are sending them, the format you are using and when you are sending it?</td>
</tr>
<tr>
<td>☐ Which other response partners with whom you will be communicating?</td>
</tr>
<tr>
<td>☐ How you will be communicating with other response partners?</td>
</tr>
<tr>
<td>☐ What specific information you need from other response partners?</td>
</tr>
<tr>
<td>☐ What information you need to share with other response partners?</td>
</tr>
</tbody>
</table>
## Primary operational objectives in conducting a rapid hospital evacuation

Does your plan specify:

- Your primary operational objectives?
- How these objectives are communicated to staff?
- Which section of your IC structure is primarily responsible for each objective?

## Hospital departments involved in the operation

Does your plan specify:

- The respective roles of hospital departments involved in evacuation operations?
- Roles for departments not directly involved in evacuation?

## Roles of partner agencies

Does your plan specify:

- The operational support your partner agencies can be expected to offer?
- The specific resources available to you from your partner agencies?
- How soon the external assets will be expected to be available?

## Primary methods of communication

Does your plan specify:

- Your primary methods of internal and external communication?
- How you will communicate the evacuation decision to staff, patients and families?
- How you will communicate changes to the plan as they occur?

## Establishment of appropriate security

Does your plan specify:

- The priorities (in order) for hospital security at the outset of evacuation operations?
- If there are adequate resources to maintain security at all operational sites?
- Additional options for security and crowd control other than local law enforcement?
- How these resources be accessed and who has authority over them?
- How this will be coordinated and supervised?
- How traffic will be managed?
- If discharge/egress routes will be segregated from transfer departures?
- Alternate routes for both?
- How you will maintain security for special patient populations?
- Infants  □  Children  □  Psychiatric patients  □  Prisoners

## Triage and/or prioritization for evacuation

Does your plan specify:

- Uniform and specific standards for triage within the institution?
- If triage standards are known to providers?
- If the units should perform and report a manual patient census prior to evacuation?
<table>
<thead>
<tr>
<th>How and to whom the units report the result of census performed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How evacuation triage is prioritized: acuity, mobility status (stretcher-bound/wheelchair/ambulatory), location of the unit within the hospital, availability of a known transfer destination or some combination?</td>
</tr>
<tr>
<td>Who (specifically) will be tasked with making triage decisions?</td>
</tr>
<tr>
<td>If the people making triage decisions received any formal training in the evacuation plan or evacuation triage?</td>
</tr>
<tr>
<td>A framework for ethical decision-making related to triage?</td>
</tr>
<tr>
<td>Mechanisms for resolving disputes over triage within the facility?</td>
</tr>
<tr>
<td>How triage information will be compiled and incorporated into IAPs?</td>
</tr>
<tr>
<td>Mechanism to allow for re-triage and resuscitation if necessary if patients deteriorate during evacuation (or while waiting)?</td>
</tr>
<tr>
<td>How triage tactics will change if your elevators were not operational?</td>
</tr>
<tr>
<td>How medical equipment is prioritized for evacuation?</td>
</tr>
<tr>
<td>How you will compile a list of the number of available equipment assets (e.g. portable cardiac monitors, portable ventilators, oxygen cylinders, suction machines, IV pumps with battery, etc.) and the location of those assets?</td>
</tr>
<tr>
<td>How you will ensure that the available equipment is matched to the evacuating patients?</td>
</tr>
<tr>
<td>Situations where portable medical equipment is allowed to leave the institution?</td>
</tr>
<tr>
<td>How patients are prepared for transfer?</td>
</tr>
<tr>
<td>If patients receive a supply of needed medications for the next 8-12 hours to support them during transfer?</td>
</tr>
<tr>
<td>If a copy of the patient’s medical and medication record, and radiography, physically accompanies the patient?</td>
</tr>
<tr>
<td>A mechanism to instruct EMS and receiving facilities on the important therapies the patient may need over the next 8-12hrs?</td>
</tr>
</tbody>
</table>

**Patient tracking system (including patient records)**

Does your plan specify:

- Multiple check-in/check-out data collection points throughout the evacuation process?
- How check-in/check-out data are collected and reported centrally?
- How tracking information will be available to the patient’s treating clinicians?
- How tracking information will be available to the patient’s family?
- If the patient tracking system is adaptable to adverse conditions (i.e. paper-only if there is no electricity)?
- Who is responsible for compiling/securing patient records?
- How the tracking system used for evacuation integrates into existing EMS patient tracking tools (MCI-based)?

**Patient destination planning**

Does your plan specify:

- How transfer beds will be identified and secured for evacuated patients?
- Who will carry out the task of finding beds, apart and separate from patient tracking activities?
<table>
<thead>
<tr>
<th>Hospital evacuation Plan Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>How point-to-point communication will occur between hospitals?</td>
</tr>
<tr>
<td>Who is expected to be the point of contact at the other hospitals?</td>
</tr>
<tr>
<td>Redundancies in knowing the patient’s destination?</td>
</tr>
<tr>
<td>If there is a preference for hospitals within your network (if applicable) when determining patient destinations?</td>
</tr>
<tr>
<td>Measures in place for the special patient populations in your hospital that need a special type of hospital for transfer (i.e. Level II nursery, burn center, tertiary hospital, etc)?</td>
</tr>
<tr>
<td>The role of EMS in destination planning?</td>
</tr>
<tr>
<td>The role of local public health in destination planning?</td>
</tr>
<tr>
<td>The role of DPH in destination planning?</td>
</tr>
<tr>
<td>How the hospital IC structure will coordinate/communicate with the relevant external agencies (DPH, EMS) during the evacuation?</td>
</tr>
</tbody>
</table>

### Patient staging

**Does your plan specify:**

- Patient staging for all or a majority of the patients outside of the main hospital building(s)?
- If the patient staging site is usable in all 4 seasons?
- If the staging site has sufficient access to emergency electrical power for medical equipment?
- Supplying the staging area with extra medications (and possibly a pharmacist) if new medical needs arise?
- A resuscitation area within the staging location if patients destabilize during transfer?
- Ready access to medical supplies (i.e. IV fluids) and oxygen for resupply of critical patient care needs at the staging site?
- How patients will receive ongoing care during evacuation (i.e medications, fluids, etc)?
- Special measures are in place for acute or critically ill patients?
- Special measures in place for pediatric (including neonatal) patients?

### Patient discharge

**Does your plan specify:**

- How staff oversee the process (centralized vs. decentralized) of discharge?
- Where patients will be assembled while awaiting family/transport after discharge?
- A main assembly point for processing evacuees once they have departed the care units?
- A mechanism to discharge patients who simply leave the hospital during an evacuation and how such patients are noted?

### Patient movement and support

**Does your plan specify:**

- Who will carry out the physical moving of patients from the units to the Assembly Point/egress?
- How routes will be established/marked and monitored for back-ups?
- If there are outdoor transit/exposure issues associated with routes?
- Mechanism in place for patient movement if the elevators are not operational?
- If you own special equipment for stair transport of stretcher-bound patients?
If your staff is trained to “package” a patient with all necessary medical equipment for stair transports?

If those expected to manually transport the patients down the stairs have practiced this transport?

How long full evacuations by stairs take?

How you will communicate with the floors to let them know when to evacuate?

If the floors leave when possible, or if they must wait for a central order?

How long you expect most patients to be in transit from original bed to destination bed?

If the oxygen, medication, etc. and other patient supplies will last for the longest anticipated transit time?

If EMS is expected to meet the patient at the curb or a staging area, or they are to come to the floors to pick up patients?

How EMS knows the destination of the patient?

If hospital medical staff (MD, RN, RT, etc) are expected to accompany certain patients to their destinations and how they will return to the main campus?

If your hospital medical staff is able to practice at other hospitals (pay, liability, etc.)?

### Resources needed for evacuation operations

Does your plan specify:

- The additional equipment you require?
- How resources are being tracked and located as they are used?
- Who is managing the labor pool?
- The labor needs at this time?
- Staff capable of performing heavy physical labor?
- Methods of patient transport that will be utilized to execute transfers?
- With whom you are coordinating regarding the transport of patients (CMED, local EMS/Fire)?
- Roles other agencies will play in the hospital evacuation?
- How other agencies will be coordinated?
- If the outside agencies have adequate resources available to assist?
- The support outside agencies can offer?
- If your organization has enough resources?
- The Mutual Aid Agreements that are in place to support this kind of operation?
- Whom you would turn to for assistance and have you coordinated with them about this?
- How patient and staff safety will be monitored during operations?
- Who stays behind to secure the hospital?
- A checklist of items that need to be secured (i.e. pharmacy, utilities, etc)?
- Source of the personnel and how long will they are available to be committed?
- The plan to handle shift changes?
Recovery

Recovery objectives
Does your plan specify:
- [ ] Your recovery priorities?
- [ ] Who determines the recovery priorities?

Process of reopening the facility
Does your plan specify:
- [ ] Who has the authority to reopen the facility?
- [ ] Who is involved in the reopening process?
- [ ] The process to make this happen?
- [ ] Defined triggers for reopening?
- [ ] The process you will use to appraise the status of your hospital?
- [ ] The functions that must be in place before you can return?
- [ ] The resources that are needed for re-entry efforts?
- [ ] If it is possible to return to the hospital before the facility is fully operational?
- [ ] The security considerations that will be factored into the decision to reopen the hospital?
- [ ] If you have enough resources/personnel to assist in the recovery?

Communication during recovery
Does your plan specify:
- [ ] Who you are communicating with at this point in time?
- [ ] How hospital staff will be notified about the reopening?
- [ ] How you will notify the public that the hospital is reopened for business?
- [ ] What role partner agencies will play in repopulating the hospital facility?
- [ ] What process will be followed to reconstitute the local response capability?
MDPH HOSPITAL EVACUATION TOOLKIT

VIII. EXERCISING EVACUATION PLANS
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Purpose of Exercising Evacuation Plans

When planned and executed properly, exercises that simulate response to major emergency situations can significantly help improve preparedness on two levels. At the individual level, exercises present an opportunity to educate staff members on disaster plans and procedures through hands-on practice. They also help staff improve their performance through constructive critiques of their actions. On a system-wide level, well-designed exercises can reveal gaps in resources, uncover planning weaknesses, and clarify specific roles and responsibilities.

All emergency plans, protocols and procedures should be tested to ensure that the assumptions upon which they are based are valid. Because hospital evacuations are typically rare events, hospitals will generally not have the opportunity to examine the successes and failures of their plans without exercising. Exercising evacuation plans can be difficult due to the 24/7 nature of hospital operations. This guidance includes suggestions and observed best practices to help hospitals test their evacuation plans.
INTRODUCTION

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When planned and executed properly, exercises that simulate response to major emergency situations can significantly help improve preparedness on two levels. At the individual level, exercises present an opportunity to educate staff members on disaster plans and procedures through hands-on practice. They also help staff improve their performance through constructive critiques of their actions. On a system-wide level, well-designed exercises can reveal gaps in resources, uncover planning weaknesses, and clarify specific roles and responsibilities.

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Exercising evacuation plans can be difficult due to the 24/7 nature of hospital operations. This guidance includes suggestions and observed best practices to help hospitals test their evacuation plans.
EXERCISING EVACUATION PLANS

Emergency Preparedness Exercising
In general, there are four progressive levels of action in an exercise program. Drills test a single specified operation, such as activating a notification system or measuring response times. In contrast, exercises test multiple operations. Tabletop exercises are low-stress events designed to identify major gaps or conflicts in planning. Participants discuss which actions they would take when faced with a given emergency, but no real resources are used. Functional exercises are higher stress events where many participants simulate their actions within an Emergency Operations Center (EOC) and must make immediate, specific decisions, but real equipment and personnel are not deployed. Full-scale exercises are the most realistic, most complex, and most costly events where personnel perform as many of their actual duties as possible in a simulated emergency in order to best assess the true capabilities of the response system.

A successful exercise depends on appropriate planning. In general, the leading reason that exercises fail is a lack of practicality in the planning process. Begin your planning process with a realistic, even generous, timeline. Choose dates well in advance and anticipate weather-related contingencies, holidays and vacations. Next, recruit participants as early as possible. Most importantly, the goals and scope of each exercise must also be kept realistic with respect to what can be performed and tested. A common pitfall of overly ambitious exercises is the desire to test all parts of a plan at once in one comprehensive exercise. In general, it is preferable to focus on assessing five specific, measurable objectives in each exercise and leave the remainder for future events.

Lastly, you must include assignments for both controllers and evaluators in the planning process.
- Controllers monitor the expected events and timeline of the exercise. Well-prepared controllers are critical to a successful exercise since nothing dulls the sense of realism more than a lull in the action or confusion about what is supposed to be happening in the sequence of events.
- Evaluators monitor the events of the exercise and offer objective measurements of how well exercise participants met the pre-specified objectives. Evaluators should be appropriately selected to be competent to assess their objectives. Also, adequate numbers of evaluators are vital since one of the most important products of an exercise is the independent assessment of the event.

Below are some suggested Drills, Tabletop Exercises, Functional Exercises and Full-Scale Exercises that may be conducted and/or adapted to test a hospital’s evacuation planning.
DRILLS

Drills test a single specified operation, such as activating a notification system or measuring response times.

Suggestions for targeted hospital evacuation drills include:

- **A floor (unit) level drill opening and using the Floor Evacuation Toolkit.**
  - Staff on a specific unit open their Floor Evacuation Toolkit and complete all of its contents with the patients currently on their unit. This exercise gives staff familiarity and comfort with the Toolkit and the Evacuation Plan.
  - It is suggested that this exercise be conducted annually.

- **A patient packaging drill.**
  - Staff on a specific unit prepare patients for transport from the floor.
  - This exercise can be done with an inanimate objects (i.e. a box), mannequins, or with live volunteers.
  - All needed medical equipment, medications, and medical records are gathered and placed with the simulated patient on their wheelchair, stretcher or other transportation device.
  - This exercise is particularly helpful to better estimate times for preparing medical records, preparing medication packages for each patient, and for loading patients onto stretchers and wheelchairs.

- **A stairwell drill moving an entire unit’s ambulatory and non-ambulatory patients down the stairwells to the ground floor.**
  - This exercise can be done with mannequins that weigh the same as typical hospital patients, or with live volunteers.
  - Additional safety and expert support staff should be present to prevent injury during this exercise.
  - This exercise is particularly helpful to better estimate times for evacuation using stairs-only, and also to test any specialty devices (such as transport sleds or stair chairs) that may be part of the hospital’s plan. Staff trained to use specialty devices must be present at any such exercise.

- **An elevator evacuation drill moving an entire unit’s ambulatory and non-ambulatory patients down the elevators to the ground floor.**
  - This exercise can be done with mannequins that weigh the same as typical hospital patients, or with live volunteers.
  - This exercise helps validate assumptions about the number of ambulatory, wheelchair, and stretcher patients that can maximally be loaded onto elevators. It also helps identify optimal configurations of such devices (i.e. 1 stretcher and 2 wheelchairs as an example).
  - This exercise also helps to better estimate times for evacuation using elevators.

- **An internal transportation drill transporting patients from the floors to the Assembly Point(s).**
  - The transportation drill can begin from the ground floor areas where patients would exit the stairwells and elevators (building on the drills above) or can begin on an individual patient care area.
  - This exercise is particularly helpful to better estimate total times to evacuate the units to arrive in the Assembly Point(s).
  - This exercise can be done with an inanimate objects (i.e. a box), mannequins, or with live volunteers.
- An Assembly Point set-up drill
  - This drill is conducted to estimate the times required to move necessary medical and other support equipment into the Assembly Point to prepare to care for evacuating patients.
  - The drill helps validate assumptions about the spaces required to support patient care and essential services in the Assembly Point.

- An Assembly Point operations drill
  - This drill is conducted to validate the assumptions of the Assembly Point to support essential care for evacuating patients.
  - The drill also helps validate assumptions about the spaces required to support patient care and essential services in the Assembly Point.
  - This exercise can be done with inanimate objects (i.e. a box), mannequins, or with live volunteers.
  - Staff working in the Assembly Point should be required to perform basic medical care functions (i.e. medication administration, oxygen administration, suctioning, wound care, monitoring and vital sign measurement, etc.) for their “patients” during this drill.

- A Staging Area drill
  - This drill helps estimate throughput times for loading patients into ambulances and to estimate the approximate number of ambulance transfers away from the hospital per hour at the selected Staging Area.
  - This exercise can be done with inanimate objects (i.e. a box), mannequins, or with live volunteers.
  - This exercise requires participation with EMS providers and several ambulances that may be recycled after they “drive away” with the loaded patients.
TABLETOP EXERCISES

*Tabletop exercises* are low-stress events designed to identify major gaps or conflicts in planning. Participants discuss which actions they would take when faced with a given emergency, but no real resources are used.

Suggestions for hospital evacuation tabletop exercises include:

- A leadership exercise reviewing the decision to evacuate and initial command decisions required
  - This exercise would focus on the complexity of the decision to evacuate. Tools from the AHRQ Hospital Evacuation Decision Guide may be used
  - The participants should activate the hospital EOP and assign ICS roles
  - The participants should practice assigning evacuation-specific positions and making the required command decisions that support evacuation

- A floor (unit) level tabletop exercise
  - This exercise would progress through the entire evacuation sequence from start to finish with all clinical representatives on a floor/unit.
  - Suggested invitees include:
    - Nursing
    - Physicians, NPs, PAs
    - Administrative support staff
    - Hospital leadership representatives
    - Respiratory therapy
    - Case management
    - Security
    - Materials management
    - Environmental services
    - Translators
    - Physical and Occupational therapy
    - Emergency management
  - This exercise is expected to reveal gaps in planning or understanding of evacuation efforts.

- A community tabletop exercise
  - This exercise would progress through the entire evacuation sequence from start to finish with all appropriate community representatives present
  - Suggested invitees include:
    - Hospital administrative and clinical leadership representatives
    - Hospital emergency management
    - State, regional, and/or local public health representatives
    - Local police
    - Local EMS
    - Local fire department
    - Local and/or regional emergency management
    - Local CMED representative
    - Regional healthcare coalition representatives (if applicable)
  - This exercise is expected to reveal gaps in planning or understanding of local community evacuation plans as well as uncover errors in assumptions about others’ plans or capabilities
A Regional tabletop exercise
  • This exercise would progress through the entire evacuation sequence from start to finish with all appropriate Regional representatives present
  • Suggested invitees include:
    ▪ Hospital administrative and clinical leadership representatives from all Regional hospitals
    ▪ Hospital emergency management from all Regional hospitals
    ▪ State, regional, and/or local public health representatives
    ▪ Local police
    ▪ Local EMS
    ▪ Local fire department
    ▪ Local and/or regional emergency management
    ▪ Local CMED representative
    ▪ Regional healthcare coalition representatives (if applicable)
  • This exercise is expected to reveal gaps in planning or understanding of local community evacuation plans as well as uncover errors in assumptions about others' plans or capabilities.
FUNCTIONAL EXERCISES

Functional exercises are higher stress events where many participants simulate their actions within an Emergency Operations Center (EOC) and must make immediate, specific decisions, but real field equipment and personnel are not deployed.

Suggestions for hospital evacuation functional exercises include:

• A hospital functional exercise
  o This exercise would progress through the entire evacuation sequence from start to finish.
  o This exercise would test communications capabilities, flow of information and situational awareness among:
    ▪ The hospital Incident Commander
    ▪ The individual care units
    ▪ The Assembly Point
    ▪ The Staging Area

• A local community functional exercise
  o This exercise would progress through the entire evacuation sequence from start to finish.
  o This exercise would test communications capabilities, flow of information and situational awareness among:
    ▪ The hospital Incident Commander and EOC staff
    ▪ The Assembly Point
    ▪ The Staging Area
    ▪ State, regional, and/or local public health representatives
    ▪ Local police
    ▪ Local EMS
    ▪ Local fire department
    ▪ Local and/or regional emergency management
    ▪ Local CMED representative
    ▪ Regional healthcare coalition representatives (if applicable)
  o Any planned local communications systems and services (such as 800 mHz radios, telephone hotlines, NexTel phones, web-based systems such as WebEOC, and others should be used in this exercise).

• A Regional functional exercise
  o This exercise would progress through the entire evacuation sequence from start to finish.
  o This exercise would test communications capabilities, flow of information and situational awareness among:
    ▪ Hospital administrative and clinical leadership representatives from all Regional hospitals
    ▪ Hospital emergency management from all Regional hospitals
    ▪ State, regional, and/or local public health representatives
    ▪ Local police
    ▪ Local EMS
    ▪ Local fire department
    ▪ Local and/or regional emergency management
    ▪ Local CMED representative
    ▪ Regional healthcare coalition representatives (if applicable)
Any planned local communications systems and services (such as 800 mHz radios, telephone hotlines, NexTel phones, web-based systems such as WebEOC, and others should be used in this exercise).
FULL SCALE EXERCISES

*Full-scale exercises* are the most realistic, most complex, and most costly events where field personnel perform as many of their actual duties as possible in a simulated emergency in order to best assess the true capabilities of the response system.

Due to the 24/7 nature of hospital operations and the nature of medical care, comprehensive, full scale exercises of hospital evacuation are generally not performed. Hospitals may wish to combine elements of the several drills, tabletop exercises, and functional exercises in this guidance to create variations on a full scale exercise. These exercises can be done with inanimate objects (i.e. a box), mannequins that weigh the same as typical hospital patients, or with live volunteers. Additional safety and expert support staff should be present to prevent injury during these exercises and avoid disrupting ongoing patient care within the hospital.
MEASURING PERFORMANCE

Every drill and exercise must have a structured evaluation and critique.

First, the independent evaluators who observe an exercise should be armed with specific, measurable, pre-specified objectives and record those observations on pre-prepared forms. Evaluators should be briefed ahead of time on the exercise scenario, timeline, and rules of play.

Second, following completion of the exercise, all participants should be given an opportunity to voice their observations and emotions in a group setting. This debriefing is often called a “hot-wash” and should be performed immediately following the exercise, since its utility diminishes very rapidly as emotions and immediate memories of events fade.

Third, a summary of the comments made by participants in the hot-wash and the structured critiques from the evaluators should then be compiled into an After-Action Report. This comprehensive report analyzes each achievement and each problem that was noted in the exercise.

Lastly, an improvement plan contains specific steps that will be taken by the participants after the exercise to address the issues discussed in the After-Action Report. The improvement plan should be circulated as widely as possible because the most important product that any exercise program can generate is visible, measurable, positive change. Participants may quickly lose interest in the exercise program if they do not see it leading to specific improvements in preparedness afterwards. Therefore it is very important to publicize the changes and improvements that result from exercises and drills to sustain interest in the program.