# HOSPITAL EVACUATION TEMPLATE

Panhandle Region Medical Response System

December 2008

## Identified Essential Elements

1. Identify Decision Makers
   - Who makes the decision to initiate Incident Command System
   - Who is Incident Commander
2. Determine Type of Evacuation
   - Internal or External
   - Partial or Full
   - Shelter in Place
3. Determination of Care Sites
   - Where are we going for full or partial evacuation
   - Where do we shelter in place
   - Secondary care sites if first care site are included in incident
4. System of Triage
   - How it is determined how patients are moved i.e. bed, wheelchair, ambulatory
   - Who moves each type of patient
5. Assignment of Responsibilities
   - Who is to do what for the evacuation
   - Assign tasks
6. Staging Area
   - Equipment- What is available and necessary
   - Personnel – Who needs to go where
7. Transportation
   - How to move people
8. Tracking
   - Patients
   - Staff
   - Visitors
9. Identification System
   - ID Bands
   - Tape to back
   - Other means to identify patients
10. Patient Items
    - Chart
    - Medications
    - Personal Items
11. Specific Unit Standards
12. Restoration of Services

## Best Practice Recommendations

1. Have a good all hazards plan
2. Keep the individual plan simple for people to initiate and follow

# Table of Contents



**ATTACHMENTS**

| Quick Reference Guide | Function |
|---|---|
| | Number |
| | Date of Prior Issue |
| | Effective Date |

**GOAL:**

To efficiently and safely evacuate the hospital.

**POLICY:**

The evacuation order will be given by the Incident Commander in collaboration with other public agencies.

**PROCEDURE:**

1. Hospital personnel will report to (insert designated area)as outlined in the Emergency Respone Plan. Department heads will generate a list of personnel present and available for reassignment.
2. All visitors will be directed to exit the nearest fire exit door. Visitor Tracking Evacuation Tool Available.
3. Early discharge or transfer of patients to long-term care facilities, assisted living facilities or other hospitals may be considered by Incident Command as conditions warrant.
4. Hospital patients will be accompanied out of the building as follows:
   a. GREEN: Those able to walk: Accompanied out in groups by nursing assistants, ward clerks, or other non-professional personnel. Infants will be carried by their parent.
   b. YELLOW: Wheel chair-dependent patients: Accompanied out by nursing assistants, or ancillary services personnel (x-ray, lab, RT, PT, OR, etc) Use wheelchairs, wheeled commodes.
   c. RED: Bed bound patients: Accompanied out by nursing assistants or ancillary service personnel. Use beds, gurneys, or backboards. Any patient requiring close monitoring (ICU, Labor, Postoperative, ER) will be accompanied by licensed personnel.
5. Patients accompanied out of the building will be documented on the Patient Evacuation Worksheet and listed at the Command Center.
6. Patients will then be accompanied to temporary shelter in the following locations:
   a. ( Insert primary designated location)
   b. (Insert secondary designated location)
   c. a location determined by Incident Command

After all patients have been evacuated from the building, the Incident Commander will designate staff to double check patient admission listings and the Patient Evacuation Worksheet to ensure that all patients have been accounted for.

7. Staffing Tracking Evacuation Tool documents the evacuation of all personnel indicating time evacuated, and arrival at destination.

# (Insert Hospital) Evacuation Plan

I. Command and Control

A. Activate Emergency Operations Plan and operate under the Incident Command Systems

1. The staff person who identifies an internal hazard or who is notified of an external hazard assumes the role of Incident Commander makes appropriate notifications according to the Hospital Emergency Operations Plan, and makes the initial decisions until Incident Command is passed to another person.
2. Incident Commander will oversee the decisions and operations regarding evacuation following the Hospital Evacuation Plan.
3. Assignments will be made as directed by the Incident Commander

B. Notification to assisting agencies may include: Law Enforcement, Emergency Manager, Fire/EMS personnel, Public Health, Panhandle Region Medical Response System (PRMRS), Behavioral Health (Insert Hospitals Notification Procedure or reference here)

II. Degree of Evacuation

The existing situation will determine the extent of evacuation necessary. The Incident Commander is to make an assessment whether the healthcare facility faces an internal or external hazard or both. **See Attachment 1** List of Potential Internal and External Hazards

**A. Decision to "Shelter-In-Place"**

1. The decisions on how to protect patients, staff and visitors by movement to a more secure area will be made by healthcare facility Incident Command in collaboration with the response agency Incident Commander or Unified Command, as appropriate.
2. The decisions on how to protect the building will be made by healthcare facility Incident Command, based on the known hazards and their effects on the building and its inhabitants in collaboration with the response agency Incident Commander or Unified Command, as appropriate.

**B. Decision to Evacuate** See Attachment 3: Decision Flow Chart

1. In the event of a hazard, which requires a complete or partial evacuation of the facility, if it is necessary to protect the life and safety of patients, staff and visitors, Incident Command is to give the order to evacuate in collaboration with the response agency Incident Commander or Unified Command, as appropriate.
2. If the circumstances are such so that there is no immediate danger to the life and safety of patients, staff and visitors, healthcare facility Incident Command is first to determine the availability of transportation resources and destination sites: internal and external (**See Attachment 2** Hospital Evacuation Map and See Alternate Care Site Plan for external sites) before giving the order to evacuate. Until the time that these resources are determined, Incident Command shall give the order to shelter-in-place.
3. Once transportation resources and destination sites (internal and external) are identified Incident Command shall give the order to activate the procedures to initiate an orderly and timely transfer of patients to the pre-designated destination site(s).

4. When it is determined that evacuation is necessary, Incident Command will provide directives according to its communications plan. Overhead announce page: The specific directive will depend upon the level of evacuation required (Incident Site, Particial: Horizontal, Vertical, or Full). Healthcare facility Incident Command will determine to which areas the patients are to be moved.

III. Type of Evacuation

A. Shelter-In-Place

1. The healthcare facility is to initiate a process to secure the building (lockdown).
2. Staff is to be advised to stay within the building and to advise all patients and visitors to stay within the building until further notice.
3. If shelter-in-place is expected to last for more than 24 hours, the healthcare facility Incident Command is to inform all departments that all resources are to be conserved. For example: (the following list is not meant to be inclusive)
    a) This is the Incident Command System Branch that puts carries out all activities related to the management of the incident. (Operations)
    b) establish a patient management plan, including identifying the current census, the cancellation of elective admissions and procedures, etc.; establish a workforce plan, including a plan to address staff needs for the expected duration of the shelter-inplace (Planning).
    c) establish communications and a back-up communications plan with the local Emergency Management, Fire Department, Law Enforcement, Public Health, EMS, Human Services, PRMRS, Behavioral Health and others, as appropriate and the Emergency Operations Center (when activated). The healthcare facility Public Information Officer is to refer all communications through PRMRS PIO and the EOC. (Liaison)
    d) provide PRMRS with a "situation report", including resources needed, e.g. the amount of generator fuel available and the duration that this fuel is expected to last (Logistics).
4. Each department head/critical function is expected to provide in writing to the Logistics Chief, within one hour of the activation of healthcare facility Incident Command, the resources that it has available, the expected duration of these resources and the contingency plan to conserve these resources, should replenishment of supplies be in jeopardy.
5. Healthcare facility Incident Command is to determine in collaboration with the response agency Incident Commander or Unified Command, as appropriate, when shelter-in-place can be terminated and to identify the issues that need to be addressed to return to normal business operations, including notification of local authorities about the termination of shelter-in-place.

B. Partial Internal Evacuation

This will be instituted when a fire or other life threat has been determined in or near patient's room or hospital area. Remove the patient(s) and other personnel from the threatened area to a separately protected area in another evacuation zone of the hospital. See Attachment 2 Evacuation Map (Add or Delete Below as per your hospital facility)

1. Vertical
    a) Vertical movement takes into consideration having multiple floors for patient care or tornado shelter basement area.

b) Move patients/visitors/employees who are closest to danger first
c) Move vertically down or up toward ground/exit floor and designated area specified by Incident Commander that provides the nearest and safest protected area.

2. Horizontal
   a) Horizontal movement refers to multiple zones and movement left to right or right to left as specified by the Incident Commander.
   b) Move patients/visitors/employees who are closest to danger first
   c) The designated area chosen by the Incident Commander to provide the nearest and safest protected area.

C. Full External Evacuation

Full evacuation will be determined by the Incident Commander based off of the present circumstance and the ability of the facility to properly maintain patient care. Activate Alternate Care Site Plan. Additional staff must be called in to assist with the evacuation as well as transportation resources be called, PRMRS and accepting facilities be contacted of the need to fully evacuate patients from the hospital.

1. Incident Command will identify and secure the designated location according to those sites available according to the Alternate Care Site Plan. This is done in collaboration with the response agency Incident Commander or Unified Command.

2. Incident Commander will determine which floors and/or smoke zones are evacuated first and in which order. Those floors that are most in danger or the floors of the incident are to be evacuated first. Then adjacent floors are to be evacuated. Otherwise, evacuation is to start at the top floor and work downwards. In all incidents, patients are to be evacuated according their Evacuation Category Level.

3. Incident Command is to identify area(s) for both Staging Area and Transportation. Incident Command will notify when these areas are secure and patients transported to site.

IV. Designated Evacuation Sites

A. partial internal evacuation sites: see Attachment 2 Map
B. Full external evacuation sites: See Alternate Care Site Plan

***Add or Delete to fit your Hospital Facility Planning, this is an example or ideas as needed

V. STAGING AREA

A. When an evacuation entails a single department/unit or even multiple areas within a single building, patients should be assigned from the Staging Area to vacant beds in other non affected units within the hospital. Areas to consider would include:
   1) physical therapy
   2) outpatient surgery
   3) ER
   4) Specialty clinic

5) Medical Plazas

B. A staging area will also be utilized as an interim location for inpatients prior to transport to other healthcare facilities, or prior to discharge if so determined. Patients will remain in the staging area until such a time as transfer can be arranged. At that point patients will be taken to the designated Patient Transport Area. Staging areas should be large enough to support several patients on stretchers and or allow set up of cots or mattresses. The following actions occur in the Staging Area:
    1) Patients are reassessed and triaged according to the level of care needed according to the Traditional START system and identified and issued identification information as stated in the Patient Tracking Section
    2) Staff are to maintain care of the patient in the Staging Area and continue to assess acuity.
    3) Healthcare facility Incident Command is responsible for accounting for all staff and care. Incident Command is also to maintain a log of staff, who accompany patients to destination sites with consideration, to the extent possible, for their lodging, food, other needs.

VI. Patient TRANSPORTATION AREA

**Note**: Patients are not to be moved to the Patient Transport Area until there is confirmation that there are transportation resources on-site. Until that time, the patients shall continue to stay in the Staging Area.

A. The Discharge Unit Leader shall assure that
    1) each patient, being transported to a destination site, has the following information logged:
        a. a triage tag before being loaded into the transport vehicle.
        b. the name of the staff person, accompanying the patient
        c. the transport company and vehicle number
        d. the names of the patient(s), being transported in that transport
        e. vehicle
        f. the destination site
    2) each patient, being transported by private vehicle, has the following information logged:
        a. the license number of that vehicle
        b. the name(s) of the patient(s), being transported in that vehicle
        c. the destination site

B. The Transportation Unit Leader
    1) Activate the Vehicle Staging area (This area should be pre-identified)
    2) Maintain open access to the healthcare facility Patient Transport Area
    3) sending vehicles to the healthcare facility Patient Transport Area as requested
    4) Document all vehicles the following information should be identified for each vehicle
        a. License Tag Number of the Vehicle
        b. Proof of Insurance
        c. Driver's License Number
    5) Each patient being transported needs checked for documentation of:
        a. a triage tag before being loaded into the transport vehicle
        b. the name of the staff person, accompanying the patient
        c. the transport company and vehicle number

Note: The healthcare facility may have a Emergency Transport Section in their Emergency Operations Plan or Alternate Care Site Plan that can be referenced for this section rather than recreate. The healthcare facility is to make every effort to pre-identify and use only authorized vehicles for patient transport. However, it is recognized that circumstances may be such that authorized vehicles may not be available and the healthcare facility may need to resort to the use of private vehicles. The use of private

vehicles poses risks to the healthcare facility and those being transported. The following protocols are examples of the best efforts that can be made to "authorize" drivers of private vehicles.

VII. Patient Triage System

A systemic method for triaging patients is key to a successful evacuation. A rational movement of patient's from the inpatient unit to a staging area prior to transfer is necessary to move patients quickly and safely. For the purpose of evacuation triaging the categories of the **START** system are reversed to get the patients to the staging area. Traditional START system will then be used at the staging area to transfer more critical patients quickly to another location. See description and chart below:

A. REVERSE START system to Staging Area

1. Inpatients that are ambulatory and relatively stable will have first priority for moving off the inpatient nursing unit. These patients are less resource intensive and many can be led off the unit with one or two staff members.
    a) GREEN: Those patients able to walk: Accompanied out in groups by nursing assistants, ward clerks, or other non-professional personnel. Infants will be carried by their parent.
    b) YELLOW: Wheel-chair dependent or Bed-Bound patients: Accompanied out by nursing assistants, or ancillary services personnel (xray, lab, RT, PT, OR, etc) Use wheelchairs and wheeled commodes. Bed bound patients utilize beds, gurneys, or backboards available.

2. Patients who are non ambulatory, acutely ill, unstable or require life saving equipment will require the most resources moving. May require 2-3 staff members. A licensed personnel and assistants as available.
    a) RED: Examples are ICU, Labor, Postoperative, or ER patients will be accompanied by licensed personnel.

B. TRADITIONAL START staging area to another location

Revert back to original priority once the patient reaches the staging area prior to transfer because you will want to get the most unstable patients moved to a healthcare facility first.

1. RED
2. YELLOW
3. GREEN

| Triage Level | **EVACUATION to STAGING AREA**<br><br>**Reversed START Priority** | **STAGING to ANOTHER LOCATION**<br><br>**Traditional START Priority** |
|---|---|---|
| RED - IMMEDIATE | These patients require maximum assistance to move. In an evacuation, these patients move **LAST** from the inpatient unit. These patients may require 2-3 staff members to transport | These patients require maximum support to sustain life in an evacuation. These patients move **FIRST** as transfers from your facility to another healthcare facility |
| YELLOW – DELAYED | These patients require some assistance and should be moved **SECOND** in priority from the inpatient unit. Patients may require wheelchairs or stretchers and 1-2 staff members to transport. | These patients will be moved **SECOND** in priority as transfers from your facility to another healthcare facility. |
| GREEN - MINIMAL | These patients require minimal assistance and can be moved **FIRST** from the unit. Patients are ambulatory and 1 staff member can safely lead several patients who fall into this category to the staging area. | These patients will be moved **LAST** as transfers from your facility to another healthcare facility. |

VIII. Patient Tracking

Tracking the movement of patients, staff, throughout the organization during an evacuation is imperative to the reconciliation process that must occur to assure everyone has gotten out safely.

A. Guidlines

1. Each patient who is being transported to destination site is triaged according to the START triage protocols and assigned a color based on acuity level and triage tag number for tracking. The triage tag should be put on the patient's chart as well.
2. A staff person is to be assigned to match the triage tag number to the list of patients, being transported
3. This same staff person must also match any patients, being discharged or being sent to a temporary shelter, to the same list.
4. Demographic information for all patients, both those, who were discharged and those who are being evacuated along with the triage tag number, are to be entered into the electronic, centralized database within one hour or, as soon as possible, of the patient leaving the healthcare facility.

Note: Nebraska is working on a Bed Tracking electronic system that is functionable in the Omaha area and is coming to out region December 2008-February 2009.

B. Patient Tracking Tools

1. **Patient Evacuation Worksheet** – documents the evacuation triage level assigned to the patient as well as equipment needs, mode of transportation, time of departure from inpatient unit, time of arrival to staging area, pt. triage number, time of departure, destination
2. **Staffing Tracking Evacuation Tool -** documents the evacuation of personnel indicating time evacuated, and arrival at destination.

3. **Visitor Tracking Evacuation Tool**: documents the name and contact number of the visitor, name of patient they were visiting, time they left the staging area, and destination.

A copy of each of these tools is to be given to the Incident Commander Hospital Emergency Command Center. The responsibility for tracking and reconciliation of patients will fall under the direction of the Patient Tracking Manager.

C. *Patient Identification System*

1. *Evacuation to Staging Area: The START triage assessments must be made by the clinical staff on the units. As the assessments are completed the staff will utilize the triage bracelets to identify what level of priority the patient has been given (RED, YELLOW, GREEN).*
2. *Triaging at Staging Area: The START triage assessments must be made by the Triage Unit Leader upon arrival to the Staging Area. As the assessments are completed the staff will re issue a triage bracelets to identify what level of priority the patient has been given (RED, YELLOW, GREEN) for transport.*
3. Triage staff are to make every effort to obtain the following "Patient Evacuation Information", if the patient is to be transported to another destination site: (Data in BOLD is required information)
    a. Name of Sending Facility
    b. Evacuation Category Level Number
    **c. Patient name**
    d. Date of Birth
    e. Patient Medical Record Number
    f. Receiving Facility (destination site, if known)
    g. Time discharged from the Assembly Area(s)
    h. Equipment sent with the patient11
    i. Whether or not family has been notified about the transport of the patient to another destination
    j. Name of primary attending physician
    **k. Diagnosis**
    l. **Type of isolation** (if applicable)
    m. **Special Considerations and Precautions** (e.g. police hold, mental
    n. health, suicide watch, etc.)
    o. Other Information or Directives (code status such as "DNR")
4. *Patient Tag Number*
    *a. A triage tag is to be assigned to patients utilizing the START System protocols,*
        *i. a color code is to be assigned to the patient based on the patient's acuity. The triage tag number is the number that will be used to track the patient after leaving the evacuated healthcare facility to destination sites.*
    *b. The triage tag should be put on the patient's chart*
    *c. A staff person is to be assigned to match the triage tag number to the list of patients, being transported*

*d. This same staff person must also match any patients, being discharged or being sent to a temporary shelter, to the same list.*

*e. Demographic information for all patients, both those, who were discharged and those who are being evacuated along with the triage tag number, are to be entered into the electronic, centralized database within one hour or, as soon as possible, of the patient leaving the healthcare facility.*

5. Family or Guardian Notification
    a. Incident Commander or assigned staff or agency to be responsible in notifying the Emergency Contact Person on each patient
    b. Track on the Patient Evacuation Worksheet when completed
    c. Information given should include: location patient will be moved to, time appropriate to call or visit, call back number to check status, etc.

D. Patient Supplies
1. Chart
    a. To be kept with the patient at all times
    b. Has identifiable tracking number same as the patients arm band
2. Personal Items
    *a)* Personal Items will be placed in hospital bags and taken with the patient if there is time and it is safe to do so. Patient items sent with the patient need to be documented in the chart.
3. Medications
    *a)* Medications will be administered in the Staging area and at the Alternate Care Site.
    *b)* Pharmacy staff will evaluate and transport any needed medications to these areas as identified.

IX. Specific Unit Responsibilities

A. **PCU:** When an emergency occurs, *nursing staff* members (clinical and non-clinical) at the facility should report to the PCU for a head count and emergency assignments. The *Charge Nurse* or designated person should direct activities. These activities may include:
    1. Assist with preparing patients for evacuation. (obtain equipment, patient records)
    2. Assist with evacuation, ambulatory first, followed by wheelchair and then gurneys/beds
    3. Assist with documentation of events

**B. OR/PACU:**
    1. Close doors to occupied OR suites and place wet towels around doors if smoke or dust or fumes are present.
    2. To the greatest extent possible, obtain equipment and services required for completion of the surgery. Keep a list of anticipated supplies on hand and be prepared to ensure additional sterile supplies can be processed quickly.
    3. Call for additional support to transport and move patients if needed.
    4. Assist with ambulatory patients and lead them to the designated safety area.

**C. ICU:** In the event of an emergency, the ICU RN must evaluate the patient and determine the safest method of evacuation, supplies needed, and call for additional help

if needed. Patient(s) may be rolled into a blanket and dragged to the designated safe location or staging area.

**D. Labor and Delivery:**

1. The OB RN will evaluate the quickest and safest method for evacuation of the patient(s).
2. Assign support staff to wheel incubator, instruments and supplies with the patient if needed to complete Labor and Delivery procedures.
3. Babies can be in the mother's arms or carried by nursing staff if needed

**E. Pharmacy:** Under the direction of Incident Command, Pharmacy personnel will prepare for the evacuation of pharmacy.

**1.** Utilizing the Pharmaceutical Supply Checklist, as well as current medication pick lists, personnel will gather pharmaceutical supplies to be taken to the designated evacuation site: Staging Area and/or Alternate Care Site

**2.** Medications are to be dispensed under the pharmacists or RN designees direction utilizing current requisition sheets available.

## X. Demobilization

**A.** In the case of a partial evacuation and shelter-in-place, healthcare facility Incident Command will provide directives according to its communications policy, e.g. notify the switchboard to announce all clear and return to normal operations can commence.

**B.** In the event of a complete evacuation demobilization of the Alternate Care Site Plan will be followed. If no Alternate Care Site operational Emergency Communication and Notification procedures will be followed to notify staff when to return to work. The PIO will inform and update the public as indicated in the Risk Communications Plan.

C. The appropriate agencies are to be notified so that they can approve the reopening of the evacuated healthcare facility.

# Attachment 1
## Factors Influencing Activation

**Internal Emergencies:**
Fire, smoke, hazardous material release, or irritant fumes from the following area:

- Laboratories
- Mechanical rooms
- Operating rooms
- Facility services and maintenance services

Loss of environmental support services:

- Heat Water Air Conditioning
- Electrical Power
- Telecommunications (paging , telephones)

Loss of Medical Gases

- Oxygen
- Compressed air
- Vacuum suction

Other examples:

- Explosion
- Police actions
- Armed and violent visitor

**External Emergencies:**

- Regional power outage
- Transportation Accidents
- Hazardous Materials releases
- Contaminated victims/toxic agents
- Radiation

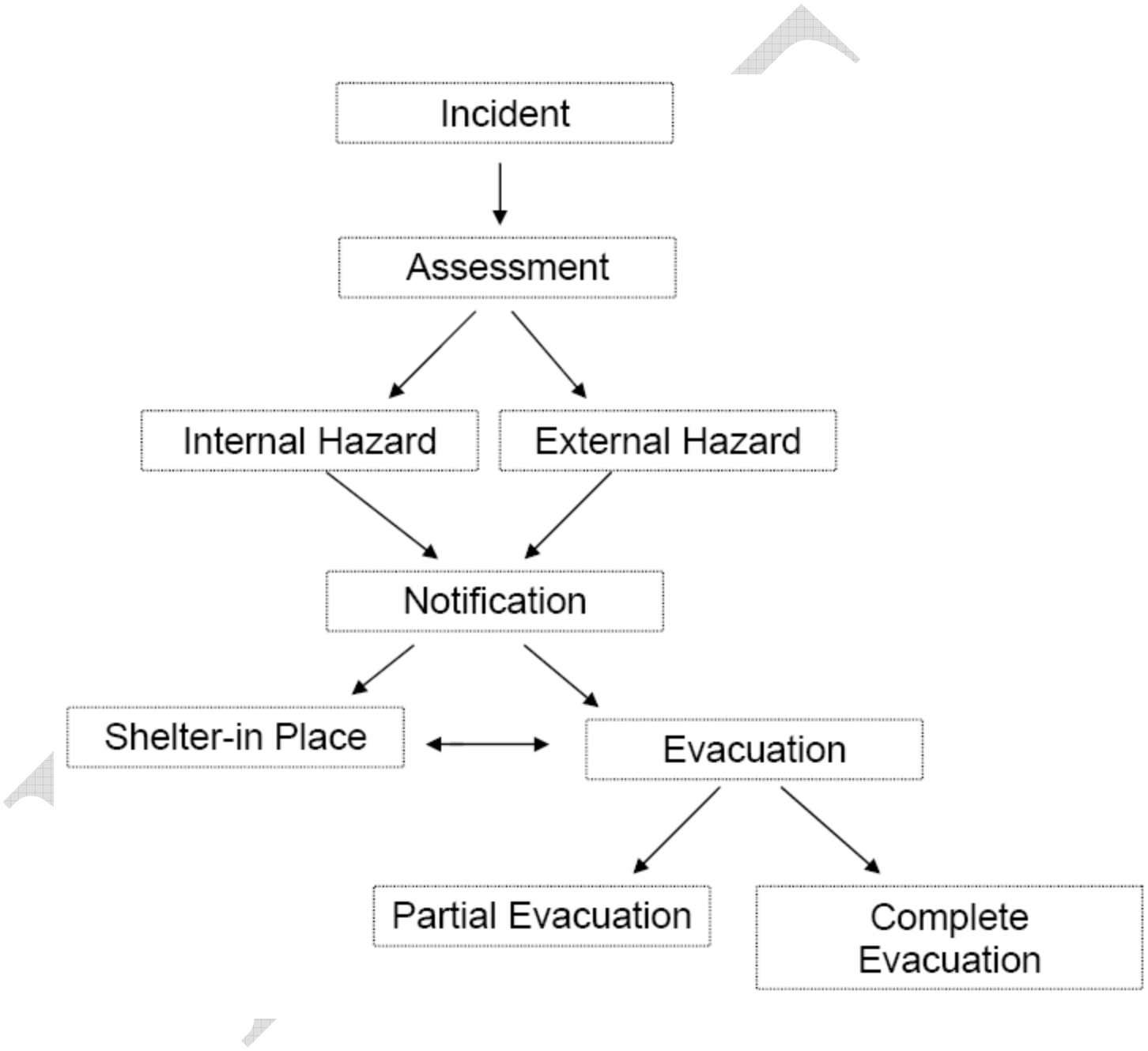
Natural Hazards

- Earthquake
- Flood
- Tornado
- Blizzard

**Attachment 2**
Hospital Evacuation Map

(Insert)

**Attachment 3**
Command Decision Flowsheet



# Attachment 4-6
# Tracking Tools