

Hospital Emergency Evacuation Toolkit



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FLORIDA DEPARTMENT OF HEALTH HOSPITAL EVACUATION TOOLKIT

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I. INTRODUCTION

A full hospital evacuation is not only a difficult process to envision but also to carry out. In the past, a hospital evacuation had been considered a remote possibility for most hospitals; however, recent hurricane seasons demonstrated that a full-scale hospital evacuation is not only a possibility, but also a grim reality. There have been many lessons-learned from Hurricane Katrina's onslaught of New Orleans and the Mississippi Gulf Coast areas, as well as the evacuations from Florida hospitals over the last ten years notably Key West, Tampa Bay, Lake County, Cape Canaveral and others. Many hospitals have been built near canals and waterfront to provide a view for patients and while, aesthetically pleasing, this has placed those hospitals in flood zones that increase the threat for evacuation from storm surge, in addition to other common threats. Storm threats are only some of the reasons that can prompt an evacuation.

This document is a toolkit that represents a guide for the development an effective evacuation plan. This guide is not a complete set of procedures that can be used during an evacuation, but requires preparedness, planning, training and exercise to ensure a safe, efficient process.

This document attempts to put many of those lessons-learned into recommendations for Florida's acute care hospitals to use as a basis to revise their current evacuation plan. This document is intended to support a hospital's preparedness activities within the context of their local Emergency Operation Center and emergency management planning.

Acute care hospitals in Florida have evacuation plans in place that deal with one of the most common evacuations planned for - fire. These plans are reviewed annually by statute and fire detection equipment is checked frequently. However, fire plans are not all-hazard plans; and, consequently, do not address all of the issues.

- Hospital Fire Safety plans address the need for rapid evacuation of an affected area, but rarely address a full facility evacuation that may be necessary over time (several hours to several days)
- Drills of the Fire Safety plan are routinely conducted including containment of the immediate risk area; patient movement of an entire unit horizontally beyond containment doors or a full facility evacuation typically will not be practiced unless there is a direct threat.
- Regardless of the reason for a hospital evacuation, there are pertinent issues that need to be addressed including:
 - ✓ Equipment necessary to move patients
 - ✓ Staging areas

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- ✓ Transportation to other facilities
- ✓ Coordination with other facilities for mass patient transfer
- ✓ Ability to evacuate from the roof

Evacuation plans should be written to encompass all gradations of an evacuation, from the “shelter-in-place” scenario up to and including a full-scale hospital evacuation. As stated previously, the recommendations and plans presented here are a work in progress and will be refined as they are implemented in the hospitals.

There are a number of potential causes for an evacuation:

- **External to a hospital** – A hurricane is approaching, and most or all patients must be evacuated. Same approach for an incoming hazardous material cloud, a nearby release of radioactive material or a flood that does not damage the hospital but will isolate it to the point that patients must be removed.
- **Internal and external to a hospital** – A flood has struck an area, including physical damage to a hospital necessitating most or all patients be removed. Same approach for an earthquake, a hurricane, tornado or storm that actually seriously damages the hospital, or a fire/explosion(s) involving the hospital and the area surrounding it.
- **Internal to a hospital** – An explosion, fire, hazardous material release or major utility failure involving only the hospital.

All-hazard evacuation plans should encompass scalable gradations of a facility evacuation from the “shelter-in-place” scenario to partial horizontal evacuations of a unit, department, or floor, to full-scale hospital evacuation that include operationalizing evacuation staging areas and activating transfer agreements. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has emergency management standards addressing the need for organizational preparedness for scalable and adaptable evacuation events.

A. Purpose and Use of This Toolkit

The purpose of this Florida Department of Health (FDOH) Hospital Emergency Evacuation Toolkit is to serve as guidance for the development of hospital-specific emergency evacuation response plans that have a common underlying basis throughout Florida’s acute care hospital system. The overall goal is to ensure that required evacuations are conducted in a planned and orderly manner with consistency from hospital to hospital that ensures sound patient care management throughout the evacuation as well as the staff and patient re-entry process.

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CAUTION: Any level of evacuation will put some patients at risk. A full facility evacuation may result in loss of life. Evacuation decisions must be weighed carefully against a clear understanding of the actual hazards and vulnerability of the facility and its occupants.

The evacuation of any hospital represents not only a potential high dollar cost in both direct cost of evacuation and lost revenue as well as a potential high cost in patient health, well-being and mortality, as the movement of patients cannot be without substantial increased risk. Therefore, any evacuation must be approached with great care and consideration as patient lives may be placed at risk and a high cost associated with the results of the decision process. The existence and use of an evacuation plan developed in accordance with the guidance in this toolkit will provide the hospital with:

- a. A consistent basis between Florida hospitals regarding the basis and need for an evacuation versus the decision to defend- or shelter-in-place.
- b. The opportunity to pre-plan contracts for transportation based on a sound logistics plan.
- c. Developing mutual aid agreements with other hospitals both locally and far enough away to be unaffected by local disasters.
- d. Understanding the need for coordination with the local Emergency Management Agency and the State ESF-8 (Health and Medical).
- e. Providing a higher level of assurance of maintaining an appropriate standard of care for all patients to minimize the risk to the patients.
- f. Providing a sound basis for staff training and exercise to ensure the plan can be executed properly.

The sections of this toolkit are arranged to guide the development of a comprehensive all-hazards hospital emergency evacuation plan for internal threats (i.e., fire, bomb threat), external threats (i.e., wildfire, hurricanes, large-scale incidents).

Finally, it is strongly recommended that hospitals initiate dialog and content review of the evacuation plans with both the local fire-rescue and law enforcement organizations, local emergency management agency, whether municipal or county level, as well as local municipal transportation systems, para-transit providers and EMS (ground and air ambulance) providers. The integration of command, control and coordination functions provided by these organizations will be crucial to ensuring a smooth and orderly patient/staff evacuation. Further, in a full evacuation for an impending disaster, resources will become scarce very quickly and the coordination of resources from the State and Federal levels that occurs through the local Emergency Management / Emergency Operations Center will be crucial to affecting a complete and efficient evacuation.

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B. Guiding Authorities

The following is a brief list of the principal guiding authorities that underscore the need for the development of evacuation plans:

1. Federal Authority

a. Occupational Safety and Health Administration (OSHA) Standards:

29CFR1910.38 – Emergency Action Plans. An emergency action plan must include at a minimum: procedures for reporting a fire or other emergency; procedures for emergency evacuation, including type of evacuation and exit route assignments; procedures to be followed by employees who remain to operate critical plant operations before they evacuate; procedures to account for all employees after evacuation; procedures to be followed by employees performing rescue or medical duties; and the name or job title of every employee who may be contacted by employees who need more information about the plan or an explanation of their duties under the plan.

b. Joint Commission on Accreditation of Healthcare Organizations (JCAHO):¹

- The hospital plans for managing the consequences of emergencies.
- The hospital must develop and maintain an Emergency Operations Plan that defines emergencies based on a Hazard Vulnerability Analysis that is used to identify the process, resources, personnel roles and responsibilities, including command, control and coordination, in an emergency.
- The hospital establishes emergency communications strategies for managing hospital workforce surge, communications to local hospitals, emergency responders, local authorities and the State, as well as the media.
- The hospital establishes strategies for managing safety and security during emergencies to ensure the safety and security of the infrastructure, patients, staff and overall operation.
- The hospital defines and manages roles and responsibilities within the context of an incident command structure that is scalable to fit any level of emergency response both internal and external.

¹ 2009 *Hospital Accreditation Standards*: The Joint Commission on Accreditation of Healthcare Organizations.

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- The hospital establishes strategies for managing patient clinical and support activities during emergencies including workforce surge, diversion to other local area hospitals and coordination of additional resources in a growing emergency.
- The hospital regularly tests its emergency management plan in accordance with established guidelines; however, a full participation exercise of the entire evacuation plan has never been performed.
- The hospital maintains a written EOP, including response procedures that include “staged evacuation” and “total evacuation.”

2. State Authority

- Florida Statute, Title XVII, Part III, §252, “The Emergency Management Act:” §§ 931, Evacuation. -- Plans for the orderly evacuation and interstate reception of portions of the civilian population as the result of any emergency or disaster of sufficient proportions to so warrant, shall be worked out and maintained between the party states and the emergency management services directors of the various jurisdictions where any type of incident requiring evacuations might occur. Such plans shall be put into effect by request of the state from which evacuees come and shall include the manner of transporting such evacuees, the number of evacuees to be received in different areas, the manner in which food, clothing, housing, and medical care will be provided, the registration of the evacuees, the providing of facilities for the notification of relatives or friends, and the forwarding of such evacuees to other areas or the bringing in of additional materials, supplies, and all other relevant factors. Such plans shall provide that the party state-receiving evacuees and the party state from which the evacuees come shall mutually agree as to reimbursement for out-of-pocket expenses incurred in receiving and caring for such evacuees, for expenditures for transportation, food, clothing, medicines and medical care, and like items. Such expenditures shall be reimbursed as agreed by the party state from which the evacuees come. After the termination of the emergency or disaster, the party state from which the evacuees come shall assume the responsibility for the ultimate support of repatriation of such evacuees.

The above “guiding authorities” are not intended to be exhaustive of all statutory authority regarding the development, implementation and maintenance of evacuation plans for healthcare facilities but to be indicative of the level of importance placed upon such planning by both Federal and State officials. Further, the Florida Emergency Management Act provides a clear delineation of the authority of the local Emergency Management Director, the Director for Florida Division of Emergency Management and the Governor for ordering mandatory evacuations both pre- and post-disaster.

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C. Evacuation Triggers and Decision Making

The key to any successful evacuation is planning and forethought that provides the basis for a clear, concise decision process that includes clear delineation of the trigger points for any evacuation from a healthcare facility. A trigger point is a decision point that provides guidance to the authority responsible for the facility that when certain threats exist, the plan calls for specific protective actions to be undertaken. One protective action can be to shelter-in-place, another being to begin staged evacuations. The objective of an Evacuation Plan is to create a concise set of rules governing the evacuation triggers such that the decision to evacuate is clear and defensible.

An overall hazard analysis based on a Hazards Vulnerability Analysis, confirmed by local Emergency Management, should be one key basis for the Evacuation Plan. Evacuation plans should be based on an all-hazards approach that considers the key factors of the hazard, the relative onset time of the threat, response time for assistance or time for resources to mobilize to support the facility evacuation. Triggers for shelter-in-place versus partial evacuation versus full evacuation must be established.

These triggers should consider the time to evacuate safely based on the initial threat as well as the post-disaster conditions, i.e., extended duration power outage with fuel shortages and unanticipated short-duration resupply; structural damage to the hospital; extended outage of potable water and sanitary services and so on. The evacuation triggers should also consider the partial evacuation of the hospital to make room for patient surge from other hospitals undergoing an emergency response and needing to evacuate their facility. This degree of patient surge is normally beyond the scope of what is considered under typical hospital diversion plans. Several types of known hazards pose a threat to the hospital and should be considered as baseline hazards and vulnerabilities:

- a. Internal disasters: bomb threats, fire, explosions, and hazardous material spills or releases,
- b. Minor external disasters: incidents involving a small number of casualties,
- c. Major external disasters: incidents involving a potentially large number of casualties,
- d. Disaster threats affecting the hospital or community (large or nearby wildfires, impending hurricane, tornado, flooding, explosions, etc.),
- e. Disasters in other communities resulting in patient surge that requires offloading patients to make room for inbound patients.

Additional trigger issues that should be included in the planning process include the damage or destruction of facility infrastructure as well as community infrastructure. Either situation could

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make sustaining operations and maintaining an appropriate standard of care difficult if not impossible. The elements of these emergency threats are explored in detail in following sections.

D. Ethical Issues

As previously noted, the evacuation of a patient from a hospital places the patient at elevated risk, especially a patient whose condition is already considered critical. The decision to shelter-in-depth versus evacuate is a life and death decision. Obviously, the condition of patients that are in intensive care (i.e., ICU or neo-natal), and so on stepping down in criticality, will likely face elevated risk that could result in adverse consequences to patient health, including mortality. Consequently, the decision to evacuate is ethical, medical and economic.

In cases where an external threat to the hospital is the cause for implementing the Evacuation Plan, it is likely that local or State authorities will participate, if not guide, the decision regarding the type or schedule of evacuation. This is one key reason for the hospital to have a well-conceived and fully vetted evacuation plan with local authorities so that both the timeline for a possible evacuation as well as the attendant consequences are fully known and understood. In most cases, except for a mandatory evacuation order from local or state authority, the final decision as to the type or scale of evacuation rests with the hospital administration.

E. Evacuation Timeline

In a notice event, such as a hurricane, it is imperative to have a timeline approximation that will show whether the facility is evacuating at a rate that all patients will be provided the necessary amount of protection. When an incident is anticipated to evacuate the hospital, county or region, hospitals must be prepared to align their evacuation timeline with state and federal resources. In that event, variables such as wind speed in an approaching hurricane will limit the availability of those resources. A good tool to aid in creating the evacuation plan and subsequent timeline is the Agency for Healthcare Research and Quality Mass Evacuation Transportation Planning Model. The model estimates the time required to evacuate patients in healthcare facilities and transport them to receiving facilities. The model is available at the website <http://massevacmodel.ahrq.gov/home.aspx>. Below is an example of a timeline that is appropriate for a hospital.

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Date/Time	Checklist Item	Completed by (signature)
PRE-EVENT	120 hours- 72 hours prior to incident	
	Receive threat notification	
	Conduct situational awareness meeting with HICS Command Center key roles and Senior Administration: discussion as to worst-case scenario (ex. cone of impact) & plan, review of disaster plan, plan management schedule for next 7-10 days.	
	As close to 120 hours as possible, a decision should be made and coordinated with the involvement of local emergency management if the event should involve evacuation. If the decision is made to evacuate: HICS needs to be activated immediately, IAP needs to be operationalized, diversion planning must be coordinated with local emergency management; hospital transportation assets to be used for patient, staff & supplies should be communicated to and coordinated with local EOC. Update local EOC as requested with evacuation activities.	
	Provide situation update to Department Directors through HICS pathways. Request that updates be provided to their staff and that department-specific plans, roles and responsibilities are reviewed with staff.	
	Conduct hospital operational readiness review at 120 hours	
	Participate in state/county EOC-ESF-8 hospital conference calls as scheduled.	
	Participate in hospital corporate level conference calls (if applicable)	
	Confirm HICS members personal plans for preparedness & availability for pre-event, event and post-event timeframes	
	Department Directors to confirm pre-event, event and post-event staff coverage (clinical including Medical Staff & non-clinical)	
	Initiate situation reports to notify staff of potential threat and need to complete personal and family readiness plans, hospital roles & responsibilities pre-event, during the event and post-event. Ensure that	

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	hospital hotline and media messaging (radio, TV) programs are known by post-event staff to monitor at home so they know when they are to report back to hospital. Assign staff who will accompany transferring patients if evacuation decision is made.	
	Confirm contract and agency staff availability during incident through stand down	
	Update Hospital AHCA ESS website twice daily (by 9am and by 5pm) with census updates; confirm other facility information	
	Review vendor agreements for supplies (food, water, pharmaceuticals, fuel, medical gases, medical supplies, blood products, non-medical supplies (linen, others)	
	Confirm hospital transfer agreements, receiving hospital points of contact re: potential for evacuation and query as to bed availability	
	Initiate protective measures for facility (storage of outdoor items, tie-downs) and verify operability of moveable shutters	
	Test run (full load) generator & arrange fuel top-off	
	Maintenance check of structure, electrical systems, equipment and related readiness supplies	
	Verify essential supplies for 7 days (minimum level); supplies for 10 days (recommended level); includes food, water, fuel, oxygen, medical and non-medical supplies	
	Confirm utility companies have facility contact information account #'s; verify utility contact information for facility	
	Confirm EOC contact numbers and ESF-8 contact info	
	Confirm special needs and general shelter locations and capacities with EOC	
	Communicate with outpatient facilities, clinics, and specialty services (such as dialysis) as to service end times	
	PIO will coordinate hospital messaging with county JIC, confirm EOC and facility contact info, and participate in scheduled conferencing	

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	Information services confirms back-up process for medical records, billing and other records	
	Telecommunications confirms supplemental equipment in event of landline phone loss; internal and external redundant systems are tested and users are reminded of protocols	
	If major disaster or catastrophic event is anticipated (ex. Cat 3 or higher hurricane): identify plan to begin cancelling elective surgeries or procedures, discharge or transfer eligible patients (home, rehab, hospice, other hospitals), transfer power-dependent patients (requiring dialysis support, ventilators, etc) to other hospitals.	
	Identify numbers of Red (Critical Care), Yellow (Tele, Medical Surgical Patients), Green (Maternity) patients in hospital in anticipation of potential patient movement	
	Coordinate transportation services (ALS, BLS, paratransit, other) for evacuated patients, staff and supplies with local EOC; Communicate to local emergency management use of any hospital transportation assets	
	Run potable water wells and verify water quality and capacity	
PRE-EVENT	72 hours - 24 hours prior to incident	
	Continue daily situational awareness meeting with HICS Command Center key roles and Senior Administration: discussion as to anticipated incident development (ex. cone of impact) & plans. Determine time for full activation of Hospital Command Center as 24/7 operation.	
	Conduct operational readiness review at 72 hours	
	Continue daily participation in state/county EOC-ESF-8 hospital conference calls as scheduled. Conference calls may increase to twice daily as threat approaches	
	Continue situation update reports to notify staff of potential threat, notification of "during staff" of details related to parking, arrival time, preparedness items to bring to hospital (extra uniforms, towel, pillow etc), sleeping arrangements, food etc.	

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	Pre-stage post-event mobile screening vans, additional supplies, transportation assets close to hospital in secure and protected areas (parking garages)	
	Prepare sleeping areas for staff, for family members of staff (in non-clinical areas only) and for staff pets	
	Prepare maternity shelter area for high-risk moms 36 weeks or greater or those told to be at hospital by their MD's; family members of these moms may also request sheltering	
	Prepare shelter area for ER discharged patients and their family members who may not be able to go home due to weather conditions	
	Prepare oxygen-dependent shelter area for persons who arrive who do not need medical care but arrive too late to go to a regular or special needs shelter	
	Anticipate sheltering/admission of ventilator dependent community-living patients and their caregivers who anticipate power loss or flooding and cannot be managed in special needs shelter	
	Confirm all shelter areas, sleep areas and clinical areas with patients with Hospital Command Center	
	Locate supplemental communication support equipment in all clinical areas and with clinical support services with call sheet	
	Locate supplemental lighting (flashlights, headlights, bathroom battery push lights, spare batteries) in strategic places in readiness of power loss	
	Initiate hard copy census reports and patient tracking mechanism if evacuation occurs (partial or complete facility).	
	Notify county EOC of evacuation decisions (partial or complete) and transportation assets used for patient, staff and supply movement	
	Institute stress management measures for staff and patients as the threat approaches.	
	Request Department Directors to provide updated pre-event, event and post-event staff coverage (clinical including Medical Staff & non-clinical)	

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	Continue to update Hospital AHCA ESS website twice daily with census update; confirm other facility information	
	Complete all hospital protective measures to mitigate damage	
	Restrict visiting hours when conditions are anticipated to deteriorate within 6-8 hours	
	Bring in all "during event" staff to hospital prior to deteriorating weather conditions to allow for drop-offs or parking & family member settlement in designated areas	
	Institute security presence with strict access control to facility through selected entrances only	
EVENT	6 hours or more prior to landfall prior or when power loss is anticipated to be threatened	
	Consolidate patients from upper floors or any areas that are vulnerable to wind damage or potential flooding into core areas of the hospital (use elevators well in advance of anticipated power loss threat)	
	Move patients into hallways away from windows	
	Confirm absence of safety hazards with electrical systems for patients in hallways (cords, trip hazards etc), call bell systems, privacy screens	
	Continue stress management rounding by behavioral health team	
	Update staff and patients as to status of threat; provide reassurance that all measures have been taken	
	Update external messaging (employee hotline etc) for post-event staff	
	Initiate "during" A & B team to relieve each other as appropriate; consider alternating every 6 hours instead of every 12 hours	
	Initiate regular rounding by administrative team members and security of entire facility; immediately report any potential risk areas, water leaks etc	
	Maintain EOC ESF-8 communication monitoring. Respond to requests for information as asked.	

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	Evaluate morgue capacity and census twice daily. Notify funeral homes about pending pickups of deceased.	
Post Event	First 12 hours	
	Continue to participate in EOC ESF-8 Hospital Conference Calls (most likely twice a day); report status of facility, patient surge, resource needs, staffing issues, structural damage, communication issues, health service needs (dialysis etc)	
	Continue AHCA ESS updates as to census, bed availability, generator status/power loss, water, sanitation,	
	Receive update from local & county EOC as to road status and weather conditions	
	Update staff and patients as to status of threat; provide reassurance as to continuity of their care and safety measures	
	Update employee hotline re: anticipated time of return to work and media messaging (for staff or for visitor updates)	
	Update resource inventory supply levels including food, water, fuel, medical and non-medical supplies, blood, pharmaceuticals	
	Conduct external and internal facility inspection by engineering team to assess damages; report to Hospital Command Center	
	Document with photographs any damaged areas of the hospital with time & date stamp	
	Relocate patients back from hallways inside inspected and intact patient rooms if winds have subsided	
	Release "during event" staff as "post event" staff arrives to relieve them.	
	Identify any clinical and non-clinical areas with personnel shortages	
	Update staffing plan based on patient surge	
	Query arriving staff as to any damage sustained to their homes & road conditions	
	Notify Employee Assistance Personnel if there are staff in need of housing, anticipated financial issues, stress management needs or other	

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	issues	
	Assess communications support for facility	
	Coordinate transportation services for staff (carpooling) and for discharge of shelter patients or inpatients to their homes as appropriate	
	Open patient surge areas for Emergency Department	
	Resupply par levels of supplies to clinical areas	
	Review plan for sustained power loss (if this is to be anticipated from communication with utility company)	
Post Event	Post 12 hours	
	Continue to participate in EOC ESF-8 Hospital Conference Calls (most likely twice a day); report status of facility, patient surge, resource needs, staffing issues, structural damage, communication issues, health service needs (dialysis etc)	
	Continue AHCA ESS updates as to census, bed availability, generator status/power loss, water, sanitation,	
	Support patient surge with manpower, supplies, space	
	Monitor any public health risks (carbon monoxide, snakebites, GI illness etc)	
	Initiate expense reconciliation	
	External contact with insurance companies	
	Evaluate staffing needs for facility	
	If there is significant structural damage, Hospital Command Center needs to evaluate if clinical and non-clinical support service areas can be consolidated or if there is a need to consider evacuation. Notify EOC ESF-8 if evacuation will be needed and for anticipated numbers of Red, Yellow and Green patients	
	Complete on-line FEMA request for public assistance if needed	

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II. SCOPE OF EVACUATIONS

Evacuation planning must be done keeping in mind that the scope of the evacuation can grow over time depending on the nature of the event.

Examples of escalating scope of evacuations:

- Shelter-in-place
- Single department/floor/unit
- Section – multiple floors/units within a single building
- Entire building to another location on campus
- Entire campus evacuation
- Citywide evacuation

In addition, the time period around evacuations can be different, ranging from a rapid evacuation in the case where the event is immediately life threatening due to the imminent structural failure of the building caused by an explosion to a slow growing need to evacuate is often the case with an approaching hurricane. Evacuations can be indicated for the sudden onset disaster or the slow developing situation; yet, in either case the proper protective actions must be evaluated and calculated in advance to ensure a coordinated, appropriate and effective response. In some cases, particularly the sudden onset as in a tornado, there is clearly insufficient time to evacuate pre-disaster and consequently the right choice would be to move away from exterior rooms and shelter-in-place within the core of the building. In other cases, such as the approach of a major hurricane, that provide sufficient time to evacuate the building, the right answer may likely be to evacuate to a safe location. These decisions need to be made with consideration for the availability of transportation, the availability and security of a safe location(s) for patients and attending staff and the overall evacuation plans of local emergency management.

Catastrophic Disaster Planning

In early 2006, the State Division of Emergency Management undertook a comprehensive catastrophic disaster-planning project funded and assisted by FEMA. There may be widespread critical and essential infrastructure damage and an evacuation plan must be adaptable for such conditions. A high-level of interface and cooperation with local Emergency Management and Department of Health officials will be needed to coordinate mass evacuation from multiple hospitals and other healthcare facilities.

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Several of the key planning elements that must be considered are:

- Staffing – Staff levels will also dramatically affect the ability to evacuate the hospital both pre- and post-disaster due to staff availability. Staff availability is an important consideration in planning for the evacuation for a catastrophic disaster. A catastrophic disaster will likely result in high levels of regional evacuations of the population and accompanying staff attrition. This will include many staff members’ families and the likelihood that staff members will leave with their families. A catastrophic disaster plan must address staffing of key positions.
- Logistics – transportation, fuel, pharmaceuticals, food and water, fresh linens and so on must be planned for pre- and post-disaster or evacuation. The logistics plan needs to take into account the protocol for obtaining resources through the local Emergency Management Office and ESF-8, Health and Medical (typically Department of Health staffed).
- Communications – a key element in the success of any disaster plan is communications and a catastrophic disaster raises the importance of this asset significantly. To have a plan is important; to communicate that plan to other hospitals, County Emergency Management, State Department of Health, Fire-Rescue and Law Enforcement well in advance of any disaster is paramount. A communications plan must consider the following elements:
 - If a private hospital, communications with corporate office or regional location outside of the impacted area,
 - Communications with authorities: local, state and federal. A catastrophic disaster will bring state and federal assistance within 48 to 72 hours. Remember, the first priority will be life-saving search and rescue,
 - Communications with staff; both to check on staff and family conditions and to identify available staff for rotation,
 - Communications with service providers and contractors – transportation, fuel for generators, pharmaceuticals, food and water, and so on. It is likely that a catastrophic disaster will prevent nearly all service providers from entering the impacted area for a time so any logistics support plan will need to rely on communications with local Emergency Management and Department of Health officials.

In addition to whom the hospital must communicate with is the planning for what communication means will be used. An evaluation of the various means of communication should result in a an assessment of the availability of both voice (V) and data (D): hard line (V,D), cellular phones (V,D), satellite phones (V/D), broadband cable (V/D), DSL (V/D), satellite data communications (D), shortwave (V) or other radio communication (V).

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- Alternate Medical Treatment Sites (AMTS) - Alternate Medical Treatment Sites (AMTS) can be established by hospitals or set up by county, regional, state or federal partners to provide medical care to those refusing to go to a shelter or those who decide to stay in their homes. They can be used to provide medical care to those citizens who wish to stay because of fear of thieves or looters and even for non-documented residents who fear deportation if they approach a government controlled facility.²
- Mass Fatality Planning – There may be significant fatalities associated with a catastrophic disaster. This reinforces the need for coordination with local Emergency Management and Medical Examiner. Hospital staff should inquire with the local Emergency Management office regarding the existence of a mass fatality plan for the county.
- Post Traumatic Stress/Psychological Disorders – the mere nature of a catastrophic disaster mandates planning for behavioral health specialists to assist the population and patients as well as staff in dealing with the aftermath of such an event. Advance planning is necessary for this assistance. Hospitals should consider reaching out to partner agencies and organizations in the community such as social service agencies, non-governmental organizations and faith-based service groups for assistance.

Federal authorities such as HHS stay alert to potential threats and begin a limited activation when identification of a potential incident is first known. Planning to move federal assets to assist states must begin early to allow sufficient lead time to notify and assemble teams, mobilize equipment and pre-stage them closer to a disaster site when this is possible.

The important thing is that hospitals do not view themselves in isolation but as part of a healthcare system. The local EOC must stay up-to-date related to limitations in access to levels of care, especially in a mass evacuation situation.

Hospitals will have different triggers for evacuation. Facilities that are vulnerable to flooding due to coastal locations or proximity to waterways, canals, lakes, dams or limited accessible roadways will make their decisions based on the anticipated threat level of a weather event. Other hospitals will take into consideration their unique architecture, strength of their structures, containment capabilities and other characteristics for other scenarios.

It takes time to evacuate hospitalized patients. The higher the acuity level, the more time may be needed to coordinate patient movement.

² Excerpts from the Florida Catastrophic Planning (FLCP) Report, dated June 2008.

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Because of the significant time element, a discussion needs to occur as soon as threat notification is made related to the potential need for evacuation. When a decision is reached, this needs to be communicated to the local EOC as there may be multiple hospitals evacuating at the same time and transportation planning must occur due to limited resources. Evacuation may be staged in phases to minimize further road congestion and travel times to other facilities.

There are more traditional and non-traditional transportation assets that can be mobilized pre-event than after a disaster has occurred. Traditional assets include air ambulances and commercial air transport and ground ambulance vehicles. Non-traditional sources for evacuee movement include private air transport services, buses, shuttle vans, marine vessels, railway connections and others. By waiting to make an evacuation decision until after a major disaster or catastrophe is anticipated, there may be significantly fewer types of resources available in terms of choices.

Patients can be categorized into groupings of disaster tag colors to assign both transportation assets and accompanying hospital staff. The disaster tag colors are red, yellow, green and black. Black patients that are deceased will have a disposition with the Medical Examiner (for ME cases) or with local funeral homes. Green tagged patients are those that can be safely discharged to home (in the care of their families, household members or friends). The remaining tasks are to assign red and yellow tagging to the remaining patients. Typically, patients in Intensive Care Units have life-threatening conditions and are therefore red-tagged patients in terms of their acuity level. However, it is assumed that an immediate review of all critical care patients should be made upon threat notification to see if any can be downgraded to a yellow-tagged status. A quick calculation can be made by determining the occupancy of each of the ICU's in a hospital to determine the red level; the remaining patients in the facility who are not ready to be discharged become yellow patients. Green tagged patients who live alone and face evacuation can be included with the hospital's evacuees or be moved to a community evacuee collection point, if coordinated with the local EOC.

It is important to plan for the appropriate type of manpower to accompany patients to other facilities. Hospitals must make their employees aware that their support may be needed in an evacuation scenario and preparation steps should be made ahead for family members and pets so staff mobilization can be rapidly accomplished. Some hospitals have plans to evacuate both staff and their families; others focus their resources on supporting staff while deployed.

These are only a few of the considerations in developing a catastrophic disaster emergency evacuation plan. The Florida Division of Emergency Management, Florida Department of Health, Federal Emergency Management Agency, Department of Homeland Security, U.S. Department of Health and Human Services, as well as a number of other local, state and federal agencies are continuing to plan for such an eventuality.

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A. Types of Evacuations

Traditionally, hospitals have focused on horizontal and vertical evacuations. Horizontal evacuations involve moving to a safer location on the same floor (horizontal evacuation to a different smoke compartment separated by fire doors is preferred to vertical evacuation), or vertical evacuations involve moving (up or down) to another floor that is unaffected by the event. Hospitals must develop plans that encompass moving patients, staff and others to a safe haven for sheltering in place or to a staging area in preparation for a move to another facility.

- **Shelter-in-Place**

There may be an event in which a decision is made that the hospital not evacuate. Hospitals must plan where the safest core areas are for sheltering in place that can accommodate continuity of care for varied patient acuity levels. The shelter locations should be towards the center of the building, within fire doors if possible. Ideally, these locations will be a horizontal evacuation; however, it may require a vertical evacuation of some patients. All shelter locations should leave access to a route of vertical evacuation should the event escalate.

The two key elements in any decision to shelter-in-place or evacuate are: 1) the triggers, what are the events that will initiate the lockdown of the hospital for a temporary period of time, i.e. shelter-in-place versus an evacuation: and, 2) the timeline to accomplish the shelter-in-place versus evacuation. The worst-case situation would be to disregard the evacuation timeline and be in the middle of an evacuation when the threat reached the location.

As part of the preplanning process facilities must develop a shelter in place plan as part of the Emergency Operations Plan. This plan should identify HVAC system vulnerabilities and how to deal with them. It should also detail the need to seal (tape and/ plastic) opening windows and doors. It should also identify safe areas and areas which cannot be used during a shelter in place event.

General Hospital Shelter-In-Place Guidelines

- The staff person, who identifies an internal hazard or who is notified of an external hazard, is responsible to notify the senior hospital administrator immediately.
- Shelter-in-place is the preferred option, unless the decision is made by the senior hospital administrator to evacuate, considering the circumstances of the incident.
- The decision to shelter-in-place or evacuate is to be made in consultation with the response agency Incident Commander and also Unified Command, if established, e.g. the local Emergency Management Director, Fire Department, Law Enforcement, Public Health, EMS, Human Services and others, as appropriate.

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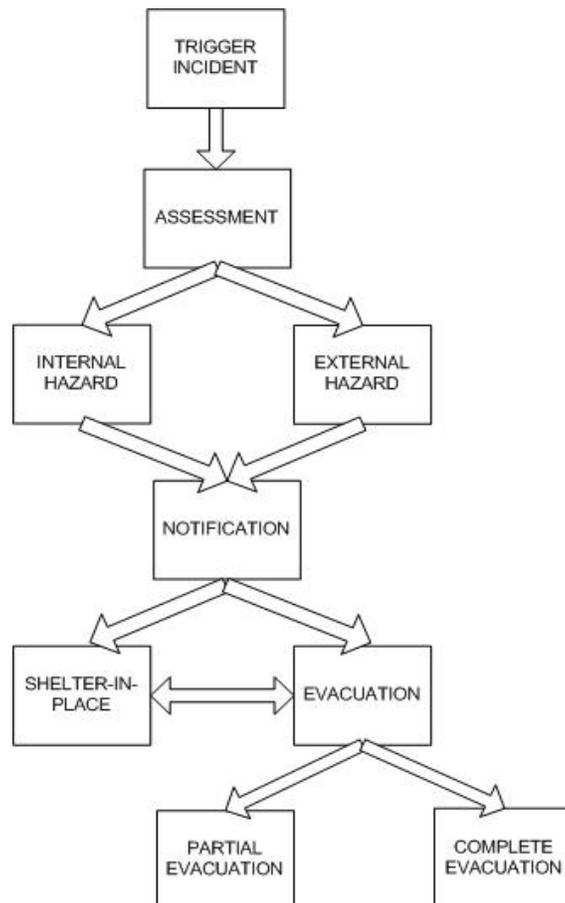
- The healthcare facility is to initiate its Emergency Management Plan and operate under the Incident Command System.
- The healthcare facility Incident Command will assess the need for the diversion of incoming patients. “911” (dispatch) is to be notified by the Liaison Officer, if patients are to be diverted. The appropriate referral facilities/agencies are to be notified that admissions are to be canceled. The healthcare facility Liaison Officer is also to notify the EOC, if activated.
- If there is no response agency Incident Commander, healthcare facility Incident Command is to do all that is necessary to protect the life and safety of its patients, staff and visitors. Hospital Incident Command is to notify 911 (dispatch) of its decision.
- Prior to the actual need to shelter-in-place or evacuate, the healthcare facility is to consult with the local Emergency Management Director, Fire Department, Law Enforcement, Public Health, EMS, Human Services and others, as appropriate so that these agencies are aware of and are in agreement with this plan and its procedures.
- If the decision is made to shelter-in-place due to an internal and/or external environmental hazard, the healthcare facility Incident Command will notify local authorities by calling 911 (dispatch), if appropriate, and will make an assessment for the need to initiate environmental engineering interventions. The primary decisions are:
 - 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.
 - The decisions on how to protect the building envelope 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.
 - Decision on shut down of HVAC unit made in coordination with emergency response personnel
- The healthcare facility is to initiate a process to secure the building (lockdown).
- 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.
- 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.
- Establish patient management plans, 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-in place (Planning).
- Establish communications and a back-up communications plan with the local Emergency Management, Fire Department, Law Enforcement, Public Health, EMS, Human Services

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and others, as appropriate and the Emergency Operations Center (when activated). The healthcare facility Public Information Officer is to refer all communications through the EOC. (Liaison)

- Provide local Emergency Management 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).
- 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 are available, the expected duration of these resources, and the contingency plan to conserve these resources, should replenishment of supplies be in jeopardy.
- 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.

Evacuation Decision Tree



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- **Single department/floor/unit**

An isolated event may deem a small area of the hospital to be unsafe for a short period of time; in this event, the best decision would be to evacuate the affected area. Knowing these hazards, the evacuation plan should have evacuation points planned so employees and clinical staff know to where specific units evacuate. The evacuation points should allow for continuity of care. Ideally, this will be a horizontal evacuation; however, it may require a vertical evacuation for some patients. When evacuating an entire floor, this will require a vertical evacuation and the evacuation points should accommodate this accordingly.

- **Section – multiple floors/units within a single building**

As an event escalates, it may spread to a section of the building including multiple floors and units and departments. To avoid confusion, affected units should evacuate horizontally, and then if necessary vertically to escape the hazard.

- **Entire building to another location on campus**

In an event where it is necessary to evacuate an entire building on the hospital campus, patients should be moved to another building on the campus that can provide the same level of care as their current location. In an event where the level of care cannot be maintained on campus, some patients may need to be evacuated to another facility.

B. Creating Comprehensive Evacuation Plans

In order to address the full scope of the stages of evacuations, it is necessary to put together plans that address three basic elements:

- Facility Issues
- People Issues
- Support Services Issues

Additionally, it is important to understand that these plans are designed so that the hospital utilizing them can scale the evacuation to their individual needs and recognizes the fact that the process of evacuation may escalate over the course of several hours to several days, from clearing several floors to a full campus evacuation.

It is important to note that any planning effort needs to include your local Emergency Operations Center (EOC) and any other relevant agencies and organizations to include first responders (Fire/Rescue, Law Enforcement and EMS) and any other organization with memorandum of understanding or mutual aid agreements (transportation, receiving facilities, etc). This will

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ensure that in an evacuation event, the necessary resources are available and all responding agencies will activate with your evacuation plan seamlessly. Planning efforts that are accomplished completely in house run the risk of calling on resources that are being requested by multiple hospitals.

NOTE: In a catastrophic situation, the Department of Health and Human Services will aid in coordinating with state and federal resources.

C. Hospital Incident Command System

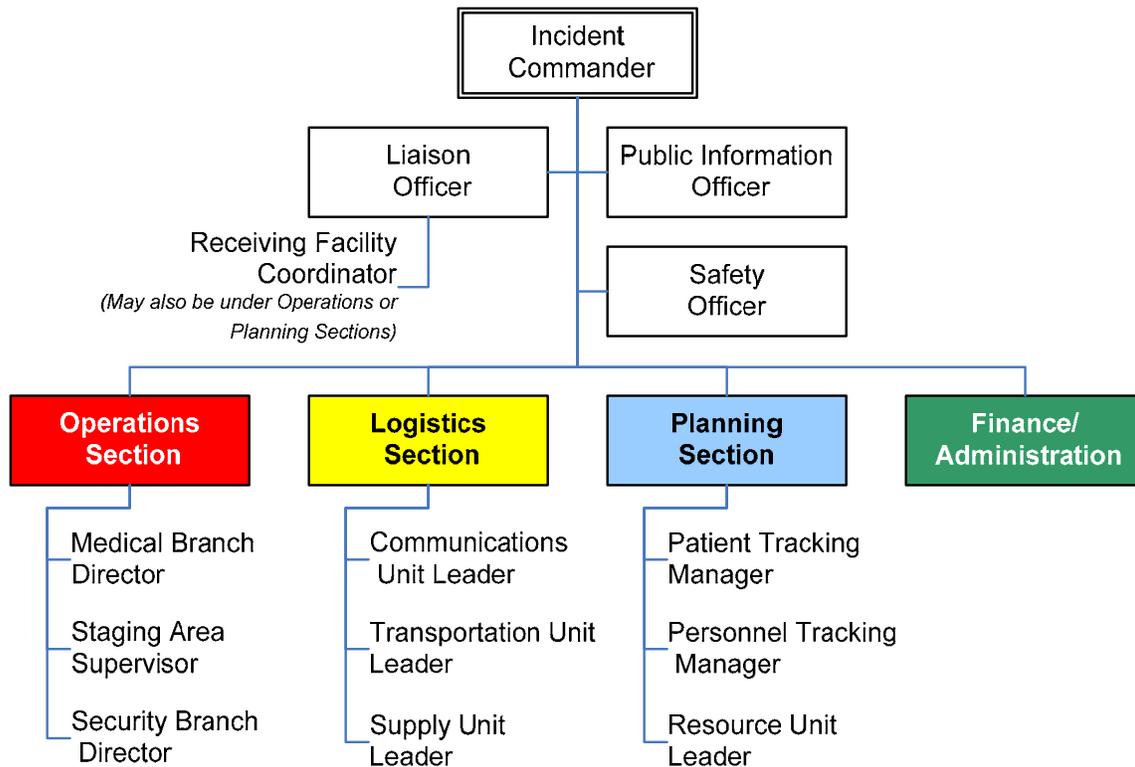
In order to effectively coordinate an evacuation, be it partial, full with notice, or full without notice, there must be an effective command and control element established. The Hospital Incident Command System (HICS, formerly the Hospital Emergency Incident Command System - HEICS IV) is a command system that is based on the National Incident Command System and is designed to allow Hospital Command Centers (HCC) to operate and communicate in a disaster environment using the same positions and terminology as resource, support and coordination agencies.

HICS allows the HCC to expand and contract the size of the command center and positions utilized to meet the needs of the current incident. The basic HICS structure consists of a Command Staff made up the Incident Commander, usually a senior administrator, a Safety Officer, a Public Information Officer and a Liaison officer. In addition, the General Staff is comprised of the four Section Chiefs, Operations, Planning, Logistics and Admin/Finance. Under the General Staff are the Branches, Units and Groups that perform specific functions during an incident.

During an evacuation, there are a minimum of positions that should be filled. These include the Medical Branch Director, the Security Unit Leader, the Transportation Unit Leader, the Communications Leader, the Patient Tracking Supervisor, the Personnel Unit Leader and the Staging Area Supervisor (if used).

The following chart demonstrates the basic command structure and positions that should be utilized during an evacuation. The system should be expanded and contacted to meet needs of the individual incident.

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This organization should be modified, expanded, and contracted as the incident unfolds, is responded to, or escalates or de-escalates. Some organizations will have to increase the number of positions under HICS to meet even the smallest events requiring partial evacuation while others may never use all the positions listed. Regardless of the size or layout of the structure activated under HICS, every position must understand and be able to perform the duties assigned to that position.

D. Notification

Communication will need to occur with a number of external response partners. If situations unfold without initial notification from police, fire or EMS, they must be called when appropriate and apprised of what is happening and any assistance requests.

Periodic information-sharing and joint decision-making should occur among all the hospitals receiving victims. As part of the interface with local Emergency Management agencies, hospitals should be included in the countywide disaster communications plan required under NIMS. In some communities, situation information is provided via the radio (e.g., VHF, UHF), telephone (including satellite phones when landlines or cellular service is not available), Amateur Radio or HAM radio (when VHF/UHF radio, landlines, cellular service or satellite phones are not

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available) and the Internet, using predetermined frequencies, forms or tables. Each of these technologies has limitations and hence, system redundancy is important to ensure that functional communication capabilities exist. Coordination with Emergency Management, EMS and other healthcare facilities is vital to ensure the ability to maintain care for patients as they are evacuated.

Hospitals will continue to communicate with other external partners as the situation unfolds. Maintaining a regularly updated resource directory of external agencies and vendors will assist in rapidly identifying contact information. Depending on the severity of incident and the type of evacuation, the following notifications should be made:

1. Local hospitals/EMS dispatch – inform them of the situation (Notification of receiving medical facilities- should a partial / full evacuation occur).
2. Fire/Rescue – to notify them of the incident, if not already done, and request assistance.
3. Transportation agencies and EMS – to arrange transportation resources for evacuation.
4. Local (City/County) EOC or County Warning Point – if not already notified of the incident.
5. State Emergency Operations Center (ESF 8) – to request assistance if the incident is beyond the capacity of local responders and medical facilities.

If uncertain whether the appropriate agencies have been notified, it is advised to err on the side of caution and make the notification.

E. Coordination with Local and State Authorities

Information received from the outset of the incident should be followed by updated operational briefings based on a set timeline or on an as-needed basis. ESF 8–Health and Medical Services will be periodically requesting updated information; they will also be a primary point of contact for the hospital when some type of resource is needed (e.g., staffing, transportation). The local EOC may ask the hospital to submit certain reports at designated times. Among the information requested will be an Incident Action Plan (IAP) and patient-tracking form. Effective preplanning should identify the forms to be completed and indicate the likely timeline for reporting.

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III. FACILITY ISSUES

Evacuation plans need to include tools that allow the HICS team, and in particular, the Incident Commander, the ability to identify rapidly areas of the hospital that require a high priority for evacuation, areas of vulnerability and areas that have potential risk.

A drill down building-by-building, then floor-by-floor within buildings is necessary to get to the specific details of the evacuation itself. Identification of staging areas where patients will be sent temporarily should be identified early on so that routes to safe haven can be incorporated into the specific departmental evacuation plans. In addition, hospitals must work with their Engineering and Facility Departments to evaluate the feasibility of evacuation of patients from a rooftop. Many buildings are not structurally designed to support the weight (load bearing) of a helicopter; therefore, it is necessary to determine if this is a feasible evacuation route.

A. Comprehensive Layout of the Hospital Campus

The easiest way to obtain a high-level look at the entire hospital campus is by utilizing a simple stacking diagram (Attachment 1). These can be easily created in either excel or word. The stacking diagram will give a floor-by-floor view of:

- ✓ Patient care areas
- ✓ Critical patient care area
- ✓ Non-patient areas
- ✓ Vacant space

These areas can also be coded using a grayscale coloring scheme so that plans can be easily and quickly reproduced and distributed during the event. Symbols should be used to identify areas that contain hazardous chemicals or materials as well those floors that may have connecting bridges between buildings.

Examples:

- Patient care areas 
- Critical patient care area 
- Non patient areas 
- Vacant space 

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- Hazardous chemicals ▲
- Connecting Bridges =

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ATTACHMENT 1 – SAMPLE BUILDING “STACKING” DIAGRAM

			FLOOR #	ROOF	ROOF	ROOF
ROOF	ROOF		12	MACHINE RM ▲		RESEARCH ▲
RESEARCH ▲	NURSING UNIT MED SURG		11	MACHINE RM ▲	ROOF	RESEARCH ▲
NURSING UNIT MED SURG	NURSING UNIT SURGICAL		10	RESEARCH	MACHINE RM ▲	RESEARCH ▲
CLOSED NURSING UNIT	NURSING UNIT CARDIAC		9	NURSING UNIT PSYCH	ON-CALL ROOMS	RESEARCH ▲
NURSING UNIT MEDICINE	NURSING UNIT ICU		8	NURSING UNIT PSYCH	LABS ▲	RESEARCH ▲
NURSING UNIT MEDICINE	NURSING UNIT ICU		7	MEDICINE ADMIN	ADMINISTRATION	BIOMED ▲
NURSING UNIT PEDIATRICS	MECHANICAL RM		6	NURSING UNIT MED/SURG	NURSING UNIT REHAB	OUTPATIENT REHAB
NURSING UNIT MATERNITY	OR LOCKERS & FAN ROOM	= 4 =	5	NURSING UNIT MEDICINE	VACANT	NUC MED/NUC CARDIOLOGY ▲
OPERATING ROOMS/PACU	CYSTO/AMBO SURGERY	= 3 =	4	LABS ▲	ENDOSCOPY	LABS/EKG
CENTRAL STERILE	MAT'L MGMT & PHARMACY ▲		3	RADIOLOGY ▲	ULTRASOUND	CATH LAB/EPS ▲
CAFETERIA/DINING ROOM/TRANSPORT OFFICE/FOOD SERVICE OFFICE	LOBBY/ADMITTING PATIENT MEDICAID OFFICE & ADMINISTRATION		2	OUTPATIENT CLINIC	OUTPATIENT CLINIC	MEDICAL RECORDS
KITCHEN	KITCHEN		1	EMERGENCY DEPARTMENT ▲	EMERGENCY DEPARTMENT ▲	MRI/SECURITY
BUILDING 1	BUILDING 2		B	MACHINE RM	MACHINE RM	MACHINE RM
				BUILDING 3	BUILDING 4	BUILDING 5

KEY: ▲ – Hazardous Materials Present,
= Connecting Bridge

Patient Care Area	Critical Care Patient Area	Non-Patient Care Area	Vacant
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B. Building Directory

A building directory will provide details of each department, service and/or administrative offices that are on each individual floor of the building. This is critical in understanding priorities for evacuation as well as for assurance that all staff, patients and others have been accounted for. It is recommended that when gathering this data, the main routes and end locations for horizontal, vertical, and external evacuation should also be identified to assist the Incident Commander and others in understanding how traffic will flow during the evacuation. (An example of a building directory template can be found in Attachment #2 as seen on the following page all attachments are available on CD in this toolkit).

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ATTACHMENT 2 - BUILDING DIRECTORY INVENTORY FOR EVACUATION

Floor	Service/Department/Unit	Horizontal Evacuation	Vertical Evacuation	Building Evacuation
Basement				
Floor 1				
Floor 2				
Floor 3				
Floor 3				
Floor 4				
Floor 5				
Floor 6				
Floor 7				
Floor 8				
Floor 9				
Floor 10				

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C. Departmental Detail

The next and final level of detail necessary is the departmental level detail. Each service, nursing unit or department should create a departmental evacuation plan using a standard template. The template should be brief and include critical information only. For the purposes of the evacuation, where it is critical that patients be quickly taken out of harm's way, the template concentrates on gathering the patient care information necessary. The recommended template includes:

- Department/Unit/Service type
- Number and type of beds
- Specialized Medical equipment
- Presence and type of hazardous chemicals
- Locked or open unit
- Presence and type of medical gases
- Location of fire exits
- Evacuation route
- Location of staging area

These templates, once completed, should be kept both in the command center and in the department itself, reviewed and revised annually, and shared with staff on an annual basis. An example of a template for Departmental Details can be found in Attachment #3 as seen on the following page (all attachments are available on CD in this toolkit).

NOTE: Any chemical or radiological material relevant to your department that is not being evacuated should be secured prior to evacuation.

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ATTACHMENT 3 – DEPARTMENTAL EVACUATION TEMPLATE

HOSPITAL: _____ **PAGE** ___ **OF** ___

UNIT NAME: _____ **UNIT LOCATION/BUILDING:** _____ **FLOOR:** _____

UNIT/FLOOR TYPE:

<input type="checkbox"/> Critical Care (OR, ICU, Recovery, ED) <input type="checkbox"/> Patient Care General <input type="checkbox"/> Support Patient Care (Labs, X-ray, EEG, EKG, ECG) <input type="checkbox"/> Administrative (Office, Medical Records) <input type="checkbox"/> Other (Mechanical Rooms, Storage, Engineering Shops)	<input type="checkbox"/> Patient Care Specialty (Telemetry, Hemodialysis) <input type="checkbox"/> Outpatient Care <input type="checkbox"/> Support non-patient care (Food, Mat'l Mgmt, Transport) <input type="checkbox"/> Research
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Number of Beds on Unit _____ Is This Unit Locked? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hazardous Chemicals present on Unit: <input type="checkbox"/> Yes, Identify Chemical(s) and Quantity <input type="checkbox"/> No
Specialized Medical Equipment on Unit: <input type="checkbox"/> Infusion Pumps; <input type="checkbox"/> Portable Ventilators; <input type="checkbox"/> Portable Oxygen <input type="checkbox"/> Portable Suction Unit; <input type="checkbox"/> Ambu Bag; <input type="checkbox"/> Defibrillator; <input type="checkbox"/> Monitors	Specialized Medications on Unit: _____ _____
Does Unit have Medical Gases? <input type="checkbox"/> Yes; <input type="checkbox"/> Piped <input type="checkbox"/> Cylinder <input type="checkbox"/> No	

LOCATION & EXITS: Attach a Floor Plan that includes the location of medical gas shut off valves; location of exits, stairways and elevators; identification of dead-end corridors and hallways; fire alarm pull stations, extinguishers, sprinkler systems, hose stations and bibs, designated smoke and fire doors and designated fire zones. (Note what fire zone is adjacent.)	
Horizontal Evacuation Route(s): To _____ via _____	Vertical Evacuation Route(s) to _____ via _____
Staging Area for full building evacuation: _____ _____	
Unit Evacuation Leader: _____	Unit Staging Area Leader: _____

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D. Staging Area

When an evacuation entails a single department/floor or unit, or even multiple floors within a single building, patients should be assigned to vacant beds in other non-affected units within the hospital campus. It is also feasible that patients could be sent to closed units for an interim period until it was deemed safe for the patients to return to their original floors.

In the case where an entire building or entire hospital campus requires evacuation, it is assumed that this will take place over time, and in an orderly fashion, at the direction of the Incident Commander. In this scenario, this plan assumes the following:

- ✓ **The Emergency Department will go on diversion and the inflow of ambulatory patients will stop. At this stage, the ED will begin to function as a dispatcher. The staging area must be prepared and have a plan for walk-in patients.**

NOTE:

The arrangements for transfer of patients to other healthcare facilities will be the responsibility of the Liaison Officer who will coordinate this directly with the receiving facility in consultation with the County Health Department, Florida Department of Health, and State Emergency Operations Center ESF #8. The physical transfer of the patients, including the arrangements for bus, para-transit vehicles, ambulance, transportation, etc., will be the responsibility of the Transportation Unit Leader in consultation with the county Emergency Management Agency.

Memoranda of Understanding (MOU's) and Mutual Aid Agreements (MAA's) should be in place with participating hospital partners along with common procedures for notification of patient receiving and discharge. Contracts must also be executed for transportation assistance with specific performance requirements in the event of a disaster.

- ✓ A staging area will be utilized as an interim location for inpatients prior to transport to other healthcare facilities, or prior to discharge if so determined. Patients coming from the inpatient unit will be transported to the pre-determined alternate treatment site/staging area. Once at the alternate treatment site/or medical transfer staging area they will be re-assessed and triaged again based on their present condition.
- ✓ Patients will remain in the staging area until transfer has been arranged. At that point, patients will be transported to the Emergency Department where they will be readied for transfer.

The staging area(s) should be large enough support the number of patients on stretchers, wheelchairs, or alternate seating, consistent with the transportation capacity (flow-through)

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and/or allow set up of cots or air mattresses. A discharge area should be designated for patients who are stable enough to discharge home, but are awaiting transportation or family members to pick them up.

Staffing for the staging area should be consistent with the level of acuity on the inpatient units, and consist of physicians, licensed nursing staff, nursing assistants and other clerical staff. The Planning Section Chief would assume the responsibility for staffing this area initially out of the labor pool and/or redeploying staff from the ambulatory setting. As the inpatient units were evacuated, staff from that area would then report to the labor pool for redeployment to the ED or staging area, as necessary.

The overall responsibility for the care delivered in the staging area/alternate treatment site would fall under the responsibility of the Operations Section Chief under the Medical Care Director.

The staff in the staging area would participate in the tracking and reconciliation of patients as they move from point to point.

NOTE:

When preparing the evacuation plan for the facility, the unit/department/facility staging areas need to ensure they meet the maximum evacuation distance required by any internal emergency, whether the threat be fire, chemical, or radiological. The minimum distance away from the hospital can be determined by referencing the Emergency Response Guidebook located in this toolkit.

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IV. PATIENT AND STAFF CONSIDERATIONS

In any evacuation scenario, whether it be a single floor, single building or total hospital campus, assessing, triaging, tracking and reconciling patients, staff, visitors and others as they move throughout the evacuation is the single most important aspect of the plan.

Clear lines of authority are also necessary to coordinate a systematic and safe evacuation. The use of ICS is imperative to the success of any evacuation. A review of the ICS for hospitals reveals no need to create additional positions; however, each floor or inpatient unit needs to have a person coordinating the evacuation for that area. That position will be referred to as the UNIT EVACUATION LEADER for the purposes of this document. The Unit Evacuation Leader should be an administrative or operational person, one that is assigned to the area being evacuated by the Incident Commander.

Clinical staff of that nursing unit should not assume this role, as they will be occupied with triaging and readying patients for transport.

Special consideration must be given with respect to fragile patients and psychiatric patients. There is an ethical decision to be made with each fragile patient: whether you would do more harm moving the patient than they would endure remaining in place. The decision to evacuate fragile patients should be evaluated in each facilities evacuation plan; however, in execution it should be made on a case-by-case basis. When dealing with psychiatric patients there are a few guidelines that should be followed:

- Speak calmly, simply, and concretely using short sentences
- Identify yourself
- Respect the dignity of the person as an equal and an adult
- Look for and take note of medications and special medical instructions
- Give the patient frequent updates

NOTE: Psychiatric patients may be moved at night, which may decrease the chance of an incident occurring during the evacuation.

This document will cover the following areas:

- System for Prioritizing/Triaging Patient for evacuation
- Tagging system to identify levels of care
- Identifying and readying patients for evacuation
 - Medical Records

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- Critical Medications
- Accounting for Patients/families/visitors/staff
 - System for inventory of patients/staff
 - System to designate when rooms/floors are empty
- Develop Evacuation Kit for every area

A. System for Prioritizing/Triaging and Tagging Inpatients for Evacuation

A systematic method for triaging patients is key to a successful evacuation. A rational movement of patients from the inpatient unit to a staging/alternate medical care site prior to transfer to another location/healthcare facility is necessary to move patients quickly and safely. It is essential, however, to realize that the triage priorities that most clinical staff is accustomed to in emergency response, i.e. the traditional START system must be approached differently in an evacuation. 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. Patients who are non-ambulatory, acutely ill, and unstable or require life saving equipment will require the most resources for moving.

As stated, for the purposes of evacuation triaging, the categories of START are reversed for the evacuation; however, they will revert to the original priority and sequence once the patient reaches the staging/alternate medical care site because the most unstable patients must be moved to a healthcare facility first. See the chart below for the prioritization:

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

These assessments must be made with clinical staff on the units. As the assessments are completed, it is recommended that the staff utilize a tagging system to indicate clearly what level of priority the patient has been given. Fluorescent tags, which are pre-strung, are one method of flagging patients. These can be affixed to the patient in some manner, one method being to apply these tags to the patient wrists (on the same arm as their patient ID band). The use of NCR paper with three copies should be considered in developing these tags as this will assist in the reconciliation process. The tags can be imprinted with the patient’s information using the patient’s addressograph plate or labels with bar codes, depending on the system utilized in the organization and as the patient moves from point to point, one of the copies can be torn off and used in the tracking and reconciliation process. It should be remembered that the triage tag and the Reverse Triage Tag are medical records and therefore will stay with the patient’s records upon discharge.

B. Rapid Disconnection of Equipment

One of the concerns with a no-notice evacuation involves pre-planning for rapid disconnection of patient equipment within both inpatient and outpatient areas. This is recommended for general medical surgical units and is critical for any specialty services. All critical care units, orthopedics, cardiac catheterization labs, special procedure departments for example need dedicated time spent on how disconnection will occur. This includes steps to be taken in priority

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order, what is taken or is left behind, and the best method of transporting such patients once disconnection has occurred. Examples include patients in traction, on ventilators, intra-aortic balloon pumps, analgesic pumps and others. Some equipment may need to accompany a patient to support reconnection in the destination area for evacuation. The backup battery lifetime may differ between varied pieces of equipment and should be known by clinical managers.

C. Tracking Tools

Tracking the movement of patients, staff, visitors and vendors throughout the organization during an evacuation is imperative to the reconciliation process that must occur to assure that everyone has gotten out safely. Three tools were developed for this purpose, attachments are found following this section (all attachments are available on CD in this toolkit):

- Patient Tracking Template – Attachments 4 and 5
- Visitor Tracking Template – Attachment 6
- Staff Tracking Template – Attachment 7

The patient tracking tool is composed of two documents; one to categorize the patients by location and the other to indicate the level of care required during evacuation.

The **Patient Care Unit Tracking Template** documents the exact location of every patient ASSIGNED to the unit. This tool takes into account patients who may be off the floor at diagnostic tests or procedures, as well as patients who may still be in the emergency department or the Admitting office awaiting transport to the unit. This tool assists in the reconciliation of total patient census (assigned census) vs. actual census (patients present on the floor). The Incident Commander in consultation with the Unit Evacuation Leaders of each area will determine the determination of whether a patient who is in the procedure area returns to the unit for evacuation or is evacuated from the procedure area to the staging area.

The **Patient Care Unit Tracking Template** documents the evacuation triage level assigned to the patient as well as equipment needs, mode of transport, time of departure from the inpatient unit and time of arrival to the staging area.

Each of these tools will be faxed to the EOC (to the attention of the ESF-8 Lead) as well as to the staging area to assist in reconciliation. In addition, the responsibility for tracking and reconciliation of patients will fall under the direction of the Patient Tracking Officer.

Tracking patient visitors as well as others that might be on the floor is equally important and may be accomplished using the **Patient Visitor Tracking Template**. Accounting for the staff as well should be done in a methodical manner using the **Staff Tracking Template**.

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ATTACHMENT 4 - PATIENT CARE UNIT EVACUATION TEMPLATE (PART 1)

Hospital Name: _____

Unit Name: _____ Unit Location/Building: _____ Floor: _____

Total Number of Staff on Unit at Start time of Evacuation:

RN's: LPN's PA's MD's/DO's Other

A. PATIENT CENCUS ON UNIT AT START TIME OF EVACUTATION

B. TOTAL PATIENT CENSUS

C. PATIENTS TO BE ACCOUNTED FOR (A - B) =

PATIENTS OFF UNIT FOR PROCEDURES/OR/RADIOLOGY/DIALYSIS AT TIME OF EVACUATION:

Patient Name	Room No.	Current Location

Total # of Patients off unit in other areas =

SHEDULED ADMISSIONS TO THE UNIT THAT HAVE NOT ARRIVED AT TIME OF EVACUATION

Patient Name	Room No.	Current Location

Total # of patients admitted to unit, not yet arrived =

PATIENTS AT RISK AT TIME OF EVACUATION: (i.e., Suicide Precautions, Patients in Restraints, Bipec, Active Labor, Temporary External Pacer)

Patient Name	Room No.	Current Location

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ATTACHMENT 5 – PATIENT CARE UNIT EVACUATION TEMPLATE (PART 2)

HOSPITAL: _____

PAGE ___ OF ___

UNIT NAME: _____

UNIT LOCATION/BUILDING: _____

FLOOR: _____

PATIENTS (use transport barcode label)	CATEGORY	EQUIPMENT NEEDS	MODE OF TRANSPORTATION	DATE & TIME PATIENT LEFT UNIT	RECEIVING FACILITY & PHYSICIAN	ARRIVAL AT DESTINATION
	<input type="checkbox"/> Red (significant resources for transport) <input type="checkbox"/> Yellow (moderate resources for transport) <input type="checkbox"/> Green (minimal resources)	<input type="checkbox"/> Oxygen <input type="checkbox"/> Monitor <input type="checkbox"/> Ventilator <input type="checkbox"/> Pump <input type="checkbox"/> Other (indicate) _____ _____ _____	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher <input type="checkbox"/> Bassinet <input type="checkbox"/> Isolette <input type="checkbox"/> Other (indicate) _____ _____ _____	Date: _____ Time: _____ _____ Staff Initials	_____ Destination _____ Equip. Lv w/Patient _____ Receiving Physician	Time: _____ _____ Contact Name _____ Staff Initials
	<input type="checkbox"/> Red (significant resources for transport) <input type="checkbox"/> Yellow (moderate resources for transport) <input type="checkbox"/> Green (minimal resources)	<input type="checkbox"/> Oxygen <input type="checkbox"/> Monitor <input type="checkbox"/> Ventilator <input type="checkbox"/> Pump <input type="checkbox"/> Other (indicate) _____ _____ _____	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher <input type="checkbox"/> Bassinet <input type="checkbox"/> Isolette <input type="checkbox"/> Other (indicate) _____ _____ _____	Date: _____ Time: _____ _____ Staff Initials	_____ Destination _____ Equip. Lv w/Patient _____ Receiving Physician	Time: _____ _____ Contact Name _____ Staff Initials

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ATTACHMENT 6 – VISITOR EVACUATION TRACKING TEMPLATE

HOSPITAL: _____ Page ___ of ___

UNIT NAME: _____ UNIT LOCATION/BUILDING: _____ FLOOR: _____

Visitor Name and Telephone Contact Number	Patient Visiting	Time Left Unit	Destination	Arrival at Destination
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____

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ATTACHMENT 7 – STAFF EVACUATION TRACKING TEMPLATE

HOSPITAL: _____

Page ___ of ___

UNIT NAME: _____

UNIT LOCATION/BUILDING: _____

FLOOR: _____

STAFF MEMBER NAME	DEPARTMENT	TIME LEFT UNIT	DESTINATION	ARRIVAL AT DESTINATION
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Initials: _____

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D. Designating When a Room or Floor is Empty

It is important to validate that all patients and staff have been cleared from the patient unit and then secure the floor. The Unit Evacuation Leader should conduct a walkthrough of each room including support space. As each room is checked, it is recommended that some method of indicating that the room is empty be utilized. As no standardized system is used uniformly across all facilities the following system has been recommended. There are many methods to designating an empty floor, some will be explored here; however, it is not necessary to use any of these methods, but it is necessary to have a way to designate an evacuated room.

One method is to have Velcro tabs attached to the doorframe of each patient room with the room number illustrated on it. As the room is evacuated, a designated person will remove the Velcro tab and place in their pocket. Once the area has been cleared the designated people will meet with an evacuation supervisor and show each tab for their rooms. If there are any unaccounted tabs, staff and emergency personnel will return and verify the room is cleared.

Another method is by having a magnet on the inside of the room by the door with the room number on it, which will be placed on the doorframe or other magnetic surface outside the door as the room is cleared. As the area is evacuated, a staff member will verify that each doorframe or designated magnetic surface has the appropriate magnet in place, verifying rooms as needed for misplaced magnets.

Another method involves items that are readily available in any nurses' station, white paper (printer or copy paper) and tape. Staff would tape one sheet of white paper to the door or designated area to note the room has been evacuated. As the area is evacuated, a staff member will verify there is a white paper in each designated spot, verifying rooms as needed for missing papers.

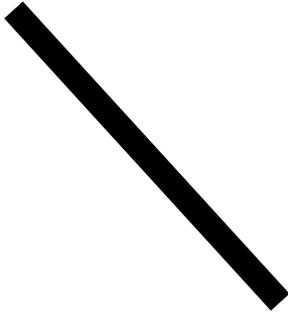
The last method illustrated is using tape on the doors of areas. Marking a room, wing or floor can easily be accomplished by affixing an "X" to the door or doorframe with tape. The tape should be 2" high visibility or reflective tape, or at least be contrasting color from the doorframe to be easily distinguishable. One leg of the "X" ("∖") should be used to indicate that partial evacuation has occurred but patients are still located inside. The full "X" should be used to indicate that the room has been cleared and all patients have been evacuated.

The same marking system should be used for wings and floors. Closing the doors to a wing and placing an "X" on it would indicate that evacuation of that wing is complete. The "∖" would indicate that the wing is currently being evacuated; no mark would indicate the wing evacuation has not begun yet. The same is true of floors. Marking the "∖" or "X" fire escape door (if using

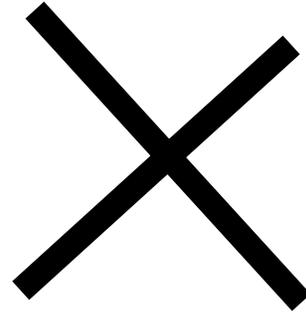
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stairs) or placing a piece of tape on the floor button in the elevator with the “\” or “X” would indicate evacuation of that floor / wing in process or complete respectively.

Once a method of designation has been chosen for the hospital, share the information with local first responders (Fire/Rescue, Law Enforcement, EMS).



Mark indicating evacuation in progress



Mark indicating evacuation complete

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V. HOSPITAL EVACUATION EQUIPMENT

It is crucial that the hospital have a sufficient number of the appropriate equipment to move patients quickly and efficiently when the Evacuation Plan is activated. A patient movement study, based on the number and type of patient to be moved from which locations (i.e., floors), will provide an indication of how much and what type of equipment is appropriate for each hospital. The types of evacuations are quite different, partial, full with notice, full without notice; however, the equipment used will be the same. There are two types of movement necessary, horizontal and vertical. Horizontal movement refers to moving about a single floor. The vertical movement gets broken into two separate, but equally important parts, vertical up and vertical down. Vertical down refers to the transfer of people from a higher floor to a lower floor (i.e. floor 3 to floor 2). The less common, but necessary to plan for, is vertical up, referring to the transfer of people from a lower floor to a higher floor.

When preparing an evacuation plan, procedures for reusing equipment to continue the evacuation of other patients need to exist. This will allow for an orderly evacuation.

A. Horizontal vs. Vertical Evacuation

During an emergency evacuation, such as a fire, the first choice in evacuation is horizontal. Patients should initially be moved from areas of risk to areas where a “shelter-in-place” posture can be maintained; usually in separate smoke compartments. As long as it is safe to remain in the “shelter-in-place” position, it is the preferred choice to attempting vertical up or down evacuation. Elevators should be used for all vertical evacuation if the evacuation³ is not the result of a fire or other event that could adversely affect elevator operation.

B. Elevators for Evacuation

In response to the potential need for more timely evacuation of occupants in tall buildings, new provisions to NFPA 101 allowing the use of elevators in certain situations prior to Phase I Emergency Recall Operation as mandated by the Firefighters Emergency Operation provision of ASME A17.1, *Safety Code for Elevators and Escalators*, has been established³. Elevators remain usable after initiation of the building fire alarm system, if the elevators have not been recalled upon detection of smoke in the elevator lobbies, machine room or hoist ways. According to the proposed Annex B of the 2009 NFPA 101⁴, in such situations the elevators would remain operable and are available for occupant evacuation as long as smoke can be kept away from elevator lobby detectors. High-rise building occupants may be able to continue to use elevators, as long as communications systems are also provided to let them know, in real time, the

³ M. Puchavsky, *High Concept: Proposed NFPA code changes for high-rise buildings*, NFPA Journal, March/April 2007, <http://www.nfpa.org/publicJournalDetail.asp?categoryID=&itemID=33325&src=NFPAJournal>

⁴ A. Wolf, *2009 Code Changes*, NFPA Journal, Many/June 2008, <http://www.nfpa.org/publicJournalDetail.asp?categoryID=1584&itemID=38647&src=NFPAJournal>

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operating status of the elevators. These guidelines would also require an exit stair enclosure immediately adjacent to the elevator lobby to provide egress for occupants waiting in the lobby once the elevator has been called out of service.

The new provision paves the way for a broader concept currently being explored, which would allow the use of elevators as a component of the means of egress. This proposal introduces a major shift in the traditional way in which elevators have been considered for use in emergencies, as building occupants have traditionally been instructed not to use elevators in fire and similar emergencies. Because of this change in philosophy and expected revision to NFPA codes, staff should be able to use elevators in adjacent smoke compartments to perform vertical up and down operations after patients have been evacuated horizontally from immediate danger.

Prior to enacting a policy to use elevators for vertical up and down evacuation during a fire, a facility **MUST** determine in which smoke compartments elevators are located and determine which circuits power the elevator(s). The proper separation and isolation of power circuits to the elevators is critical to ensuring that elevators in adjacent smoke compartments would continue to receive power in the event that the power was cut off in an affected compartment. ***Elevators should not be used unless their power source is secure from interruption as a result of the event that is driving the evacuation.***

NOTE: When developing the evacuation plan, consult the local Fire Marshall to determine local regulations and first responder preferences.

C. Commercially Available Equipment

We will now explore some of the different types of equipment possible to be used for implementation of your evacuation plan. Research has been applied toward multiple equipment types across different price ranges and manufacturers.

Evacuation Stair Chair



The first option explored is the Evacuation Chair. Immediately noticeable is the chair's ability to perform in horizontal, vertical up and vertical down situations. This chair is equipped with a patented Stair-TREAD system, eliminating manual lifting when moving immobile persons through stairs, drastically reducing the risk of operator injury. This chair is lightweight and rugged with its aluminum construction enhancing utility and ease of operation. A key feature for this chair is the upper control handle, which is extendable and



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provides optimal operator control as well as ergonomic lifting technique, resulting in improved line-of-vision and reduced back strain. The Evacuation Chair exceeds fire safety requirements and emergency response guidelines established to support the Americans with Disabilities Act. This chair is designed to be collapsible for compact storage making it especially convenient for possible storage in a stairwell.



Another “stair chair” design maintains the same benefits of the previously version. It is capable of both horizontal and vertical movements. This device maintains a one-inch track to ground clearance, providing great maneuverability over all surfaces, even with the tracks deployed. The chair has an extending footrest and lower track angle increasing patient sense of security, and is capable of transporting patients up to 500 lbs. This chair has a five position adjustable handle to accommodate personnel of various heights. As with the previous chair, this one also has a storage cover and secure mount, to prepare for rapid deployment in prearranged



locations, such as the hospital stairwells.

One option available for consideration in selection of a stair chair design is a powered track for vertical up applications. This feature allows a single user to accomplish a vertical up evacuation of a patient who is able to sit in a chair. The only drawback to powered designs is cost. This feature may add many thousands of dollars to the cost and a cost-benefit analysis may indicate that the expenditure is not acceptable for the benefit (as this equipment may never be used).

Emergency Cots

Emergency Cots are very similar to beds already in use by hospitals and EMS personnel. They are slightly limited in use, only being effective in horizontal transport, but offer a more stable method of patient movement. The cot also offers a way to move safely patients not capable of walking assistance or chair movement, with limited use of hospital personnel. This device offers a way to move patients quickly, in a manner similar to hospital bed without the cumbersome size of the hospital beds, allowing the patient to be fully evacuated via ambulance.



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The ambulance cot is very similar to the emergency cot previously explored. This option has similar advantages and disadvantages, including the ease in moving patients requiring a higher level of care, and fewer personnel required to transport the patients. However, as with the emergency cot, this device would be ineffective at vertical up and vertical down transport, but would put the patients in a form easier for relocation via ambulances and other transport vehicles.

Basket Stretcher

The Basket Stretcher is another form of transportation usable for horizontal, vertical up and vertical down. This device, as with the Transfer-Flat, is hand-carried and requires more personnel than a chair or cot. However, the versatility of this equipment makes it ideal for most rescue situations. The basket stretcher has a load capacity of 600 lbs, making it possible to transport most patients and the minor medical gear they require (i.e. oxygen, IV pump, etc.). This device can also be adapted with accessories designed to aid with flotation, lifting, wheeled transport and backboard integration.



Med Sled



The Med Sled was designed for use in hospitals and nursing homes for rapid extraction of non-ambulatory patients. It is a cost-effective and efficient transport solution which, by using the roll and drag method, requiring no heavy lifting; a 120lb person can effectively transport a 250lb person with relative ease. Notable benefits include a stairwell breaking system allowing for safe and controlled descents, low personnel requirements per unit, and a rigid plastic that limits flexing when moving a patient. The Med Sled also is capable of integrating NICU and toddler inserts for patient customization. The versatility of this unit allows for compact storage and rapid deployment from the hospital's prearranged points, such as stairwells or hallways. The main disadvantage to this device is its lack of effectiveness in vertical up movement.



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Transfer-Flat

The Transfer-Flat is a heavy-duty vinyl that adds another level of versatility and flexibility to your emergency evacuation capabilities. This device is also capable of all types of patient transfer, however requires more people for safe use. It can be used as an independent piece of equipment or to move patients to other transport equipment. It is easily portable and deployed, offering practical, simple solutions to the transfer needs of hospitals. This transportation device has 12 rigid handles, reinforced construction with a 1600 lb weight capacity. It is portable and compact for ease of use and storage. In its stow-away size, the Transfer-Flat is ready to be stored at the hospitals pre-arranged evacuation equipment storage locations. As with the previous drag device, there is a lack of good vertical up capacity although the number of handholds makes it more adaptive for vertical up applications than drag devices.



NOTE: The Center for Domestic Preparedness in Anniston, Alabama conducted an assessment of non-motorized extrication devices, which has been made available electronically in this toolkit.

NOTE: When evacuating ambulatory patients may be “chained” by having them place one hand on the shoulder of the person in front of them, making sure to have a staff member at the front and back, to lead and keep everyone together. The “chain” should hug the walls if visibility is limited.

NOTE: When evacuating in smoke, patients should be kept as close to the ground as possible, out of the thick smoke.

D. Pediatric Evacuation Equipment

In any evacuation situation, there is always serious concern for pediatrics. There is special equipment available for pediatric evacuation however, it is also important to note that with the addition of blankets or pillows, emergency cots, basket stretchers, and med sleds can be adapted to evacuate several pediatric patients. To make an evacuation device “pediatric friendly” with blankets and pillows, you should place the pillows and blankets around the child to remove as much extra space and movement capability as possible to safeguard the child.

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NOTE: An easy way to move pediatric patients is to put more than one patient in an incubator.

Baby Apron

For years, pediatric units have used aprons with large pockets in the front that hold two or three babies. Even though there is more specialized equipment available, baby aprons are still a valid and efficient method for pediatric evacuation. When using baby aprons, great care must be taken with respect to falling or running into objects. In addition, there must be a plan for the babies in the staging area post evacuation; they should not just be laid on the ground.



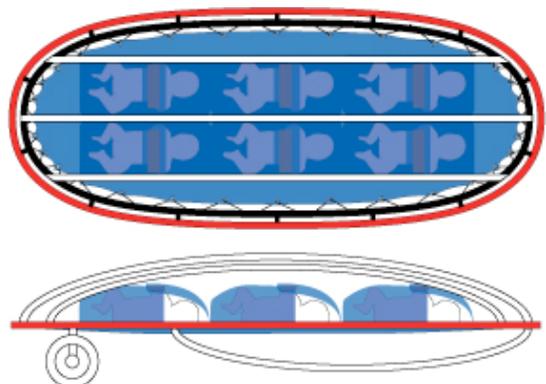
Med Sled

As discussed above, the Med Sled can be modified to handle toddlers and infants. This is made possible with inserts that fit into the Med Sled. The toddler insert is designed for ages 6 to 24 months. It is capable of securing 1 child and PICU equipment, including a long cutout down the side for an oxygen tank. There are also two cutouts at the bottom for other equipment. The infant insert is designed for ages 0 to 5 months. It is capable of securing 3 infants and NICU equipment, including oxygen tanks, which fit inside the sled under the insert. There are also two cutouts at the upper and lower end of the inserts to hold other equipment.



Baby Scatt

The Baby Scatt is designed to maximize personnel in an evacuation situation. One personnel can effectively evacuate six babies. The babies are placed in pockets made of open weave fabric, which does not restrict breathing. Patients are protected by a bumper bar, which goes all the way around the outside edge of the Baby Scatt. Three bumper bars cover the top, and two surround the bottom; in essence, forming a cocoon, so even if the personnel trip and fall, the patients will not be injured. Also, when the evacuation is complete, the Baby Scatt may be used as a protective barrier for the patients.



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Regardless of the type of evacuation equipment, selected limitations to vertical up and down will exist. The choice of horizontal only evacuation is always preferred if there is no elevator access, as in a fire.

E. Improvised Transportation Techniques

The following sections explore the use of alternate carry/transportation techniques. These should be used in emergencies and not for routine use or notice evacuations, as in a hurricane or other notice event. While some are noted as being acceptable for vertical up and down applications, they should not be used in those situations unless all other vertical transportations means have been exhausted. Vertical up and down should always be done in a powered lift (alternate elevator system or other device) unless a condition that precludes their use is encountered. In the event of a fire, horizontal evacuation to a different smoke compartment and then use of the elevator system is the optimum choice. If there is no means to reach an elevator in an unaffected smoke compartment, then horizontal evacuation to a safe location, to wait for assistance from trained rescue personnel, is the second choice. The third and final choice would be to attempt vertical evacuation using one of the alternate techniques described in this section.

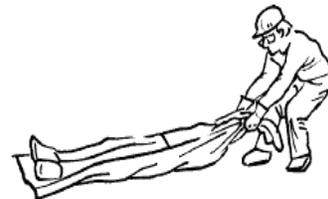
1. One Person

In extreme emergencies, it may be necessary for an individual staff member to act as a rescuer and move a patient to a safe area. One-person techniques should not be used in non-life threatening situations due to the risk of injury to both the patient and staff member. One-person techniques should never be used for vertical up or down movement due to the risk of serious injury both to the patient and staff member.

Blanket Drag

This is the preferred method for dragging a victim if only one person available.

1. Place the victim on the blanket by using the "logroll" or the three-person lift.
2. The victim is placed with the head about 2 ft. from one corner of the blanket.
3. Wrap the blanket corners around the victim.
4. Keep your back as straight as possible.
5. Use your legs, not your back.
6. Try to keep the pull as straight and in-line as possible.



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Drag Carry

The drag carry is preferred to the ankle pull. It supports the head of the victim. The negative is that it requires the rescuer to bend over at the waist while pulling.

1. Grasp the victim by the clothing under the shoulders.
2. Keep your arms on both sides of the head.
3. Support the head.
4. Try to keep the pull as straight and in-line as possible.



Ankle Pull

The ankle pull is the fastest method for moving a victim a short distance over a *smooth* surface. This is not a preferred method of patient movement.

1. Grasp the victim by either ankles or pant cuffs.
2. Pull with your legs, not your back.
3. Keep your back as straight as possible.
4. Try to keep the pull as straight and in-line as possible.
5. Keep aware that the head is unsupported and therefore patient head injury is possible over bumps and surface imperfections.



One Person Lift

This only works with a child or a very light person.

1. Place your arms under the victim's knees and around their back.

Care must be taken to ensure proper lifting technique is used to reduce the risk of injury to the mover and reduce the risk of dropping the patient.



Firefighter Carry

This technique is for carrying a victim longer distances. It is very difficult to get the person up to this position from the ground. Getting the victim into position requires a very strong rescuer or an assistant.

1. The victim is carried over one shoulder.
2. The rescuer's arm, on the side that the victim is being carried, is wrapped across the victim's legs and grasps the victim's opposite arm.



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Pack-Strap Carry



When injuries make the firefighter carry unsafe, this method is better for longer distances than the one-person lift.

1. Place both the victim's arms over your shoulders.
2. Cross the victim's arms, grasping the victim's opposite wrist.
3. Pull the arms close to your chest.
4. Squat slightly and drive your hips into the victim while bending slightly at the waist.
5. Balance the load on your hips and support the victim with your legs.

Psychological Patient Carry

The Psychological Patient Carry is applicable when transporting a patient who is capable of walking, but may not be completely aware of what is happening.

1. Stand behind the patient.
2. Grasp the patient's wrists of the same hand, left hand to left hand, right to right.
3. Hug the patient.
4. Walk slowly as you step use your knee to help the patient start their steps.
5. Be mindful of the possibility of the patient's head to roll back into the rescuer.

2. Two-Person

Two-person carries are preferred to any one-person carry due to the reduced risk to both the movers and the patient. Two person carries are acceptable in moving some patients even in non-life threatening situations. Two person carries are not recommended for vertical up or down evacuation due to the risk of injury to both the movers and patient, although they are more acceptable than any of the one-person carries. Rescuers should choose partners who are of similar height to avoid unequal distribution of weight.

Chair Carry

This is a good method for carrying victims up and down stairs or through narrow or uneven areas.

NOTE: *The chair used should be a sturdy one. Do not use aluminum beach chairs, resin patio chairs, swivel chairs or lightweight folding chairs.*

REMEMBER: *Chairs with wheels can be used to roll the victim, but should not be used for a carry.*



1. Pick the victim up and place them or have them sit in a chair.

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2. The rescuer at the head grasps the chair from the sides of the back, palms in.
3. The rescuer at the head then tilts the chair back onto its rear legs.
4. For short distances or stairwells, the second rescuer should face in and grasp the chair legs.
5. For longer distances, the second rescuer should separate the victim's legs, back into the chair and, on the command of the rescuer at the head, both rescuers stand using their legs.

Two-Handed Seat

This technique is for carrying a victim longer distances. This technique can support an unconscious victim.

1. Pick up the victim by having both rescuers squat down on either side of the victim.
2. Reach under the victim's shoulders and under their knees.
3. Grasp the other rescuer's wrists.
4. From the squat, with good lifting technique, stand.
5. Walk in the direction that the victim is facing.



Two-Person Drag / Human Crutch

For the **conscious victim**, this carry allows the victim to swing their leg using the rescuers as a pair of crutches. For the **unconscious victim**, it is a *quick* and easy way to move a victim out of immediate danger.

1. Start with the victim on the ground.
2. Both rescuers stand on either side of the victim's chest.
3. The rescuer's hand nearest the feet grabs the victim's wrist on their side of the victim.
4. The rescuer's other hand grasps the clothing of the shoulder nearest them.
5. Pulling and lifting the victim's arms, the rescuers bring the victim into a sitting position.
6. The **conscious victim** will then stand with rescuer assistance.
7. The rescuers place their hands around the victim's waist.
8. For the **unconscious victim**, the rescuers will grasp the belt or waistband of the victim's clothing.
9. The rescuers will then squat down.
10. Place the victim's arms over their shoulders so that they end up facing the same direction as the victim.
11. Then, using their legs, they stand with the victim.
12. The rescuers then move out, dragging the victim's legs behind.



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Variation –One Person Human Crutch

This carry is performed in the same manner as the Two-Person Drag for a conscious patient but is performed with only a single rescuer. If the patient is able to stand he/she may assist in getting into position, if not an assistant should help get the patient in position. This technique is not as stable as the two-person option because the patient is only supported on one side. This technique may be more useful in a life-threatening situation, such as fire or immediate threat, where speed is more important than maximized safety.



Four-Handed Seat

This technique is for carrying conscious and alert victim's moderate distances. The victims must be able to stand unsupported and hold themselves upright during transport.

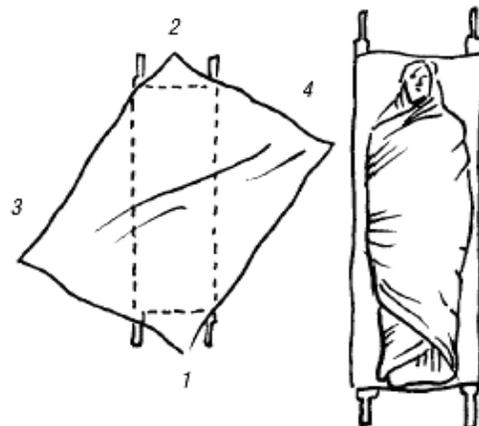
1. Position the hands as indicated in the graphic.
2. Lower the seat and allow the victim to sit.
3. Lower the seat using your legs, not your back.
4. When the victim is in place, stand using your legs, keeping your back straight.



Blanket Stretcher

This technique requires two poles and a blanket.

1. Place the blanket down on the ground.
2. Place one pole approx. 1 foot from the middle of the blanket.
3. Fold the short end of the blanket over the first pole.
4. Place the second pole approx. 2 feet from the first (this distance may vary with victim or blanket size).
5. Fold both halves of the blanket over the second pole.



3. Three or More Person Carry

Three person carries are the preferred techniques as they provide for the least risk to both the patient and movers by distributing the weight among more individuals. The down side to these techniques is they are personnel intensive and in life-threatening situations, there may not be sufficient staff available to perform these techniques.

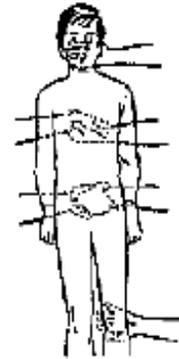
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Hammock Carry



Three or more rescuers get on both sides of the victim. The strongest member is on the side with the fewest rescuers.

1. Reach under the victim and grasp one wrist on the opposite rescuer.
2. The rescuers on the ends will only be able to grasp one wrist on the opposite rescuer.
3. The rescuers with only one wrist grasped will use their free hands to support the victim's head and feet/legs.
4. The rescuers will then squat and lift the victim on the command of the person nearest the head, remembering to use proper lifting techniques.



Note: this technique may also be used in a four or six person carry to distribute weight to more transporters.

Three-Person Carry or Stretcher Lift

This technique is for lifting patients onto a bed or stretcher, or for transporting those short distances.

1. Each person kneels on the knee nearest the victim's feet.
2. On the command of the person at the head, the rescuers lift the victim up and rest the victim on their knees.



If the patient is being placed on a low stretcher or litter basket: On the command of the person at the head, the patient is placed down on the litter/stretcher.



If the victim is to be placed on a high gurney/bed or to be carried: At this point, the rescuers will rotate the victim so that the victim is facing the rescuers, resting against the rescuers' chests.



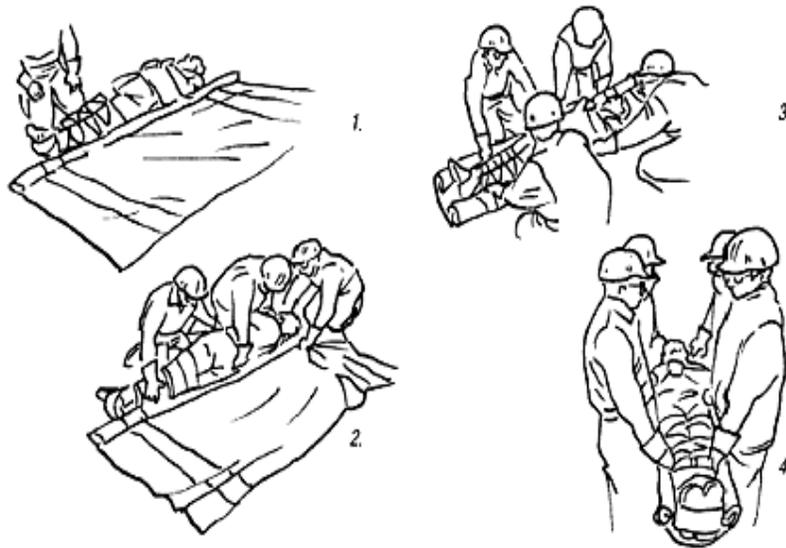
3. On the command of the person at the head, all the rescuers will stand.
4. To walk, all rescuers will start out on the same foot, walking in a line abreast.

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Blanket Lift

Do not use this technique if head/spinal injuries are suspected.

1. Roll the blanket or rug lengthwise for half its width. Position bearers at the head and feet, neck and body in line.
2. Kneel at the patient's shoulder and position a bearer at the waist to help logroll the patient onto the uninjured side. Turn the patient as a unit so that his/her body is not twisted during the logroll.



3. Roll the patient back over the blanket roll to lay face up on the blanket. Unroll the blanket and then roll the edges of the blanket to each side of the patient. Get ready to lift the patient – have bearers grip the rolls at the head and shoulders, and at the hips and legs.

Additional transporters may be used if the patient weight is too great for four transporters. If head support is needed an additional transporter may clasp the blanket at either side of the head to provide additional support during transport.

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VI. MEDICAL INFORMATION

The transfer of critical patient information from one geographic area to another as well as to other healthcare facilities is important. In such a scenario, there will not be time for providers to review patient medical records or even transfer these records with the patient. Therefore, a summary of the pertinent information is required. Healthcare organizations that utilize electronic medical records should consider including an emergency patient summary in their planning and installation of such systems. However, it should also be recognized that in the event an evacuation is necessary, electronic systems may be down, so extracting this information will become impossible and therefore manual methods must be identified.

The brief summary should be completed prior to moving the patient and copies of critical pieces of information should go with it including:

- Copy of Medication Administration Sheets
- Copy of most recent set of complete medical orders
- Copies of Latest lab reports
- Copy of DNR
- Copy of Advanced Directives
- Restraint Orders
- Receiving Physician Authorization papers

See Attachment #8 – Critical Patient Information, on the following page

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ATTACHMENT 8 – PATIENT CRITICAL EVACUATION INFORMATION – PART 1

Patient Name (PRINT): _____ Medical Record No.: _____

Admission Date: _____ Sending Facility: _____

Consent Obtained for Transfer: Yes No Unable to Obtain

Emergency contact: _____ Telephone # _____

Notified of Transfer YES NO

Attending Physician: _____ Notified of Transfer YES NO

Primary Diagnosis: _____

Secondary Diagnoses: _____

Allergies: _____

Vitals at Time of Transfer: T=_____ P=_____ R=_____ BP=_____

Do Not Resuscitate Yes No (Copy Attached) Advanced Directives: Yes No (Copy Attached)

Isolation Status: Contact Droplet Airborne Other:

Precautions: Aspiration Seizure Fall Elopement Other: _____

Oxygen: Mask Cannula Other: _____ Oxygen Requirement: _____

Tube Feeding: Yes No Enteral Formula: _____

Diet: Regular Low Salt Diabetic Bland Other: _____ Feeds Self YES No

Other Intravascular Device Central Line PICC Line Arterial Line Other: _____

Foley Yes No Incontinent Yes No Bowel Bladder

Behavior: Cooperative Disruptive Belligerent Combative Wanders Withdrawn

Mental Status: Oriented Alert Sedated Forgetful Confused

Transfers: Independent Supervision Partial Assist Total Assist

Assistive Devices: None Cane Walker Wheelchair Glasses Dentures: Upper Lower Hearing Aid

Prosthesis Type _____

Pressure Ulcer: Yes No Location: _____

Restraint: Type _____ How Long _____

ADL Independent Supervision Partial Assist Total Assist

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ATTACHMENT 8 – CRITICAL PATIENT EVACUATION INFORMATION – PART 2

List IV access and infusing fluids or medications:

Access site	Gauge	IV Fluids And Amount	Medications added Name and concentration	Infusion Rate	If pump going Asset Tag Number

Endotracheal Tube size: _____ Level at Lip: _____ Trach Tube size: _____

Ventilator Settings at time of transfer:

Mode: Assist Control Intermittent Other: _____

FIO2: _____ % Tidal Volume _____ Rate: _____ PEEP: _____

Pressure Support: _____ Other: _____

Other important information about this patient: _____

FLORIDA DEPARTMENT OF HEALTH HOSPITAL EVACUATION TOOLKIT

A. Medical Records

The hospital must assure that a process is in place to secure medical records. This should be discussed with the Medical Records Department. Policies should be developed that address the securing and transfer of records. Three areas should be addressed in formulating a policy to deal with the securing of medical records:

1. Old/Discharged Records: Distinction needs to be made between active records and inactive records (patients who have previously been discharged but whose records have not been forwarded to Medical records). Medical Records personnel should work with unit staff to collect all medical records on the unit. These records should be placed in a storage box and appropriately marked with permanent marker.
2. Active patients Medical Records: As patients are readying to leave the patient care unit, the Medical Record staff should collect all active medical records on the unit. These should be placed in a storage box and appropriately marked with permanent marker. (Active Medical Records- Name of Patient Care Unit).
3. Split Medical Records: Consideration needs to be given to split charts. Split Charts are medical record documents that are part of the patient's current hospitalization but due to volume (most usually from prolonged hospitalization); non-urgent information has been removed from the active chart and stored elsewhere. The Medical Records staff must work with the unit staff to collect all split medical records on the unit. These should also be placed in a storage box and appropriately marked with permanent marker. (Split Medical Records- Name of Patient Care Unit).

It is also recommended that once secured, the medical records be safeguarded from water damage. Boxes of medical records can be placed in clear plastic bags, which are then sealed in order to protect them from water damage. Clear plastic bags should be utilized so that the markings on the boxes can be easily viewed.

NOTE: When preparing the staging areas for facility evacuation, the placement of high speed copiers should be considered for the duplication of necessary medical records.

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VII. SUPPLIES

Hospitals must work with their pharmacies to identify what medications need to accompany patients and/or be available in the patient staging area. It should be recognized that several hours might elapse until transportation to another healthcare organization is accomplished and therefore it is essential that provisions for critical medications to be made available at the staging area.

In addition, emergency medications and equipment to address cardiac and respiratory arrests must also be provided at the staging area. Many hospitals now utilize “Code” carts whose medication drawers can be easily removed and relocated to the staging area. It is recommended that in drafting these policies hospitals work with their pharmacies to assure the movement of critical life saving medications and equipment.

Finally, the transferring facility should assess if the receiving facility has specific patient medications. In the instance where a specific patient medication is critical and not available at the receiving institution, the sending facility’s pharmacy department should arrange to transfer the medication to the receiving facility.

See Attachment #9 – Suggested medications for staging areas, found on the next page all attachments are available on :

<http://www.nyc.gov/html/doh/downloads/pdf/bhpp/bhpp-hospital-evac-plan.pdf>

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ATTACHMENT 9 – EMERGENCY EVACUATION PHARMACEUTICAL SUPPLIES

Medication	Strength	Oral/ Inj/Top	Category	Quantity
Oral Prep				
Acetaminophen	325mg	Tab	Pain	500
Aspirin	325mg	Tab	Pain/CV	100
Clopidogrel	75mg	Tab	CV	100
Erythromycin	250mg	Tab	Antibiotic	50
Furosemide	40mg	Tab	CV	100
Ibuprofen	400mg	Tab	Pain	500
Lisinopril	10mg	Tab	CV	100
Metoprolol	50mg XL	Tab	CV	100
Oxycodone/APAP (CII)	5/325mg	Tab	Pain	500
Pediatric Oral Prep				
Acetaminophen	160mg/5ml	Liq	Pain	100
Erythromycin	200mg/5ml	Liq	Antibiotic	10
Ibuprofen	100mg/5ml	Liq	Pain	100
Injectable Prep				
Cefazolin	1gm	IM IVPB	Antibiotic	20
Ciprofloxacin	400mg	IVPB	Antibiotic	20
Diphenhydramine	50mg	IM IVP	Antihistamine	50
Diphtheria & Tetanus Toxoid		IM	Vaccine	50
Enoxaparin	30mg 60mg 80mg	SC	LMWH	20 20 20
Furosemide	40mg	IM IVP slow 1-2min	CV	50
Gentamicin	80mg	IM IVPB	Antibiotic	50
Haloperidol	5mg	IM	Antipsychotic/ Sedative	50
Insulin R	100units/ml , 10ml	SC	Hypoglycemic	100
Lidocaine	1% 30ml 2% 30ml	SC	Local anesthetic	25 25
Lidocaine w. epin	1% 30ml	SC	Local anesthetic	10
Lorazepam (CIV)	2mg	IM IVP slow (=2mg/min)	Antianxiety/ Sedative/ Anticonvulsant	100
Meperidine (CII)	50mg	IM SC	Pain	30
Metoprolol	5mg	IVP slow 1- 2min	CV	50

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ATTACHMENT 9 – EMERGENCY EVACUATION PHARMACEUTICAL SUPPLIES (Continued)

Medication	Strength	Oral/ Inj/Top	Category	Quantity
Methylprednisolone	40mg 500mg	IM IVP slow (Dose =125mg, IVP over 3min)	Corticosteroid	50 20
Morphine (CII)	2mg 10mg	IM SC IVP	Pain	50 50
Moxifloxacin	400mg	IVPB	Antibiotic	20
Phenytoin	100mg	IVP slow (=50mg/min)	Anticonvulsant	50
Tetanus Immune Globulin		IM	Immune Globulin	10
Code Cart trays - Adult/Pediatric	See attached			Minimum 3
Oral Inhaler				
Albuterol		MDI	Asthma/COPD	50
Ipratropium		MDI	Asthma/COPD	50
Ophthalmic Prep				
Erythromycin	3.2gm	Ophthalmic oint	Antibiotic	50
Sulfacetamide	10% 3.5gm	Ophthalmic oint	Antibiotic	50
External Prep				
Silver Sulfadiazine Cream	20gm	Topical cream	Antibiotic	20
Miscellaneous Supplies				
Alcohol swab				500
Calculator				1
Drug reference				1
Gloves	Small Medium			100 100
Label				1 roll
Needle	18G x 1in			100
NS	0.9% 10ml		Diluent/ Line flush	50
Patient Profiles				1
Pen/Marker				10
Plastic Bag	4x6 9x12			50 50
SWFI	10ml		Diluent	50
Syringe	1ml 5ml			100 100

Prepared by Sara S. Kim, Pharm.D 12/05

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A. Evacuation Kits

Pulling together the materials, documents and supplies to assist in evacuating a patient care floor cannot be left to the last minute. Each healthcare organization should consider assembling an evacuation kit for each department and patient care area and keeping this with the emergency equipment, for example with the “Code” carts.

An example of such a kit is given in Attachment #10, found after this section (all attachments are available on a CD in this toolkit).

B. Additional Materials Management/Purchasing Assistance and Guidance

The Department of Health and Human Services Medical Surge Capacity and Capability handbook⁵ outlines a Six-Tiered Integrated Response System, which offers hospitals and materials managers, a tiered approach to disaster/emergency situations for healthcare organizations.

Tier 1: Individual Hospital Preparedness

- This could be defined as a comprehensive “disaster ready hospital network.” Materials Managers should consider this in three parts: (1) Provider Networks, (2) Supplier Networks and (3) Transportation Networks.

Tier 2: Cooperative Groups of Healthcare Organizations

- Competitors work together: Historically hospitals see themselves in competition with other area hospitals. This competition remains in effect today; however, much has been done to cross these competitive lines in supporting one another since healthcare is forced to operate on much more lean margins. Many metropolitan health systems rely on such agreements to support daily surge and traumatic events.
- Caregivers: Healthcare is an environment of caring people who place the needs of patients above competing business interests. This may be why during disasters, hospitals and their personnel come together in support of a single cause.

Tier 3: Jurisdiction Incident Management

⁵ Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies, Second Edition, 2007

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- At tier 3, hospitals and all other support organizations within a city, county or other sub-state region are functioning as a fully integrated “organic response” entity. All hospitals are fully integrated with police, fire, EMS, EMA’s public health departments, public works and other public and non-governmental organizations including faith based organizations.

Tier 4: Management of State Response and Coordination of Intrastate Jurisdictions

- Hospitals and all other support organizations within a state or territory are functioning as a fully integrated “organic response” entity.

Tier 5: Interstate Regional Management Coordination

- At this level of integration, regional alliances of states and their respective support agencies form to create an integrated response to disasters. States share information and resources with each other in order to complement each other’s role in the disaster response.

Tier 6: National Integrated Emergency Response

- Fully integrated national response. The NDMS system is fully capable and operational.

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ATTACHMENT 10 – EVACUATION KIT CONTENTS

- Laminated Cards Evacuation Triage Levels
- Pre-Strung Fluorescent Tags (Colors: Red, Yellow, Green)
- 2” Wide Adhesive Tape to Mark Doors and Hall Entrances that area is EVACUATED
- Labels for Addressograph
- Permanent Markers
- Rubber Bands for Medical Records
- Legal-size Storage Boxes for Medical Records
- Clear Plastic Bags for Storage Boxes Containing Medical Records
- Patient Care Unit Evacuation Forms
- Patient Tracking Templates
- Departmental Evacuation Template
- Departmental Contact List
- Staff Tracking Templates
- Visitor Tracking Templates
- Sheet Protectors/Plastic File Pockets for Transfer Documentation to Accompany Patient
- Non-Skid Socks for Ambulatory Patients without Shoes
- Wind Up Flashlight
- Fluorescent Vest with Place for Name on the Back – Colored Coded by Assignment
- Pens or Pencils

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VIII. SUPPORT SERVICES

A. Logistics

The Logistics Section within the HICS is primarily responsible for ensuring that the proper resources are provided at the right place and at the right time so that the incident objectives established by the Operations Section and approved by the Incident Commander can be accomplished in a timely manner. What this means in the context of a hospital evacuation is that the Logistics Section is responsible for:

- The movement of patients and staff from the hospital to the staging area.
- Establishing Alternate Care Sites and Evacuation Staging areas infrastructure support as well as maintaining operational support throughout the period of evacuation.
- Movement of patients and staff from the affected hospitals and facilities to designated safe zone alternate care sites and staging areas.
- Identification and coordination of medical/surgical materials, medical gases, laboratory reagents, linen and regulated/non-regulated waste management sufficient to support the facility census and staff need.
- Assist Operations Section in performing a re-entry damage assessment.
- The re-entry of staff and patients back to the hospital when it is safe to do so.

The Logistics Section will be responsible for transportation resources, linen, medical equipment assets, food and water, fuel for vehicles (not included in the contracts) and diesel generator(s) and necessary provisions for the patients and staff during transport, at a minimum.

B. Materials Management

The Materials Management Department and specifically the Materials Manager are vital to the preparedness of the facilities evacuation plan. The Materials Manager is responsible for advanced identification of medical surgical supplies and materials sufficient to support the facilities patient census capacity prior to any evacuation or contingency event. Materials Managers must routinely review and coordinate advanced distribution support from distributors, vendors, manufacturers and mutual aid contracts, memorandum of agreement, or pre-positioned stock (hospital owned or consigned).

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Establish memoranda of agreement with adjoining municipalities, physician practices and faith-based organizations for assistance through volunteerism and/or evacuation facilities to support the necessary level of evacuation staging or alternate care sites.

C. Medical Asset Management

Medical Equipment and durable instrumentation will be necessary to transport with intermediate and critical patients during any evacuation. This commodity represents not only a vital life-sustaining item, but also one that represents considerable cost to the facility. Therefore, medical asset tracking becomes a necessary process both for accountability and for return, but also for future reimbursement due to loss. The Materials Management Department in conjunction with the Clinical / Nursing Department will provide the level of accountability and tracking.

D. Transportation

The transportation unit will be responsible for arranging transportation of all patients who need to be moved to alternate facilities because of a partial or full evacuation. Transportation should be arranged in coordination with the Medical Branch Director and Incident Commander to ensure all patients receive the proper level of care during transfer and the communications unit to ensure a receiving facility has been identified.

Contracts must already be in place and coordinated for transportation with transportation vendors and providers. Transportation contracts should be accompanied by a list of predefined relocation facilities with which the hospital has established Mutual Aid Agreements (MAA) in place for patient transfer.

Transportation may be divided into several categories:

- **Air Transport** - use of air transport is expensive but may be the only acceptable means for some critical patients, especially if the transport distance is large. If air transport is to be used for a storm or other notice event, it must be arranged well in advance of the event, as aircraft may not be able to fly in the area once the event has occurred.
- **Water Transport** - use of boats such as; Ferry's, Cruise Ships (Medium/Large) offer value when transporting the more ambulatory to intermediate level patients out of the targeted strike zone. This mode of transportation requires advanced planning sufficient time phased activation to board patients, providers and clinicians hours ahead of the anticipated impact. This may be a valued option for the Florida coasts, keys and peninsula given advanced notification.
- **Ground Transport** - ground transport may be further divided according to level of care needed:

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- **ALS Transport** - the resources should be used to transport the most critical patients as they maintain the higher standard of care. Acceptable for transporting all types of patients.
- **BLS Transport** - these assets provide a basic level of care during transport but do not take staff as the previous category. BLS units may take non-ambulatory patients and those who may not sit for extended periods.
- **Para-Transit Accessible Transit** - these resources provide transportation of those patients who may not sit for extended periods and do not require direct medical care. This type of transportation might require the assignment of staff to meet the required level of care.
- **Wheelchair Accessible Transit** - these resources provide the same level of care as busses and might require the assignment of staff to meet the level of care, but have the ability to transport patients who may be moved in wheelchairs. May not transport patients who may not sit for extended periods.
- **Public Transit/Bus** - these transportation assets may be utilized to move ambulatory patients to alternate facilities. Medical staff may be dispatched with patients traveling in this manner to maintain the level of care. May not transport non-ambulatory patients, or patients who may not sit for long periods.
- **POV – Privately Owned Vehicles** - consideration may be given to patients who have friends or family willing to provide transportation as long as the patient is capable of being released from medical care for the time that would be necessary to reach an alternate location. Patients being released for transport via POV should be discharged and re-admitted to the receiving facility upon arrival. Patients not discharged cannot be transported by POV. Arrangements should be made with the receiving facility to advise them the patient is coming via POV and will need to be admitted as a new patient. Medical records will either need to be faxed to the receiving facility or copies provided to the patient to take to the receiving facility.

A major planning component to transportation is pre-event identification of on-site hospital transportation resources. When identifying these resources, the vehicle specifics including how many patients, number of staff required, and if there is a special license to operate the vehicle, should all be noted. Also, the types of patients that can be transported in that vehicle should be identified pre-event. This will allow for immediate preparing of specific units to be transported in a specific vehicle type when the evacuation notice is given. A template to aid with this is provided in the toolkit on CD.

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E. Needs During Transport

Regardless of the type of transport provided, the current recommendation is that all patients must be transported with sufficient medications and supplies (Bandages, IV Solutions and Gases) to last a minimum of 96 to 120 hours. Additionally, food and water supplies should be provided to each patient being transported to last the duration of the anticipated transport time and accommodate for any delays that might occur during transfer to other facilities. If staff are assigned to be transported with the patient, sufficient food and water must be included for their use as well.

F. Water and Fuel

Water, fuel and power must be available for the facility to continue to provide care for patients that cannot be moved. Facilities should have a minimum fuel supply to run generators. If this supply drops below 50%, arrangements should be made to have fuel resupplies made. In a large scale, natural disaster power disruptions may be many days and while hospitals are a priority for power reconnection, there is no guarantee of how long infrastructure will take to repair. The Logistics Section should coordinate, through the ESF-3, ESF-8 and ESF-12 desks at the local EOC regarding infrastructure damage assessment, time to repair or reconstruct and to have fuel deliveries begin before fuel reaches a critical level, if the hospital has contracted suppliers are unable to fulfill the contract for fuel.

As with fuel, water must be available to continue operations and care for patients that cannot be moved. If water systems are disrupted and no water storage capability is present at the facility, the Logistics Section is responsible for coordinating delivery of water supplies through the ESF-8 desk and the Local EOC. Logistics Section should coordinate through the ESF-8 desk referencing area designation 13 (potable water, wastewater and solid waste disposal) and local EOC with public works on restoration of potable water and sanitation service to the facility.

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IX. RE-ENTRY & RETURN

The process of returning patients to the facility can be initiated when the threat necessitating evacuation is over and necessary infrastructure repairs have been completed. Depending on the size of the event, hospital administration, in conjunction with local emergency personnel, will be responsible for determining if the hospital or affected area can be reopened and to what level it will provide patient care. A facility evaluation by representatives of the Florida Department of Health and the Agency for Health Care Administration (ACHA) will also be required prior to reopening the facility and the return of patients.

A. Facility Assessment

In small-scale events, where less than the entire facility was evacuated, re-entry will be either by returning the patients to their previously assigned rooms once an all clear has been given or by reassigning them to rooms in unaffected areas of the hospital.

In the case of a large event hospital, administration in coordination with the appropriate department directors and local county and state officials should inspect the facility before reentry of patients and staff. Once access to the hospital is restored, hospital administration should meet and tour the facility, determine damage and estimate time for repairs. Depending upon the extent of known damage, this inspection should be conducted in consultation with appropriate professionals to assess the building's structural integrity as well as systems that provide: safety; security; sanitation; electrical distribution; compressed gases; heating, ventilation, air conditioning (HVAC); and communications at a minimum.

B. Staff Re-entry

Notification of associates, physicians, and the public should be made through the Incident Commander to the Hospital PIO through ESF-14 at the local EOC and by means established for hospital communication polices. Essential departments should be opened first, i.e., ED. Staff return should be based on units opening and expected patient load. Upon personnel re-entering the facility, they should be prepared to begin readying their units for patient re-entry. The hospital should cooperate with all agencies and relief agencies to facilitate recovery of the hospital as soon as safely and quickly as possible.

C. Patient Re-entry

Plans to reopen will be dependent on a number of factors, including access to the hospital, the amount of damage sustained by the building and equipment, the availability of personnel, and the availability of support systems as noted in Section A above. Once the hospital has been

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reopened, the master list of patients should be used to call the transferring facilities, and obtain condition information and assess for possibility of return to the hospital.

The process of re-entry is as logistically complicated as an evacuation and therefore, the hospital must have a coordinated plan in place before reopening the facility. Coordination with local emergency management, fire-rescue and law enforcement is mandatory following a disaster declaration as re-entry cannot occur without approval of the local jurisdiction.

Once a time has been established to reopen the facility, the Hospital Command Center (HCC) will open as the “command post” to direct the return of patients. The Liaison Officer or designee(s) will call facilities that have received patients during the evacuation to determine their status. Patients remaining in those facilities will be given the option to stay at their current facility or to return. A priority list will be identified based on several factors including bed availability, staffing availability, and identified units to be reopened. Receiving hospitals will provide a list to the HCC of all patients to return. The Logistics Section Chief will maintain this list and coordinate assigning these patients to units/rooms. The Operations Section Chief will coordinate staffing of the Staging Areas for receiving patients and transport to the units. The Logistics Chief ensures coordination of patient transportation with transportation companies and arranges transportation devices (wheelchairs, gurneys, etc) to be available to assist in reentry. The Security Officer will coordinate securing of areas for transport vehicles, traffic control, and monitor entrances/exits for visitor/associate/patient control. The Medical Staff Director will confer with Operations Section Chief and Incident Commander and coordinate with physicians the return of patients assigned to their care.

After any evacuation has been completed, an After-Action Report should be completed. As part of this report, lessons learned should be identified by people on all levels of involvement of the evacuation. The report should be shared with other hospitals through the local ESF-8 and local Emergency Operation Center or emergency management planning; and planning documents updated to reflect the lessons learned.

D. Additional Considerations

With any Re-entry plan, considerations need to be made for several factors, to include:

1. Special Needs Shelters
2. Disaster Medical Assistance Team (DMAT)
3. Medical Reserve Corps
4. Pharmaceutical needs

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ATTACHMENT 11 – FLORIDA EMERGENCY SUPPORT FUNCTIONS

ESF #1 Transportation

- Florida Department of Transportation
- US DOT
- US DOT Office of Emergency Transportation
- Federal Aviation Administration
 - Southern Region
- United States Coast Guard

ESF #2 Communications

- Department of Management Services- Wireless Services
- Department of Management Services- Radio Communications
- FCC Emergency Alert System
- Florida Association of Broadcasters
- National Telecommunications and Information Administration
- National Communications System (NCS)
- ESS/Telecommunications Unit, United Nations Office at Geneva - The Working Group on Emergency Telecommunications Web
- Association of Public-Safety Communication Officials - International
- National Public Safety Telecommunications Council
- Amateur Radio
 - USRACES (Radio Amateur Civil Emergency Services)
 - North Florida Amateur Radio Emergency Services
 - Southern Florida Amateur Radio Emergency Services
 - National Association for Amateur Radio
- Radio Emergency Associated Communications Teams (REACT)
 - REACT International
 - Florida Council of REACT Teams
 - Florida Disaster Communications Assistance Teams
 - Florida REACT Teams
- Commercial Communications
 - BellSouth
 - ALLTEL Corporation
 - AT&T
 - MCI
 - Sprint

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ATTACHMENT 11 – FLORIDA EMERGENCY SUPPORT FUNCTIONS

ESF #3 Public Works

- Florida Department of Transportation
- USACE - United States Army Corps of Engineers
- South Atlantic Division, U.S. Army Corps of Engineers
- U.S. Army Corps of Engineers, Jacksonville District
- Florida Water Management Districts
 - St. Johns River
 - Southwest Florida
 - South Florida
 - Suwannee River
 - Northwest Florida

ESF #4 Firefighting

- State Fire Marshal
- Florida Fire Chiefs' Association
- Florida's Forest Protection Bureau
- Florida State Firemen's Association
- International Association of Fire Chiefs (IAFC)
- FireWise
- USDA Forest Service

ESF #5 Information and Planning

- Ordinances, Statutes, and Regulations
 - Florida Statutes and Constitution
 - Code of Federal Regulations - CFR Services available online via GPO Access
 - U.S. Code (searchable) - U.S. House of Representatives Internet Law Library
- Florida Data
 - Florida Cooperative Extension Service
 - Florida's Government Services Direct
 - Florida Information Resource Network Info Server

ESF #6 Mass Care

- American Red Cross
 - Florida Chapters of the American Red Cross
 - Salvation Army
- Mid-Florida Area Agency on Aging
- Agency for Workforce Innovation
- Florida Department Business and Professional Regulation
- Florida Department of Children and families
- Florida Department of Elder Affairs
- Online Training

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ATTACHMENT 11 – FLORIDA EMERGENCY SUPPORT FUNCTIONS

ESF #7 Unified Logistics

Unified Logistics

ESF #8 Health and Medical

Florida Department of Health

DOH Emergency Operations Section ESF#8

Florida Division of Medical Operations

U.S. Department of Health and Human Services

Office of Emergency Preparedness

Centers for Disease Control

Agency for Toxic Substance and Disease Registry

World Health Organization

The Global Health Network

ProMED Electronic Network of Information Exchange

ESF #9 Search and Rescue

State Fire Marshal

Florida Association of Search and Rescue

Air Force Rescue Coordination Center

Civil Air Patrol -National

Civil Air Patrol - Florida

NASAR - National Association for Search and Rescue

National Disaster Search Dog Foundation

National Institute for Urban Search and Rescue, USA

NOAA SARSAT Homepage – saving lives via satellite

CMC Rescue - CMC ranks among the largest stocking distributors of rescue equipment in the world.

RescueNet, The Internet Resource for the Rescue Community

Search and Rescue Dogs Listing

ESF #10 Hazmat

State of Florida

State Emergency Response Commission

Florida Department of Environmental Protection

Federal

US EPA

The Office of Solid Waste and Emergency Response

US Environmental Protection Agency Management

National Response Center

National Response Team

United States Chemical Safety and Hazard Investigation Board (CSB)

Florida's health

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ATTACHMENT 11 – FLORIDA EMERGENCY SUPPORT FUNCTIONS

ESF #11 Food and Water

Florida's Department of Agriculture and Consumer Services
United States Department of Agriculture -USDA

ESF #12 Energy

Florida Public Service Commission
Florida Reliability Coordinating Council - (FRCC)
Florida Electric Cooperatives Association, Inc.
Florida Progress Energy
Florida Power and Light Company
Central Florida Electric Cooperative, Inc.
Gainesville Regional Utilities
North American Electric Reliability Council
TSIN.COM - Transmission System Information Networks (TSINs)
Department of Energy
Office of Fossil Energy (FE)
Energy Information Administration
Federal Energy Regulatory Commission Nuclear Regulatory Commission

ESF #13 Military Support

Florida National Guard (FLNG)
United States Department of Defense
United States Army
United States Navy
United States Air Force
United States Marine Corps
The National Guard
United States Coast Guard

ESF #14 Public Information

News Sites

ESF #15 Volunteers and Donations

The Governor's Commission on Volunteerism and Community Service
National Voluntary Organizations Active in Disaster

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ATTACHMENT 11 – FLORIDA EMERGENCY SUPPORT FUNCTIONS

ESF #16 Law Enforcement

State of Florida

Florida Attorney General

Florida Department of Law Enforcement

Florida Department of Corrections

Florida Fish & Wildlife Conservation Commission

Florida Highway Patrol

Florida Division of Alcoholic Beverages & Tobacco

Federal

Federal Bureau of Investigation

Bureau of Alcohol, Tobacco, Firearms, and Explosives

United States Customs and Border Protection

United States Secret Service

United States Department of Justice

United States Drug Enforcement Administration

United States Marshals Service

ESF #17 Animal Protection

Florida's ESF 17 - Division of Animal Industry , Department of Agriculture and
Consumer Services

FEMA - Animals and Emergencies

Florida Animal Disaster Planning Advisory Committee

Sunshine State Horse Council

Pets and Animals Preparedness

U.S. Humane Society Disaster Center

American Humane Association - Protecting Animals

American Veterinary Medical Association - Veterinary Medical Assistance Teams
(VMATs)

Find Pet-Friendly Lodging at Petswelcome.com

ESF #18 Business, Industry and Economic Stabilization

Governor's Office of Tourism, Trade, and Economic development

Florida Department of Revenue