

Hospital Mass Casualty Incident Planning Checklist

Purpose: To assist hospitals in assessing, updating or developing plans for response to a significant surge incident.

Overview: A Mass Casualty Incident (MCI) is a significant event or set of circumstances that impact the healthcare system resulting in the demand for care exceeding capacity and/or capability.

This guidance provides planning recommendations for mass casualty incidents (MCI) as related to hospital and health care facility emergency preparedness planning in the United States. The guidance is for public and private health personnel who are involved in emergency management, disaster preparedness, planning, response, mitigation, protection and/or recovery. This guidance is based upon current knowledge regarding MCIs and may be updated as needed.

A government-centric approach is not enough to meet the challenges posed by a catastrophic incident. Focus has shifted to a 'Whole Community approach' which leverages all of the resources of a community in preparing for, protecting against, responding to, recovering from and mitigating against all hazards. Collectively, a team of partners may work together to meet the needs of an entire community. This larger group includes: federal partners; local, tribal, state and territorial partners; non-governmental organizations; faith-based organizations; non-profit groups; private sector and industry partners; and, individuals and families. Both the composition of the community and the individual needs of community members, regardless of age, economics, or accessibility requirements, should be accounted for when planning and implementing disaster strategies.

For the healthcare system, the whole community approach combines public and/or private community health and medical partners. This would include: public health; hospitals and other healthcare providers; emergency medical service providers; long-term care providers; mental/behavioral health providers; private entities associated with healthcare (hospital associations, etc); specialty service providers (dialysis, pediatrics, woman's health, stand alone surgery, acute/urgent care, etc.); support service providers (laboratories, pharmacies, blood banks, poison control, etc.); primary care providers; community health centers; tribal healthcare; and, federal entities (National Disaster Medical System (NDMS), Veterans Administration (VA) hospitals, Department of Defense (DoD) facilities, etc.). For this document, community health system partners encompass these entities.

The Department of Homeland Security's medical surge target capability refers to the ability to provide adequate medical evaluation and care during an incident that exceeds the limits of the normal medical infrastructure of an affected community. Healthcare systems need to survive a hazard impact and maintain or rapidly recover operations that are compromised. Surge capability is also a key component of a surge response and may be defined as the ability of the health care system to manage patients who require specialized evaluation or interventions. Incidents that involve a large number of children, burn patients, or other specialized scenarios are examples of the need to plan beyond routine conventional emergencies.

Hospitals may view surge capacity as the ability to quickly expand normal services in response to a sharp increase in demand for medical care of arriving patients. A more appropriate way to view surge capacity is from a community-wide perspective. An integrated community response to a mass casualty incident supports a health care system to rapidly expand beyond normal services to meet the increased demand for medical care from that incident. Hospital plans and response operations should align with local community response partners.

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Medical surge response includes having:

- An incident command system for crisis management
- Potential patient beds or available space in which patients may be triaged, managed, decontaminated, and/or sheltered
- Available personnel of all types
- Necessary equipment and supplies, medications, and patient care items
- Mechanism for evaluation and critique of response

For planning purposes, hospitals should assume the incident may overwhelm existing resources.

Surge Plan Options: Many elements that should be addressed in developing Surge Plans may already be included in the Emergency Operation Plan (EOP) or other hospital plans, policies, procedures, or protocols.

Surge Plans (and policies and procedures) should address internal and external communication regarding current emergency status for surge levels, regulatory status, the type, scope, and expected duration of an incident, and escalation and de-escalation as new information is received. The strength of a good plan is to have adequate detail to allow implementation by staff that may not be familiar with the plan. Job action sheets, task checklists and other tools for activating the surge plan may be developed for this purpose. Policy and background documentation should be referenced and available, but should not serve as primary resources providing direction at the onset of a surge incident.

Plans should be in compliance with state and federal requirements and with standards set by accreditation organizations.

Note: Florida's checklist has been adapted with permission from the California Hospital Association version.

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Using the Checklist: The individual or team responsible for disaster planning should review the checklist.

The checklist is organized into four main sections that cover key aspects of a comprehensive surge plan: Command and Management Structure; Surge Capacity and Space; Surge Staffing; and. Surge Supplies.

Note the status of plan elements in the “Status” columns (C-Completed, IP-In Progress, NS-Not Started, NA- Not Applicable) and the Location (EOP, Safety Management Plan, Infectious Disease Plan, etc).

1. Command and Management Structure

Status	Location	Plan Elements
		Identifies triggers, who has decision-making authority, the process for activating the Emergency Operations Plan (EOP), and surge plan:
		<ul style="list-style-type: none"> • Clearly defined process for the verification of the incident and activation of the Hospital Incident Command System (HICS) and determination of appropriate positions to be activated
		<ul style="list-style-type: none"> ○ Activation of the Hospital Command Center (HCC) based on a scaled approach
		<ul style="list-style-type: none"> ○ Medical Technical Specialists/Subject Matter Experts (SMEs) identified and resources available for consultation as needed (e.g. Hazmat for chemical incidents; Infection Control Preventionists and Epidemiology for Biological events; Radiation Safety Officer for Radiological/Nuclear incidents).
		<ul style="list-style-type: none"> • Communications: Plan describes primary and back up internal and external communication systems, assigned frequencies and uses, maintenance and equipment locations (texting, internet, telephone, cell, radios, satellite phones, HAM radio, Incident Management Software)
		<ul style="list-style-type: none"> ○ Initial notification and assessment of the incident type, scope and magnitude, estimated influx of patients, real or potential impact on the hospital, and special response needs (infectious disease, hazardous materials)
		<ul style="list-style-type: none"> ○ The EOP identifies the local government points of contacts with 24/7 contact numbers; alternate contacts; appropriate notification priorities and processes; and, a process for updating information

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		<ul style="list-style-type: none"> ○ Notification from or to appropriate local governmental points of contact (local health department, local emergency medical services agency, local emergency management, Regional POC, and community health system partners) of the surge status and activation of the EOP and surge plan.
		<ul style="list-style-type: none"> ○ Establish ongoing communications with ESF-8 reporting system to report: patient census and bed capacity using HAvBED standardized reporting terminology; hospital status, critical issues, and resource requests
		<ul style="list-style-type: none"> ○ Internal notification/communications and staff call-back protocols (call trees, contact information, etc.) based on a scaled approach
		<ul style="list-style-type: none"> ● Consider Memoranda of Agreement (MOA) or Memoranda of Understanding (MOU) with community health system partners
		<ul style="list-style-type: none"> ● Security – Facility Access: Plan for securing and limiting facility access during a surge incident
		<ul style="list-style-type: none"> ○ Security assessment with plans to address vulnerabilities
		<ul style="list-style-type: none"> ○ Plan for activating traffic control measures for vehicular and pedestrian access to facility (pre-planned traffic control measures, tools, etc.)
		<ul style="list-style-type: none"> ○ Road map outlining ingress, egress, and traffic controls during surge incident (coordinated with law enforcement), parking considerations and other transportation needs
		<ul style="list-style-type: none"> ○ Specific staffing assignments and instructions for traffic control (who, what, how) during a surge incident
		<ul style="list-style-type: none"> ○ Plan for initiating hospital or campus lock-down and/or limited access and entry
		<ul style="list-style-type: none"> ○ Identification/diagram of all access points in hospital and facilities on hospital campus
		<ul style="list-style-type: none"> ○ Identification of limited access points for entry and procedures for monitoring/managing staff

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		<ul style="list-style-type: none"> ○ Criteria and protocols for entry and exit to hospital or campus facilities- including staff, volunteers, patients, family, and other individuals (who, identification requirements)
		<ul style="list-style-type: none"> ○ Staffing plan for monitoring closed entrances (which will only be locked for external entry)
		<ul style="list-style-type: none"> ○ Communication between security, manned access points, and HCC
		<ul style="list-style-type: none"> ○ Special considerations following a no-notice attack (e.g. creating a secure perimeter, restricting access to adjacent parking areas, increasing surveillance, limiting visitation, etc.)
		<ul style="list-style-type: none"> ○ Training for staff that may be utilized in security roles (including protocols, handling abusive behavior, chain of custody etc.)
		<ul style="list-style-type: none"> ○ Plan and mutual aid agreements for assistance with hospital security (e.g. hospital staffing pool, local law enforcement, outside agencies, etc.)
		<ul style="list-style-type: none"> ○ Consider alternative parking area(s) and transportation to and from alternate parking area(s)
		<ul style="list-style-type: none"> ● Resources: (See Hospital Mass Casualty Incident Planning Resources document) Activation of resource management system including inventory, tracking, prioritizing, procuring, and allocating of resources:
		<ul style="list-style-type: none"> ○ Identify incident-specific resource needs
		<ul style="list-style-type: none"> ○ Consider supply chain/materials management de-activation procedures and documentation (see HICS)
		<ul style="list-style-type: none"> ● Continuity of Operations: Hospital has a Continuity of Operations Plan (COOP) which identifies critical/essential services, non-essential services and protocols for staff reassignments during a disaster or significant surge incident. Manual backup processes and forms are identified
		<ul style="list-style-type: none"> ○ Plan identifies triggers for evacuation or shelter in place based on structural integrity of facility infrastructure or community damages
		<ul style="list-style-type: none"> ▪ Work with local law enforcement agencies about requirements for entry/re-entry)

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2. Surge Capacity and Space

Status	Location	Plan Elements
		<ul style="list-style-type: none"> • Surge Space: Specific protocols for creating capacity to care for a significant surge of disaster patients (includes expanding ambulatory and inpatient capacity beyond licensed capacity).
		<ul style="list-style-type: none"> ○ Plan for immediate cancellation/delay of scheduled/non-emergent admissions, procedures, and diagnostic testing
		<ul style="list-style-type: none"> ○ Inpatient admissions (scheduled surgeries/procedures)
		<ul style="list-style-type: none"> ○ Clinic visits
		<ul style="list-style-type: none"> ○ Outpatient surgeries and procedures (endoscopy, catheterization, radiology)
		<ul style="list-style-type: none"> ○ Diagnostic/Ancillary services (Laboratory, Imaging, and Special Procedures)
		<ul style="list-style-type: none"> ○ Protocols for rapid and periodic review of patients for admission discharge or transfer
		<ul style="list-style-type: none"> ○ Communication and coordination with HCC regarding activated and available community resources to triage, discharge or transfer (plan should include checklist with location, level of care and contact information)
		<ul style="list-style-type: none"> ○ Identify how clinical areas may be utilized
		<ul style="list-style-type: none"> ○ Include information related to short and long-term planning for disruption of services for all care areas
		<ul style="list-style-type: none"> • Capacity and use, considering cohorting of patients (inpatient, minor care, holding)
		<ul style="list-style-type: none"> • Activation (define responsibility and activation process)
		<ul style="list-style-type: none"> • Management and operation of the area (describe responsibilities and procedures)

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		<ul style="list-style-type: none"> • Equipment and supplies (including re-supply)
		<ul style="list-style-type: none"> • Staffing (identify requirements and staffing plan)
		<ul style="list-style-type: none"> • At-Risk populations requiring medical treatment, sheltering and/or safe harboring (includes admission and/or transfer information)
		<ul style="list-style-type: none"> • Method of triage to discharge from area, including transport method(s)
		<ul style="list-style-type: none"> ○ Initial Treatment Areas: Plan for activation and operation (to include identification of sites, signage, capacity, responsibility, communications, staffing, equipment and supplies, patient tracking/medical records, etc.). Emergency department space should be prioritized to higher acuity patients.
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Immediate care area(s): Red tagged patients
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Delayed care area(s): Yellow tagged patients.
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Minor care area(s): Green tagged patients
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Palliative Care area: Black tagged expectant patient
		<ul style="list-style-type: none"> ○ Morgue area(s): Fatality management plans have been established for management and disposition of black tagged deceased patients.
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Plans are consistent and coordinated with county/regional Medical Examiner Plans
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Includes mortality estimates by type of incident to anticipate and secure supplies
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Plan for expanding decedent storage capacity; including alternative hospital areas (identify current and prospective capacity)
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Agreements with external agencies for additional decedent transport and storage capacity, consistent with local plans (contacts and capacity)
		<ul style="list-style-type: none"> ○ Additional initial care area(s):

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		<ul style="list-style-type: none"> ▪ Operating Room/Post Anesthesia Care Unit (for patients requiring surgeries in order of highest priority)
		<ul style="list-style-type: none"> ▪ Pediatric care
		<ul style="list-style-type: none"> ▪ Infectious disease care area (specific to type of contagion)
		<ul style="list-style-type: none"> ▪ Behavioral health / psychiatric care
		<ul style="list-style-type: none"> ○ Inpatient capacity: Specific plans for increasing bed capacity to care for a surge of inpatients, including expanding beyond licensed capacity while maintaining continuity of operations and care for current patients. Consult with licensing and regulatory agencies as appropriate.
		<ul style="list-style-type: none"> ▪ Critical care: expansion of bed capacity in existing units, use of other areas/units. This may include admitting trauma, burn patients, or specialty patients unable to transfer to appropriate level of care
		<ul style="list-style-type: none"> ▪ Intermediate care: step-down, telemetry units
		<ul style="list-style-type: none"> ▪ Medical/surgical care: Use of alternative care areas
		<ul style="list-style-type: none"> ▪ Specialty units: Pediatric, Neonatal, or Maternity. This may include plans for increasing bed capacity, or delivery of care for those unable to transfer to appropriate level of care
		<ul style="list-style-type: none"> • Isolation: Identify specific hospital unit(s) or areas for negative pressure or isolation through independent ventilation if incident involves contagious/infectious disease.
		<ul style="list-style-type: none"> • Triage: Plans to activate and operate triage area(s) during a surge incident include:
		<ul style="list-style-type: none"> ○ Activation triggers for establishing alternate/additional triage areas are defined
		<ul style="list-style-type: none"> ○ Primary and alternate triage areas (consider external triage areas, incident type, and facility damage) are identified
		<ul style="list-style-type: none"> ○ Defined responsibility and processes for set-up and operation of

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		triage area(s)
		<ul style="list-style-type: none"> ○ Communications plan for communications between triage areas, emergency department, other key departments and the HCC (landlines, radios)
		<ul style="list-style-type: none"> ○ Staffing of the alternate triage sites
		<ul style="list-style-type: none"> ○ Provision of supplies and equipment for the triage area (consider scope and type of incident, based on the facility hazard vulnerability analysis (HVA))
		<ul style="list-style-type: none"> ○ Infectious and/or exposed patient triage area(s) and protocols (standard precautions, respiratory protection protocols, staff personal protective equipment (PPE), ventilation)
		<ul style="list-style-type: none"> ○ A process for how the flow of patients may occur to and from the triage area(s)
		<ul style="list-style-type: none"> ○ A process for directing patients to triage area(s)
		<ul style="list-style-type: none"> ○ Patient Tracking: Plan includes minimum patient documentation requirements for use during a surge incident and protocols for patient tracking (HICS form 254 – Disaster Victim Patient Tracking Form) and reporting to appropriate agencies (County ESF-8/EOC, American Red Cross)
		<ul style="list-style-type: none"> ○ Communication with the HCC to identify available community resources (checklist with level of care capability and contact information)
		<ul style="list-style-type: none"> ○ Triage protocols for internal and external patient disposition (START and/or JumpSTART)
		<ul style="list-style-type: none"> ● Decontamination: Plan to activate and perform decontamination, as necessary.
		<ul style="list-style-type: none"> ○ Primary and alternative decontamination areas: Consider external areas, type of incident, type of substance, and facility damage potential
		<ul style="list-style-type: none"> ○ Plan for set-up, designation of space and operation of holding and decontamination area(s). Include a list individuals or the team

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		responsible
		<ul style="list-style-type: none"> ○ Plan for segregation and decontamination of prioritized contaminated individuals and their belongings
		<ul style="list-style-type: none"> ○ Plan for segregation of contaminated vehicles, equipment, and supplies
		<ul style="list-style-type: none"> ○ A process for directing patients to decontamination area(s)
		<ul style="list-style-type: none"> ○ Communications protocols within the decontamination area(s) and between other units
		<ul style="list-style-type: none"> ○ A process for human and material resource staging, demobilization, and reconstitution
		<ul style="list-style-type: none"> ○ Plan for staging and rehabilitation of decontamination teams
		<ul style="list-style-type: none"> ● Ambulatory Care Capacity: Specific plans for expanding capacity to care for surge of emergency/ambulatory patients, including use of ambulatory care centers, and opening alternative treatment areas (surge tents, clinics, other hospital areas and facilities).
		<ul style="list-style-type: none"> ○ Identified trigger to use alternative care sites (ACS's) including medical staff supervision, types of patients who may be treated, staffing, supplies and re-supply provisions, communications, security, protocols, patient flow, documentation, billing, discharge instructions
		<ul style="list-style-type: none"> ● Family Assistance Center: Specific plans to dedicate space to support family members with information, reunification, and counseling.
		<ul style="list-style-type: none"> ○ Identify how space may be set up with communications, trained support staff, waiting areas, security, food, and water
		<ul style="list-style-type: none"> ● Media Staging Area: Plan includes protocols for communication with the media in coordination with county and other healthcare providers.
		<ul style="list-style-type: none"> ○ Protocols for communication with media and identifying media spokesperson(s)
		<ul style="list-style-type: none"> ○ Coordination with County Emergency Operations Center/Joint Information Center (JIC) to establish common messaging and

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		information dissemination
		<ul style="list-style-type: none"> ○ Pre-prepared templates for issuing press statements (consider key incident types, common statements and facts)

3. Creating Surge Capacity Staffing

Status	Location	Plan Elements
		<ul style="list-style-type: none"> ● Staffing: Specific plans for staffing during a significant surge incident using hospital staff, contracted pools, and mutual aid resources, taking into consideration type and scope of incident including: <ul style="list-style-type: none"> ○ Identification of staffing needs by staff type, service area ○ Contingency staffing plan identifies minimum staffing needs and prioritizes critical and non-essential services ○ Current staff contact information and ensure availability to HCC and individuals responsible/systems used for making staff contacts ○ Staff notification and call-back protocols, including responsibilities. Multiple methods identified and automated if possible ○ Staff disaster response assignments/roles (labor pool, specific units/areas, etc.) considering type of incident ○ Reassignment of staff to support critical/essential services ○ Cross-training/JIT availability for staff ○ Agreements with staffing agencies (assume multiple organizations have agreement with the same agencies) ○ Protocols for requesting and receiving staff resources (volunteers, special needs teams, etc.) through HCC to local government point of contact ○ Identify responsibility to check status of regulatory waivers regarding staffing ratios, licensure, and scope of practice

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		<ul style="list-style-type: none"> ○ Provide regular updates to staff as to the status of the incident
		<ul style="list-style-type: none"> ○ Address shift change, rotation, rest areas, clothing, personal hygiene areas, and feeding of staff
		<ul style="list-style-type: none"> ○ Protocols for shift changes and rotation of staff (consider type of incident)
		<ul style="list-style-type: none"> ○ Specific areas designated for staff respite and sleeping.
		<ul style="list-style-type: none"> ● Volunteers: Plan includes utilization of non-facility volunteers including policies and procedures for accepting, credentialing, orienting, training, and using volunteers during a surge incident.
		<ul style="list-style-type: none"> ○ Volunteer check-in protocols including staffing of check-in location (single entry)
		<ul style="list-style-type: none"> ○ Registration, credentialing, and privileging protocols
		<ul style="list-style-type: none"> ○ Systems to collect, track, and maintain volunteer information (HICS form 253 Volunteer Staff Registration)
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Issuance of temporary identification badges
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Protocols for assignments and roles by type of volunteer
		<ul style="list-style-type: none"> <ul style="list-style-type: none"> ▪ Process and identified personnel for Just-in-Time (JIT) training as appropriate to volunteer role(s)
		<ul style="list-style-type: none"> ● Staff/Family Needs: Specific plans for addressing staff needs, family, and domestic concerns during a surge incident.
		<ul style="list-style-type: none"> ○ Internal or external arrangements for dependent care to include, if necessary, boarding, food and special needs to remove barriers that may prevent staff from coming to work (encourage staff to have family disaster plan and to pre-arrange, if possible)
		<ul style="list-style-type: none"> ○ Internal or external arrangements for pet care (encourage staff to pre-arrange)
		<ul style="list-style-type: none"> ○ Protocols and specific assignment of appropriately trained professionals to monitor and assess staff for stress-related needs and other health

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		concerns
		<ul style="list-style-type: none"> ○ Provide hospital and community resource listings to support recovery

4. Creating Surge Supplies

Status	Location	Plan Elements
		Plan addresses supplies, pharmaceuticals and equipment for patients and staff for a significant surge incident.
		<ul style="list-style-type: none"> • Essential supplies, pharmaceuticals and equipment have been identified and summarized (consider type of incident and patient age).
		<ul style="list-style-type: none"> ○ Equipment (beds, cots, ventilators, IV pumps, etc.)
		<ul style="list-style-type: none"> ○ Supplies (linen, patient care supplies, clinical supplies)
		<ul style="list-style-type: none"> ○ Personal Protective Equipment (masks, respirators, gowns, gloves, goggles, hand hygiene products)
		<ul style="list-style-type: none"> ○ Pharmaceuticals (for treatment and prophylaxis (as needed) for inpatients, staff, and family members)
		<ul style="list-style-type: none"> ○ Blood and blood products
		<ul style="list-style-type: none"> ○ Food and water for patients, staff, families, and volunteers
		<ul style="list-style-type: none"> • Plans to meet supply needs/requirements have been established (who, how, where).
		<ul style="list-style-type: none"> ○ Standard on-site hospital resources/supplies
		<ul style="list-style-type: none"> ○ Hospital caches (including pallets, trailers, and methods for transportation/delivery)
		<ul style="list-style-type: none"> ○ Agreements with vendors for surge supplies (list of contacts and deliverables) and list of alternative vendors (assume multiple organizations have agreements with the same vendors)
		<ul style="list-style-type: none"> ○ Agreements with local pharmacies and stores (list of contacts and

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		deliverables)
		<ul style="list-style-type: none"> ○ Community/government caches (list of cached items)
		<ul style="list-style-type: none"> ○ Facilities/Engineering considerations
		<ul style="list-style-type: none"> ○ Other resources (hospital corporate system or other agreement)
		<ul style="list-style-type: none"> ○ Security needs during transport, delivery, and storage of supplies
		<ul style="list-style-type: none"> ● Identified reporting process on status of resources available and/or needed, and urgency of needs to be shared with: community partners, healthcare system partners, and local emergency management.\
		<ul style="list-style-type: none"> ● Describe responsibilities and protocols for providing, requesting, accepting, distributing, and tracking mutual aid resources (who, where, how).\
		<ul style="list-style-type: none"> ● Strategies/protocols included for how priorities would be established if there is a need for triage and allocation of scarce resources for limited patient equipment, pharmaceuticals, critical care beds, and other resources.\
		<ul style="list-style-type: none"> ● Medical Waste: Plans have been established for storage and/or disposition of increased medical waste during a surge incident.
		<ul style="list-style-type: none"> ○ Expansion of storage facilities and/or disposition capabilities.\
		<ul style="list-style-type: none"> ○ Agreements with vendor(s) to increase pick-up