**FRANCES MAHON DEACONESS HOSPITAL**
**621 3rd St. So.**
**Glasgow, MT 59230**

**DEPARTMENT: Environment of Care** **PROCEDURE: EOC-225**

**SUBJECT:** Evacuation

**PURPOSE:** The purpose of the procedure is to enhance the ability of hospital personnel and their healthcare partners to manage an evacuation of the hospital. The procedure provides the guidance, concepts, organization, and information that can be engaged in any emergency situation necessitating either a full or partial evacuation of the hospital.

**PROCEDURE:**

1. Scope of Evacuations
    a. Evacuation planning at Frances Mahon Deaconess Hospital (FMDH) must be done keeping in mind that the scope of the evacuation can grow over time depending on the nature of the event. In fact, an evacuation can start as a "defend in place" scenario, where minor adjustments are made to accommodate the event, but essentially no one is moved. This "defend in place" strategy can move over the course of several hours or days to a full scale evacuation, where the entire hospital must be relocated.
        i. Examples of escalating scope of evacuations:
            1. Defend in place
            2. Single Department / Floor / Unit
            3. Section - Multiple floors / Units within the building
            4. Entire building
            5. Citywide evacuation
    b. FMDH's evacuation planning encompasses moving patients / staff and others to a safe haven / staging area in preparation for a move to another location / facility.
2. Decision to Evacuate
    a. The Incident Commander (IC), has the authority to identify areas of the hospital that require a high priority for evacuation, areas of vulnerability and areas that have potential risk. Identified areas at FMDH are in order for priorities are: 1) patient care areas, 2) critical patient care areas, 3) non-patient areas, 4) vacant space.
3. Staging Area
    a. When an evacuation at FMDH entails a single department / floor or unit, patients should be assigned to vacant beds in other non-affected units within the hospital. It is also feasible that patients could be sent to other departments, until it is deemed safe for the patients to return to their original location. Other areas to consider would include:
        i. Physical therapy
        ii. Outpatient surgery

iii. Glasgow Clinic
iv. Hi-Line Surgery
v. FMDH Orthopedics & Sports Medicine

b. In the case that the entire FMDH facility requires evacuation, it is assumed that this will take place over time, and in an orderly fashion, at the direction of the Incident Commander. This plan assumes the following:
    i. The Nursing floor will go on diversion and the inflow of patients will stop. Instead the nursing floor and charge nurse will begin to function as a dispatcher.
    ii. The Emergency Department will utilize triage procedures and divert all patients, unless critically ill or injured.
    iii. Arrangement of transfer of patients to other healthcare facilities will be the responsibility of medical director who will coordinate this directly with the receiving facility(s).
    iv. The physical transfer of patients (ambulance, aircraft, etc.) will fall under the auspice of the Emergency Medical Services director in consultation with county Emergency Operation Center (EOC) emergency management and public health.
    v. A staging area will be utilized as an interim location for patients prior to transport to other healthcare facilities. Patients will remain in the staging area until such time as transfer has been arranged. At that point patients will be moved to the Emergency Department (ED) where they will be readied for transfer.
    vi. A staging area will be designated for patients who are stable enough to discharge home, but are awaiting transportation or family members to pick them up.
    vii. Staffing for the staging area(s) should be consistent with the level of acuity of patient care required. The planning chief will be responsible for staffing this area. As these patient staging areas are evacuated, staff from these areas would then report to the labor pool for redeployment to the ED or other staging areas. The overall responsibility for the care delivered in the staging areas will fall under the responsibility of the Operations Chief and the Medical Director.
    viii. Staff in the staging area(s) will participate in the tracking and reconciliation of patients as they move from point to point.

4. People Issues
    a. In any evacuation, assessing, triaging, tracking and reconciling patients, staff, visitors and others as they move throughout the evacuation is the single most important aspect of this plan. The Incident Commander is the clear line of authority to coordinate a systematic and safe evacuation. Each floor / unit will be assigned an administrative or operational person (Unit Evacuation Leader) to the area being evacuated by the Incident Commander. The unit evacuation leader is responsible for coordinating the evacuation for the assigned area. This role should not be assumed by clinical staff as they will be occupied with triaging and readying of patients for transport.
5. System for Prioritizing/Triaging and Tagging Patients for Evacuation

a. A systematic method for triaging patients is key to a successful evacuation. A rational movement of patients from the unit to a staging area prior to transfer to another location / facility is necessary to move patients quickly and safely. It is essential, however, to realize that the triage priorities that most clinical staff are accustomed to in emergency response, i.e. the START system, must be approached differently in an evacuation. Patients in the facility that are ambulatory and relatively stable will have first priority for moving out of the unit. These patients are less resource intensive and many can be led out with one or two staff members. Patients who are non-ambulatory, acutely ill, unstable or require life-saving equipment will require the most resources for moving. As stated, for the purpose of evacuation triaging, the categories of START are reversed for the evacuation, however, they will revert back to the original priority once the patient reaches the staging area prior to transfer, as FMDH will want to get the most unstable patients moved to a healthcare facility first. See the chart below for the prioritization:

**System for Prioritizing / Triaging and Tagging Patients for Evacuation**

| Triage Level | Priority for Evacuation off unit – REVERSED START PRIORITY | Priority for Transfer to another healthcare facility – TRADITIONAL START PRIORITY |
|---|---|---|
| **RED – Immediate** | These patients require maximum assistance to move. In an evacuation, these patients move **LAST** from the patient 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 FMDH to another healthcare facility. |
| **YELLOW – Delayed** | These patients require some assistance and should be moved **SECOND** in priority from the patient 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 FMDH to another healthcare facility. |
| **GREEN - Walking** | These patients require minimal assistance and can be moved **FIRST** from the patient 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 FMDH to another healthcare facility or discharged. |

6. Tracking
    a. Tracking the movement of patients, staff, visitors and vendors throughout the facility during an evacuation is imperative to the reconciliation process that must occur to assure that everyone has gotten out safely. Two tools have been developed for the purpose of tracking patients, one to categorize the patient by location and the other to indicate the level of care required during evacuation:
        i. Patient Tracking Tool 1
            1. documents the exact location of every patient. 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.

This tool assists in the reconciliation of total patient census. 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 will be determined by the Incident Commander in consultation with the unit evacuation leaders of each area. See Patient Tracking Tool 1

ii. Patient Tracking Tool 2
    1. documents the evacuation triage level assigned to the patient as well as the equipment needs, mode of transport, time of departure from the unit and time of arrival to the staging area. Each of these tools will be faxed or delivered to the Incident Commander as well as the staging area to assist in reconciliation. In addition, the responsibility for tracking and reconciliation of patients will fall under the direction of the medical director. See Patient Care Tracking Tool 2

b. Tracking visitors and accounting for staff is equally important and should be done in a methodical manner.

7. Designating when a floor or unit is empty
    a. It is important to validate that all patients and staff have been cleared from the unit and then secure the area. The Unit Evacuation Leader should conduct a walk -through of each room including support space. As each room is checked a strip of blue tape will be affixed on each of the doors within the area indicating that the room is empty.
8. Medical Information
    a. 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. 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. A brief summary of pertinent information for each patient should be completed prior to moving the patient and copies of critical pieces of information should go with it including:
        i. Copy of medication administration sheets
        ii. Copy of most recent set of medical orders
        iii. Copy of latest lab reports
        iv. Copy of POLST, Advanced Directives or DNR
        v. Restraint Orders
9. Medications
    a. FMDH Pharmacy will work with medical staff to identify what medications need to accompany patients and/or be available in the patient staging area(s). It should be recognized that several hours may elapse until transportation to another healthcare organization is accomplished and provisions for critical medications to be made available at the staging area is essential. In addition, emergency medications and equipment (crash cart) to address cardiac and respiratory arrests must also be provided at the staging area(s). Prior to transferring a patient, FMDH

will assess if the receiving facility has specific patient medications. In the instance where a specific patient's medication is critical and not available at the receiving facility, FMDH pharmacy will arrange to transfer the medication to the receiving facility.

10. Support Services Issues
    a. Support Services will, upon order of the Incident Commander, address the following:
        i. Systematic shut down of medical gases, utilities and generators
        ii. Supply communication systems to staging areas
        iii. Assist in movement of medical supplies, food, water, etc, to the staging areas
        iv. Securing floors, buildings and equipment to protect the assets of the hospital
11. Transportation
    a. Patients are not to be moved to the Emergency Department to be readied for transport until there is confirmation that there are transportation resources on-site. Until that time, patients will remain in their respective staging area. The physical transfer of patients (ambulance, private vehicle, aircraft, transit bus, wheel chair van, etc) will fall under the auspice of the Emergency Medical Services Director, FMDH Medical Director and Valley County EOC emergency management and public health. The actual route of evacuation will be determined by Valley County EOC. Each patient being transported to an alternate site will have the following information logged:
        i. Destination site
        ii. Triage tag
        iii. Transport method and service / vehicle identification
        iv. Name(s) of patient(s) being transported in that vehicle
        v. Name of staff person / service employee, accompanying the patient
        vi. Special considerations and precautions
    b. FMDH will make every effort to use only authorized vehicles for patient transport. However, it is recognized that circumstances may be such that FMDH may need to resort to the use of private vehicles. If a private vehicle is going to be used to complete a patient transport the following information will be documented:
        i. License plate number of the vehicle
        ii. Description of the vehicle
        iii. Proof of insurance
        iv. Identity of driver and driver's license photocopied.
12. Family or Guardian Notification
    a. FMDH Incident Command will assign staff to be responsible in notifying the family, guardian or emergency contact person on each patient. Information given in the notification should include:
        i. Location patient will be moved to
        ii. Time appropriate to call or visit
        iii. Call back number to check status

b. All patients transported to other facilities will remain patients of the receiving facility to which they were transported until their course of treatment is completed and they have been discharged or transferred.

13. Essential Equipment
    a. Every department director at FMDH is responsible to create a list of essential supplies/equipment for functionality at an Alternate Care Site. Department directors will follow FMDH's tagging system for identifying the priority of evacuating equipment and supplies. Each department director will be responsible for identifying, maintaining and rotating supplies that would be transported. The system is as follows:
        i. Green dot or Tag are highest priority items
        ii. Yellow dot or Tag are intermediate priority items
        iii. Red dot or Tag are lowest priority items
    b. Essential Equipment will be transported to the appropriate alternate care site utilizing the hospital's vehicle pool and staff, Valley County EOC support staff, or volunteers.
14. Recovery
    a. Ongoing assessments will be conducted to determine the necessary actions to bring the facility back to normal operations. Based on this assessment, FMDH Incident Command will develop a demobilization plan outlining the appropriate resources and steps necessary to resume operations. FMDH will not be re-entered and used for normal operations until the facility has been inspected by appropriate engineers with credentials for assessing the facilities condition and safety for use. In addition, appropriate State agencies will be contacted to ascertain the necessary licensure and certification processes that are required before reentry.
15. Demobilization
    a. In the event of a complete evacuation from FMDH, a demobilization plan of the alternate care site(s) will be followed. The appropriate agencies will be notified by the Incident Commander so that approval for reopening the evacuated healthcare facility can be accomplished. The Public Information Officer (PIO) will inform and update the public and staff as necessary, as to when to return to work or when FMDH will be back in operation.

**REVIEW PROCESS:**

- This procedure should be reviewed and revised every three years unless significant changes warrant earlier revision.
- Continued and regular revision and updating will keep this document valid and useful.

**Tool #1 – Evacuation Planning for FMDH – Departmental Evacuation Template**

| | | |
|---|---|---|
| **Department:** | | |
| **Unit / Type Service** | | |
| Critical Care (OR, ICU, Recovery, ED) | Patient General Care | Patient Care Specialty (Ortho, OB/GYN |
| Outpatient Care | Support Patient Care (lab, radiology, cardiac) | Clinic Care |
| Support Non-Patient (food, material management) | Administrative (office, medical records) | Other (mechanical rooms, storage) |
| **Number of beds on unit:** | | |
| **Specialized Medical Equipment Present in Unit** | | |
| Infusion Pumps | Portable Ventilators | Portable Oxygen |
| Portable Suction | Ambu Bag | Defibrillator |
| Patient Monitors | Other: | Other: |
| **Specialized Medications:** (list) | | |
| **Hazardous Chemicals / Materials in Unit:** | | |
| No Yes | If yes (list): | |
| **Is this a locked unit?** | Yes No | |
| **Are there medical gases?** | Yes ( Piped / Cylinder) | No |
| **Location and Exits:** Attach floor plan that includes location of medical gas shut off valves; location of exits; pull stations; extinguishers; sprinkler systems; designated smoke and fire doors. | | |
| **Evacuation Route(s):** | | |
| **Horizontal** To:_____via_____ | | |
| **Vertical** Down to:_____ Up to:_____ | | |
| **Staging Area for full building evacuation:** | | |

**Tool #2 FMDH Patient Care Unit Evacuation Template**

| **Department / Unit** | | | | | |
|---|---|---|---|---|---|
| **Total Number of Staff in Unit at start time of evacuation:** | | | | | |
| RNs | LPNs | PAC | MD | NA | Other: |
| A. Patient Census in Unit at Start Time of Evacuation: | | | | | |
| B. Total Patient Census: | | | | | |
| C. Patients to be Accounted For: A – B = : | | | | | |

| **Patients off unit for procedures / radiology / other / at time of evacuation:** | | |
|---|---|---|
| Patient Name | Room Number | Current Location |
| Utilize Patient Labels | | |
| Utilize Patient Labels | | |
| Utilize Patient Labels | | |
| Total Number of Patients Off Unit in Other Areas = | | |

| **Scheduled Admissions to the Unit That Have Not Arrived at Time of Evacuation:** | | |
|---|---|---|
| Patient Name | Room Number | Admitted From (ED, Clinic) |
| Utilize Patient Labels | | |
| Utilize Patient Labels | | |
| Utilize Patient Labels | | |
| Total Number of Patients to Unit, Not Yet Arrived= | | |

| **Patients At Risk At Time of Evacuation:** (109, Restraints, Bipap, Active labor, Temp External Pacer, ) | | |
|---|---|---|
| Patient Name | Room Number | Risk Issue |
| Utilize Patient Labels | | |
| Utilize Patient Labels | | |
| Utilize Patient Labels | | |

| | | |
|---|---|---|
| Utilize Patient Labels | | |