



Policy and Procedure Manual: Administrative and Safety Manuals	Effective: Nov. 2002	
Department: All Departments	Revised: Dec. 2002; Aug. 2007; July 2008; Jan. 2010; Aug. 2010; Jan. 2011	Reviewed:
Title: ALL-HAZARD EMERGENCY MANAGEMENT PLAN (DISASTER PLAN)		

SUBJECT: ALL-HAZARD EMERGENCY MANAGEMENT PLAN

GOAL: To provide direction for staff to adapt to unforeseen emergency or disaster situations which change the hospital environment. The plan addresses the four phases of Emergency Management: Preparedness, Mitigation, Response and Recovery.

SCOPE: This Emergency Management Plan provides a mechanism for effective timely response to emergencies/disasters within a *Hospital Emergency Incident Command System (HEICS)* Structure. (see Appendix B)

The plan will be implemented with a natural or man made disaster/emergency affecting the facility that reaches proportions that cannot be handled by routine measures and will be designed to ensure appropriate care for all casualties. Some emergency situations can be handled with little disruption to the organization. Only the events that:

- impact or could impact the entire organization or,
- during which multiple injuries/victims are expected, or
- a large portion of the structure or vital utilities are jeopardized

constitute a “disaster”. The scope of this plan will include preparedness, mitigation, response and recovery.

This plan addresses a variety of disaster/emergencies and is designed to comply with federal, state and local laws and standards in regards to Incident Command Systems. The Universal Titles and mission statements allow Emergency Responders from a variety of organizations to communicate quickly and clearly with management. In the event of a local, community-wide or state-wide emergency, Texas Spine & Joint Hospital will be prepared to handle transferred patients from local hospitals who require further acute care that is within our capabilities (surge capacity). It is part of the regional plan for TSJH to handle at least five (5) patients over our current bed-space.

OBJECTIVES:

The Emergency Management Plan and its associated sections will meet the following objectives:

- Specify procedures in response to a variety of disasters
- Define and, when appropriate, integrate the organization’s role with community-wide Emergency Management efforts
- Notify external authorities of emergencies
- Notify personnel when emergency procedures are initiated
- Assign available personnel in emergencies to cover all necessary staff
- Manage space, supplies and security
- Evacuate the facility when the environment cannot support adequate patient care and treatment
- Establish an alternative care site when the environment cannot support adequate patient care
- Manage patients during emergencies
- Establish an alternate source of essential utilities
- Establish a backup communication system

- Provide an orientation and education program
- Identify performance improvements standards
- Conduct an annual evaluation
- Conduct required drills

MITIGATION:

The hospital participates in County and Regional emergency preparedness planning activities. It holds at least two drills or exercises per year and those are critiqued for enhancement of response activities. As a member of the local medical community, it has a direct communication link with local EMS providers and Level I and II Trauma centers. The Out-Patient Surgical Services center is an off-site facility that can be utilized for emergency patient care in the event of severe facility damage. Medical Staff are linked to the emergency plan through their Medical Director and the Medical Executive Committee.

PREPAREDNESS/:

The facility utilizes an Emergency Management Plan that will provide for flexible implementation in response to a multitude of emergencies including internal situations such as earthquake, radiation exposure, fire, loss of utilities and external situations such as multi-casualty disasters, civil disturbances, local fires, etc. The plan also would be exercised during threats of biological or nuclear terrorism (see policy for specific elements).

The Safety Officer and the Emergency Preparedness Committee will conduct regular Hazardous Vulnerability Analysis (HVA) to determine which types of disasters pose the greatest risk to the facility. A summary of the HVA will be written after the HVA is completed stating the objective, scope, performance for the past year, and the effectiveness.

RESPONSIBILITIES:

1) Organizational:

- a) The E.P. Committee will have the responsibility for planning and implementation of the Emergency Management Plan. Responsibilities include the following.
 - (a) Formulate policies regarding provisions and procedures
 - (b) Initiate drills exercising the provisions of the plan, evaluate the drill, review the results of the drill to determine what, if any, improvements will be made in the system and document their findings
 - (c) Advise the Medical Staff and Administration on issues relating to the coordination of community-wide emergency/disaster plans and activities.
 - (d) Evaluate performance during implementation of the plan, document and report evaluation to the Performance Improvement/Safety Committee.
 - (e) Serve as a liaison with state and local disaster medical care officials and area emergency management representatives.
 - (f) Review and revise the Emergency Management Plan.
 - (g) Maintain an updated inventory list of supplies and medications that might be utilized in the event of a large-scale emergency.

- b) Administrative:
 - i) The Implementation of the Emergency Management Plan will be the responsibility of the Incident Commander. The Incident Commander will evaluate the scope of the emergency, organize and give overall directions for hospital operations to include – activation of HEICS Section Chiefs if Disaster so warrants, and if needed, authorize evacuation. An Incident Command Center will be established in the Conference Room or Administrative Conference Room.
 - ii) Between the hours of 0800 and 1700 the CEO or designee, in conjunction with the C.N.O, Safety Officer, and Clinical Improvement Specialist or their designee’s will function as Incident Commanders.
 - iii) After hours, weekend and holidays, the Emergency Department Charge Nurse will serve as the Incident Commander until arrival of the designated person.
 - iv) The role of Incident Commander may be filled by either the Safety Officer or a member of administration/management with documented National Incident Management System training (NIMS).

- c) Departmental:
 - i) It will be the duty and responsibility of each department manager to maintain and update policies and procedures related to the Emergency Management Plan.
 - ii) Department managers are responsible for providing the services and maintain the capability of their department to the best possible level in order to meet the needs of all patients.
 - iii) Each department manager or designee will keep updated information concerning recall of personnel in their department. Updated call rosters will be maintained on the “P” drive for use in an emergency to notify staff if needed to

iv) Each department manager will report to his or her department or if designated, to the Command Center.

d) Individuals:

- i) It will be the responsibility of each individual to read the provisions of the Emergency Management Plan, to understand their role and to respond whenever called upon activation of the Emergency Management Plan.
- ii) If an individual becomes aware of a situation, which could constitute an emergency/disaster, immediate action will be taken in accordance with the procedures outlined in this plan. At a minimum, the individual's manager will be contacted.

2) **MEDICAL STAFF RESPONSIBILITIES:**

- a) The Chief of Staff will be notified of a major emergency event by the C.E.O. The Chief of Staff will coordinate with the designated E.R. Physician to ensure that patient care needs are met. Additional medical staff members will be notified by the Chief of Staff if necessary. Current members of the medical staff who come to the hospital to aid in emergency care will "check-in" in the O.R. lounge for assignment.

3) **PROGRAM COMPONENT/SYSTEMS:**

a) Incident Command System:

- i) The Incident Command System for dealing with emergencies/disasters will be implemented by the facility.
- ii) The Incident Command System has been developed to provide structure and direction to the disaster response. This program consists of organizational structure (see Organizational Chart) with a clearly delineated chain of command and titles.
- iii) Job Action Sheets for each position identified in the organizational structure will be provided to assist the individual in focusing upon his/her assignments. (Found in the Safety Manual.)
- iv) A detailed discussion of each type of emergency/disaster will be found in the Safety Policy and Procedure Manual or on the Public drive/Policies & Procedures/Safety folder.
- v) The senior person present in the department accomplishes initial management of an emergency when the emergency is discovered.
- vi) The Incident Commander will assume management of an emergency/disaster.
- vii) The Incident Commander ensures that the Emergency Management Plan will be correctly implemented, will ensure that assistance is obtained and provided to support the control and management of disaster and will make contact with outside agencies.

b) Declaration of state of emergency:

- i) Code Activation Authorization:
 - (a) Patient care codes (Code Blue) will be called by the caregiver finding the patient in that state.
 - (b) Other emergency codes will be activated by the supervisory person (Manager or Administrator) in charge at the time. Only the Administrator on Call will activate Code Yellow emergency plan.
- ii) Evacuation of either all or part of the hospital must be authorized by the Incident Commander and/or CEO.

RESPONSE

4) Activation Duties:

- i) Notification of the Emergency Management Plan activation by the receptionist or appropriate personnel through the overhead paging system will be by repeating the following statement every 10 seconds times three (3) or as often as the Incident Commander directs.

“ YOUR ATTENTION PLEASE”
“CODE ----- (LOCATION)”

5) Response upon activation:

- i) On-duty staff: Upon hearing the activation code Department Managers and staff will follow directions for designated codes. If Emergency Management Plan will be activated Code Yellow Internal or External will be called. At this time all employees will return to their department and await instructions from the Incident Command Center. First Responders to the activation will be the Incident Commander (CEO/CNO or ED Charge Nurse), Safety Officer for security, ER/ICU Manager and Public Information Officer. These first responders will report to the Incident Command Center to don vests/name tags and receive instructions or contact by phone or send representative if unable to come immediately to Incident Command Center. After the Incident Commander is briefed of situation he/she will decide at this time who else will be activated in the organizational chart. Notification to those needed will happen at this time. Medical staff will notify staff of possible discharges to make room for possible incoming patients. All non emergency functions will cease.

- ii) Recalled Staff: Will report to the appropriate labor pool/ staffing center
- b) Termination of Code:
 - (1) The decision to terminate the Disaster (CODE YELLOW) - Emergency Management will be made by the Incident Commander. Notification of termination of the Emergency Management Plan activation will be made over the overhead paging system by repeating three times:
 - 6) “CODE -----, ALL CLEAR”

7) TYPES OF EMERGENCIES/DISASTERS:

- a) The initial designation of the following codes will not activate the Emergency Management Plan unless determined to be necessary by the Incident Commander.
 - i) CODE BLUE: MEDICAL EMERGENCY – Follow procedures outlined in CODE BLUE Policy and Procedure.
 - ii) CODE AMBER: INFANT OR CHILD ABDUCTION – Follow procedures outlined in CODE AMBER policy and procedure.
 - iii) CODE RED: FIRE – Follow procedures outlined in Safety Policies and Procedure. May develop into Code Yellow if severe threat.
 - iv) CODE ORANGE: NUCLEAR, BIOLOGICAL, CHEMICAL EXPOSURES (NBC) - Follow procedures outlined in the CODE ORANGE Policy and Procedure. May involve Bioterrorism.
 - v) CODE WHITE: SECURITY ALERT SITUATION (INCLUDING BOMB THREAT) – Follow procedures outlined in the CODE WHITE Policy and Procedure. In special threat situations the major objectives are to isolate the situation, confine any further involvement and allow law enforcement to deal with the situation.
 - vi) CODE GREEN: SEVERE WEATHER/ TORNADO – Follow procedures outlined in the CODE GREEN Policy and Procedure. Secure visitors, staff and patients to designated areas of safety (i.e. away from windows, in hallways or secure rooms, blankets and pillows).
 - vii) CODE BLACK: EVACUATION- **This will be called only if authorized by the CEO or Incident Commander** on recommendation of the Safety Officer, in response to severe structural damage or threat to the entire facility. See Evacuation Plan policy
 - viii) INFECTIOUS DISEASE OUTBREAK/ PANDEMIC – Due to limited size and resources, TSJH cannot accept an influx potentially highly infectious patients (such as SARS, H1N1, Smallpox, etc). These patients will be diverted to a regional hospital with isolation capability.
- b) **CODE YELLOW – INTERNAL OR EXTERNAL DISASTER –**
 - i) These events may either: impact the entire organization, produce multiple injuries/casualties, or jeopardize the structure or vital utilities.
 - ii) **ALERT STATUS:** A confirmed threat either in the facility or externally. The Incident Commander or Administrator-on-call will be notified of the potential for internal or external events that may produce a number of casualties that cannot be handled with normal operating procedures. The IC/ AOC, at their discretion, begins notifying first responders to report to the facility.
 - PAGE:** “Your Attention Please: **Code Yellow ALERT- Internal (or) External**”
 - iii) **ACTIVE STATUS:** Confirmed transfers or victim arrival OR facility damage is imminent. The full Code Yellow Emergency Plan is activated and the Command Center is established. If the facility is damaged to a significant extent and/or there are more casualties than can be handled, the City Emergency Operations Center will be contacted by dialing the FIRE Department (EOC) 903-526-0043.
 - PAGE:** “Your Attention Please: **Code Yellow ACTIVE- Internal (or) External**”

8) KEY LOCATIONS:

The following Key Locations will be planned for and established during activation of the Emergency Management Plan, as directed by the Incident Commander.

- a) Incident Command Center (Conference Room or Admin. Conference Room)
- b) Finance Division Office (Administrative Office Area or Material Management)
- c) Medical Staff (Physician Lounge-OR)
- d) Triage Area– Ambulance Bay - Front Lobby will be used if the this area is compromised)
- e) Emergent/Urgent Treatment Area (Emergency Room, Operating Room, PACU)
- f) Non Urgent Treatment Area (Pre/Post and Pain Management)
- g) Morgue/Body Holding area (Preop Clearance)
- h) Patient Information Center (Lobby or West entry foyer)
- i) Press Room/Briefing Area (Business Office Foyer)
- j) Labor Pool: Employees: Café - Physicians/PA/NP: OR Lounge
- k) Emergency Immunizations: Are provided to key staff/physicians/ volunteers in the event of a communicable disease outbreak. The Pharmacy Manager will coordinate dispensing and immunization administration and name an appropriate location for that activity.

- l) **Employee Rest Area:** In a prolonged response to a disaster, it may become necessary to create a location for staff members to sleep, obtain food and to relax. The Human Resources Rep. will create an area for this purpose (Azalea Waiting Room). The Operations Section will handle food services for patients and healthcare workers.
- m) **Employee Assistance Center:** In conjunction with a Rest Area, an Assistance Center may be established for use by all staff members. The purpose of this Center will be to provide a large scope of assistance from helping resolve administrative problems to helping prevent secondary injury caused by emotional trauma
- n) **ALTERNATE CARE SITE:** If the facility is damaged to the extent that it must be evacuated, then all patients who cannot be discharged to home or a lower level of care will be transported by EMS to another area hospital (ETMC). If they cannot accommodate TSJH patients due to a community wide disaster, then patients will be moved to TSJH Out-Patient Surgical Services center by EMS or other designated transport. The Medical Director/ Chief of Staff must authorize this action and each patient's surgeon and/or internal medicine physician must be notified. If the city or entire region of the RAC G is in jeopardy from a weather or other environmental disaster, then the local RAC will be in contact with RACs F and H to determine evacuation sites for patients and others with special needs. This is coordinated through the county EOC/MOC using the electronic communication system "Web EOC" but if the system is down, by phone or Ham radio.

9) DOCUMENTATION:

- a) An Internal Reporting Form will be completed by all department managers at the start of the CODE YELLOW. These worksheets will normally report personnel and departmental readiness, patient numbers and status and disruption of service information (damage reports).
 - (a) The manager is responsible for initial assessment and actions, transmitting this data to the Section Chief at initiation of the Emergency Management Plan. (See Organizational Chart and Internal Reporting Form- attached).
 - (b) IPCU, OR, Pre/Post and Pain complete Bed Tracking Forms at the start of the incident and at prescribed intervals during the event in order to plan for open beds/available spaces.
- ii) The Section Chief will relay reports to the Incident Commander. The Incident Commander will designate the frequency of on-going reporting requirements.
- b) A report of disaster involving the discontinuance or disruption of services, or earthquakes, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients will be rendered to the Department of State Health Services.
- c) Patient Tracking: Location of patients/causalities will be recorded on a patient tracking form in each patient care area. These forms will be utilized at initial triage and maintained as patients are transferred from department to department, area to area. Each department will record the patient's name and/or identification number, time of arrival, identification number, diagnosis (or injury) and disposition. The Morgue Unit Leader may provide assistance to the Situation Unit Leader in patient discharge, tracking or transfer to other locations.

10) COMMUNICATIONS:

- a) The telephone system will be utilized as a primary source of communications, both for internal and external communications. In the event of telephone service disruption, the Ham Radio will be utilized to communicate with area EMS, Fire Department and Law Enforcement. Emergency Department personnel will monitor radio communications. In addition, Administration has 5 multi-channel radios which can be used for internal communication..
- b) External communications will be maintained with the Power-Fail telephones. Ham Radio Operators will be available for external communication. Internal communications will be maintained by the use of multi-channel radios located in administration. These will be issued to the Incident Commander for distribution. Runners will be utilized for internal communication as needed.
- c) The Public Information Officer will remain in constant communication with the Incident Command Center and monitor all information being reported outside the facility.
 - (a) Public Information Officer will initiate all communication with the media and distribute press release items. Information will be provided that addresses the role of the facility, transfers, and any information that will be helpful to friends and families.
 - (b) All media representatives will be asked to wait outside (if weather permits) or at the Business Office building. Any special instructions concerning treatment capacities will be given to staff and patients.
- d) Anecdotal human-interest stories may be dispersed to the media.
- e) The Patient Information Officer will set up communication with patients and patient's families. Patient families must be notified of any EVACUATION activity and or relocation to alternate care site.
- f) If requested by the Department of State Health Services, the Planning Section Chief will report on available beds: particularly Med-Surg beds, isolation rooms, OR's, ER Divert Status, and ventilators available.
- g) In the event of the death of one or more victims, the Operations Chief will notify the Incident Commander, who will gain administrative approval for release of patient names. After approval, the P.I.O. will notify next of kin

of all victims. Notification may be delayed until daytime hours if death occurs at night; no death will be reported to the media until family notification and approval of the Incident Commander is gained. All deaths will be reported to the local police department following organizational policy. (See policies on Expired Patients- Release of Body, Deaths Requiring Notification of Law Enforcement). Hospital privacy policies will be adhered to at all times. The Operations Chief will ensure that a medical doctor has pronounced death and that each body is appropriately identified and tagged.

Responsibilities for the operation of the Morgue may be delegated to a Morgue Unit Leader. (see Job Action Sheet)

- j) In the event of a disaster and patient information needs to be communicated with outside entities then the policies for privacy in the HIPPA policies will be followed.
 - h) For HAZMAT emergencies/disaster which cannot be internally managed, the appropriate HAZMAT offices will be contacted by dialing 911 and stating that a chemical, biological or radiological emergency exists (See CODE ORANGE policy and procedure). No decontamination facility exists at this location.
- 11) **SECURITY:** The Building Attendants and/or the Safety Officer will monitor entrances and maintain a secure environment to deter information seekers and unauthorized access to the facility. It may be necessary to LOCK DOWN the facility if security is threatened. This will be authorized by the Incident Commander. In the event that patient or employee safety is at risk due to inadequate security, the Incident Commander has the authority to contact the Smith County E.O.C. for assistance from the local police, sheriff or national guard if needed.
- 12) **EVACUATION (CODE BLACK):** In some instances, evacuation of parts of the building may be required due to fire, smoke or other structural damage or danger. If the entire facility is not in jeopardy, then movement of staff, patients and visitors to the parking lot in front of or across the street might be all that is required. In that instance, the Fire Marshall and/or Safety Officer (with approval of the CEO) will direct persons through the nearest safe exit route.
- i) Facility Evacuation Authority and Determination: The Safety Officer has the authority to evacuate partially, horizontally or vertically through the facility when a life threatening situation has been identified. Incomplete (horizontal or vertical from the second floor offices) evacuation will be put into effect due to any of the following:
 - ii) Bomb Threat
 - iii) Major Fire
 - iv) Tornado
 - v) Structural Damage to the building
 - vi) Loss of heating or cooling
 - vii) Nuclear attack or contamination of radioactive materials
 - viii) Hazardous chemicals or fumes
 - ix) Bio-Terrorism Event
 - b) Evacuation Procedure:
 - i) The Safety Officer will make the initial evaluation of any emergency situation and determine if Complete Evacuation is necessary. Only the Fire Marshall, CEO or Incident Commander can authorize this decision; the Safety Officer implements evacuation after approval.
 - ii) The Safety Officer will distribute walkie-talkies to the evacuation personnel.
 - iii) Safety Procedures – The Safety Officer will identify safe evacuation routes prior to the execution of any evacuation.
 - iv) Stair usage – The primary means of vertical evacuations will be the exit stairwells at each end of the respective building wings.
 - v) Evacuation of patients and personnel will be coordinated with EMS or the Fire Department if available to help.
 - vi) Right and left traffic lanes will be established to prevent confusion and congestion between emergency personnel.
 - vii) Elevator usage – Elevators will be under the control of the Fire Department and only used if authorized by them.
 - c) Evacuation Priorities – Use the following guidelines
 - i) Patient priority – beds will be tagged to alert teams of patient evacuation status.
 - ii) Ambulatory
 - iii) Non-ambulatory
 - iv) Bedfast
 - v) First priority – Patient and personnel located on the same floor as the life threatening situation.
 - vi) Second priority – the floor immediately above.
 - vii) Third priority – The floor immediately below.

- d) Evacuation Procedures:
 - i) Loading teams – Under supervision of the Safety/Security Officer
 - (a) Bring all available stretchers, wheelchairs, and blankets to area.
 - (b) Assist with preparing all non-ambulatory patients to be moved.
 - ii) Moving and carrying teams – Under supervision of the Safety/Security Officer
 - (a) Transport all patients through the nearest safe exit, designated by the Safety/Security Officer.
 - (b) Transport to the designated area. This may be another location within the hospital or outside on the lawn or parking lot (away from roadway entrance) that is a safe distance from the hospital.
 - (c) Consult with nursing staff and pharmacist to ensure medications, medical record and critical supply needs are met at the alternate care site.
 - iii) Receiving teams – Under supervision of Emergency Department personnel
 - (a) Log each arriving patient including room number
 - (b) Assess patient condition and prioritize care
 - (c) Procure necessary supplies, equipment and medications.
 - (d) Advise Incident Command Center of manpower needs.

- e) Responsibilities:

All hospital personnel will have the responsibility of evacuating patients.
 All personnel called in for duty will sign in at the Labor Pool center and receive duty station assignments.

 - i) If temporary housing will be needed, the Incident Command Center will determine and designate locations.
 - ii) Admitting staff are responsible for patient family notification of evacuation plans and location.
 - iii) The Incident Command Center will arrange any necessary transfers to area hospitals. Transportation will be arranged with the following entities:
 - (a) ETMC EMS
 - (b) Private Vehicles
 - iv) Plant Services personnel will shut off utility or gas control valves or switches if required for the emergency.
 - v) Interfacility Communication between hospital and alternative care site will be done via phone, cell-phone or designated runner will communicate back and forth.

13) ADDITIONAL REQUIREMENTS:

- a) Employee's identification:
 - i) The facility identification badges will function as staff identification during activation of the Emergency Management Plan.
 - ii) Section Chief/Leaders and supervisors will be identified by color coded HEICs vest or name tags
 - iii) Non-employees (medical, volunteers, clergy, etc.) will be identified with Disaster Name tags issued by Medical Staff Unit Leader or Labor Pool Leader.
 - iv) Community volunteers who present credentials as physicians, nurses or other medical personnel will be directed to assume tasks that are not patient care oriented unless credentialing requirements of the Medical Staff Office are met.
- b) On duty staff personnel:

Staff personnel on duty, upon initiation of this plan, will not be allowed to depart the facility without approval from their department manager. The department manager or designee will receive approval to release individuals from the appropriate section leader.
- c) Off-duty staff personnel:

During activation of the Emergency Management Plan, individuals will be contacted to either come to the facility or be on standby. During a widespread disaster such as tornado or flood, staff personnel will report to the labor pool as soon as possible when notified.
- d) Clergy:

Clergy will be allowed in restricted areas to minister to the spiritual needs of the casualties at the discretion of the Safety Officer or Public Information Officer. Clergy will also be utilized to assist in family notification at the direction of the Family Resource center leader. A list of clergy will be maintained at the Switchboard and they will be contacted and assistance requested, if required.

- 14) **THE PINEY WOODS REGIONAL ADVISORY COUNCIL** has prepared a community-wide Hospital Preparedness Plan that was first developed in 2003 but has been broadened in scope to include 'all hazards' and to enable them to distribute funds from the Office of the Assistant Secretary for Preparedness and Response to regional hospitals. TSJH participates in the Plan by providing beds if needed for acute-care patients and participates in local meetings and training events. The Plan provides for the following:
 - i) Patients requiring respiratory isolation following a Bioterrorism event will be sent to UTHSCT as long as beds are available.

- ii) A Medical Special Needs shelter can be established at UTT's Patriot Gymnasium for use by victims in surrounding areas of the state.
- iii) An advanced telecommunications system is available (NETnet). The web-based system called "WebEOC" is utilized by all RAC-G hospitals, the County Health Departments, Fire Departments and Police to communicate individual entity events and status. Drills are conducted annually to test the system and to ensure that all involved individuals are able to log-in and use the system. EMSsystem is another web-based system that tracks hospital beds and resource allocation. Individual hospital ER managers are responsible for updating the system routinely and during local or community events.
- iv) Use of Level 1 & 2 Trauma centers at ETMC, TMFH and GSMC
- v) In the event that the Trauma centers are at capacity in a community-wide event, TSJH will respond by providing "Surge Capacity" of at least 5 beds for victims or transfers from ETMC.
- vi) In the event of a large scale, community-wide event, all ET hospitals will suspend or postpone elective surgery so that supplies and staff can be made available to the care of victims.
- vii) Hospitals have access to stockpiles of pharmaceuticals for use with a Bioterrorism event. TSJH Pharmacy will maintain a certain level of antivirals and antibiotics for this eventuality and will evaluate that level on an annual basis.

ALTERNATIVE MEANS OF MEETING ESSENTIAL BUILDING UTILITY NEEDS

- a) Will maintain regular routes of getting supplies needed by hospital for disaster. In the event the regular routes cannot supply what is needed then requests will be made thru the RAC G.
- b) **ELECTRICITY:** In the event of an electrical power failure an emergency generator is readily available. Rechargeable flashlights are available in each department when needed.
 - i) All unauthorized electrical equipment will not be operated during power failures. Only equipment authorized for emergency use will be connected to Red Emergency power outlets.
 - ii) The facility will evacuate after prolonged failures of 48 to 72 hours, when patient support cannot be maintained due to seasonal temperatures.
 - iii) See Safety Policy - Electrical Disruption/ Outage Plan
- c) **WATER:** In the event of a failure in the city water system or supply, follow Safety Policy: Water Shortage or Outage. The Safety Officer will coordinate the water – rationing schedule for each department. Water services will be shut off to all non-patient departments. A supply of water will be maintained for patient drinking and also for toileting.
- d) **VENTILATION:** See Safety Policy – Heating, Ventilation, and Air Conditioning.
- e) **MEDICAL GAS/VACUUM SYSTEMS.** See Safety Policy – Major Utility Outage and Medical/Surgical Vacuum

2) RADIOACTIVE, BIOLOGICAL, CHEMICAL ISOLATION AND DECONTAMINATION

- a) Radioactive Exposure: See Hazardous Material Exposure Policy and Radioactive Waste Management Plan.
- b) Biological – See Bioterrorism Readiness Plan.
- c) Chemical: See Hazardous Material Exposure Policy
- d) See Medical Waste Management Plan
- e) See Safety Policy Sewer/flooding
- f) Victims or staff requiring Decontamination must be diverted to another site with a decontamination facility, such as ETMC.

3) SURGE CAPACITY:

- a) In the event the facility will need to expand health care beyond our normal services for medical care the following procedure will be followed:
 - i) The PACU can be utilized for patients who are in need of acute care; patients who are recovering and nearing readiness for discharge can be placed in the Pre/Post Nursing Unit.
 - ii) Communication to the unit will be done by cell phone or two-way radios if phone system is not working.
- b) Medical supplies, food and pharmaceutical items are routinely inventoried twice per year. A sufficient number of items will be maintained to meet the needs of the "surge" capacity of the facility for at least 96 hours. After that point, the Logistics Chief will coordinate with the Material Manager, Food Service Manager and Pharmacy Manager to purchase additional items from the regular supplier or to network among other facilities in the RAC G or State. A list of phone numbers will be utilized to place orders if electronic means are not possible.

4) RECOVERY PHASE:

- a) When an emergency situation has passed and the hospital is ready to begin routine operations, the first act may be to delay the start of the elective procedures until adequate resources are available. The department manager must ensure that enough supplies, equipment and pharmaceuticals are at hand to care for those patients.

Collaboration between the Out-Patient Surgery Center staff and the hospital will ensure that patient care is not delayed for a long period of time.

- b) Evaluation and Assessment
 - i) The facility will develop performance standards that evaluate the effectiveness of the Emergency Management Plan through planned tests. Through this process, the facilities set program goals that are measurable and quantifiable, monitor and assess performance in meeting those goals and adjusts the program as necessary to ensure continued improvement.
 - ii) The Planning Section is responsible for critiquing each emergency response and reporting to the P.I. Committee. The Texas After Action Report can be utilized for this purpose.
 - iii) The objective, scope, performance and effectiveness of the Emergency Management Plan will be evaluated annually. The evaluation will address these issues and be reported to the Patient Safety Committee and/or the Emergency Planning Committee. The Medical Executive Committee & Board will review and approve the plan and any changes.
 - iv) Staff involved in the processes for the emergency will be offered debriefing counseling from Employee Assistance Program. This will be set up through Director of Human Resources.

5) TRAINING:

- a) Orientation and Annual Training:
 - (a) The facility supports an ongoing program of new employee Emergency Management orientation and training and annual refresher training thereafter. Employee knowledge will be assessed during hazard surveillance and safety rounds and during annual refreshers. Specific responsibilities are:
 - (b) Human Resources: New employee and new manager orientation coordination
 - (c) Safety Officer: Facilitate facility-wide Emergency Management Training
 - (d) Department/Units: Provide department specific training
 - (e) Administration and Patient Care Division Managers facilitate training opportunities.
- b) Assignment Specific Training:
 - (a) In those cases where disaster control assignments involve the utilization of skills not normally acquired, Department Managers will ensure that specialized training is conducted to develop the requisite skills.
 - (b) The hospital utilizes FEMA educational programs for NIMS training of Command staff and for Emergency Room staff.
- c) The facility regularly tests their emergency management plan:
 - Exercises:**
 - (a) The facility tests its emergency management plan twice a year whether in response to an actual emergency or in a planned test. One test a year will include an influx of volunteers or simulated patients; it will be a communitywide practice test relevant to the priority emergencies identified in its hazard vulnerability analysis. Planned test scenarios will be realistic. Measurable performance expectations will be established during the tests to evaluate the timeliness and quality of the following core performance areas: event notification, communication, resource mobilization and allocation, and patient management.
 - (b) During planned tests, a person(s) not participating in the test will monitor performance and documents variation from established measurable performance expectations.
 - (c) Completed test will be critiqued through a multi-disciplinary process that includes administration, clinical and support staff.
 - (d) All events will be critiqued using the Texas approved After Action Plan and then submitted to the Regional Advisory Council (RAC-G) for submission to the state.
 - (e) Planned tests will evaluate the effectiveness of improvement that was made in response to previous test critiques.
 - (f) The strengths and weaknesses of performance during tests will be communicated to the Safety Committee/P.I. Committee.

REFERENCES:

Surge Hospitals: Providing Safe Care in Emergencies, Joint Commission Resources
CAMH Standard, EC 1.4 and EC 2.9.1., **San Diego County Emergency Plan**, Annex D, Medical Multi-Casualty Plan, September 1996, **Hill County Memorial Hospital Health System Emergency Management Plan**, January 2002, **Joint Commission Resources Guide to Emergency Management Planning in Health Care**. Oakbrook Terrace, IL 2002
RAC-G Piney Woods Regional Advisory Committee Area G- 2008 Regional Trauma Plan
Texas Department of State Health Services- 2007 regulations for general hospitals.

BURN CENTER CONTACTS

Shreveport, Louisiana	Louisiana state University Health Science Center - Shreveport	Kevin Sittig, MD Medical Director	318-675-6136 ksitti@lsuhsc.edu 318-657-6850 Fax: 318-675-6857
Oklahoma City, Oklahoma	Children's Hospital at Oklahoma		405-271-5922 405-271-4876 Fax: 405-271-8344
Oklahoma City, Oklahoma	Paul Silverstein Burn Center		405-945-4577 405-949-3345 Fax: 405-949-3662
Tulsa, Oklahoma	Alexander Burn Center	Medical Director	918-599-8200 918-579-4580
San Antonio, Texas Fort Sam Houston	U.S. Army Institute of Surgical Research	Steven Wolf, MD Director	210-916-3301 210-916-2876 Fax: 210-916-4281
Galveston, Texas	Shriners Hospitals for Children	Medical Director	409-770-6731 409-772-2023 Fax: 409-772-6606
Houston, Texas	John S. Dunn, Sr. Burn Center Herman Memorial		713-500-7181 713-704-4350
Lubbock, Texas	Timothy J. Harnar Burn Center University Medical Center	Medical Director	806-743-1615 806-743-3406 Fax: 806-743-1233

Trauma Center Contact List

Trauma Center / Level of Designation	Medical Director / Trauma Coordinator	Transfer Line	Special Capabilities
ETMC – Level 1	Art Chance, Incident Commander	525-6220	General medical/trauma care
	ER Manager, Delisa Blanchard	Same no.	
Medical Operations Center- Tyler	Judy England	939-5783	Makes determination of patient assignments

Hot Lines

Contact Agency	Director	Phone Number	Special Capabilities
RAC-G/ MOC	Judy Englund, Chair	939-5783 cell: 253-4585	
Smith Co. Health Dept Medical Authority	Jonathan MacClements, MD	877-7339	
EOC - Tyler	Neal Franklin (Tyler Fire Dept)	526-0043	

Smith Co. Emergency Coordinator	Jimmy Seaton	566-8911	
Tyler Water Utilities		903-531-1237	Water Supplier
Brookshires Food Store		903-593-1411	Alternative food supplier
CVS Pharmacy		903-526-8183	Alternative pharmacy
AAA Sanitation		903-593-5909	Portable commodes

APPENDIX B

