HOSPITAL EVACUATION PROTOCOL
DRAFT March 2006

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New York Center for Terrorism Planning and Preparedness (NYCTP)

Background

The New York Center for Terrorism Planning and Preparedness (NYCTP) is a consortium of nine hospitals organized under the Federal Health Resources & Services Administration (“HRSA”) Hospital Preparedness Grant for the purpose of improving New York City Hospitals’ capacity to respond to bio-terrorist attacks as well as other public health emergencies. It is composed of three core facilities: Bellevue Hospital Center (a city hospital system), New York University Medical Center (an academic voluntary hospital system), and the Manhattan Veterans Administration (VA) Hospital (a federal hospital network). The six partner institutions (both acute care and chronic long-term care facilities) include: Coler/Goldwater Specialty Hospital and Nursing Facility, the Hospital for Joint Diseases Orthopedic Institute, Woodhull Medical and Mental Health Center, Gouverneur Healthcare Services, and the Brooklyn VA and Queens (St. Alban’s) VA Hospitals.

The purpose of the NYCTP, in responding to duties specified under the grant, is to both assess current emergency preparedness and surge capacity activities in the participating hospitals and also develop and further implement strategies and protocols for managing resources, patient influx and staff activity during a mass casualty event. Each hospital acknowledged its strengths in each area of disaster preparedness and worked to increase the capabilities of all hospitals involved by integrating response plans and formulating memorandums of understanding (MOUs) for the sharing of staff and supplies between facilities during a disaster.

In addition to the general requirements of the grant, our CBPP has also maintained a unique focus on the inclusion of what we have termed “vulnerable populations”, such as children, in these disaster plans. A strong emphasis has also been placed on the psychosocial issues involved in experiencing a disaster and the importance of acknowledging the impact disasters can have on staff and families, such as by developing employee assistance programs and a family resource center.
1. PURPOSE OF PROTOCOL

The CBPP, the Center for Bioterrorism Preparedness Planning and the New York Center for Terrorism Preparedness and Planning (NYCTP), has developed this Evacuation Protocol (EP). The Evacuation Protocol has been developed to provide NYC Hospital personnel with a plan of action should an emergency arise that may lead to an evacuation of the patient care facilities in an NYC Hospital. It outlines responsibilities of individuals and departments, prioritizes evacuation requirements and conceptually establishes how the evacuation should take place. The EP has been developed as a portion of a more comprehensive Emergency Management Plan for NYC Hospitals. It has been designed to integrate with the existing fire safety protocols, Fire Safety Handbook, the Hospital Emergency Incident Command System (HEICS) and other standard NYC Hospital operating procedures.

The orderly evacuation of a hospital is an entirely different process than is recommended for most other buildings and involves special considerations. Due to the fact that so many patients may be medically unstable and dependent on mechanical support equipment, complete evacuation of the facility is to be initiated only as a last resort, and must proceed in a planned and orderly manner.

An Evacuation Protocol such as this should be maintained by the Emergency Management Department with the cooperation of all departments within your hospital. Every department within your hospital should be responsible for implementing the protocol and for maintaining up-to-date disaster procedures in their work area. Departments should notify the Emergency Management Department at your hospital if significant changes or alterations in their departments transpire which could impact implementation or performance of your protocol.

Your evacuation protocol should be reviewed and updated regularly or as major changes/events in the facility occur. Your hospital should conduct a scheduled review of the protocol and coordinate updates with hospital emergency programs.

The purpose of the EP is to save lives. It is intended to provide for the safety of the staff as well as the patients during a response to an emergency where partial or full patient evacuation may be required.
2. Activation of the Protocol

The decision to evacuate is a difficult decision. Patients should be evacuated only when absolutely necessary. Situations worthy of evacuation include danger posed by fire, smoke, flooding or a potential exposure to hazardous materials. Evacuation may also be required as a result of facility structural damage or the potential for damage imposed by severe climatic changes, where personnel and patients are in more danger within the facility than any risks posed by evacuation. Not all emergencies will require an emergency evacuation response. The procedures that follow apply only to those situations when an actual evacuation is necessary.

During any evacuation, unique challenges will be faced due to the physical layout of the facility and the unstable nature of the patients within the facility. All staff members perform important roles in the implementation of an evacuation.

The decision to implement the EP should be determined by the Incident Commander (according to the facility’s HEICS model). Once consideration is being given to implement an evacuation, the Communications Department should be notified so that they can activate their code. Once a given hospital has activated their plan, a facility’s Communications department should notify personnel they have identified in their plans.

Hospital personnel in the vicinity of an incident requiring immediate life saving action may order the partial, (either horizontal or vertical evacuation) of a particular area when conditions are life threatening. The objective is to get patients and personnel to safe refuge areas.

Hospital employees should immediately assume the responsibilities of their assigned roles upon activation of the EP. Inter-hospital and regional coordination of activities should be coordinated under the Disaster Plan of the City of New York by the Office of Emergency Management (OEM).

When the decision is made to activate the EP, the magnitude of the emergency response must be determined. For large scale events or total facility evacuation, the Liaison Officer (or the Incident Commander) should immediately notify:

Office of Emergency Management (Disaster Control Board)
(718) 442-8700
24/7 operations (If no answer, call 911)

NYC Hospital’s EOC should coordinate w/OEM and other local agencies to establish, as needed, inner and outer perimeters. Once notified that an evacuation is in progress and assistance is needed, the Office of Emergency Management should call:

Emergency Medical Services (EMS)
Operations (718) 999-2770
24/7 contact City Wide (718) 422-7396 or (718) 422-7398

EMS should then contact other area hospitals and collect information as to ED census, number of beds available, and the number and type of patients other hospitals can accept. The following contacts are for reference only. EMS should make the initial contact.
3. FACTORS INFLUENCING ACTIVATION

The following are examples of what could lead to activation of any given hospital’s EP.

A. INTERNAL EMERGENCIES
Fire, smoke, hazardous materials release, or irritant fumes in the following areas:
- Laboratories
- Mechanical rooms
- Operating rooms
- Emergency department
- Clinics and patient rooms
- Facility services and maintenance areas

Loss of environmental support services
- Heat
- Water supply
- Air conditioning
- Sterilization
- Electrical power
- Computer network
- Telecommunications (paging, telephones)

Loss of medical gases
- Oxygen
- Compressed air
- Vacuum suction

Other examples
- Explosion
- Police actions
- Armed or violent visitor

B. EXTERNAL EMERGENCIES
Natural Hazards
- Earthquake
- Hurricane
- Flood
- Tornado
- Blizzard

Regional power outage
Civil disturbance
Terrorism
Transportation accidents
Hazardous materials releases
Contaminated victims/toxic agents
Radiation
4. GENERAL EVACUATION GUIDELINES

During an emergency, initial evacuation of persons in immediate danger must take precedence over all other actions. Initial evacuation routes should be posted at the hospital’s Nursing stations. Initiation of a vertical or complete evacuation of the hospital, with the exception of the need to move persons in immediate danger, should be coordinated under the direction of the hospital’s Incident Commander. Incident specific evacuation routes and the process by which floors should be evacuated must be coordinated through a hospital’s Incident Commander.

During a major emergency, a hospital’s telephone service may be overloaded or disrupted. In such an event, the person responsible for hospital communications should ensure consistent communication. The Communications Department should handle and coordinate internal communications and serve as a focal point for incoming and outgoing calls. In addition, the Communications Department, with the support of Security, should provide emergency communication equipment, such as radio systems, public address systems, and portable radio units, for communications between employees throughout the emergency and for contacting emergency personnel. Evacuation and specific guidance for travel route and in-house transportation must be a systematic, coordinated effort in order to remove all patients, visitors, and staff from the facility in a safe and timely manner.

A hospital should assign a designated, trained representative to the affected department(s) or unit discharge/exit point. This individual should be able to help provide in-house transportation information and real time guidance required to move patients to the appropriate Refuge or Triage Areas within the facility. This individual should maintain radio contact with the assigned representative within the facility (e.g. Emergency Operations Center (EOC) via Logistics Chief) and relay information regarding departmental conditions and needs. They will maintain contact with the EOC throughout the incident or until evacuation of the area is complete.
5. EVACUATION RESPONSIBILITIES

The Incident Commander or representative assigned for an incident should retain the full authority and remain responsible for the decision-making process until relieved by a more senior ranking official. Evacuation responsibilities for specific departments are summarized below.

A. ALL HOSPITAL EMPLOYEES
If a disaster occurs in a patient care area, or threatens a patient care area, employees should remove patients who are in immediate danger. DO NOT WAIT FOR INSTRUCTIONS. Patients should be taken to the nearest safe area on the same floor if possible (horizontal evacuation). If the patients are not in immediate danger and the alarm has been activated, WAIT for evacuation orders.

Do not leave patients unattended. It should be ensured that hospital staff members assume responsibility for patients under someone else’s care before they leave to report to pre-assigned disaster response assignments. For example, appropriate hand-off must be conducted before leaving any patient.

B. SECURITY DEPARTMENT
All members of a hospital’s Security Department should immediately communicate with their department for a head count and to receive emergency orders. Communication should be done by radio or telephone. They should be prepared to perform a variety of duties including but not limited to:

- Ensure that an officer is dispatched to the front entrance of the hospital to meet the emergency responders and direct them to the scene of the problem.
- Ensure that officers are dispatched as needed to direct entrances/exits and activate lock-down procedures for the facility.
- Security staff, using radios or an alternate communications system, should be located at exit(s) of patient care units to ensure that all patients, visitors and staff are accounted for.

C. LABOR POOL
A representative should contact the facility’s Emergency Operations Center (EOC). Normal visiting hours will be suspended during the disaster situation. It is anticipated that a significant number of people will volunteer their help during an emergency, including family members, visitors and nearby residents. The Human Services department or Planning Officer at the facility should help manage this influx and assign personnel to register these volunteers and assign them to a specific Staging Area. They should be prepared to perform a variety of duties including but not limited to:

- Report to the Planning Officer or other representative assigned at the hospital for a head count and to receive emergency assignments.
- Manage and establish the control centers and staging areas for volunteers, patient families/visitors and medical students.
- Record volunteers level of fitness, as they may be needed to transport patients up & down stairs.
- Ensure that responsible personnel are assigned to stay with relatives of victims in the
hospital waiting area and provide the EOC with the names of family members and volunteers that are in the facility.

- All volunteers should sign-in at the facility and should provide their full name, contact information, credentials, and list any special talents - especially knowledge of another language.

D. BUILDING SERVICES

*Building Services* or other maintenance personnel should report to the leadership of their assigned work unit. They should be prepared to perform a variety of duties including but not limited to:

- Help move patients, and assist as directed by the unit leadership
- Maintain staffing of elevators and coordinate support from Security as needed
- Ensure that hallways or traffic areas are clear of carts and equipment and be responsible for setting up extra beds if needed.
- Transport storeroom supplies and bring in resources from other areas of the facility as requested.
- In the event of a facility wide evacuation, the representative should be expected to help move patients and victims from patient rooms to refuge/treatment areas and then to ambulances or other vehicles as appropriate. Canvass organization for existing patient transport equipment and redirect as needed to critical areas. Ensure adequate number of stretchers and other equipment to move patients.
- Perform other duties as requested or redeploy to provide labor resources as needed

E. FOOD SERVICES

Food Service employees at the facility should be prepared to perform a variety of duties including but not limited to:

- Assist in directing visitors in the food service areas to exit the hospital.
- Immediately clear hallways of all tray carts, steam carts and food serving carts.
- Prepare and serve nourishment to patients, family members, volunteers and other personnel if good health practices can be maintained.
- Set up menus or backup service in disaster situation and maintain adequate supplies.
- Evaluate the impact of the disaster situation to determine if utilities and appliances in kitchen and cafeteria areas should be shut off and are safe.

F. FACILITIES MANAGEMENT

The *Facility Department* or other assigned department representative at the facility should be prepared to perform a variety of duties including but not limited to:

- Stand by to ensure shutdown of gas valves, heating, ventilation, air conditioning and other facility equipment as appropriate.
- Maintain and control functioning of all available elevators, ventilation equipment and emergency generators.
- Be available to set up extra beds in hospital if needed.
- Assume additional duties as needed.
6. FACILITY EVACUATION

A. EVACUATION OF NON-PATIENT AREAS

Should an incident occur of such magnitude requiring total evacuation from the building or evacuation of a specific floor, the staff personnel on that floor should immediately evacuate to a safe area at the facility such as an Assembly/Staging Area, to await specific emergency response assignments. For purposes of identification, staff members of these non-patient care areas should be classified as non-clinical. Under emergency conditions, this group of personnel should report to the designated Staging Area (as determined by the hospital’s Incident Commander) to receive emergency response assignments if they do not have pre-designated duties. General facility evacuation guidelines should include:

1. Persons in immediate danger should vacate first via the nearest exit. Prior to opening an interior door, first using the back of your hand, feel the door for heat. **NEVER** open a door that feels hot to the touch. Try to find an alternative exit. Pull the fire alarm if you see fire, smoke or any hazardous condition.

2. In threatened areas, first close all windows and doors if you can do so without placing yourself in danger.

3. In an area where there are visitors, calmly gather them in one area and direct them in a single file to the nearest exit. Assign one volunteer or employee to lead them, and one volunteer or employee to be the last in line. These visitors should be sent or escorted to one of the pre-designated Assembly Areas in the facility. Visitors should remain in the assembly area until an “all clear” communication is declared or other directions are given. Available staff should then report their availability to the assigned Staging Area.

4. Always close doors you pass through.

5. Once you have reached a safe area of refuge, call should be placed to the operator the exact location of the hazard area should be given.

B. EVACUATING PATIENT CARE AREAS

During an evacuation of patient areas, patients should be prioritized for evacuation in the following manner:

1. Patients in Immediate Danger
2. Ambulatory Patients
3. Wheelchairs, Isolettes, Cribs
4. Bed Bound Patients

Response to a disaster situation should typically be addressed by one or more of the following activities:

**Definitions:**

**Defend in Place:** Based upon the type of building construction and fire protection systems in the facility; staff, patients and visitors may be instructed to remain where they are until further instructions are provided to them. Closing doors and windows in patient rooms should provide initial protection from fire. In most incidents, the safest place for a patient is in his/her room. **NEVER hesitate to relocate because of imminent danger:** Certain instructions may be given to maintain order and keep everyone informed of the latest status of the incident. Initiation of the Defend in Place policy requires that all routine activities stop, and that preparations are made to enable immediate movement of patients should the incident necessitate such actions as outlined in
the following types of patient evacuation.

**Horizontal Evacuation:** This stage involves patients who are secured from immediate danger but remain on the same floor. Horizontal evacuation typically means that everyone in the Unit should be moved to the opposite side of the building.

**Vertical:** This stage refers to the complete evacuation of a floor. For a localized incident, occupants can be transferred to an area of refuge identified elsewhere in the hospital, typically at least two floors beneath the incident floor. In the case of a complete facility evacuation, occupants should be removed to the assigned Refuge Area. All patients should be tagged and/or triaged by designated leadership before they leave their floor.

**Total Evacuation:** This stage involves the complete evacuation of the facility. Total evacuation should be initiated only as a last resort. Patients should be transferred to alternate locations and facilities. This decision should require coordination between all Sections operating under the facility’s Hospital Emergency Incident Command System (HEICS).

C. **EVACUATION LEVELS**

Any employee, who reasonably believes that an emergency is taking place, or is about to take place, that could put patients or staff in imminent danger, should initiate the emergency evacuation of an area. When the fire alarm sounds, employees should be expected to implement fire response protocol appropriate to his or her work area. There is no code to indicate if an alarm signifies a drill or real fire. Therefore, every alarm should be treated as a potentially serious event.
7. CLINICAL DEPARTMENT REQUIREMENTS

GENERAL STANDARDS

- Maintain continuity of care by assigning responsibilities for ancillary personnel assigned to the unit which may include: BSD (Transport, Housekeeping, and Laundry), Respiratory, Food/Nutrition, Materials Management, Central Services etc and request additional resources as needed.
- Report to or assign staff to communicate with the Emergency Operations Center (EOC)
- Request additional personnel to support and transport patients, especially during nights and weekend shifts
  - Provide adequate drug and medical equipment (e.g., Propaq, oxygen, IV pump, etc) to support each patient during transportation and evacuation procedures.
- Assign staff to clear all obstructions from corridors and then stand by to control fire/smoke doors and exits as required.
- Coordinate the discharge and movement of current patients to create room for incoming patients or evacuees from other areas in the hospital
- Evacuate patients in immediate danger first, followed by ambulatory patients. Appoint a helper to go with them and lead them to the safest part of the same floor (toward exit). Direct the leader as to where to take the patients if they must leave the floor. Do not leave ambulatory patients without staff guidance. When possible, use wheelchairs to remove non-ambulatory patients to a safe place on the same level and then take the chairs back for additional patients.
- The immediate safety of the patient at this time must be given preference over aseptic techniques
- As unit is evacuated, assess the need to shut off utilities (e.g., medical gases, equipment, lighting, etc).
- Be alert for further instructions or changing environment hazards. Make periodic checks to assess patient’s safety and emotional health.
- Ensure that doors are closed and mark an “X” (with a grease pencil) after a patient room is evacuated.
- Before initiating a horizontal evacuation of patients, supervisors should do a quick check of the adjoining area of refuge to avoid unnecessary movement to potentially unsafe areas.
- In collaboration with physicians evaluate the condition of each patient
  - Secure a triage transportation tag to the patient gown or robe; provide a copy of tag to Patient Access for tracking
  - Determine the best available method for transportation for each patient and most appropriate destination based on patient acuity and care needs (e.g., SNF, etc).
  - Identify and procure specialty equipment, as needed, that will be necessary for transportation and continued patient care
  - Place patient records, medications, clothing and valuables in a bag with each patient’s name clearly marked in indelible ink on the bag.
  - Assist Patient Access and Social Services in notifying patient emergency contact

REMEMBER, IF HORIZONTAL EVACUATION IS IMPLEMENTED, IT COULD BE JUST THE INITIAL STEP IN A SERIES OF MOVEMENTS TO SAFETY. BE ALERT FOR FURTHER INSTRUCTIONS!
A. MEDICAL AND SURGICAL PATIENT CARE UNITS

Requirements for Evacuation:
When an emergency occurs, nursing staff members at the facility should report to their own department for a head count and emergency assignments. The Unit Nurse Manager or designated leadership responsible for nursing staff in a particular unit should direct activities of the Unit staff. These activities may include, but are not limited to:

UNIT SPECIFIC STANDARDS
Orthopedic patients who are fastened into traction devices may not fit through doorways. To the extent possible, patients should not be left unattended. Ropes and straps may have to be cut to move the patient.

B. OPERATING ROOMS, POST ANESTHESIA CARE UNITS & HEMODIALYSIS

Requirements for Evacuation:
The following personnel are responsible for ensuring the safety of all patients:

- Operating suite, the surgeon in charge in each case.
- PACU, the covering anesthesiologist is responsible to coordinate with nursing
- Hemodialysis unit, Nursing is responsible

The Unit Nurse Manager or designated leadership will direct activities of the Unit staff. These activities may include, but are not limited to:

UNIT SPECIFIC STANDARDS
- Close doors to occupied OR suite(s) and place wet towels around the doors if smoke, dust or fumes are present; keep the surgeon advised on safe exit routes, relocation or refuge areas;
- To the greatest extent possible, obtain equipment and services required for completion of the surgery; Keep list of anticipated supplies on hand and be prepared to ensure additional sterile supplies can be processed quickly;

OR/PACU Nights and Weekend Shift/Hemodialysis Unit:
- Immediately call for additional support to transport and move patients.
- Evacuate ambulatory patients first. Gather these patients together and have them form a chain by holding hands.
- Appoint a helper to go with ambulatory patients and lead them to the safest part of the same floor (toward exit) and direct the leader where to take them if they must leave the floor.
- Do not leave ambulatory patients without staff guidance. When possible, use wheelchairs to remove non-ambulatory patients to a safe place on the same level conference room and then return the chairs for remaining patients. Non-ambulatory patients may be rolled in a blanket and moved to a safe location.
C. INTENSIVE CARE UNITS

Requirements for Evacuation:
In the event of an emergency, the Unit Nurse Manager or designated leadership must evaluate patients in the Intensive Care Units in collaboration with intensivist or medical/surgical house staff for possible discharge. Using established discharge criteria as a guide, as many patients as possible should be transferred out the Intensive Care Units. The Unit Nurse Manager or designated leadership should direct activities of the Unit staff. These activities may include, but are not limited to:

UNIT SPECIFIC STANDARDS
- Patients may be rolled in a blanket and dragged to a safe location in addition to using stretchers and beds where feasible;
- Work with medical/surgical house staff and respiratory therapists to evaluate whether it is appropriate to shut-off oxygen, ventilation equipment and other gases and provide interim support.
- Children should be handled like other patients, except that in ambulatory evacuation alternate the older and younger children in the evacuation line, if time and circumstances permit;
- Patients may be rolled in a blanket and dragged to a safe location.

D. LABOR AND DELIVERY UNITS

Requirements for Evacuation:
Designated Nursing staff members should report to their own department for a head count and emergency assignments. The Unit Nurse Manager or designated leadership will direct activities of the Unit staff. These activities may include, but are not limited to:

UNIT SPECIFIC STANDARDS
- Assign support staff to wheel incubators, instruments and supplies with the patient if needed to complete Labor and Delivery procedures;
- Babies can be in the mother’s arms or be carried by a nurse.

E. MOTHER-BABY UNIT, PEDIATRICS, NICU AND PICU

Requirements for Evacuation:
In the event of an emergency, the Unit Nurse Manager or designated leadership should ensure that as many babies as possible are taken to their mothers. The Unit Nurse Manager or designated leadership should direct activities of the Unit staff. These activities may include, but are not limited to:

UNIT SPECIFIC STANDARDS
- Boarder babies will remain in cribs/bassinets with a nurse in attendance during defend in place and horizontal evacuations;
- Incubator babies should be moved in their incubators to other locations, and if necessary, multiple babies may be placed into a single crib or incubator;
- Helpless patients may be rolled in a blanket and dragged to a safe location.
UNIT SPECIFIC STANDARDS

- Disoriented patients (e.g., Psych) should be handled like other patients. If time and circumstances permit, alternate the confused ambulatory patients between coherent patients.
8. **EVAUCATION TRANSPORTATION TAG**

An Evacuation Transportation Tag System can be useful to track patients who require evacuation from the facility. Physicians and Nursing staff at your facility should be responsible for patient assessment/triage which will dictate mode of transportation based on acuity and care needs.

Conditions permitting, the assessment/triage process and transportation tag completion should be completed prior to movement of patient from hospital. The tags should be updated and referred to during triage and transportation to the areas of refuge and possibly other healthcare facilities.

*Patient Access* or designated representative at the facility should be responsible for:
- Maintaining a supply of the evacuation tags
- Coordinating the distribution of evacuation tags during an event
- Tracking patients who are being transported to other locations.
9. TRANSPORTATION RESOURCES

Transportation needs should be assessed and appropriate types of vehicles (ambulance, ambulette, van, etc.) will be determined. The Transportation Officer or other assigned representative should coordinate travel arrangements through contracted vendors.

Transportation requirements for large numbers of patients, medical supplies and equipment are difficult. In addition, available relocation sites with the necessary advanced life support equipment and emergency medical facilities tend to be scarce. The Contracts with transportation resources/services should be reviewed and renewed on a regular basis.

Additional transportation resources can be accessed via contact with the NYC Office of Emergency Management (NYC OEM). NYC EMS may or may not be able to provide additional transportation resources during an evacuation based on the nature of the event and its effect on citywide resources.

The need for activation of EMS mutual aid agreements between NYC and surrounding EMS agencies (located in NJ, CT, PA) such as commercial and volunteer agencies may be required to augment the EMS and transportation resources available to your facility and others during an event.

10. ALTERNATE CARE SITES

A list of hospital affiliations should be kept and made available during an event. The most prominent issue, as is the case with many hospitals, is that of staffing, specifically nurses, for the extra beds and even for existing beds. The Centers for Bioterrorism Preparedness Planning (CBPP) has a number of affiliated hospitals they can reach out to during an event. The CBPP affiliated hospitals consist of NYU Hospitals Center, the Manhattan VA Hospital, and Bellevue Hospitals as core hospitals. Additional Strategic Partners of the CBPP include: Coker Goldwater Hospital, Gouverneur Hospital, Hospital for Joint Diseases, Woodhull Hospital, the Brooklyn and Queens VA Hospitals.

Through the CBPP initiative, there is currently a memorandum of agreement amongst the hospitals to serve as alternate care sites for each other if the need arises. Examples of such needs include but are not limited to: surge capacity, decontamination, and special populations. This memorandum of agreement is part of ongoing project with the NYC Department of Health and Mental Hygiene (NYC DOHMH) and Health Resources and Services Administration (HRSA).
11. GLOSSARY OF TERMS

**ALL CLEAR:** Discontinue Disaster Protocol. Internal/External disaster situation has been alleviated and operations can return to normal. Personnel may return to their normal work assignments.

**ASSEMBLY AREA:** A remote (outside) location away from the building and out of the way of responding emergency personnel where visitors, staff, students, patients can meet after an evacuation so that they may be accounted for. There may be more than one assembly point depending on the size of the building. Most hospital patients are in need of medical support and will be evacuated to “Refuge Areas” for treatment and tracking instead of being directly taken to Assembly Areas.

**CRITICAL:** Vital signs are unstable and not within normal limits. Patient is acutely ill or unconscious. Indicators are questionable or unfavorable.

**DEFEND IN PLACE:** Patients, staff and visitors may be put on alert, but instructed to remain where they are until further instructions are given, such as to evacuate because of imminent danger. Based on the specific incident, type of construction, built in fire protection, and with concurrence with local fire officials it is sometimes the safest course of action so that patients are kept out of harms way, order is maintained and everyone can be kept informed of the latest status of the incident.

**EXTERNAL DISASTER:** A disaster that occurs outside the hospital, somewhere in the surrounding community or New York City. A disproportionate amount of hospital staff is often required to care for the incoming Emergency Room patient or victim load.

**FIRE DOORS AND SMOKE-BARRIERS:** Doors and corridor walls designed to divide the hospital into compartments to prevent the spread of fire and/or smoke and protect patients and personnel for a rated period of time.

**HORIZONTAL EVACUATION:** This type of evacuation takes place when air contaminants, fire or heavy smoke from a single room threatens to spread to adjoining areas. All patients, personnel and visitors in the affected areas should be moved laterally to the nearest area that is protected by fire doors, smoke barriers and is adjacent to an exterior exit way, (which includes enclosed stairwells).

**INCIDENT COMMANDER:** The individual responsible for the management of all incident operations during the hospital disaster event.

**HOSPITAL EMERGENCY INCIDENT COMMAND SYSTEM (HEICS):** A standardized on-scene emergency management concept specifically designed for hospitals to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demands of single or multiple incidents.

**INTERNAL DISASTER:** An incident that occurs inside the facility or has a direct impact on the safety of patients, or the structural facility. A need for additional resources and extra hospital personnel to care for patients, including possible transport and evacuation, due to an emergency.
within the facility such as power failure, fire, flood or explosion.

**MESSENGER:** A person who writes down messages and transports them to the intended receiver.

**NON-CRITICAL:** Vital signs are stable and within normal limits. Patient is conscious and can be either comfortable or uncomfortable. Patient may or may not be ambulatory. Indicators are favorable.

**ON-CALL STAFF:** The members of the various hospital departments who are on call for hospital business or emergency response on a 24-hour basis.

**PARTIAL EVACUATION:** Could also be termed immediate action evacuation or the removal of patients who are in immediate danger to an area of relative safety. A single rescuer usually accomplishes this. When assistance becomes available, or as time permits, the patients can be relocated to an area farther from the hazard or fire.

**REFUGE AREAS:** The locations established to hold triaged hospital patients following evacuation from their rooms and/or awaiting discharge or transfer to other facilities.

**RUNNER:** A person who carries supplies, equipment or communicates information between hospital departments or units during an emergency situation.

**STAGING AREAS:** Locations at which resources are kept while temporarily awaiting incident assignment. Most large incidents will have separate Staging Areas for non-clinical hospital staff, volunteers, supplies and other resources.

**TRANSPORTER:** A person who transports victims by wheelchairs, carts, stretchers, blankets, beds or accompanies ambulatory patients and remains with the victims/patients until released by the person in charge of the area.

**TRIAGE:** The sorting and classifying of patients or casualties for treatment and care. Triage will be used to determine order of transfer to other facilities. Triage categories:

- Red – Immediately life-threatening. Those tagged as red need critical interventions. This category may also include high-profile patients the media will be asking about.

- Yellow – Serious and potentially unstable. These patients may deteriorate into category red. They have a potential threat to life or limb and should be transferred to a tertiary care facility.

- Green – Slightly injured or “walking wounded” patients. They do not have life or limb threatening injuries.

- Black – Dead or near death. These are the dead or dying who under ordinary circumstances would need extensive resources to stay alive.

**VERTICAL EVACUATION:** The movement of patients in a downward direction. Typically this should be the next step after horizontal movement. Vertical movement of patients may
become necessary if a fire or smoke is threatening the floor, gases makes the floor untenable, or structural conditions make it unsafe to stay. Refuge should be found on a lower floor. If possible, two floors below the involved floor are recommended. Ambulatory patients should be grouped and taken down the stairs. Elevators for non-ambulatory patients can be used only after FDNY has deemed the elevators safe. In preparing for patient vertical movement, hospital personnel should perform certain duties as teams or units.
12. References

I. VA-NYHHS Mental health/Social Support Emergency Response Plan

II. VA New York Harbor Healthcare System Emergency Management Surge Capacity Plan

III. VA NYHHS New York Campus Surge Capacity Database Health Emergency Response Data System General Reporting

IV. Bellevue Hospital Surge Capacity Database

V. Bellevue Hospital Center: Policy for Emergency Management of Infectious Diseases With the Potential to Overwhelm Organizational Resources

VI. Bellevue Hospital Center Evacuation Plan

VII. NYU Medical Center Emergency Management Plan

VIII. NYU Hospital Center Departments of Nursing Surge Capacity Database

IX. NYU Medical Center’s Evacuation Plan

X. VA NYHHS Evacuation Plan

XI. Joint Planning with Hospital for Joint Diseases Orthopedic Institute, Coler/Goldwater Specialty Hospital and Nursing Facility, and Gouverneur Healthcare Services
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