HEALTH CARE FACILITY

EMERGENCY MANAGEMENT CHECKLIST

Health Care Facility Emergency Management Checklist
A Planning Tool for Health Professionals

Emergency management for healthcare facilities includes the emergency management principles of prevention, preparedness, response, and recovery. Plans should take into account such factors as the appropriateness and adequacy of physical facilities, organisational structures, human resources, and communication systems. The Department of Health is the designated support agency to provide the health function in response to mass casualties – please refer to WestPlan Health. This checklist must be interpreted in the most appropriate context, as some items will be more relevant at the tertiary care level than at the small peripheral hospital level. It is therefore important to remember the Emergency Management principle of a graduated response, that is, if resources are overwhelmed at the local level then the response scales up firstly to the district and then the State level.

This checklist is provided to assist health care facilities develop their own Standard Operating Procedures for the health support role in the response to an emergency (mass casualty or chemical/biological/radiological event). It is designed to provide facilities with questions that stimulate assessment and dialogue with key stakeholders internally and externally as well as at the local level and beyond. Although comprehensive, the facility assessment will undoubtedly identify new questions and considerations for each individual facility that will need further discussion and resolution.

The checklist does not attempt to address the technical aspects of responding to individual chemical/biological/radiological (CBR) agents, however, it is recommended that Plans incorporate national guidelines whereever possible (eg Commonwealth smallpox vaccination guidelines).

In any preparation for a mass event it is important to maintain close liaison with other agencies that may respond (eg Ambulance, Police, Fire and Rescue). Communication is vital in any Emergency Management response. This can be enhanced by the designated health representative regularly attending Local Emergency Management Committees/District Emergency Management Committees as well as by regular facility participation in joint exercises.

The resultant plan must also be able to cater for escalating orders of patient magnitude – for example, incidents up to 100 patients; incidents with 100 – 10,000 patients; and incidents with greater than 10,000 patients. How would the response differ?

Note that a Checklist has also been developed for the Public Health Emergency Management response (please see Public Health Emergency Management Checklist). Emergency Management planning should involve close liaison between practitioners from both the acute and preventative health care sectors.

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June 2003

Acknowledgement
This template has been adapted from the *Mass Casualty Disaster Plan Checklist: A Template for Healthcare Facilities – APIC (Association for Professionals in Infection Control and Epidemiology, Inc and CSB&EI (Centre for the study of Bioterrorism & Emerging Infections)* at http://www.apic.org/bioterror/checklist.doc

1. INITIAL CONSIDERATIONS:	Assessment
A. Does the facility have a disaster plan?	
B. Is there a disaster planning committee? Is it multidisciplinary and include administrative members?	
C. Is there currently a collaborative relationship with the local Emergency Management (EM) Agencies? Is there health representation on the Local or District Emergency Management Committee?	
D. Does the plan detail actions to be taken for both internal and external disasters?	
E. Does the plan detail how it links with the local EM Agencies?	
F. Is the plan widely distributed and readily available throughout the hospital/healthcare facility? Distribution should include hard copies of the plan or an automated version that is readily available to all staff members.	
G. When was the plan last updated?	
H. When was the plan last tested?	
I. How often is the plan tested ? Are subsequent recommendations incorporated into the plan ?	

2. SURVEILLANCE:	Assessment
A. Does the facility currently have a baseline established for numbers of patients seen in the facility Emergency Department, outpatient clinics, or via direct admission, grouped by clinical symptoms? (for example, respiratory tract infections; gastrointestinal illness)	
B. Is there currently a process to monitor and review 100% of all microbiology results and group according to organism?	
C. Does a process exist to notify infection control/clinical microbiology 24 hours a day/ 7 days a week?	
D. Does the plan specify the number and location of isolation or positive pressure rooms? • Are their locations clearly identified in a document readily available to the disaster coordinator or command team? • Are isolation facilities monitored to ensure adequate airflow as well as patency?	

3. IDENTIFICATION OF AUTHORIZED PERSONNEL:	Assessment
A. Is there an individual designated as a disaster coordinator on a 24-hour per day basis?	
B. Has the hospital/healthcare facility designated a physician medical commander who will be responsible for the hospital's medical responses during the time the plan is activated?	
C. Have other key position holders who have a role in disaster management been identified? This should be identified in the disaster plan. See #24 Incident Command for a guide to an Incident Command structure	
D. Is a notification system in place that can alert personnel to a potential disaster situation?	
E. Does the plan include lines of authority, role responsibilities, and provide for succession?	
F. How often are training sessions held for personnel involved in implementing the plan ?	
G. Have job action sheets or role cards been developed for all personnel involved in disaster response?	
H. Are there sufficient numbers of tabards available to identify staff (especially if being deployed outside of the hospital)?	

I.	Does the plan designate how people will be identified within the hospital (e.g., hospital staff, outside supporting medical personnel, news media, clergy, visitors)?	
J.	Can staff gain access to the hospital/healthcare facility when called back on duty?	
K.	Is there designation of assembly points to which all personnel report and does it change if staff are involved in patient care or have administrative responsibilities?	

	4. ACTIVATION OF THE PLAN:	**Assessment**
A.	Does the plan specify the circumstances under which the plan can be activated?	
B.	Does the plan stipulate the position holder who has the authority to activate/deactivate the plan including nights, weekends, and holidays?	
C.	Have activation stages been established and roles outlined with each stage?	
Alert	Disaster situation possible: there is an increased level of preparedness	
Stand by	Disaster situation probable: available for immediate deployment	
Call out	Disaster situation exists: there is deployment	
Stand down	Disaster situation is contained	

	5. ALERTING SYSTEM:	**Assessment**
A.	Does the plan provide for activation within 1-2 hours during normal as well as out of hours including weekends and holidays?	
B.	Does the plan specify how notification within the hospital/healthcare facility will be carried out?	
C.	Does the plan specify the chain of command to notify internal staff and appropriate external personnel indicating the status of the hospital/healthcare facility?	
D.	Does the plan detail responsibility to initiate a system for recalling staff back to duty?	
E.	Does the plan provide for alternative systems of notification that considers people, equipment, and procedures?	
F.	Does the plan provide mechanisms to ration staffing according to their skill levels and availability?	

	6. RESPONSE:	**Assessment**
A.	Has the hospital/healthcare facility developed internal disaster plans for internal emergencies?	
B.	Has the hospital/healthcare facility developed internal plans to respond to an external disaster? Does this plan indicate how the hospital will respond to an abnormally large (greater than >10% of the licensed beds) influx of patients?	
C.	Has the hospital/healthcare facility developed plans indicating how the hospital will be able to supply resources and personnel in response to an external disaster? Is there an evaluation of current supply and equipment levels that are kept on hand during normal facility operation?	
D.	Have provisions been made for activating a hospital disaster medical team in response to both internal and external disasters? Can this team be composed of appropriately skilled physicians and nurses?	

E. Does the plan include procedures for incorporating and managing volunteers and unexpected medical services responders who want to help? Has risk management been involved to develop a process with the facility insurer to provide insurance, liability, and safety for volunteers?	
F. Has each department developed standard operating procedures to reflect how the department will continue to provide services in a timely and 24 hour manner? These services may include:	
1. Administrative	
2. Emergency	
3. Nursing	
4. Radiology	
5. Infection Control/Hospital Epidemiology	
6. Occupational Health	
7. Laboratory	
8. Pharmacy	
9. Critical Care	
10. Central Supply	
11. Maintenance and Engineering	
12. Biomedical Engineering	
13. Respiratory Therapy	
14. Security	
15. Food and Nutrition	
16. Housekeeping	
17. Social Services	
18. Pastoral Counselling	
19. Mortuary	
20. Physician services including Medicine and Surgery	
G. In the Emergency Department section of the plan, are the following detailed?:	
1. Is there a separate entry to the Emergency Department for contaminated patients, if necessary?	
2. Is there a dedicated facility, area, or portable device for decontamination, if necessary?	
3. Is there a hot and cold water supply to the decontamination area?	
4. Can water run-off from the decontamination area be contained?	
5. Can the ventilation system in the Emergency Department be isolated from the rest of the facility, if necessary?	
6. Is a communication method established within the Emergency Department so communication can be established and maintained with the Medical Controller of the Business Continuity Plan, the Department of Health and local Emergency Management Agencies (Ambulance, FESA, Police)?	
7. Are current toxicological reference materials and antidote information readily available, along with the telephone number of the Poisons Information Centre ?	
H. Has jurisdictional control been discussed and staff informed of the hierarchy in the event outside law enforcement assistance is requested or required?	
I. Will there be a dedicated contact number established for patient enquiries?	
J. Will email access be provided to allow communication between victims and their families (especially if from outside of the local area) ?	
K. Has consideration been given to establishing and managing a database for donations if these are sent to the hospital for victims ?	

7. **SPECIFIC CBR RESPONSE:**	**Assessment**
A. Does the hospital have portable chemical or radiation monitoring devices to assist with recognition of a CR event ?	
B. Personal Protective Equipment.	
1. Does the hospital/healthcare facility have adequate PPE?	
2. Are the storage conditions for PPE adequate?	
3. Is there a mechanism in place for PPE to be regularly checked?	
4. Is there adequate training for use of PPE and is competency checked?	
5. Can staff be rapidly deployed in full PPE ?	
C. Decontamination.	
1. Have options for decontamination been considered (include: dedicated facility; designated area or portable device)?	
2. Are there adequate facilities for appropriate decontamination on site (ambulatory and non-ambulatory)?	
3. Can patients be re-directed to external decontamination facilities ?	
4. Is there controlled entry (signage) for contaminated patients into the facility?	
5. How is specialised triage and rapid patient processing to occur ? (including primary triage, undressed & clothing/belongings secured and labelled; adequate privacy provisions; adequate wash; secondary triage; medical care; patient observation and registration; psychological care; long-term surveillance registration; formal discharge)	
6. Are potential warm zones clearly demarcated at hospital ED entrances?	
7. What mechanisms are in place to deal with large numbers of self-presenters +/- vehicles arriving at EDs ?	
8. Are staff trained to set up and operate the facility?	
D. Can a chain of custody be maintained for potential forensic evidence?	
E. Can the plan accommodate very large numbers of people presenting (ie crowd management)?	
F. Can other departments and facilities within the hospital be used should the hospital become contaminated or subject to a secondary incident?	
G. What procedures are in place for staff ? (including decontamination; incident review and psychological management; employee long term surveillance)	
H. What are the arrangements for managing the contaminated deceased?	
I. What procedures are in place to decontaminate the facility and declare that the facility is "clean" ?	

8. **HOSPITAL COMMAND CENTRE:**	**Assessment**
A. Does the plan indicate where the hospital Command Centre is to be located with preference given to an area away from the Emergency Department?	
B. Has an alternate location been determined?	
C. Is the Command Centre equipped with adequate phone lines, power points, computer terminals, seating, white boards, TV monitor, radio? Is there an area close by for tea/coffee making, reheating meals and accessing toilet facilities?	
D. Have standard operating procedures been developed for the Command Centre?	
E. Do the procedures for the Command Centre specify chain of command and communication channels for the key position holders within the Command Centre? Key position holders should be determined at the initiation of the disaster plan. See Section 24 for additional help in determining roles.	
F. Is there provision for alternative communication arrangements in the event the hospital communication system fails or is overloaded?	
G. Have special communication networks been established and tested that will maintain communication between the facility and the local Emergency Management Agency?	

H. Have provisions been designated (e.g., space, equipment, communications) for extra people who may come to the hospital to provide services (e.g., volunteers and outside agencies) should assistance be requested by the local, or Commonwealth agencies responding for disaster assistance?	

9. SECURITY:	**Assessment**
A. Does the facility have the ability to lock down so entry and exit to all parts of the facility can be controlled? Has this process been tested?	
B. Have steps been taken to minimize and control points of access and egress in buildings and areas without utilization of lock down procedures?	
C. Is there a plan to control vehicular traffic and pedestrians?	
D. Have arrangements been made to meet and escort responding emergency service personnel?	
E. Does the facility have the ability to communicate with individuals immediately outside the facility in the event lock down is initiated?	
F. Does the plan designate how people will be identified within the hospital (e.g., hospital staff, outside supporting medical personnel, news media, clergy, visitors)?	
G. Can staff gain access to the hospital/healthcare facility when called back on duty?	
H. Is there designation of assembly points to which all personnel report and does it change if staff are involved in patient care or have administrative responsibilities?	
I. Does the facility security plan recognize the extent of the security problems for the individual facility? These considerations include the uniqueness of the physical plant, geographic location, entrances, etc.	
J. Does the facility have an established process to credential healthcare workers from outside the individual network in order to facilitate safe and qualified patient care?	

10. COMMUNICATIONS SYSTEMS:	**Assessment**
A. Does the plan include provisions in the event that normal systems (e.g., telephone, facsimile, cellular phones, and paging) may be overloaded and rendered unserviceable during disasters?	
B. Is there provision for alternative communication arrangements in circumstances where the hospital communication system fails/overloads (e.g., unlisted numbers, pay phones, walkie-talkie sets)?	
C. Is there an organized runner, messenger system as back-up for communication system and power failures?	
D. Has a plan been developed to utilize runner personnel and have they been provided with schematic area layout maps showing key areas for disaster operations? Do these schematics currently exist and are readily available in hard copy?	
E. Has the hospital established communication networks with the local EMS Agency and Emergency Management Agency?	
F. Are mobile phone charging facilities (+ spare batteries) available ?	

11. INTERNAL TRAFFIC FLOW AND CONTROL:	**Assessment**
A. Have provisions been made for internal traffic that allow for movement of patients through corridors and staff movement throughout their areas?	
B. Have egress routes for patients and staff been provided for evacuation purposes?	
C. Will elevators be manned and controlled?	

D. Has elevator usage been prioritised (e.g., casualties, supplies)?	
E. Have movement routes been designated within the hospital and have traffic flow charts been prepared and posted?	

12. EXTERNAL TRAFFIC FLOW AND CONTROL:	Assessment
A. Have arrangements been made for both vehicular and people entrance to and exit from the hospital premises?	
B. Have the following been established:	
1) Uninterrupted flow of ambulances and other vehicles to casualty sorting areas or emergency room entrances	
2) Access and egress control of authorized vehicles carrying supplies and equipment to a dock area	
3) Authorized vehicle parking	
4) Direction for authorized personnel and visitors to proper entrances	
C. Have arrangements been made for police support in maintaining order in the vicinity of the facility?	
D. Does the plan include a method to impact the management of vehicle and people convergence upon the facility?	

13. VISITORS:	Assessment
A. Does the plan include mechanism to deal with anticipated increases in visitors and curious onlookers seeking to gain entrance during disasters?	
B. Has provision been made to establish waiting areas, with supportive counselling, away from the Emergency Department to minimize unwanted access to the relatives and friends of disaster victims?	
C. Has provision been made to handle medical and emotional situations resulting from the anxiety and shock of the disaster situation? This includes dealing with the worried well.	
D. Has a position holder been designated to control and take care of housekeeping issues that arise due to visitors?	

14. MEDIA:	Assessment
A. Do the media have a designated area?	
B. Has this been located as not to be in close proximity to the Emergency Department, Command Centre, and waiting areas for relatives, family and friends?	
C. Has a position holder been designated to control and take care of the housekeeping needs of the media?	
D. Does the plan designate an internal spokesperson as a media contact?	
E. Does the plan determine the communication tree connecting the internal spokesperson with the external spokespersons for the Emergency Management Agency or other lead agency?	
F. Have provisions been made to identify the procedures for handling requests for information from the media? Have these provisions been made to work in concert with the State Health Department and the Federal police?	
G. Have locations been identified for press briefings?	

15. RECEPTION OF CASUALTIES AND VICTIMS:	Assessment
A. Is there a precise plan of action whereby at short notice (within 1 hour), multiple casualties can be received and:	
1) Identified	
2) Triaged	
3) Registered	
4) Treated in designated treatment areas	

5) Admitted or transferred	
6) Transported as needed	
B. In the confirmation notification of a disaster, does the plan provide for:	
1) Clearance of all non-emergency patients and visitors from the emergency department	
2) Cancellation of all elective admissions and elective surgery	
3) Determination of rapidly available or open beds	
4) Determination of space that can be converted to patient care areas	
5) Determination of number of patients who can be transferred or discharged	
C. Is the receiving and sorting area accessible and in close proximity to the areas of the hospital in which definitive care will be given?	
D. Is the reception area equipped with portable auxiliary power for illumination and other electrical equipment, or can power be supplied from hospital emergency power (generator) circuits?	
E. Does the reception area allow for retention, segregation and processing of incoming casualties?	
F. Are sufficient equipment, supplies, and apparatus available, in an organized manner, to permit prompt and efficient casualty movement?	
G. Can radiological monitors and radiation detection instruments be assigned to the area, if required?	
H. Has provision been made for a large influx of casualties to include such factors as:	
1) Bed arrangements	
2) Personnel requirements	
3) Extra resources such as interpretive services, linen, pharmaceutical needs, dressings, etc?	
I. Are the medical records and admission departments organized to handle an influx of casualties	
J. Is there a system for retention and safe-keeping of personal items removed from casualties?	
K. Is there a plan to segregate/isolate disaster victims from the rest of the hospital if those victims are contaminated (e.g., hazardous materials)?	

16. HOSPITAL EVACUATION:	**Assessment**
A. Is there an organized discharge routine to handle large numbers of patients upon short notice?	
B. Is it detailed that a position holder is responsible for removal and control of patient records and documents?	

17. RELOCATION OF PATIENTS AND STAFF:	**Assessment**
A. Has provision been made for the movement of patients and staff to an immediate area of safe refuge within the hospital in the event the area must be evacuated or staff and patients relocated?	
B. Have agreements been made with other healthcare facilities for the relocation of patients should the facility be unable to support patient care?	
C. Have satellite locations been pre-determined and confirmed for the housing of patients and staff in the event of an evacuation?	
D. Have transportation requirements been pre-designated for the movement of people?	
E. Have transportation resources been identified for patients that must be moved in hospital beds, on ventilators, and connected to specialized equipment?	
F. Has provision been made for the movement of patient records and documents?	

G. Is there a time sequence built into the plan designating appropriate moving times, assigned personnel including profession staff assignment, and priority of patients when moving to specific locations?	
H. Is there a sequence for patient transfers along pre-established routes?	
I. Are procedures established for the orderly disposition of patients to their homes, if applicable?	
J. Has provision been made for immediate refuge, care, and comfort for the patients and staff on the hospital grounds during inclement and winter weather?	

18. HOSPITAL OUT OF COMMUNICATION OR CUT OFF FROM RESOURCES:	**Assessment**
A. In the event the hospital/healthcare facility is completely out of communication or cut off from resources, has the plan assigned position holders responsible for the following:	
1) Auxiliary power?	
2) Rationing of food and water?	
3) Waste and garbage disposal?	
4) Rest and rotation of staff?	
5) Rationing of medication and supplies	
6) Laundry	
7) Staff and patient morale	
B. Has consideration been given to utilization of patients and visitors to assist staff with duties?	

19. EQUIPMENT, SERVICES, FACILITY, AND LABORATORY ASSESSMENT:	**Assessment**
A. Current number of the following pieces of equipment readily available within the facility:	
1) Ventilators (adult)	
2) Ventilators (paediatric)	
3) Ventilators (neonate)	
4) IV pumps	
5) IV poles	
6) Suction Machines	
7) Beds	
8) Stretchers	
9) Wheelchairs	
B. Current level of medical supplies maintained and readily available within the facility (days), particularly items that provide personal protection (i.e., masks, gloves, eye protection)	
C. Are local suppliers of medical equipment identified? Are there 24-hour contact numbers for these suppliers?	
D. Current level of linen maintained and readily available (days)	
E. Does the facility have the ability to shut down air intakes?	
F. What is the current Biosafety Level capability of the hospital microbiology laboratory?	
G. Are shipping containers readily available to safely transport specimens as requested by agencies such as the CDNA, Federal police?	
H. Does the plan include measures to insure the ability to provide handwashing/hand-sanitizing measures?	
I. Does the plan include measures to insure adequate amounts of personal protective equipment?	

20. PHARMACEUTICALS:	Assessment
A. What is the current level of stock for the following pharmaceuticals:	
1) Ciprofloxacin, oral and intravenous	
2) Doxycycyline, oral	
3) Bronchial dilators	
4) Other fluoroquinolones, oral and intravenous	
5) Bulk Atropine and Pralidoxime Chloride (2-PAM CL)?	
B. Does the pharmaceutical allocation plan make provision for prophylaxis of caregiving staff and their immediate family? Have these job categories been defined?	
C. Has the plan identified and established relationships with another hospital/healthcare facility outside the immediate region as a means to identify potential sources of needed pharmaceuticals as well as equipment, supplies, and staff ?	
D. Does the plan identify pharmaceutical warehouses within the local area?	
E. Does the plan outline how pharmaceuticals can be procured, transported, and delivered to the facility while within a secure environment?	

21. POST DISASTER RECOVERY:	Assessment
A. Does the plan designate who will be in charge of recovery operations?	
B. Does the plan make provision for the following during recovery?	
1) Documentation	
2) Financial matters	
3) Inventory and resupply	
4) Record preservation	
5) Cleanup	
6) Hazard removal and cleanup	
7) Salvage	
8) Garbage and waste disposal	
9) Utility and equipment servicing	
10) Physical plant restoration and renovation	
C. Does the plan address the following programs?	
1) Critical Incident Stress Debriefing Program	
2) Employee Assistance Program	
3) Group/Individual counselling services	
4) Family Support Program	
D. Who will be responsible for evaluation of the response ?	

22. EDUCATION AND TRAINING:	Assessment
A. Does the plan specify who is responsible for the training program?	
B. Does the plan include methods for ramp up and extemporaneous training for new and altered roles?	
C. Do the hospital/healthcare facility departments have ongoing, mandatory disaster training programs?	
D. Has the hospital/healthcare facility considered adapting disaster procedures for application when dealing with routine procedures so personnel can become familiar with them?	
E. Does the program provide disaster education material at staff orientation to facilitate staff awareness?	
F. Does the program provide ongoing disaster education to facilitate staff awareness and currency of procedures?	
G. Does the program have inter-organization joint training sessions that deal with common aspects of disaster response?	

23. KEY INTERNAL PERSONNEL	TELEPHONE / BEEPER / MOBILE PHONE
Facility CEO	
Administrator on call	
Medical Commander	
Director, Emergency Department	
Administrative Supervisor (House Manager)	
Director of Security	
Chief Nursing Officer	
Director of Engineering	
Director of Infection Control/Hospital Epidemiologist	
Chief of Microbiology/Laboratory Medical Director	
Director, Medical Services	
Risk Manager	
Public Relations	
Information Technology/Communications	
Product Resources	
Director of Pharmacy	
Chaplain/Pastoral Counselling	
Social Services	
Ethics Officer	

KEY EXTERNAL PERSONNEL/AGENCIES	TELEPHONE / BEEPER / MOBILE PHONE
Department of Health, Duty Officers, Emergency Management	9480 4960 (24 hours)
Ambulance service	
Fire & Emergency Service	
Police	
BCP Medical Coordinator	

24. INCIDENT COMMAND SYSTEM

If utilizing the Hospital Emergency Incident Command System (HEICS) as your framework for hierarchy in a disaster scenario, have you identified positions, not an individual(s), to fill each role?

HEICS Position	Current Position	Job Action Sheet Completed? Y or N
Incident Commander		
Public Information Officer		
Liaison Officer		
Safety and Security Officer		
Logistics Chief		
Planning Chief		
Finance Chief		
Operations Chief		
Medical Care Director		
Ancillary Services Director		
Human Services Director		
Medical Staff Director		

25. EXERCISING THE DISASTER PLANNING PROGRAM:	Assessment
A. Does the hospital safety program conduct an annual exercise?	
B. Does the exercise ensure all key participants are familiar with the contents of the plan?	
C. Are specific aspects of the plan tested?	
D. Is a formal critique performed with results distributed to all key individuals and participating groups?	