

Recommendations for Evacuation of Healthcare Facilities

The evacuation and/or shelter-in-place of a healthcare facility is a very complex task. Even with a well-defined plan and trained staff, it is very likely that, during the implementation of the decision to evacuate or shelter-in-place, there will be patient deaths and injuries, staff injuries and exacerbation of existing patient illnesses and injuries.

The healthcare facility should plan to shelter-in-place and to evacuate with its own resources and not depend upon the assistance of resources outside the facility. It is critical that the healthcare facility have emergency operations plans and resources that allow it to function on its own for up to 72 hours. Other emergency response organizations may not be able to respond to the needs of the healthcare facility due to other competing demands for resources, caused by the hazard.

Recommendation #1: It is recommended that all healthcare facilities in the State of Wisconsin adopt one common and consistent policy and procedure for the evacuation and or shelter-in-place of the facility.

Rationale: This is recommended so that emergency responders, who come to the aid of the healthcare facility, will be better prepared in their response, knowing that all healthcare facilities follow essentially the same procedures in the implementation of the decision to evacuate or shelter-in-place. This is especially true when the response is multi-jurisdictional in nature.

Recommendation #2: It is recommended that any changes to this policy and its procedures be only “site-specific” changes or enhancements and not to materially change the protocols of this policy.

Note: “Enhancements” are defined as going into further detail about a particular procedure with no material change to the procedures.

Rationale: This is recommended so that emergency responders, who come to the aid of the healthcare facility, will be better prepared in their responses, knowing that all healthcare facilities follow essentially the same procedures in the implementation of the decision to evacuate or shelter-in-place. This is especially true when the response is multi-jurisdictional in nature. Material deviations from this policy and its procedures may jeopardize patient and staff safety, since it is likely that emergency responders, especially those who come from other jurisdictions, will not be aware of any material changes, made by the facility.

Recommendation #3: It is recommended that the healthcare facility review its policy with local authorities during the planning stages and identify any site-specific changes and enhancements.

Rationale: The evacuation and/or shelter-in-place of a healthcare facility has a major impact upon the community. It is critical that local authorities be involved in the

development of the plan and be aware of any site-specific changes and enhancements. No healthcare facility can successfully evacuate or shelter-in-place without the assistance of local authorities and will require their expertise in their respective fields to review and adapt the plan to the unique local environment, both of the healthcare facility and the geographic area.

Template Policy on Healthcare Facility Patient Evacuation and Shelter-in -Place

Policy: It is the policy of the healthcare facility to have defined procedures to protect the life and safety of both patients¹ and staff should there be a hazard that causes the healthcare facility to decide either to shelter-in-place or to evacuate.

Definitions:

1. **Alternate Care Site:** a building or facility to which patients from the evacuated healthcare facility can be taken to for continued care and treatment and shelter
2. **Assembly Area:** In a complete evacuation, this is an area(s) where patients are processed before going to the Patient Staging Area(s) for transport out of the healthcare facility. (The Assembly Area(s) could be the patient rooms)
3. **Complete Evacuation:** evacuation of the entire facility
4. **Emergency Management Plan (Disaster Plan):** the procedures, developed by the healthcare facility, to manage an internal or external hazard that threatens patient, staff, and visitor life and safety.
5. **Emergency Operations Center (EOC):** a village, town, city, county, regional, state central command and control facility responsible for managing an emergency situation
6. **Healthcare Facility:** a facility where patients/residents, who need assistance in caring for themselves, are supervised by healthcare professionals
7. **Healthcare Facility Incident Command:** This is used to refer to the authority that makes any decision, coming from the healthcare facility Command Center.
8. **Horizontal Evacuation:** evacuation beyond corridor fire doors and/or smoke zones into an adjacent secure area on the same floor.
9. **House Supervisor:** for the purposes of this policy, this refers to the person, who has the authority, at any given moment, to intervene to protect patient, staff, visitor and facility safety
10. **Incident Site Evacuation:** evacuation of persons from the room or area of the incident.

¹ For the purposes of this template policy, the word “patient” is used with the realization that for different healthcare facilities this is not the applicable term. Each facility is to adapt this policy to their unique environment and use the appropriate term such as “resident”, “client”, etc.

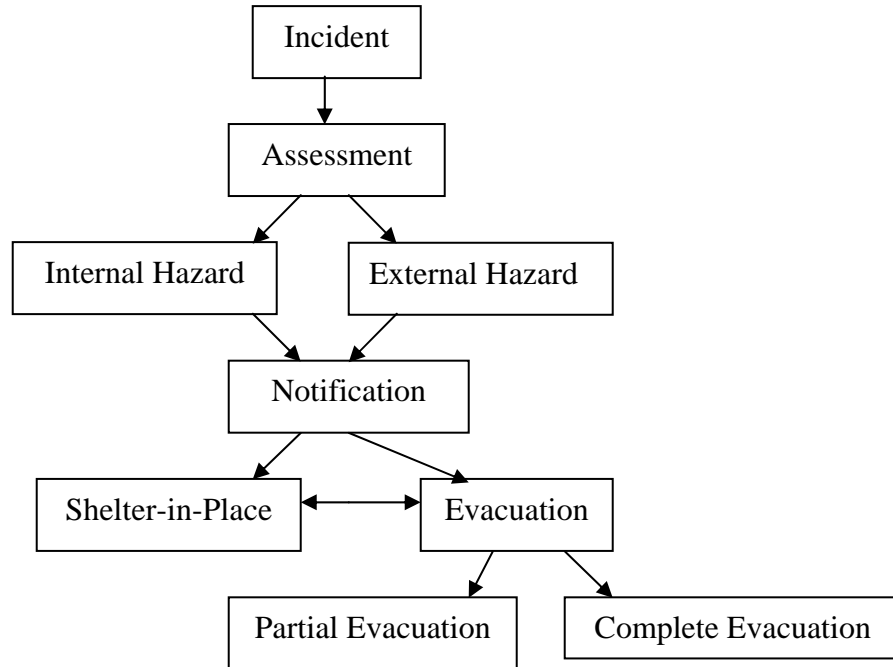
11. **Local Authorities:** for the purposes of this policy this includes, but is not limited to the chief elected official, local Emergency Management Director, Law Enforcement, Fire Department, Public Health, EMS and Human Services.
12. **Partial Evacuation:** an evacuation of certain groups of patients/ residents or of areas within the facility.
13. **Patient Transport Area:** In a complete evacuation, this is an area(s) to which patients are sent for transport out of the healthcare facility.
14. **Remote Vehicle Staging Area:** In a complete evacuation, this is a remote area(s) at which vehicles that will transport patients from the evacuated facility will wait until summoned by the Healthcare Facility Transportation Supervisor.
15. **Response Agency Incident Commander:** The person, usually first on-scene, such as the Fire Department, Law Enforcement, etc. that assumes command and is responsible for the management of the incident.²
16. **Shelter-in-Place:** a protective action strategy taken to maintain patient care within the facility and to limit the movement of patients, staff and visitors to protect people and property from a hazard
17. **START:** a rapid assessment of every patient, determining which of four categories patients should be in and visibly identifying these categories for rescuers, who will treat the patients.
18. **Triage Tag:** this is “slip of paper” that is attached to a patient, usually by Emergency Medical Services (EMS) in the field, to provide key information about the patient. The “tag” includes an identification number and a color-coded system to document the acuity level of the patient.
19. **Unified Command:** a structure that brings together the "Incident Commanders" of all major organizations, involved in the incident, in order to coordinate an effective response while at the same time carrying out their own jurisdictional responsibilities.
20. **Vertical Evacuation:** evacuation from one floor(s) to the floor(s) below or above.

² “Healthcare Facility Incident Command” is responsible for command of internal facility operations, but must collaborate with the Response Agency Incident Commander or Unified Command, if it is established.

Part A: Decision to Shelter-in-Place versus Evacuation

1. The staff person, who identifies an internal hazard or who is notified of an external hazard, is responsible to notify the house supervisor immediately.
2. Shelter-in-place is the preferred option, unless the decision is made by the house supervisor to evacuate, considering the circumstances of the incident.
 - a. The healthcare facility is to initiate its Emergency Management Plan and operate under the Incident Command System³.
 - b. The healthcare facility Incident Command will assess the need for the diversion of incoming patients. (Hospital) “911” (dispatch) is to be notified by the Liaison Officer, if patients are to be diverted. (Healthcare facility) The appropriate referral facilities/agencies are to be notified that admissions are to be canceled. The healthcare facility Liaison Officer is also to notify the EOC, if activated.
3. The decision to shelter-in-place or evacuate is to be made in consultation with the response agency Incident Commander and also Unified Command, if established, e.g. the local Emergency Management Director, Fire Department, Law Enforcement, Public Health, EMS, Human Services and others, as appropriate.
 - a. If there is no response agency Incident Commander, healthcare facility Incident Command is to do all that is necessary to protect the life and safety of its patients, staff and visitors. Hospital Incident Command is to notify 911 (dispatch) of its decision.
 - b. Prior to the actual need to shelter-in-place or evacuate, the healthcare facility is to consult with the local Emergency Management Director, Fire Department, Law Enforcement, Public Health, EMS, Human Services and others, as appropriate so that these agencies are aware of and are in agreement with this plan and its procedures

³ The Wisconsin Hospital Emergency Preparedness Plan has recommended that the top 8 positions of the Incident Command System be used by all hospitals: Incident Commander, Safety Officer, Public Information Officer, Liaison Officer, Operations Chief, Planning Chief, Logistics Chief, Finance Chief. It is recommended that all healthcare facilities adopt these top 8 positions. These positions are functions and not necessarily individual persons. One person can fulfill more than one function, if necessary.



Note: A healthcare facility may decide to both evacuate parts of the facility and also shelter-in-place in another part of the facility.

Part B: Decision to Shelter-in-Place

1. The healthcare facility Incident Command is to make an assessment whether the healthcare facility faces an internal or external hazard or both.
2. If the decision is made to shelter-in-place due to an internal and/or external environmental hazard⁴, the healthcare facility Incident Command will notify local authorities by calling 911 (dispatch), if appropriate, and will make an assessment for the need to initiate environmental engineering interventions. The primary decisions are:
 - a. How to protect patients, staff and visitors by movement to a more secure area will be made by healthcare facility Incident Command in collaboration with the response agency Incident Commander or Unified Command, as appropriate.
 - b. How to protect the building will be made by healthcare facility Incident Command, based on the known hazards and their effects on the building and its inhabitants in collaboration with the response agency Incident Commander or Unified Command, as appropriate.

⁴ The healthcare facility is to consider the most likely to occur hazards as identified in the Regional Hazards Vulnerability Analysis. Fire, power outages and floods are the major hazards that healthcare facilities have faced historically.

3. The healthcare facility is to initiate a process to secure the building (lockdown).
4. Staff is to be advised to stay within the building and to advise all patients and visitors to stay within the building until further notice.
5. If shelter-in-place is expected to last for more than 24 hours, the healthcare facility Incident Command is to inform all departments that all resources are to be conserved. For example (the following list is not meant to be inclusive):
 - a. This is the Incident Command System Branch that puts carries out all activities related to the management of the incident (Operations).
 - b. Establish a patient management plan, including identifying the current census, the cancellation of elective admissions and procedures, etc.; establish a workforce plan, including a plan to address staff needs for the expected duration of the shelter-in-place (Planning).
 - c. Establish communications and a back-up communications plan with the local Emergency Management, Fire Department, Law Enforcement, Public Health, EMS, Human Services and others, as appropriate and the Emergency Operations Center (when activated). The healthcare facility Public Information Officer is to refer all communications through the EOC (Liaison).
 - d. Provide local Emergency Management with a “situation report”, including resources needed, e.g. the amount of generator fuel available and the duration that this fuel is expected to last (Logistics).
6. Each department head/critical function⁵ is expected to provide in writing to the Logistics Chief, within one hour of the activation of healthcare facility Incident Command, the resources that is has available, the expected duration of these resources and the contingency plan to conserve these resources, should replenishment of supplies be in jeopardy.
7. Healthcare facility Incident Command is to determine in collaboration with the response agency Incident Commander or Unified Command, as appropriate, when shelter-in-place can be terminated and to identify the issues that need to be addressed to return to normal business operations, including notification of local authorities about the termination of shelter-in-place.

⁵ Each healthcare facility is to identify its critical functions that will need to continue the provision of services during shelter-in-place.

Part C: Decision to Evacuate

1. In the event of a hazard, which requires a complete or partial evacuation of the facility, if it is necessary to protect the life and safety of patients, staff and visitors, the healthcare facility Incident Command is to give the order to evacuate in collaboration with the response agency Incident Commander or Unified Command, as appropriate.
2. If the circumstances are such that there is no immediate danger to the life and safety of patients, staff and visitors, healthcare facility Incident Command should first determine the availability of transportation resources and destination sites (internal and external) before giving the order to evacuate. Until the time that these resources are determined, healthcare facility Incident Command will give the order to shelter-in-place.
3. Once transportation resources and destination sites (internal and external) are identified healthcare facility Incident Command will give the order to activate the procedures to initiate an orderly and timely transfer of patients to the pre-designated destination site(s).
4. When it has been determined that the healthcare facility is unsafe or unable to deliver adequate patient care⁶ the building or a portion of the building will need to be evacuated.
5. When it is determined that evacuation is necessary, healthcare facility Incident Command will provide directives according to its communications policy, e.g.⁷ call the switchboard and instruct the operator to make an announcement over the PA system. The specific directive will depend upon the level of evacuation required (Incident Site, Horizontal, Vertical, or Complete). Healthcare facility Incident Command will determine to which area(s) (internal or external) the patients are to be moved.
 - a. If an Incident Site Evacuation is necessary, the directive will state “Incident Site Evacuation”: evacuate from (room number or name of area) to (room number or name of area)
 - b. If a Horizontal Evacuation is necessary, the directive will state “Horizontal Evacuation”: evacuate from (area) to (area).
 - c. If a Vertical Evacuation is necessary, the directive will state “Vertical Evacuation”: evacuate from (floor) to (floor).
 - d. If a Complete Evacuation is necessary, healthcare facility Incident Command will define the sequence of evacuation and when to begin the movement of patients to the Assembly Area(s) and/or to the Patient Transport Area(s).
6. The following procedures apply to Incident Site, Horizontal and Vertical Evacuation:

⁶ Examples of possible incidents that require evacuation include: fire, bomb threat, major structural damage, threat of explosion, major power loss, flood, major gas leak, or exposure to a hazardous material.

⁷ Throughout this document, the healthcare facility is to make site-specific adaptations, where appropriate. In many cases, the “e.g.” is usually an indication of where a site specific procedure may be necessary.

- a. After the directive to evacuate, all available staff need to report to the Labor Pool or a designated area. Staff will be assigned to departments needing additional help at the direction of the Operations Chief.
- b. All patients, not on their respective units, are to be returned to their respective units, if possible. If this is not possible, ancillary staff (e.g. Dietary Department, Physical Therapy, etc.) are to maintain the census of all patients and their room numbers and report this census to the Planning Chief. Ancillary staff and patients are to remain in place until further directives are received.
- c. After the evacuation of the patients and others (family members, visitors) from the area, staff in collaboration with the local Fire Department, are to apply a “visual cue”⁸ to the door of the room to indicate that the room has been cleared.
- d. Staff must be prepared to evacuate from the area all patients, along with visitors and staff, according to the level of acuity of the patients:
 - 1) **Evacuation Level 4**⁹: self-sufficient patients, who are ambulatory, require minimal nursing care and are candidates for rapid discharge to home or to a temporary shelter(s).
 - 2) **Evacuation Level 3**: Ambulatory patients, who require moderate nursing care and require assistance in evacuation
 - 3) **Evacuation Level 2**: Patients, who are non-ambulatory, require frequent supportive nursing care and observation (e.g. post-operative patients, step-down unit patients)
 - 4) **Evacuation Level 1**: Patients, who are non-ambulatory, require continuous nursing care and observation (i.e. ICU, Telemetry, isolation rooms and other patients with special needs)
- e. The patient’s chart, medications and patient ID are to accompany the patient as they are evacuated.
- f. The charge nurse or designee must compile a list of all patients in the evacuation area(s).

⁸ Examples of visual cues include a sign, taped to the door, use of pillows, waste baskets, etc.

⁹ This “numbering system” is used to be in compliance with the National Incident Management System (NIMS) where a higher number indicates a lesser degree of intensity and a lower number indicates a higher degree of intensity.

- g. If time permits and there is no threat to the safety of the staff, the staff are to return to obtain any devices necessary for daily living (glasses, dentures, prosthesis) and any other valuables and belongings. Staff may also want to collect their own personal belongings.
 - h. Healthcare facility Incident Command is to make the necessary arrangements to secure the evacuated area, primarily to keep people from entering the evacuated area.
 - i. Staff are to enforce “Keep to the Right” when moving down hallways.
 - j. Staff should remain with patients in the relocated area until the patient(s) has been reassigned/handed off.
 - k. Upon completion of evacuation of each area, staff are to report to healthcare facility Incident Command that the evacuation of the area has been completed.
7. The following procedures apply to a “Complete Evacuation”:
- a. All the procedures identified in Section 5 must be followed for a Complete Evacuation. The following additional procedures are also to be implemented:
 - 1) Sequence of Evacuation: healthcare facility Incident Command in collaboration with the response agency Incident Commander or Unified Command, as appropriate will determine which floors and/or smoke zones are evacuated first and in which order. Those floors that are most in danger or the floors of the incident are to be evacuated first. Then adjacent floors are to be evacuated. Otherwise, evacuation is to start at the top floor and work downwards. In all incidents, patients are to be evacuated according their Evacuation Category Level.
 - 2) Healthcare facility Incident Command is to identify area(s) for both Assembly and Patient Transport.
 - b. Assembly Area(s): The following activities will take place in the Assembly Area(s):

Note: Patients are not to be moved to the Assembly Area(s) until there is confirmation that there are transportation resources and destination sites (internal and external).

 - 1) Patients are to be assessed for rapid discharge, if appropriate.
 - 2) Staff are to maintain care of the patient in the Assembly Area(s) and continue to assess acuity.

- 3) Staff are to make every effort to obtain the following "Patient Evacuation Information" (see Form A¹⁰), if the patient is to be transported to another destination site: (Data in **BOLD** is required information):
 - a) Name of Sending Facility
 - b) Evacuation Category Level Number
 - c) **Patient name**
 - d) Date of Birth
 - e) Patient Medical Record Number
 - f) Receiving Facility (destination site, if known)
 - g) Time discharged from the Assembly Area(s)
 - h) Equipment sent with the patient¹¹
 - i) Whether or not family has been notified about the transport of the patient to another destination
 - j) Name of primary attending physician
 - k) **Diagnosis**
 - l) **Type of isolation** (if applicable)
 - m) **Special Considerations and Precautions** (e.g. police hold, mental health, suicide watch, etc.)
 - n) Other Information or Directives (code status such as "DNR")

- 4) Healthcare facility Incident Command is responsible for accounting for all staff. Healthcare facility Incident Command must maintain a log of staff, who accompany patients to destination sites with consideration, to the extent possible, for their lodging, food, other needs.

- c. The Patient Staging Area(s) is the designated area(s) for patients, who are being discharged and also for those patients, who are being transported to external destination sites.

Note: Patients are not to be moved to the Patient Transport Area(s) until there is confirmation that there are transportation resources on-site. Until that time, the patient(s) should continue to stay in the Assembly Area(s).

- 1) A triage tag¹² must be applied by the Disposition Unit Leader to all patients, who are being transported to destination sites. The patient is also to be triaged

¹⁰ The Expert Panel asked that healthcare facilities Admissions/Registration investigate whether the "Face Sheet", which is already available at the facility, can serve the same purpose as Form A

¹¹ The healthcare facility is to ensure that any equipment that is being transported with the patient is to be clearly identified as the property of the sending healthcare facility so that it can be returned at the appropriate time.

¹² Hospitals and EMS have triage tags. Healthcare facilities may purchase triage tags for this purpose or, in an emergency, request these tags from the hospital or EMS.

according to the START¹³ and JumpSTART triage protocols, that is, a color code is assigned to the patient based on the patient's acuity. The triage tag number is the number that will be used to track the patient after leaving the evacuated healthcare facility to destination sites.

Note: The triage tag should be put on the patient's chart, if there is concern that the patient may lose the tag or tear it off.

- a) A staff person is to be assigned to match the triage tag number to the list of patients, being transported, that was generated in Part C.6.f.
 - b) This same staff person must also match any patients, being discharged or being sent to a temporary shelter, to the same list that was generated in Part C.6.f.
 - c) Demographic information for all patients, both those, who were discharged and those who are being evacuated along with the triage tag number, are to be entered into the electronic, centralized database within one hour or, as soon as possible, of the patient leaving the healthcare facility according to the "Policy on Patient Tracking".
- 2) The on-site healthcare facility Discharge Unit Leader shall assure that:
- a) each patient, being transported to a destination site, has the following information logged:
 - i. a triage tag before being loaded into the transport vehicle.
 - ii. the name of the staff person, accompanying the patient
 - iii. the transport company and vehicle number
 - iv. the names of the patient(s), being transported in that transport vehicle (see Form B)
 - v. the destination site
 - b) each patient, being transported by private vehicle, has the following information logged:
 - i. the license number of that vehicle
 - ii. the name(s) of the patient(s), being transported in that vehicle (see Form C)
 - iii. the destination site

¹³ START refers to "Simple Triage and Rapid Treatment. JumpSTART are the triage protocols as applied to children. GREEN is assigned to ambulatory patients; YELLOW to patients whose care can be delayed; RED to patients in need of immediate care; BLACK for those patients that are deceased or expectant.

d. Remote Vehicle Staging Area

- a) To maintain open access to the healthcare facility Patient Transport Area(s)¹⁴, the healthcare facility Incident Command will activate the Remote Vehicle Staging Area. (This area(s) should be pre-identified).
- b) The Remote Vehicle Staging Area Supervisor is responsible for sending vehicles to the healthcare facility Patient Transport Area(s) as requested by the Healthcare Facility Transportation Supervisor.

Note: The healthcare facility should make every effort to pre-identify and use only authorized vehicles for patient transport. However, it is recognized that circumstances may be such that authorized vehicles may not be available and the healthcare facility may need to resort to the use of private vehicles. The use of private vehicles poses risks to the healthcare facility and those being transported. The following protocols are examples of the best efforts that can be made to “authorize” drivers of private vehicles.

- c) All vehicles need to be documented before being sent to the healthcare facility from the Remote Vehicle Staging Area. The Remote Vehicle Staging Supervisor will verify the following information for each vehicle before it is sent to the healthcare facility (see Form C):
 - i. License Tag Number of the Vehicle
 - ii. Proof of Insurance
 - iii. Driver’s License Number
- d) Form C should be given to the driver of the vehicle by the Remote Vehicle Staging Area Supervisor to present to the healthcare facility Transportation Supervisor at the healthcare facility.
- e) No patient is to be released to a vehicle without obtaining Form C from the driver. The Transport Supervisor is to verify all the information on Form C before assigning a patient for transport by the private vehicle.

¹⁴ The healthcare facility should have a policy for internal and external traffic control, which should be implemented, when the decision to shelter-in-place or evacuate is given by healthcare facility Incident Command.

e. Methods for Evacuating Patients

- 1) The healthcare facility is to use elevators, if permitted by the Fire Department.
- 2) Ambulatory patients are to be guided down the stairs, accompanied by a staff person with a ratio, based on the acuity of the patients. For example, ambulatory patients, needing assistance, may be assisted with belts or “fore and aft” carry, shoulder-to-shoulder human chain, mother carries baby, etc.
- 3) Non-ambulatory patients¹⁵ may need special equipment such as stair chairs and stoker baskets are an option and require staff to be trained in their use.

f. Alternate Care Sites

- 1) The healthcare facility is to identify two sets of Alternate Care Sites:
 - a) the first set is to include facilities that are geographically close to the healthcare facility in those cases where the hazard has affected only the healthcare facility.
 - b) the second set is to include facilities that are geographically distant from the healthcare facility in those cases where the hazard has affected the entire area around the healthcare facility.
- 2) The healthcare facility on-site Transport Unit Leader is to triage the patients as they are being transported to the various Alternate Care Sites. Evacuation Acuity Level 3 and 4 patients are to have priority for transport.
- 3) The healthcare facility is to identify facilities¹⁶ in the sequential order that it will use these facilities to shelter evacuated patients, based on the acuity level of the patients that the facility can manage. The following is a list of facilities, to be used in sequential order, for exemplary purposes only:
 - a) hospitals (for Evacuation Acuity Levels 1, 2, 3, 4)
 - b) skilled nursing facilities (for Evacuation Acuity Levels 1, 2, 3)
 - c) clinic buildings (for Evacuation Acuity Levels 1, 2)
 - d) hotels (for Evacuation Acuity Levels 1, 2)

¹⁵ A special workgroup is addressing the ethical issues involved in those situations where patients cannot be evacuated.

¹⁶ The Alternate Care Site should be a building that is already being used for medical purposes, e.g. clinics and nursing homes or buildings that are set up to shelter people and take care of their needs such as hotels versus schools or community centers which will create serious logistical issues in regard to patient care.

- 4) The healthcare facility is to pre-identify Alternate Care Sites and have Memoranda of Understanding¹⁷ with these facilities in case the healthcare facility needs to utilize these facilities in an evacuation.
- 5) Supplies and equipment for the Alternate Care Sites
 - a) For each Alternate Care Site, the healthcare facility is to pre-identify what equipment and supplies are already available on-site and at what quantity.
 - b) For each Alternate Care Site, the healthcare facility is to pre-identify what equipment and supplies will need to be delivered to the site and at what quantity. The EOC, if activated may be able to assist with the procurement of these supplies and equipment.
- 6) Staffing for the Alternate Care Site
 - a) The healthcare facility is to assign one of its staff as Site Supervisor of the alternate Care Site.
 - b) The staffing plan for the Alternate Care Site will need to take into consideration the acuity of the patients at each site.
 - c) There is to be an agreement with the Alternate Care Site to pre-identify any of its staff, who can be retained for patient care or other services
 - d) If possible, a healthcare facility staff person is to accompany the patient to the Alternate Care Site and hand over the patient to the staff there with a briefing on the care and treatment of the patient.
 - e) It is important to keep in mind that staff from the evacuated healthcare facility will be tired and stressed and may not be able to provide care at the Alternate Care Site, until they get the necessary rest and recuperation.
- 7) The Site Supervisor at each Alternate Care Site is responsible for triaging patients, based on changes in patient acuity, and moving them to a more appropriate facility.

¹⁷ A template for state-wide use is being developed.

g. Notifications

- 1) The city/county Emergency Management Director is to be notified that the healthcare facility has been evacuated.
- 2.) For Hospitals: The Joint Commission on the Accreditation of Health Care Organizations is to be notified that the healthcare facility has been evacuated
- 3) For other Healthcare Facilities: The Bureau of Quality Assurance, Wisconsin Department of Health and Family Services to be notified that the healthcare facility has been evacuated

Part D: All Clear

1. In the case of a partial evacuation and shelter-in-place, healthcare facility Incident Command will provide directives according to its communications policy, e.g. notify the switchboard to announce all clear and return to normal operations can commence.
2. In the event of a complete evacuation, the healthcare facility Public Information Officer will contact the EOC, if activated, and request that the local media make an announcement notifying healthcare facility employees when they should return to work.
3. (Hospitals) The Joint Commission on the Accreditation of Healthcare Organizations is to be notified so that it can approve the reopening of the evacuated hospital. (Healthcare Facilities) The Bureau of Quality Assurance is to be notified so that it can approve the reopening of the evacuated healthcare facility.

Part E: Recovery

1. The healthcare facility should have a policy on business continuity to provide direction for the return to normal operations.
2. The healthcare facility should plan for Critical Stress Debriefing to assist staff in their recovery.

Form A: Patient Evacuation Information

Note: Items in **BOLD** are required information.

Sending Hospital	
Evacuation Acuity Level	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Patient Name	
Patient Medical Record Number	
Receiving Facility (if known)	
Time Discharged from Assembly Area	
Equipment Sent with Patient	
Family Notification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Primary Attending Physician	
Diagnosis	
Type of Isolation	<input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne
Special Considerations and Precautions	
Other Information and Directives	

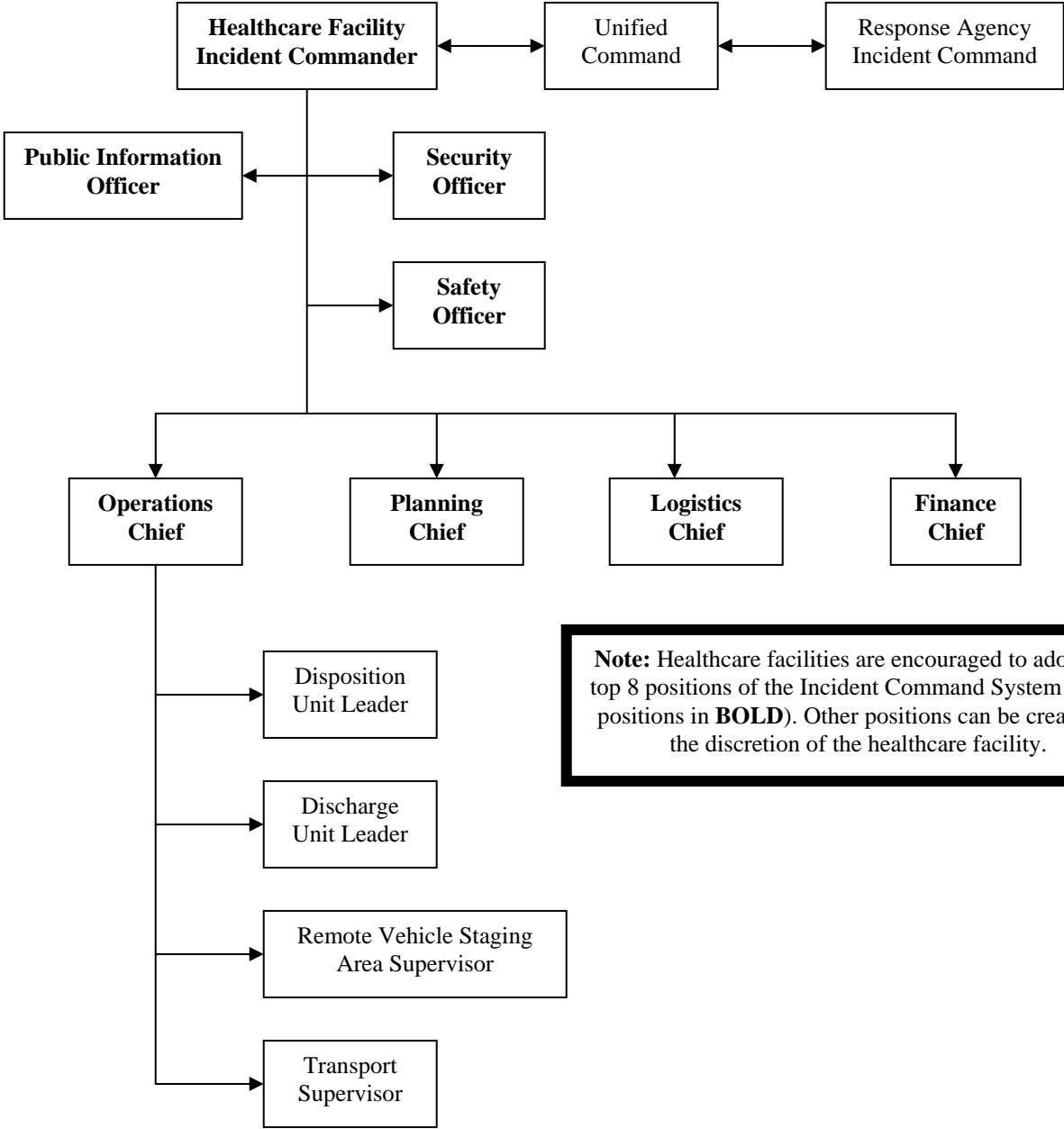
Form B: Transportation Log for Evacuated Patients

Transport Vehicle # _____	
Name of Transport Company	
Number or License Number of Transport Vehicle	
Patient #1 Name:	Triage Tag Number:
Patient #2 Name:	Triage Tag Number:
Patient #3 Name:	Triage Tag Number:
Patient #4 Name:	Triage Tag Number:
Name of staff person, accompanying patient	
Destination Site	
Transport Vehicle # _____	
Name of Transport Company	
Number or License Number of Transport Vehicle	
Patient #1 Name:	Triage Tag Number:
Patient #2 Name:	Triage Tag Number:
Patient #3 Name:	Triage Tag Number:
Patient #4 Name:	Triage Tag Number:
Name of staff person, accompanying patient	
Destination Site	
Transport Vehicle # _____	
Name of Transport Company	
Number or License Number of Transport Vehicle	
Patient #1 Name:	Triage Tag Number:
Patient #2 Name:	Triage Tag Number:
Patient #3 Name:	Triage Tag Number:
Patient #4 Name:	Triage Tag Number:
Name of staff person, accompanying patient	
Destination Site	
Transport Vehicle # _____	
Name of Transport Company	
Number or License Number of Transport Vehicle	
Patient #1 Name:	Triage Tag Number:
Patient #2 Name:	Triage Tag Number:
Patient #3 Name:	Triage Tag Number:
Patient #4 Name:	Triage Tag Number:
Name of staff person, accompanying patient	
Destination Site	

Form C: Transportation Log for Discharged Patients

Private Vehicle # _____	
Name of Driver	
Vehicle License Number	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Verification Form	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Vehicle # _____	
Name of Driver	
Vehicle License Number	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Verification Form	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Vehicle # _____	
Name of Driver	
Vehicle License Number	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Patient #1 Name:	
Destination:	
Verification Form	<input type="checkbox"/> Yes <input type="checkbox"/> No

Incident Command System at a Healthcare Facility¹⁸



Note: Healthcare facilities are encouraged to adopt the top 8 positions of the Incident Command System (those positions in **BOLD**). Other positions can be created at the discretion of the healthcare facility.

¹⁸ Healthcare facilities are encouraged to learn the National Incident Management System (NIMS) by going to www.fema.gov. Healthcare facilities can also find numerous Job Action Sheets for various functions in the Incident Command System structure by learning about the “Hospital Incident Command System” (HICS) at www.hicscenter.org