Emergency Management Planning Criteria for Hospital Facilities (State Criteria Form)

FACILITY INFORMATION:

FACILITY NAME: FIELD (Company)  ST. LIC. NO.: FIELD (Lic. #)
FAC. TYPE: Hospital  STATE RULE: 59A-3.078 F.A.C
CONTACT PERSON: FIELD (Name)  PH. NO.: FIELD (Phone)
STREET ADDRESS: FIELD (Street Address)
CITY / ST. / ZIP: FIELD (City, State, ZIP)

DATE RECEIVED: __________  DATE REVIEWED: __________
APPROVED: NO / YES (CIRCLE ONE)  DATE: __________
DATE RETURNED: __________  DUE BACK DATE: __________

The following minimum criteria are to be used when developing Comprehensive Emergency Management Plans (CEMP) for all hospitals. The criteria serve as the required plan format for the CEMP. Also, the criteria will serve as the compliance review document for Escambia County Emergency Management upon the submission for review and approval pursuant to Chapter 252, F.S. These minimum criteria satisfy the basic emergency management requirements of s.395.1055, F.S. and Chapter 59A-3.078, F.A.C.

We do not intend these criteria to limit nor exclude additional materials facilities may decide to include to satisfy other relevant rules, requirements, or any special issues facility administrators deem appropriate for inclusion. As before, such voluntary inclusions will not be subject to the specific review by Escambia County Emergency Management personnel, but only those items identified in these criteria.

You must attach this form to your facility’s CEMP upon submission for approval to Escambia County Emergency Management. NOTE: Please use this criteria form as a cross reference to your plan, by listing the page number and paragraph where the criteria are found in your plan on the line provided to the left of each criteria item. This will ensure accurate and expeditious review of your facility’s CEMP.
I. INTRODUCTION

A. Provide basic information concerning the facility to include:

___ 1. The name of the facility, address, telephone number, emergency contact telephone number (if a facility telephone is down) and fax number (if available).

___ 2. Year facility(ies) was built, type of construction, and date of any subsequent construction.

___ 3. Name of Administrator, address, work and home telephone numbers and an alternate contact person.

___ 4. Name and title of person(s) who developed this plan. (Please provide phone number where they can be reached should a question arise.)

___ 5. Provide an organizational chart with key management positions identified.

B. Provide an introduction to the Plan that describes its purpose, time of implementation, and the desired outcome that will be achieved through the planning process. Also, provide any other information concerning the hospital that has bearing on the implementation of this Plan.

II. AUTHORITIES AND REFERENCES

A. Identify the hierarchy of authority in place during emergencies. Provide an organizational chart, if different from item (A)(5.) above.

III. HAZARD ANALYSIS

A. Describe the potential hazards that the hospital is vulnerable to, such as, hurricanes, tornadoes, flooding, fires, hazardous materials incidents from fixed facilities in you area (i.e., Chemical Plants, Paint Stores, Pool Supply Stores, Public Water Treatment or Supply) or transportation accidents on highways in your area (i.e., chemical tanker truck accident), power outages during severe cold or hot weather, hostile intruder or bomb threat, etc.

B. Provide site specific information concerning the hospital to include:

___ 1. Location map identifying hospital relative to potential hazards.

___ 2. Number of facility beds, maximum licensed number of patients on site, average number of patients on site.

___ 3. Type of patients served by your facility to include, but not limited to, patients requiring special equipment or other special care, such as oxygen or dialysis.

___ 4. Identification of the hurricane evacuation zone your facility is in. *Call our office at (850) 595-3311 for this information.
Identification of which flood zone your facility is in as identified on FEMA’s Flood Insurance Rate Map. *Call our office at (850)595-3311 for this information.

Identify the proximity of the hospital to a railroad(s) or major transportation artery(ies) to identify potential sources of future occurrences of hazardous materials transport incidents.

Identify if your facility is located within the 10 mile or 50 mile emergency planning zones of a nuclear power plant. – NOT APPLICABLE IN OUR AREA

IV. CONCEPT OF OPERATIONS
This section of the Plan should define the policies, procedures, responsibilities and actions that the hospital will take before, during, and after any emergency situation. At a minimum, your facility Plan needs to address the following: direction and control, notification, and evacuation and sheltering.

A. DIRECTION AND CONTROL

Define the management function for emergency operations. Direction and control provides a basis for decision making and identifies who has the authority to decide for your facility.

Identify by position title, who is in charge during an emergency and one alternate should that person be unable to serve in that capacity.

Identify the “Chain of Command” to ensure continuous leadership and authority in key positions.

State the procedures to ensure timely activation and staffing of the hospital in emergency functions.

State the operational (day-to-day) and support (emergency incident) roles for all established positions within the hospital. This will be accomplished through the development of Standard Operating Procedures (SOP), which you must have available for review.

State the procedures to ensure you supply the following needs. Since hospitals must plan for both internal and external disasters, the plan should take into consideration self-sufficiency, dependence upon other sources, and a contingency plan in case of community-wide (area-wide) disasters. (LOGISTICAL SUPPORT SUPPLIES)

Food, water and other essential supplies. (A minimum of 72 hour supply of food, water, medicines, etc…. needed for logistical support.)

Identify the type of emergency power supply. If natural gas, identify alternate means should loss of power occur which would affect the natural gas system. What is the capacity of the emergency fuel system
B. NOTIFICATION

Procedures must be in place for the facility to receive timely information on impending threats and alerting of facility decision-makers, staff and patients of potential emergency conditions:

___1. Explain how your facility will receive warnings, to include off hours and weekend/holidays.

___2. Explain how your key staff will be alerted.

___3. Define the procedures and policies for reporting to work for key workers.

___4. Define how patients will be alerted, and the precautionary measures that your staff will take.

___5. Identify alternative means of communication should your primary alert system fail.

___6. Identify procedures for notifying those areas or facilities to which patients will be moved or relocated.

___7. Identify procedures for notifying families of patients that you are evacuating your facility and to what prearranged evacuation shelter(s).

C. EVACUATION

Hospitals must plan for both internal and external disasters. Although facilities must be prepared for the possibility of relocating patients to another facility, there are instances when moving patients to another part of the hospital would be more appropriate. The following criteria should be addressed to allow the hospital to respond to both types of evacuation:

___1. Describe the policies, roles, responsibilities and procedures for the moving and relocating of patients.

___2. Identify the individual responsible for initiating the hospital’s evacuation procedures.

___3. Identify transportation arrangements made through mutual aid agreements or understandings that will be used to relocate patients. If transportation is coordinated through a central agency, i.e., county EOC, please explain. In addition, if there is a “transportation shortfall” in the area, please explain how the problem is addressed under current limitations.

*Please provide copies of any Transportation Agreements in the appendix

___4. Describe arrangements for transporting support services, including: moving of important medical records, medicine, food, water, and other necessities. If this is
arranged through a coordinating agency, i.e., county EOC, please explain.

___ 5. Identify locations where patients will be moved or relocated. If relocation is coordinated through a centralized agency, i.e., county EOC, please explain.

___ 6. Identify evacuation routes that will be used, including secondary routes if the primary route is rendered impassable.

___ 7. Specify the amount of time it will take to successfully move or relocate patients.

___ 8. What are the procedures to ensure hospital staff will accompany relocated patients? If staff will not be accompanying patients, what measures will be used to ensure their safe arrival (i.e., who will render care during transport)?

___ 9. Identify how patients will be tracked once they have been relocated. If patients will be considered discharged at the time of relocation, please explain.

___ 10. Establish procedures for responding to family inquiries about patients who have been moved or relocated.

___ 11. Establish procedures for ensuring all patients are accounted for and are out of the facility.

___ 12. Determine at what point to begin the pre-positioning of necessary medical supplies and provisions.

D. RE-ENTRY

Once a facility has been evacuated, procedures need to be in place for allowing residents or patients to re-enter the facility.

___ 1. Identify who is the responsible person(s) for authorizing re-entry to occur.

___ 2. Identify procedures for inspecting the hospital to ensure it is structurally sound.

___ 3. Explain how patients will be transported from the host facility back to the hospital following relocation. If patients will not be re-admitted, please explain the criteria that will be used to make this determination.

E. SHELTERING

If your hospital will be accepting patients from an evacuating hospital, your plan must describe the procedures that will be used once the evacuating hospital’s patients arrive.
1. Describe the receiving procedures for arriving patients from an evacuating hospital.

2. Identify the means for providing, for a minimum of 72 hours, additional food, water, and medical needs of those patients being hosted.

3. Identify how the hospital will notify the Agency for Health Care Administration (AHCA) if it exceeds its licensed operating capacity.

4. Describe procedures for tracking additional patients within the hospital.

**IV. INFORMATION, TRAINING, AND EXERCISE**

*This section will identify the procedures for increasing employee and patient awareness of possible emergency situations and provide training on their emergency roles before, during, and after a disaster.*

A. Identify how you will instruct key workers in their emergency roles during non-emergency times.

B. Identify a training schedule for all employees and identify the provider of the training.

C. Identify the provisions for training new employees regarding their disaster related roles.

D. Identify a schedule for exercising all or portions of the disaster plan on a semi-annual basis.

E. Establish procedures for correcting deficiencies noted during training exercises.
APPENDIX

The following information is required, yet placement in an appendix is optional if the material is included in the body of the Plan.

A. A roster of Employees and Companies with KEY disaster related roles.
   ___ 1. List the positions of all staff with disaster related roles.
   ___ 2. List the name of the company, contact person, telephone number and address of emergency service providers such as transportation, emergency power, fuel, food, water, police, fire department, Red Cross, etc.

B. Agreements and Understandings:

   Provide copies of any mutual aid agreement entered pursuant to the fulfillment of this plan. This is to include reciprocal host hospital agreements, transportation agreements, current vendor agreements, or any other agreement needed to ensure the operational integrity of this plan.

C. Evacuation Route Map(s):

   Provide a map of the evacuation routes (primary and secondary routes to each hospital) and a written description of how to get to each receiving hospital for drivers.

D. Support Material:

   ___ 1. Any additional material needed to support the information provided in the plan.
   ___ 2. Copy of your facility’s Fire Safety Plan that your Local Fire Department has reviewed and approved. If your Local Fire Department will not review and approve this portion, please contact:

       Mr. Roy Foley, Fire Inspector
       Escambia County Fire-Rescue
       6575 North “W” Street
       Pensacola, Florida 32505
       850-471-6400

       They will be glad to assist you in reviewing and approving the fire safety plan portion of your disaster plan. However, you will need to complete the standard review criteria form established for Fire Plans before the Fire Safety Inspection Division can complete their review. This completed form will help the review your plan quickly.

       *Note: The Emergency Management Division cannot review and approve the Fire Safety Plan portion of your Plan.

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