

East Tennessee Children's Hospital

Emergency Operations Plan: Introduction

Administrative Policy No: O-911

May 2003

July 2005

May 2006

December 2006

August 2007

December 2007

May 2008

May 2009

November 2009

April 2010

August 2011

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I. INTRODUCTION / PURPOSE

East Tennessee Children's Hospital's (ETCH) Emergency Operation Plan's scope is to provide a program that ensures effective mitigation, preparation, response, and recovery to disasters or emergencies affecting the environment of care. Each section of the plan focuses on specific procedures, developed to meet potential disasters or emergencies.

These include:

Code Orange:	Biological, Chemical or Radiation Disaster
Code Yellow:	Mass Casualty
Code E:	Evacuation
Code Green:	Security
Code Blue:	Medical Emergency

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Code Red:	Fire
Code Gray:	Tornado
Code Pink:	Infant / Child Abduction
Code Boy/Girl:	Patient Elopement
Code Black:	Bomb Threat
Code Purple:	Hostage Situation
Inclement Weather	
Pandemic Disease	
Utility Failures	
Information Systems Failure	

ETCH recognizes that in emergency preparedness goals, the special needs of children and their families must be included in the planning. In any emergency situation, such as fire or tornado, the emotional needs of children must be assessed and addressed. In addition, in mass casualty incidents or incidents that include weapons of mass destruction, specific pediatric concerns including the need for different dosages of antidotes or treatments, different sizes of equipment, and different contamination efforts must be addressed (AAP, 2002). In all situations, it is important to keep children and parents together, as possible.

II. Definitions

Code Yellow Standby: The hospital has been notified of a situation that may warrant implementation of a code yellow.

Code Yellow: Any mass casualty incident that threatens the integrity and function of the institution and requires mobilization of all hospital resources.

Code Orange: Any mass casualty incident involving nuclear, biological and/or chemical injuries, and that threatens the integrity and function of the institution and requires mobilization of all hospital resources.

Decontamination: The process of eliminating toxic substances from exposed individuals.

Building Controlled Access: Patients, hospital visitors and hospital staff have designated controlled access to the building.

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Building Lockdown: Complete control of all entrances and exits to the building. No one is allowed into or out of the building without approval and proper identification.

Building Air Safety: Controlled inflow of potentially contaminated air into the building. This involves control of all fresh air intakes including air handlers and all entrances and exits. When the building air safety plan is in effect, entrances/exits will be strictly controlled.

Hazard Vulnerability Assessment: The process of identifying hazards that could affect the organization and analyzing the vulnerability of the hospital to those hazards.

Mitigation: Activities a health organization undertakes in an attempt to lessen the severity and impact a potential disaster or emergency might have on its organization.

Expectant: Casualties who have suffered catastrophic injuries and who are not expected to survive.

Preparedness: Those activities an organization undertakes to build capacity and identify resources that may be used should a disaster or emergency occur.

Incident Command Center: Structure set in place during emergency situations that outlines alternate roles and responsibilities to oversee hospital operations during an emergency or disaster situation.

Personnel Tracking / Deployment Center: Area of hospital designated to coordinate staffing needs, secure additional staff and to assign staff to areas of need.

Weapons of Mass Destruction (WMD): Biological, chemical or radiological weapons.

III. Planning / Oversight

Hospital leaders that participate in planning emergency responses include the CNO/VPPCC, COO/VPO, and the President (EC.4.11and EOP B1). The Acute Care Committee provides medical oversight to the plan. The safety officer and disaster coordinator in conjunction with the Emergency Preparedness Committee and Safety Committee are responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan at ETCH, including hazard vulnerability analysis, mitigation, preparedness, response, and recovery.

Community, state, and national emergency planning activities occur monthly through the Regional Hospital Coordinators Office of the Knox County Health Department.

Representatives from area hospitals, KCHD, KEMA, and EMS participate. The ETCH

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disaster coordinator and safety officer participate in the Local Emergency Planning Committee (LEPC) and share information with the Emergency Preparedness Committee and the Safety Committee.

ETCH also prepares for disaster readiness by the following:

1. Maintaining an ongoing planning process.
2. Participating in community wide disaster drills.
3. Creating an inventory of resources that may be needed in an emergency, including agreement with vendors.
4. Staff orientation and ongoing education on hospital procedures.
5. Collaborating / participating in community and regional planning processes.

IV. Hazard Vulnerability Assessment

Hazard vulnerability assessments include internal and external risks and assist in identifying high-risk events that could affect demand for services and ability to provide services, the likelihood of those events occurring and the consequences. Hazard vulnerability assessments are done on an annual basis (See Addenda; Code Yellow). ETCH HVA is prioritized with assistance from the LEPC members (EC.4.11).

V. Mitigation

Mitigation activities reduce or even eliminate the possibility of disaster occurrence. Mitigation activities include, but are not limited to, building design, evacuation plan, back up systems for electrical power, communication, computerized information, emergency phones and radios, water, emergency staffing, security and building lockdown. National alert systems for inclement weather is addressed in Policy O141 and in Code Gray procedures. Risk of terrorism is addressed in section V. Bioterrorism response and pandemic disease are addressed in E01 and O92 policies.

VI. Hospital Incident Command System

The Hospital Incident Command System (HICS) is utilized to provide organization and structure during significant disasters or emergency situations at ETCH (see Establishment of Incident Command Center). Only the functions necessary are activated by the Incident Commander and Section Chiefs.

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VII. Communication

- Staff is notified of the need to mobilize emergency resources through paging of the appropriate code or through activation of the personnel deployment / tracking function of HICS.
- ***Radio communication is utilized for all emergency codes except Code Blue. Internal paging (WaveWare) is utilized for Code Blue. Report to Security to obtain a radio if your assigned radio is not functioning. Always state your name before speaking on the radio.***
- Waveware or Meditech email messages are also sent from Incident Command Center to keep staff informed and updated on emergency events (EC.4.13).
- External authorities are notified of internal events affecting operations through the HICS as indicated:
 - Police – Code Pink, Code Purple – Code Boy / Girl (Suspected terrorism or other criminal acts)
 - Fire Dept. – Code Red
 - EMS – Evacuation
 - KCHD – Influx of contagious patients

The Director of Community Relations or designee will communicate information to the press.

Patients / families are made aware of emergency responses and exercises as needed through nursing staff communication on the units. In the event of patient relocation (to an alternative site) the patient Tracking Center will notify families.

If phone communication to families is not possible, email or other means of notification to Red Cross for assistance in contacting families is done.

The Regional Hospital Coordinator maintains names and phone numbers of HICS staff and radio contact with area hospitals, and emergency services including the Red Cross.

See also the [Disaster Call List](#) (Levels I, II, III) for additional contact information.

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VIII. Assets / Resources / MOU

An inventory of medications, equipment and supplies needed in a disaster are reviewed annually and updated on The Hospital Resources Tracking Center website and on ETCHNet. Suppliers of emergency equipment / supplies / resources are notified by the department director or designee of the need for additional resources.

A memorandum of understanding (MOU) exists for all hospitals in the 16 county area of EMS Region 2. Hospitals have agreed to share resources and assets as coordinated by The Regional Hospital Coordinator. Patients may be evacuated and transferred to one of these facilities. Staff, medications, supplies and equipment may be needed to accompany the patient. The MOU is on file in administration.

IX. Staff Responsibilities / Education / Exercises

Staff are educated on each section of the ETCH Emergency Operations Plan and participate in emergency exercises as identified and scheduled by the Emergency Preparedness Committee. Code Yellow exercises are done twice a year. Fire drills are conducted quarterly and Code Blue drills are conducted monthly. At least one exercise / year include escalation of events (EC.4.20) and one exercise includes community involvement. Exercises are critiqued and EOP revised as recommended by Emergency Preparedness Committee, Safety Committee and Acute Care Committee.

X. Clinical Activities / Staffing Patterns

Some clinical activities may be cancelled or scaled back due to the impact of the emergency. Elective surgeries, ambulatory clinics, non-emergent care, outpatient testing, Children's Corner are some examples. Patient care ratios during normal operations may be revised to accommodate meeting the essential patient care needs of all patients.

Patients may be triaged and referred to other hospitals if their needs are outside the usual scope of care for pediatric patients (obstetrics, psychiatric, burns, adult medical/surgical).

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XI. Safety / Security

External and internal security and safety are maintained through controlled access to 20th Street from White Avenue and Clinch Avenue, building lockdown, controlled inflow of air, hazardous material management, decontamination procedures, and evacuation plan.

XII. Utilities Management

A. Electrical Power Failure

Switch only necessary patient care equipment to the red emergency power receptacles. Remove non-essential electrical equipment from red outlets, if applicable. Radios, video games, CD players, laptops, electrical beds (plug in only as needed). Use Downtime forms. Emergency power can operate 72-96 hours. Admit patients to alternate nursing units. Begin planning for possible evacuation to an alternate nursing unit after 48 hours of emergency power utilization. Plan for possible evacuation to Fort Sanders Regional Hospital.

B. Heating / Cooling Failure (HVAC)

Air heating/cooling failures can be managed on a nursing unit from 4-6 hours before patients should be moved to a different location of the hospital. Depending on location of failure, consider moving PICU patients to PACU or ED; NICU patients to PACU or PICU, med-surg patients to another unit.

Fans may be obtained from Maintenance for cooling purposes. Move patients in open cribs away from windows.

C. Medical Gases Failure

Notify Respiratory Care and place patients on portable tanks. Additional tanks may be brought in by Respiratory Care vendors.

D. Vacuum Failure

Notify Central Supply to obtain portable suction equipment. Additional equipment may be brought to the hospital Children's Home Health or a vendor depending on patient need.

E. Water Outage

1) Drinking Water

Obtain bottled water from Food and Nutrition. Additional supplies may be obtained from water cooling-dispensing machines or vending machines located throughout the hospital, Children's Medical Office Building and the Koppel Plaza. Responsibility for obtaining drinks from the vending machines will be that of the Director of Food and Nutrition or designee. ICC may request the emergency water filtration system from the RHC (Regional Hospital Coordinator).

2) Sanitation/Hygiene

Conserve water use throughout hospital. Use baby wipes for bathing patients. Obtain garbage bags and solidifier from MOB storage room and

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place in toilet for individual use. Sprinkle solidifier in bag and secure top of bag. Dispose of bag in red trash bags.

F. Communication Failure

- 1) Phone – Emergency phones are available on each clinical unit. Notify Security for portable radios for in-house communication.
- 2) Faxes
 - i. Pharmacy – Tube medication orders to Pharmacy
 - ii. Orders/Consults from Offices - Orders may be phoned in to nursing units or Children's Home Health.
 - iii. ED Visits – Faxes to MD offices will resume when system is operational.
- 3) Computer – see Computer Downtime Procedures
- 4) Printers – All critical test results and tests ordered stat will be called to the nursing unit for physician notification. Routine results will be printed to the nursing unit when printers are operational or results may be tubed within 8 hours of test completion.

XIII. Extended Operations

The hospital will remain operational for Critical Care, Emergency Dept., medical inpatients, and non-elective surgical patients until / unless the need to evacuate the patients is established. The hospital will maintain sufficient stock of pharmaceuticals, equipment, food, water, and medical supplies, to operate at licensed bed capacity without vendor support for 96 hours. An "on call" staffing pattern may be implemented and staff may be required to work more than their authorized hours as determined by the Manager/Director and HICS.

XIV. Termination of Code

ICC will determine when an emergency situation no longer exists and will notify the operator to page that the code is clear.

XV. Recovery

Under each of the scenarios of the Disaster Plan, recovery plans should be implemented at the termination of the disaster plan including:

- A. Assessment of resources utilized and restocking of equipment / supplies / medications.
- B. Debriefing and counseling (as necessary).
- C. Review and evaluation of the process, procedures, results and areas for improvement (as necessary).
- D. Reconciliation of all records.
- E. Transition from disaster staffing to normal operations.

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ADDENDA:

- A. [Hospital Emergency Incident Command Center Flowchart](#)
- B. [Emergency Preparedness Plan Locations](#)
- C. [Departmental Responsibilities](#)
- D. [Response to Chemical Agent](#)
- E01 [Bioterrorism Response Plan](#)
- E02 [Small Pox Post Event Vaccine Administration](#)
- E03 [Management of the Smallpox Patient](#)
- F. [Radiation Disaster: Triage and Decontamination Procedure](#)
- G. [Building Lockdown Flowchart](#)
- H. [Air Safety Flowchart](#)
- I. [Medical Privileges in Emergency Events](#)
- J. [Evidence Collection of a WMD Incident](#)
- K. [Vulnerability Assessment Tool](#)
- L. [Academy of Pediatrics – Children and Terrorism](#)
- M. [Metropolitan Medical Response System Forward Movement of Patients](#)
- N. [Pandemic Disease](#)