FLOYD MEDICAL CENTER
POLICY AND PROCEDURE MANUAL
ENVIRONMENT OF CARE
EMERGENCY PREPAREDNESS

TITLE: Disaster/Mass Casualty Response Plan	Policy No.: EC-04-003
Purpose: To serve as a guide for the prompt mobilization of personnel and facilities in the event of a potential or actual disaster or mass casualty event.	**Developed Date:** 12/92 **Review Date:** 12/96, 1/00, 1/03, 6/06, 5/09 **Revised Date:** 1/97, 8/01, 1/02, 3/08, 4/12, 5/15, 4/17
Policy: In the event of notification of a possible disaster or mass casualty event in the community or arrival of victims showing signs and symptoms of exposure to possible terrorist, infectious, radioactive or toxic agents, Floyd will implement the process for evaluation of the level of response needed and activation of this plan. It is expected that all personnel and contract services will meet the needs of the organization during a disaster.	**Review Responsibility:** Safety Officer, Risk Manager, Department Directors, EOC Committee, Executive Team
Expected Outcomes: Prompt and accurate treatment of disaster victims	
Reference Standards: Joint Commission: EC.01.01.01	

Floyd is the designated regional Level 2 Trauma Center. In a mass casualty incident, Floyd is the Regional Coordinating Hospital and should be in direct communication with on-scene Incident Command as well as other regional hospitals involved with the multiple/mass casualty event. Floyd participates with the Rome/Floyd County Local Emergency Planning Committee and other emergency response agencies in the planning and implementation of emergency drills. In the Floyd County Emergency Operations Plan, Floyd is designated as the Regional Trauma Center.

EVENT CLASSIFICATION

Multiple Patient Event (MPE) The number of victims stresses hospital resources. Patients will not receive appropriate/timely care without escalation of the usual resources.

Near simultaneous arrival:

5 – 10	severely injured (trauma protocols)
10 – 20	moderately injured (trauma responses)
20 – 40	walking wounded

Multiple Casualty Event (MCE) The number of victims will stress local resources to the point that treatment must be prioritized. Further escalation of the usual response will often involve coordinated effort of all local hospitals.

Near simultaneous arrival:

10 – 20	severely injured (trauma protocols)
20 – 30	moderately injured (trauma responses)
40 – 75	walking wounded

Mass Casualty Incident (MCI) Local resources are overwhelmed/resources are directed toward victims with the greatest chance for survival. The most critically injured (who may have survived in non-mass casualty event) are often placed in the expectant group. This requires an all out response by the hospital.

Near simultaneous arrival:

>20	severely injured (trauma protocols)
>30	moderately injured (trauma responses)
>75	walking wounded

MCI is further subdivided into:

Level I	Managed using local resources
Level II	Management requires help from adjacent jurisdictions
Level III	Management requires help from state and/or federal resources

OVERVIEW OF HOSPITAL RESPONSE

Goal: Staff critical areas with personnel who normally work in that area. This usually requires calling in off-duty personnel who are familiar with the area in need. Although some shifting of personnel is inevitable (often for time or economic reasons), things usually work much more efficiently if shifting of personnel can be kept to a minimum. During a crisis, the best Team Members should be in place. Shifting of personnel outside of their normal environment (except as outlined below) would only be used as a temporary measure until routine Team Members can be mobilized. Personnel should be appropriately compensated for working beyond their normal schedule.

Exception: During a Level II or Level III Mass Casualty Incident, there will have to be considerable shifting of usual roles as the system is severely overwhelmed.

Multiple Patient Event (MPE)

Rate limiting processes usually involve X-Ray and Laboratory

1. Additional X-Ray Radiologic Technologists should be brought in to staff 1 – 2 X-Ray rooms in the main X-Ray department. An additional dedicated technician should be assigned to portable X-Rays in the ED.
2. Consider need for attending Radiologist.
3. Additional lab personnel needed to assist with blood draws. Also consider additional staff for blood bank if there is a great need for blood products.
4. Additional ED nurses needed for ED evaluation and resuscitation and to assist with monitoring in X-Ray.

5. Additional physicians:
    - ♦ Consider need for 1 -2 additional ED physicians
    - ♦ Consider need for second trauma attending
    - ♦ Consider need for dedicated ICU attending
6. Additional security staff for crowd/family control
7. Consider need for additional ED Techs to assist with patient transport
8. Consider need for additional Registration/Unit Secretary personnel

Multiple Casualty Event (MCE)
Escalation of plan as outlined above under Multiple Patient Event, with the addition of the following:
1. Establish Command Center
2. Mobilize additional members of the medical staff based on type of incident
3. Call back additional nursing staff and ancillary staff as needed
4. Establish public relations/media protocol
5. Establish additional security for crowd control
6. Arrange to have all visitors immediately leave the hospital
7. Bring in additional PACU nurses to expand the PACU into additional ICU beds
8. Implement additional considerations listed below under Mass Casualty Incident as needed

Mass Casualty Incident (MCI)
Escalation of plan as outlined above under Multiple Patient Event (MPE) and Multiple Casualty Event (MCE) with the addition of the following:
1. Consider cancelling all elective surgeries
2. Consider canceling all elective radiology procedures (CT, Fluro studies, etc)

INCIDENT COMMAND STRUCTURE

INITIAL REPORT
The information that a mass casualty event has occurred can come from many sources. Whoever receives such information, in the hospital should immediately notify the Emergency Care Charge Nurse or Physician on duty that will be in charge of collection of information and verification of a possible incident or of victims of exposure to biological agents. If evaluation indicates the need for possible implementation of Emergency Preparedness Plan(s), the President or designee will be contacted and the evaluation process will begin.

When Code Triage (Internal/External) is activated, the President or designee will be the Incident Commander and will designate a location for the Command Center. In the event the Command Center must be relocated, the location and telephone numbers will be communicated to all Departments. The decision to evacuate will be determined by the Incident Commander.
Transportation will be coordinated with Rome City Transit and Floyd County EMA.

The purpose of Incident Command is to provide a central link to all Hospital departments, coordinate Response Plan procedures while maintaining hospital operations and provide a mechanism for communication.

Person in Charge	President or designee
Location	Administration or other area as designated by Incident Commander
Who Should Report	President or designee Executive Team Members Emergency Care Center Medical Director or Senior ED Physician Resource Nurse Public Relations Director (or designee) Director of Security ECC Director (or designee) Safety Director

SYNOPSIS OF KEY ROLES IN COMMAND STRUCTURE

Incident Commander

1. Establish Command Center
2. Coordinate the establishment of communications and security
3. Coordinate the expansion of additional treatment areas
4. Advise the Operators to announce the activation and de-activation of the event
5. Refer to “Job Action Sheet” for additional job responsibilities

Public Information Officer (All requests for information should be forwarded to this position)

1. Establish a news media briefing area
2. Ascertain whether or not radio and television stations have been requested to broadcast an emergency announcement; if necessary, contact the CEO or designee and request him to take the necessary action for release
3. Compile, sort and release information as indicated
4. Maintain control of all representatives of the news media and VIP personnel
5. Ensure all news media personnel have the proper credentials and are tagged appropriately
6. Have all news media personnel park In designated area
7. Refer to “Job Action Sheet” for additional job responsibilities

The **Liaison Officer’s** role is to serve as the point of contact for assisting and coordinating activities between the Incident Commander and various agencies and groups. This may include Congressional personnel, local government officials, and criminal investigating organizations and investigators arriving on the scene.

1. Establish contact with liaison counterparts or each assisting and cooperating agency
2. Request assistance and information as needed through the interhospital emergency communication network or county Emergency Operations Center
3. Relay any special information obtained to appropriate personnel in the receiving facility
4. Refer to “Job Action Sheet” for additional job responsibilities

The **Safety/Security Officer’s** role is to develop and recommend measures to the Incident Commander for assuring personnel health and safety and to assess and/or anticipate hazardous and unsafe situations. The Safety Officer also develops the Site Safety Plan, reviews the Incident Action Plan for safety implications, and provides timely, complete, specific, and accurate assessment of hazards and required controls.

1. Implement Floyd’s Access Control policy, if applicable
2. Establish Security Command Post
3. Remove unauthorized personnel for restricted areas

4. Secure the EOC, triage, patient care, morgue and other sensitive or strategic areas from unauthorized access
5. Advice Incident Commander of any unsafe, hazardous or security related conditions
6. Confer with PIO to establish area for media personnel
7. Provide vehicular and pedestrian traffic control
8. Refer to “Job Action Sheet” for additional job responsibilities

Logistics Chief

1. Coordinate with facility operations, materials, supplies, and/or any additional staff required
2. Obtain transportation (i.e. Rome Transit) for the use of buses to transport patients, EMS, etc.
3. Contact Red Cross chapter for possible housing needs for disaster victims
4. Refer to “Job Action Sheet” for additional job responsibilities

Refer to the Incident Command Center/Structure policy (EC-04-004) for more specific information about the roles and responsibilities.

LEVEL OF RESPONSE AND ACTIVATION OF PLAN

The information provided to the Hospital on the number of anticipated casualties and severity of the injuries will be used in the determination of the level of response required. The Emergency Care Director or Senior Attending Physician and/or President and CEO will determine if there will be an activation of the Response Plan, other Hospital emergency plan or modified response.

The Emergency Attending Physician in conjunction with the Emergency Care Center Charge Nurse and the President (or designee) may activate the Emergency Response Plan after obtaining information from EMS, Fire Service, Police Department or other Medical Facility. The initiator of the plan will be responsible for getting as much information from the field as possible to assist in the determination of the implementation of the Bioterrorism Plan.

TRIAGE

Triage is the process of ***sorting*** and ***prioritizing*** patients into specific care categories. By definition of a Mass Casualty Incident (MCI), there are inadequate resources to care for this number of patients in the usual manner. The correct concept for MCI when the system is truly ***overwhelmed*** is to do the greatest good for the greatest number. Triage may occur at several levels and patients my need to be ***re-triaged*** if evacuation is prolonged. Triage needs to be repeated after arrival at the local or definitive care facility. ***Re-triage at appropriate time intervals is essential.***

Four categories:

- Immediate/Red tag — needs immediate treatment of life-threatening injuries
- Urgent/Yellow tag — treatment can be delayed 1 – 2 hours
- Ambulatory/Green tag — treatment can be delayed up to 6 – 12 hours
- Expectant or Dead/Black tag — expected to die given current patient load and resources

In a true Mass Casualty Event, the first and most challenging modification is shifting the most critically injured from immediate care to dead and dying category. The threshold will depend on the balance between the number of victims, the magnitude of their injuries and available resources. Patients allocated to dead and dying would include:

- Patients with low GCS with fixed and dilated pupils
- Advanced neurological findings
- Systolic BP 50mmHg after initial resuscitation
- Massive burns >80% Total Body Surface Area (TBSA)

INITIATING/CANCELING DISASTER/MASS CASUALTY RESPONSE PLAN

The operator will announce that the Code Triage has been activated and/or is no longer in effect. The announcement will be made over the hospital PA system and the paging systems.

1. Announcement activating the Plan:

"Attention, all personnel. Code Triage (Internal/External) is now in effect."

This announcement is to put the hospital staff on notice that the Disaster/Mass Casualty Response Plan will be activated.

2. "All personnel report to your assigned stations immediately."
3. All visitors please leave the hospital at once, through the main entrance on the second floor, do not use the elevators, unless you are disabled."

4. Announcement canceling the Plan:

"Attention, please. Code Triage (Internal/External) is ALL CLEAR."

Announcements for the implementation or cancellation of Code Triage will be made three (3) times allowing for a ten second interval between announcements.

NOTIFICATIONS

1. The Emergency Care Center will notify the following:

- President or designee (to evaluate the report and respond if necessary)
- Chief of the Medical Staff
- Emergency Care Center Medical Director
- Emergency Care Center Director
- Public Relations
- Law Enforcement—Rome City and Floyd County (notified of any possible terrorist related illness)
- Floyd County Department of Health (notified of any possible victim of biological, chemical or radioactive Agents)
- Safety Officer

2. Additional Notification Responsiblities:

- ♦ Leadership Team and Department Managers. The Incident Command team will designate an individual to initiate the Leadership Team Call Back.
- ♦ Vice President of Nursing. The Administrative Resource Nurse will contact the Vice President of Nursing.
- ♦ Attending Physicians. The Chief of Staff and the Emergency Care Center Medical Director will determine and implement contact of needed Medical Staff.
- ♦ Hospital Staff. Department managers/supervisors will implement departmental recall lists.

Employees are asked not to contact the Command Center, Switchboard or Emergency Care Center directly.

REPORTING PROCEDURE AND ENTRY INTO THE HOSPITAL

1. All personnel called in, or off-duty personnel who come in voluntarily, should report directly to their department unless otherwise specified by manager. Department managers or designees will make assignments.

2. Once staff has been notified to come in, they should refrain from calling in, thereby tying up the hospital telephone lines.

3. The Hospital will be under Access Control during Terrorism Response. Hospital personnel will be required to wear their identification badges or show a picture ID to enter. The identification badge will enable them to pass without difficulty through Police lines. Physicians not recognized will be asked for ID for entry into the facility.

DEPARTMENT RESPONSE

ADMITTING DEPARTMENT

Admissions Process

1. Available Admitting Staff will report immediately to the Emergency Care Center/Triage area. Admitting staff will assign a typonex wrist ID and a disaster folder to each patient, which will be utilized throughout the treatment process, until the patient can be admitted in an inpatient department.

2. The Admitting Staff will coordinate all activities involved in the admission of patients to the Hospital.

Casualty Lists

1. Admitting staff will prepare a list of casualties, as the information becomes available and forward to representative in Incident Command.

Bed Availability Notification

1. The Patient Placement staff will keep the Command Center informed regarding availability of beds in each nursing unit.

BEHAVIORAL HEALTH AND PASTORAL SERVICES

Behavioral Health staff will be utilized for critical stress incident debriefing for the disaster victims or hospital personnel. Upon request from the Command Center, staff will report to the Emergency Care Center to assist with patient needs. Pastoral Care also assumes responsibility for the emotional needs of the staff, patients and families.

ENVIRONMENTAL SERVICES

The Supervisor will send at least two staff members to the ECC to clean rooms and replace linen.

FOOD AND NUTRITIONAL SERVICES

1. The food services director will be responsible for obtaining necessary supplies and food to maintain operations for a minimum of 96 hours
   - ♦ Meals to bed and stretcher patients
   - ♦ Nourishments to victims in the treatment areas
   - ♦ Nourishments and meals to personnel at duty stations. Also, the cafeteria will be opened if the operation will require shift work

NURSING

1. The following persons are responsible for implementing the Nursing Disaster Plan procedures, oversight of the nursing general Labor Pools and supervision of care within all nursing areas.

   - ♦ Senior VP of Patient Care Services/CNO
   - ♦ Nursing Directors
   - ♦ Clinical Supervisors
   - ♦ Emergency Care Center Director
   - ♦ Evening and night Resource Nurses

2. Staff will advise all patients to return to their rooms.

3. Staff will advise visitors/family members to remain in the patient’s room or leave the hospital.

4. All patient care units should call Patient Placement to confirm bed listing and provide a list of potential discharges.

PUBLIC RELATIONS

Upon activation of the Response Plan, the Public Relations Department will provide the following support:

1. Public Relations representative will report to the Incident Command Center

2. Public Relations Director or designee will assist Incident Command in developing all releases for the news media.

3. Public Relations representative will provide assistance in directing and coordinating media activities.

4. All information regarding casualties will be coordinated through the Public Relations Department.

SECURITY

1. Upon activation of the Plan, the Security Director (or designee) will report to the Command Center.

2. Security officers with the assistance of Plant Facilities staff will monitor access to the Hospital.

3. Security officers with the assistance of Plant Facilities staff will be responsible for coordination of campus traffic and crowd control.

4. Security will be responsible for re-routing non-emergency vehicular and walking traffic away from the Emergency Care Center.

5. Security will secure the triage area.

6. Security will control the elevators for procuring wheeled equipment from the upper floors.

HOSPITAL DEPARTMENTS

1. Generally, Hospital Departments will follow their Departmental Disaster Plan as well as responsibilities included in this plan.

2. The following areas provide direct patient care:
   - ♦ Nursing
   - ♦ Laboratory
   - ♦ Radiology
   - ♦ Medical Personnel
   - ♦ Cardiopulmonary Services

3. Pharmacy personnel will facilitate the acquisition of medication supplies and tracking of narcotic use.

4. Health Information Management will support Registration personnel and assist with admissions and identification.

5. Materials Management and Central Supply personnel will facilitate the acquisition of supplies and equipment as needed, including food, linen and water.

6. Transport and ancillary personnel will be assigned to each area to transport patients, supplies and messages as needed.

7. Unassigned Team Members who do not have a specific assignment in this plan should remain in their departments. If a personnel pool is required, a general announcement will be made requesting personnel to report to the Care Coordination Hub on 1st floor.

8. Volunteer services will provide support personnel to areas where their skills are necessary.

LABOR POOLS

Nursing Service Labor Pool

The purpose of the Nursing Labor Pool is to provide a central location for the evaluation of available nursing personnel, to assist in the process of assigning nursing personnel to needed areas and to make nursing staff available to the Emergency Care Center as patients area admitted through the triage area.

Person in Charge	Senior VP of Patient Care Services/CNO (or designee)
Location	1st floor ~ Care Coordination Hub
Who Should Report	Nursing Directors and Clinical Supervisors Nursing personnel assigned by Nurse Manager

ALL Nursing staff are asked to bring a stethoscope, and when available, a wheelchair and Dinamap. Staff will be assigned to a patient in the Emergency Care Center from Pool.

General Labor Pool

The purpose of the General Labor Pool is to provide a central location for the gathering and evaluation of available non-clinical personnel. Needs for assistance required throughout the Hospital will be evaluated by the Command Center and communicated to the General Labor Pool.

Person in Charge	Human Resources Representative (or designee)
Location	1st floor ~ Care Coordination Hub
Who Should Report	Clerical and Non-clinical staff Environmental Services staff (Housekeeping may be assigned to either clean or prepare treatment areas or to assist with transport duties) Plant Facilities staff Others

Physician Labor Pool

The purpose of the Physician Labor pool is to provide a central location where attending and resident physicians can report to indicate their availability to provide care to the disaster patients and to establish a mechanism which will enhance communication between the Command Center and physician regarding the Hospital's need for physician expertise.

Person in Charge	Chief of Medical Staff, Executive Vice President, or designee
Location	Physician's Lounge
Who Should Report	All available attending physicians, residents and mid-level practitioners.

1. The chain of command regarding direction for the Medical Staffing during the Response period will be in the following order:

   - Chief of Staff
   - Emergency Care Center Medical Director
   - Senior Emergency Care Center Physician

2. The Medical Staff will plan for physician coordination and coverage for disaster treatment areas, in-house patient coverage and coverage of private practices.

STAGING AREAS

Staging Areas are pre-assigned areas designated as locations to assist in the provision of patient care, to gather and house pools of hospital personnel for the purpose of coordinating services, or to designate an area to direct non-hospital personnel or visitors, to maintain a secure facility.

PATIENT FLOW

Field (EMS) Triage

1. All patients are classified and tagged by EMS personnel prior to arrival at the Hospital.

2. Classification is based on the severity of injury and is as follows:

Category	**Condition**
RED	Critical…life threatening
YELLOW	Serious…significant, stable injuries
GREEN	Minor/Observations
BLACK	Dead on Arrival/Unsalvageable

Emergency Care Center Triage

The purpose of triage is to quickly evaluate needs of patients and forward them into the Hospital for definitive care.

Location	Ambulance EMS Entrance
Procedures	Triage and provide disaster designation for patient identification

1. Upon arrival to the Emergency Care Center, all patients will be triaged by an emergency room physician and/or triage nurse. Classification of patient injury determined by EMS from the field will be reassessed and patients will be reclassified if necessary.

Decontamination

1. Decontamination needs will be evaluated and appropriate decontamination will take place prior to patients being admitted to the Emergency Care Center.

Emergency Care Center Treatment

1. Patients will be triaged upon arrival. If decontamination is needed prior to medical treatment the patient will be transported to the loading dock area. Treatment zones for severity and type of injury will be established in the Emergency Care Center.

2. After injuries have been evaluated and stabilized, the patients will be forwarded to other support services for diagnosis or definitive care.

Discharge or Admission

1. After injuries have been evaluated and stabilized, the patients will be forwarded to the designated Discharge area (usually waiting room in ECC) for processing and discharge, or be escorted/transported to a designated area for admission or observation.

Patient Admission Process

1. All patients admitted to the Hospital through the emergency triage area will be assigned a “Disaster Folder” for identification purposes.

2. A Typonex ID bracelet in the folder will be placed on the patient with an identifying number. The ID band should remain on the patient until the patient is admitted to an inpatient area and the Admitting Department has officially admitted them to the Hospital.

3. All documents, charts, specimens, etc. should utilize the patient’s disaster ID number, until the patient has been officially admitted to the Hospital.

4. The triage nurse or charge nurse of each Emergency Care Center treatment zone will assign a healthcare worker from the Nursing Labor Pool to stay with patients needing constant observation.

5. Health care providers assigned to a Terrorism Response patient are instructed to travel with the patient to all areas of the Hospital. They are to remain with the patient until they are admitted to an inpatient floor or are discharged from the Emergency Care Center.

Patient Care Staging Areas

The Emergency Care Center will establish treatment zones as needed in and around the Emergency Care Center.

Classification	**Location**
Triage Area	Ambulance EMS Entrance
Major Casualties	Emergency Care Center
Minor Casualties	Emergency Care Center designated zone
"Stat" Surgery Cases	Emergency Care Center
Intake/Admission Area	ECC Registration area
Casualties	Morgue
Discharges	ECC Sub Waiting Area
X-ray	Radiology

Emergency Care Center

The Emergency Care Center serves the purpose of stabilizing the very critically ill/injured Terrorism Response patients. All patients will initially be placed in the ECC and in the treatment zones around the Emergency Care Center.

Location	Zone C (Rooms 24 – 32)
Procedures	Suturing of lacerations, stabilization of one system injuries
Staffing Needs	Needs must be determined by Incident Command Physician and Nursing personnel availability will be evaluated
Location	Zone C (Rooms 33 – 36)
Procedures	Less Serious, Category Yellow Patients
Location	Zone C (Rooms 37 – 42) Overflow may go to Zone B
Procedures	Serious Injuries, Category Red Patients
Location	Zones A and B (Rooms 1 – 23)
Procedures	Less Serious, Category Yellow Patients

Pre-op Holding

Location	2nd Floor
Procedures	"STAT" Surgical cases will be forwarded for monitoring and surgery preparation
Staffing Needs	Needs must be determined by Incident Command Physician and Nursing personnel availability will be evaluated

330 Physicians Center

Location	330 Physicians Center
Procedures	Treatment of non-urgent patients, “walking wounded”
Staffing Needs	Needs must be determined by Incident Command Physician and Nursing personnel availability will be evaluated

OP Infusion Unit (and/or other designated area)

Location	2nd Floor
Procedures	Intake area for patients who have been decontaminated, treated and stabilized, and are awaiting admission to the Hospital. (patients NOT requiring advanced monitoring)
Staffing Needs	Needs must be determined by Incident Command Physician and Nursing personnel availability will be evaluated

Recovery Room

Location	2nd Floor
Procedures	Intake area for unstable patients awaiting admission to the Hospital. (patients requiring advanced monitoring equipment)
Staffing Needs	Needs must be determined by Incident Command Physician and Nursing personnel availability will be evaluated

Morgue

Location	1st Floor
Procedures	Morgue storage
Staffing Needs	Security officers and pathology

ECC Sub Waiting Area

Location	Emergency Care Center
Procedures	Process patients for discharge and reuniting with families
Staffing Needs	Needs must be determined by Incident Command Nursing Personnel, Admitting Staff, Social Services

Radiology

Location	2nd Floor
Procedures	X-rays, CT Scans, MRI, Ultra Sound, Imaging
Staffing Needs	Needs must be determined by Incident Command Radiologist, Technician, RN

Red Cross Communications

1. If the Red Cross Chapter requests to establish a center, a location will be assigned.

Waiting Area for Relatives

1. Relatives of the injured will be directed to the Cafeteria located on the 2nd floor.

2. The Chaplain will be assigned to coordinate the staffing of this area (with Critical Incident Response Team members, Social Workers, or Counselors) to counsel and help relatives of all casualties.

News Media

1. The News Media will be briefed by Public Relations at a designated area to be determined by Public Relations staff.

ADDITIONAL DISASTER PLAN ISSUES

Dismissal of Patients from the Hospital

In-house patients

1. At the request of Incident Command, in-house patients will be evaluated for potential discharges in order to accommodate patient arrival. The decision to discharge any in-house patient should be made in keeping with the following conditions:
    - ♦ No patient is to be discharged against his/her wishes
    - ♦ No patient is to be discharge without the approval of his or her Physician
    - ♦ Relatives of patients to be discharged are to be notified by the Nursing Unit
    - ♦ All discharged in-house patients are to be escorted to the Main Lobby in anticipation of arrival of family members to escort the discharged patient home.
    - ♦ If patients do not have a residence to go to, they will be bused to a reception center, determined by local emergency management and/or American Red Cross.

Mass Casualty

All patients involved in Terrorism Response activation and approved for discharge should be escorted to the ECC Sub Waiting Area. An order must be written for the patient prior to discharge. Law enforcement agencies may assume command of victims of crime or terrorist acts.

Fatalities

Fatality Identification/Information

1. Admitting Office will forward information regarding fatalities/casualties to Pastoral Services and Public Relations, as it becomes available to the admitting office.

2. The Waiting Area for Relatives (Cafeteria) and the Switchboard will refer all calls and requests seeking casualty information to the Public Relations representative.

3. Pastoral Services will direct families of fatalities to the Chapel.

4. Public Relations will oversee the dissemination of information of casualties.

Communication Systems

1. Internal telephone system. Communication should be limited to Terrorism Response related issues as much as possible.

2. Security and Plant Facilities will provide any unused radios to the Command Center. Portable radios will be assigned to the following areas:
   - ♦ Incident Command
   - ♦ Emergency Care Center Triage Area
   - ♦ General Labor Pool Area
   - ♦ Nursing Labor Pool Area
   - ♦ Decontamination Facility
   - ♦ ECC Charge Nurse

STAFF DEBRIEFING

See Critical Incident Stress Response policy (AD 01-065) for Staff Debriefing procedure.

NOTE: Each department will have a department specific disaster plan that is to be used in conjunction with the hospital wide plan that outlines duties/responsibilities specific to that department.