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EMERGENCY ACTION PLAN
ALL HAZARD APPROACH

A FACILITY GUIDED APPROACH

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Contents

1. INTRODUCTION

1.1 General

North Memorial Ambulatory Surgery Center (NMASC) has adopted an all-hazards, integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal or manufactured emergencies and natural disasters or any combination of the above. This approach to emergency management, considers the hazards most likely to occur in Hennepin County and throughout the region based on a hazardous vulnerability assessment. These include but are not limited to, care-related emergencies, equipment and power failures, interruptions in communications, pandemics, biohazard and interruptions in the normal supply of utilities such as power and water. This plan will assist the ASC in efforts to prepare for, mitigate, respond, and recover from a disaster and includes information on locations of staff and guests during a disaster, documentation of any patient/staff transfer, incorporation of local and federal waivers and training requirements. The North Memorial Ambulatory Surgery Center (NMASC) will utilize information from the local, regional or national Emergency Management system in order to promote integration of effective emergency management needs, including but not limited to government agencies, local city municipal agencies, private sector and potentially media outlets.

Ultimate control for all functions at the ASC including the Emergency Action Plan is approved by the NMASC governing body and reviewed on a biannual basis along with the hazardous risk assessment, policy and procedures as well as drills and evaluations (both internal, tabletop and regional). The governing board will receive information from the Medical Executive committee related to findings from drills, triggered review events and will provide oversite related to regulatory compliance. The Administrator at the center will receive annual validation by the Governing board which includes control for daily operational needs, authority to manage the emergency management program and make changes to the program related to ongoing requirements, findings from drills, orientation, education as well as updated policies and procedures. Any updates and changes will be approved by the governing body. The Emergency Plan will be based on patient populations served as well as anesthesia types.

The current patient population at the NMASC includes.
4% Pediatric Patients
96% Adult Patients

Anesthesia types.
9% Local Cases

26% Regional Block with IV sedation
20% MAC Cases
45% General Anesthesia Cases

Current Staff Mix
0 Front Office Staff with BLS
0 Other ASC staff with BLS (facilities, housekeeping, NA, transport aid)
71 Clinical Staff with BLS
48 Clinical Staff with ACLS
32 Clinical Staff with both ACLS and PALS
124 Privileged physician providers at the ASC – surgeon
95 Privileged Anesthesia providers physician and CRNA at the ASC

Supplies and resources available at the ASC for EMS services – See Appendix A
Staff and provider list and Emergency Contacts – See Appendix B

1.2 Purpose

The purpose of the NMASC Emergency Action Plan (**EAP**) is to establish a written emergency plan and provide a timely, integrated, and coordinated response to the wide range of natural and manufactured events that may disrupt normal operations. The EAP is an “all-hazards” plan which guides the ASC staff in responses to any types of a disaster or emergency. Additionally, this plan is consistent with city and county Emergency Operations Plans & response

The objectives of the emergency management plan include:

- Protection of patients, visitors, and staff and providers within the center during the event and treatment of those persons which have been evacuated
- Mitigation activities designed to reduce risks and any potential damages due to an emergency
- Preparedness activities which assist with the organization and mobilization of essential resources.
- Provision of prompt and efficient medical care, including response strategies, actions required to restore systems that are critical to normal care.
- Protection of clinic property, facilities, and equipment, including the monitoring of assets and resources in the facility (building elements, specialized equipment, supplies, pharmaceutical products and human capital). The center will keep a documented inventory of supplies and resources it has on site which could be used during an emergency. Products will be assessed monthly for outdates. The center will manage supplies manually on paper forms in the event any

online systems are unavailable. The administrator will work with the consulting pharmacist related to replenishing pharmaceutical supplies.

- Training requirements and establishment of drills, within the facility and community
    - All staff at hire will have emergency training during orientation and annually thereafter. Emergency drills will focus on center needs and focus on episodes which could occur most commonly. Drills will also adhere to accreditation requirements.
- Employ the recovery plan to return to normal operations.

1.3 Activation of the Emergency Action Plan

This plan shall be activated whenever an emergency exists in which immediate action is required to:

- Save and protect lives.
- Prevent damage to the ASC and/or environment and staff
- Coordinate communication.
- Operate under a Unified Emergency Command (local, state or Federal).
- Provide essential services to persons in need
- Daily operations are interrupted and may affect patient care & safety
- There is an infectious disease outbreak.

1.4 Community Response Agencies

The following are considered ASC partner agencies during an emergency. Efforts will be made to contact the appropriate needed municipal safety entity which could include any or all of the following entities.

See Appendix C – Emergency Management Contacts

2 Communication Plan

2.1 Establishment of clear chains of command as well as communication needs within the ASC and outside the ASC related to external sources are key to understanding ongoing needs related to weather events, transportation needs, road closure, etc.

Communication plans will be tested for integrity of established equipment (phone, cell phone, walkie talkie, other). When possible, the primary phone lines will be used. In the event that the phone lines are damaged, cell service will be utilized for external communication, internal communication will utilize walkie talkies – this allows center staff to keep phones charged and available for external access. Key command positions will carry the walkie talkies which will remain charged and assessed weekly for operations.

A clear communication plan which complies with both federal and state laws as well as the adoption of any 1135 waivers related to governmental disaster requirements is implemented. The communication plan will be reviewed every 2 years when the entire Emergency Plan is reviewed. Information in the communications plan includes.

- Information related to staff, provider and contract databank
- Coordination of patient care within the facility, across healthcare providers, including state and local public health departments and emergency management systems.
- Transportation needs during an emergency event and management of patient care during transport.

All staff inside the building will be accounted for pending their role. The nurse manager or designee will utilize the daily schedule to ensure all staff and providers are accounted for within the building. A log of visitors (sales reps, contracted vendors, etc.) will be utilized to ensure that all outside personal are safe and reported present.

See Appendix B, C, related to communication needs
See Appendix D– Transfer form

3.0 HAZARD VULNERABILITIES AND RISK ASSESSMENT

A hazard can be either internal or external and may occur during or after operating hours of the Center. It may impact part of the Center or the complete Center, requiring partial or complete evacuation. A situation may require patients, employees, and visitors to take shelter or evacuate during the given emergency. The situation may require transport of patients or other injured persons, (employee, provider, sales rep, contracted service provider) as a result of an emergency within the facility to a local hospital. All these situations will require the Center to activate its EAP utilizing a method to track all transported persons and provide communication information (written and verbal) to the receiving facility.

3.1 Hazard Vulnerabilities

NMASC may be exposed to many hazards that have the potential for disrupting the Center, the building (partial or complete), the surrounding community or region. All which can cause both facility and personal damage and resulting in injuries. Possible natural hazards include weather related events including but not limited to, snowstorms, wildfire, ice storms, tornado or earthquakes. There is also the threat of manufactured events including armed intruder, civil unrest, health related incidents, hazardous material events, cyber-attacks or other acts of terrorism. Other manufactured event may include chemical spills, loss of potable water, electricity, or communications.

3.2 Risk Analysis

NMASC utilized information from an internal assessment with the Kaiser Emergency Risk assessment, CDC, and CMS Websites and created a list of potential hazards and performed a risk analysis to prepare its EAP.

A detailed Risk Assessment is listed in Appendix E

- Based on risk analysis, the likely hood of emergency by category is:
    - Natural: (39) % - (snowfall) - main cause
    - Technological: (26) % - (sewer failure)- main cause
    - Human: (20) % - (biological terrorism)- main cause
    - Hazmat: (26) %
    - Overall risk: (0.12) %
- Emergencies that may require complete evacuation based on risk assessment:
    - Fire
    - Explosion

- Emergencies that may require shelter in place:
    - Fire outside the safe zone
    - Active shooter
    - Inclement weather

3.3 Planning Assumptions

Emergency planning requires a commonly accepted set of operational conditions that provide a foundation for establishing protocols and procedures.

- A disaster may occur at any time with little or no warning. Such disasters are generally manufactured including technological/cyber or related to hazmat. There may be times when alerting the staff and taking preemptive actions may not be possible.
- Disaster may result in requiring partial or complete evacuation.
- Critical lifeline utilities may be interrupted including Medical Gases, suction, evacuation, water delivery, electrical power, telephone communications, cellular telephones, information systems (EMR), and the inter/intranet system.
- Disruption of supplies requiring the center to find alternates or refrain from procedures requiring unavailable supplies until the products are obtained and/or the supply chain resumes.
- Staff and Patients, during an emergency situation will remain in an environment promoting safety. Patients will continue to be cared for until they can be transferred to an appropriate facility or discharged to a safe environment. Staff will be released to a safe environment when patients are out of the facility.
- Transportation including major roads, overpasses, bridges, and local streets may be closed or unusable during a disaster. Evaluation of open roads and transport of patients and supplies may be impacted, the ASC will utilize local EMS for travel need information and updates related to road closures.
- Contact including land line, cell service phone, Wi-Fi and satellite may be interrupted. Staff will utilize a walkie talky system inside the building should all other methods be inaccessible. Patient and staff families will be notified as possible related to the given situation.

Definition of Terms during an emergency

Code Orange: - Emergency – Disaster Alert - An event that has occurred creating a need for services above and beyond what is currently available.

Code Blue – Emergency, Cardiac or Respiratory event

Code Red - Emergency Fire Event

All Clear: Discontinue Disaster Plan-Code Orange. The disaster is finished, and all victims have been treated.

Messenger: Transports written or oral messages to the intended receiver.

Transporter: Transports victims by stretcher, wheelchairs or accompanies them ambulatory and remains with the victims until released by the person in charge of the area.

Guard: A person stationed at doors and checks identification of persons attempting to gain entrance to the facility. This person will also direct any person without the proper identification to Center Command Center for identification.

Internal disaster: A need for extra personnel to care for patients and possible evacuation of the patients due to an event within the facility. This would include events such as fire, tornado, earthquake or explosion.

External Disaster: A disaster which occurs outside the Center in the community, causing a disproportionate number of staff to care for the victims. *The Center is not considered a part of the community emergency response plan because it is not equipped to handle community emergencies. However, in the event of a community disaster, the Center would cooperate with Maple Grove Hospital to provide assistance as needed. The Center's status will be reviewed on an annual basis to see if the community would like to include them in the community response plan.*

Critical: Vital signs are unstable and not within normal limits. The patient is acutely ill or unconscious. Indicators are questionable or unfavorable.

Non-critical: Vital signs are stable and within normal limits. The patient is conscious and can be either comfortable or uncomfortable. Indicators are favorable or excellent.

4. ROLES & RESPONSIBILITIES

4.1 General

All Staff at NMASC, will be prepared to respond to a natural or manufactured emergency in a manner that protects its patients, visitors, and staff. All regional emergencies will be coordinated with a community-wide response.

- All employees at hire during orientation and annually will receive emergency response education and will be involved in drills and required education.
- All employees will know and be prepared to be part of a team to provide the best possible emergency care in any situation.
- Administration will ensure that employees are aware of their responsibilities and monitor that drills are attended with evaluation post drill and education related to findings as well as completion of annual education.
- NMASC will work with the local emergency agencies and health care providers to ensure a community-wide coordinated response to disasters – every 2 years the ASC will engage in a regional disaster drill, with internal tabletop and scenario drills held in house related to specific emergency needs (code, MH, intruder, etc.).

4.2 The Incident Command System

Emergency Response Flow Chart

See Appendix F – Command System and assignments

North Memorial Ambulatory Surgery Center will utilize all staff according to the needs of the center. The administrator and staff work together to perform all functions that help respond to emergencies and recover from the emergency. Anyone at the center which suspects, finds or determines there is a threat of disaster or emergency will notify the administrator related to findings

4.3 Command Staff

In general, the Board of the ASC is responsible for approval of policies and procedures for EAP, staff training, and annual evaluation. The following information provides a summary of the Command and General Staff positions and lines of authority.

4.3a Incident Commander (IC)

- Administrator or Medical Director will be designated as Incident Commander or person in charge of the the emergency. In the absence of administrator or Med Director, the Nurse Manager will perform the responsibilities of IC.
- IC is responsible for the overall operation of the incident including:
  - Coordinating activities for management of emergencies.
  - Communicating with partner agencies such as fire department, polices department, local hospital, and building management.
  - Keeping senior management informed of the status and progress.
  - Releasing information to public and press.
  - Performing other duties as necessary for the situation.

4.3b General Safety Officer (GSO)

Clinical Leader or designee is designated as Safety Officer. They are responsible for:

- Identifying initial hazards, performing risk analysis, and list hierarchy of risks.
- Creating policies and procedures for preventing, mitigating, responding to emergencies and for recovery process.
- Creating communication plans
- Employee training at the time of hire, and then annually to meet compliance with accreditation, federal and state, standards.
- Assessing and monitoring safety of response personnel.
- Advising IC of any safety concerns.
- Exercising emergency authority to prevent or stop any unsafe acts.
- Activation and termination of emergency management plan.

4.3c Patient Safety Officer (PSO)

- The Lead/Charge Peri anesthesia Nurse is designated as patient safety officer.
- PSO provides and coordinates patient care till the time emergency is over and ensures that all patients have appropriate clinical coverage.

4.4 General Staff

Designation of other staff responsibilities

Specific Areas and Staff assigned to those areas are also outlined in the flowchart:

- Patient Tracking (medical records office or center nurse’s station)
- Triage if needed

- Immediate Care (Operating Rooms) save one room for morgue Black Zone if required
- Immediate recovery care post procedure- (Post Op Phase I)
- Delayed Care (Pre-Op)
- Minor Care (PACU – Phase Two)
- Emotional Care (Front Lobby)

- Front Desk Staff
  - Evacuating patients and visitors from lobby
  - Carry patient schedule and EMS contact information for patients, providers, staff emergency contact information, vendor information
- Peri anesthesia Lead RN – under the direction of the Safety Officer, the RN will assess all medical gas and suction outlets. No Oxygen will be shut off unless approved by Safety Officer or designee and if portable O2 is available.
  - Continue to help the nurse with patient care if complete evacuation is not required.
  - Move Crash Cart to triage area or area where most unstable patients are being housed. This may include an area outside of the ASC if complete evacuation is required due to hazards present within the ASC.
- OR Staff (RN, ST, SPD, RT, Materials) – Continue to provide patient care as the situation warrants depending on nature and severity of emergency, till discharge from the OR or transfer to hospital.
  - Any staff not involved in direct pt. care will report to the incident commander for assignment
  - Available physician and anesthesia providers will report to the incident commander to determine best use of skills. The regional EMS director in the event of large-scale emergency may assign providers to alternate locations according to 1135 federal waivers.
- Messenger – one staff member will be assigned as a messenger from the command center to any or all areas of need. This person will be free to move between areas and communicate messages to all areas in the facility. The messenger may also assist the front office staff with moving pt. families to the lobby or safe zone outside of the facility and attest to all visitors in the facility.

5. EMERGENCY COMMUNICATION PLAN

When an emergency occurs, the need to communicate is immediate. If the operations of NMASC are interrupted, the patients will want to know how they are impacted. Regulatory agencies may need to be notified. Families of patients who are receiving care, and employees' families may be concerned and may need more information. The list of potential audience is:

5.1 Emergency Communication Phone Listing See Appendix B & C

5.2 Emergency Communication Responsibilities

- Administrator or designee is responsible for contacting the emergency response partners and service providers.
- Administrator or designee is responsible for reporting to management and governing board leadership.
- Clinical leader or Medical Director are responsible for coordinating transfer of patient care with the local emergency room and triaging patient needs. Pending regional needs, the local EMS director may direct transfer to a facility other than the local emergency room.
- Front desk staff is responsible for communicating with patients and families and ensuring that no additional persons enter the building without appropriate identification. The staff will also keep media outside of the building.
- Administrator informs building management if ASC is housed within another building.
- Administrator is responsible for contacting government and regulatory agencies as needed
- Administrator or senior leadership and/or board is responsible for contacting or discussing the given situation with media as needed.

5.3 Emergency Communication Job Action Sheets – See Appendix F

Administrator or designee communicate with emergency response partners using language that factually describes incident and need for service. This is accomplished using landlines, cell phone or internet if the phone lines are inaccessible.

1. Communication within the Center, if landlines are down, may be accomplished using walkie talkies or cell phones.
2. Administrator formulates a message to be communicated to the patients, employees, and families. This is accomplished using available methodology.

3. Where possible, staff will personally handle all enquiries. When personal communication is not feasible, Front Desk staff will record a message on phone system informing the all-stake holders of the incident, the status of Center's operations, and when the Center will resume for operations.
4. Administrator is responsible for communicating with government and regulatory agencies for incident reporting. Communication is accomplished using medium such as email, fax, online reporting, etc., as directed by such regulatory or government agencies.
5. Senior Leadership is responsible for communicating with media. Communique is issued though a prepared text by either the Medical Director or Board Chairman or designee either in person, during a press conference, via email, or phone as appropriate.

6. EMERGENCY EVACUATIONS

In the event of a disaster or emergency, the Administrator/Nurse Manager/Medical Director will determine if partial or complete evacuation is necessary. If evacuation is required, the Administrator/Clinical Nurse Leader or Medical Director will coordinate the safe and rapid evacuation of the Center, in accordance with established procedures. Evacuation diagrams are posted throughout the Center and clearly show the location of pull boxes, exits and fire extinguishers.

See Appendix G – Fire Evacuation plan for North Memorial Ambulatory Surgery Center includes safe evacuation meeting location (park lot map included)

6.1 EMERGENCY ACTION PLAN CONSIDERATIONS:

1. All Center employees are trained at hire and annually related to evacuation routes in the building, safe rooms for seclusion and a plan for fire events and other internal disasters.
2. The ASC is constructed with fire sprinklers, fire rated smoke walls & doors including fire resistive materials as per Medicare codes. Pending specific building emergencies, a total evacuation of the building may not be necessary. In the case of a fire, the fire evacuation plan will be followed.
3. The staff will understand and practice evacuation procedures during drills (either total or partial) and will be confident and comfortable with both protocols and evacuation routes.
4. The ASC operates (1) Procedure Room, (6) Operating Rooms. The average duration of patient under anesthesia from start to recovery is generally sixty (60) minutes. At any given time, maximum anticipated patients who are incapacitated due to anesthesia which may require monitoring or care is four (4).
5. Specific Areas and Staff assigned to those areas
6. In the unlikely event where a death occurs during the disaster – an OR room will be designated as the morgue. All personal effects will remain with the victim. All information related to the patient and medical records number will be placed on the patient with a toe tag. Transport of all persons including bodies will be maintained including the name of the agency removing the body from the ASC (police, fire department, coroner, etc.). Both live and deceased persons will be noted on the transport log.

6.2 EMERGENCY EVACUATION PROCEDURE:

Once EAP has been activated by Administrator or designee, the following procedure will be used in the event a complete evacuation is required. Such emergency requiring complete evacuation may arise due to fire in multiple areas or an area which encompasses multiple fire partitions of the building or an area which is not located in a one-hour fire safe environment. In the event where a small, contained fire occurs within a fire rated barrier – a partial evaluation may occur pending location of the fire and patients/staff.

Full evacuation includes:

1. Evacuation with patients nearest the disaster – start removing these patients prior to any others. Move patient in a manner which provides most safety.
    a. Remove ambulatory patients first to ensure unimpeded passage for the patients requiring transport assistance. A nonclinical staff member may be assigned to walkout of the building and locate together in a safe area. The staff member will keep all patient names, documents with them for future needs.
2. Evacuate non-ambulatory patients by wheelchair, stretcher or blanket drag.
3. In case of evacuation, the front desk staff will carry to the outside the patient schedule, vendor or visitor log in and any required emergency supplies located in the lobby. The front staff will coordinate with the clinical leader any other documentation requirements and remove from building and take with them to the safe meeting location.
4. Full evacuation with general and MAC patients will be done with a stretcher and required resuscitation tools. In the event that the entire building is evacuated – the crash cart will be moved to the area housing the most critical patients as indicated. All monitors will be removed from wall mounts and placed on pt. stretchers in order to continue monitoring pt. hemodynamic status. Ambu bags with portable oxygen will be used for intubated and deeply sedated patients. Anesthesia providers will remain with patients under general anesthesia and will maintain airway and hemodynamics. PACU nurses will remain with Stage I peri anesthesia patients. All RN and anesthesia providers monitoring patients will continue to document required vitals, medication administration on paper provided by the command officer.
    a. The patients being monitored will be rolled out on stretchers in the event that the pt. can be moved from the OR table to a stretcher. If patient condition does not allow for transport to stretcher the OR table will be utilized for transport (although only as last resort).
        i. Pt. safety strap will remain. Arms will be tucked to promote safety and avoid need for arm boards. This will also ensure that the table is more narrow for transport. Two staff (one may include Anesthesia) will move all patients remaining on the OR table. The attending surgeon will also remain with the patient to maintain wound care. Prior to transport – sterile drapes will be placed over the incisional area to maintain safety in the event which the cavity or incision cannot be closed in a timely manner.
        ii. Pt. privacy will be maintained
        iii. OR patients will utilize the closest and most safe exit which is nearest the OR room.
5. Administrator or designee will carry contact information for all emergency response agencies.
    a. Administrator or designee will call 911 informing of emergent situation and ask for ambulances be dispatched immediately and provide a short status report based on number of patients and required needs.

b. Administrator or designee contacts the hospital ER providing and update on patient condition and status report, including any allergies or specific patient information. Each patient being transported will have their medical record sent with them for review needs and continuity of care requirements. The pt. Arm band will remain in place in the event the patient cannot verbalize name, DOB, allergy. All ASC charts will be saved at the ER for ASC administrator to pick up once new hospital chart is created and to ensure that all ASC information related to the patient visit/transport is documented. In the event which the pt. chart is destroyed – the patient will have data written on their chest/upper body in ink with name/dob/allergy/dg/provider noted.
c. Once all patients are attested to and in a safe location the ASC Administrator or designee contacts will connect with patients/families and providers to reschedule the procedure.

6. The Administrator/Nurse Manager/Medical Director will ensure that all patients, visitors and staff have been evacuated from the disaster area and attested in the safe reporting zone. Use of the staff schedule, daily schedule, rep/visitor log will be used to ensure that all persons previously located inside the building are safe and accounted.
7. If patients are evacuated from the Center, the patients will be transported to the central safe location at the Northeast corner of the parking lot, (the direction of Caribou) or the local hospital accepting patients requiring acute care. The Administrator/Nurse Manager/Designee will conduct a roll call to ensure that all patients are accounted for utilizing the daily schedule, staff schedule, visitor/rep log. If a patient, patient family, staff, provider, vendor rep is missing, the Administrator/Nurse Manager/Designee will notify the police/fire department with a description of the person and expected location of the person missing. Staff will not reenter the building to look for missing persons UNLESS directed by Fire/Police or EMS personal after the building is deemed safe for entrance. If a staff member leaves the central safe zone – the time which the person leaves and the location going to will be noted by administrator.
8. If the patient needs to have their procedure completed same day and the center is inaccessible the Administrator will work with the provider and local hospital to add the case to the hospital schedule.
9. Once evacuation is complete, the Administrator will continue to monitor the Center and encourage the local security agency to ensure there are no issues or intruders.
10. If the emergency is transient and is safe to return to the office building as declared by emergency response agencies such as Fire Department, or Police Department, administrator declares emergency is over and it is safe to return to work and Center resumes operations.
    a. The center staff will ensure the area is clean and move patients from the safe center area into the building if they would desire to continue with their procedure.
    b. Any postop patients will return to the Peri anesthesia area for completion of recovery, discharge teaching and medication reconciliation prior to discharge.

c. Any Preop patients will return to the center to continue with preop needs, and movement to the procedure area for treatment and postoperative care. In the event that the surgeon is unavailable to perform the procedure the procedure will be rescheduled with information provided to the patient.

11. If the emergency results in damage to the facility and renders it unfit for use:
    a. The Center cancels all procedures and offers the patients to be scheduled at a later date or in coordination with their provider and the hospital scheduling staff.
    b. The Center will advise healthcare providers that Center is closed for operations, advising of circumstances, so that they can schedule procedures at another facility.
    c. The Center will advise staff that the Center will remain closed and provide date when it is expected to open and encourage engagement with the staff to help prepare the center for reopening. The center governing board will determine employee HR needs related to time off and benefits. The Administrator will inform staff of coverage needs.
    d. The Center will leave an automated phone message advising callers that the Center is closed indefinitely due to - (state the specific cause) and will resume operations as soon as is deemed fit for operations. If a date is anticipated, the date will be noted on the message. All offices and providers utilizing the ASC will be notified related to the emergency and return to operations date. The center will not be open until all area is safe and clean, meeting opening requirements.
    e. The ASC will inform the accrediting body AAAHC and MN Department of Health of the incident and advise them that the ASC closed based on the emergency. The center should also be prepared for an opening accreditation survey from the given surveying agency.
    f. In the event that any reconstruction is required prior to reopening, the local licensing entities will ensure that all construction and MEP utilities are appropriate for use prior to initial new procedures.

12. After any evacuation – the Administrator and leadership team will perform an assessment of the event and provide any information for a Root Cause Analysis to analyze strengths and weaknesses of employee/provider responses, current policies and procedures, equipment, and implementation of emergency protocols. Staff will be debriefed post emergency and offered any employee assistance should trauma have occurred, or staff need access to councilors. Any finding from the post emergency assessment/ Root Cause analysis will be share with staff and utilized to update and better current policy and procedures, drill planning, information sharing processes and future education needs.
13. Prior to reopening the center staff will review the event, will discuss any findings and receive any retraining or drill planning as needed.
    a. Documentation of staff training and review will be put into place for all employees.

7. SHELTER IN PLACE PLAN (INCOMPLETE EVACUATION)

1. In the event which the center has a partial evacuation – the center will be prepared to offer care and handling for patients, visitors, staff and providers during the emergency.
2. Sheltering in place and planning for future needs will be based on the annual Hazardous risk evaluation.
3. Findings of the risk assessment may indicate
    a. Exposure – weather potential. The Center may be exposed to severe weather such tornado, hurricane, ice or snowstorms.
        i. Center may choose to close for operations if a local emergency is declared. If the weather-related emergency is pending – the center administrator and leadership team will review weather alerts and connect with future patients related to rescheduling their procedure. In the event that procedures are rescheduled the center will close the center, allowing staff and providers to stay in a safe environment.
        ii. The Center Administrator will monitor the inclement weather closely and confirm with medical director/board chair related to closing the facility and will in house staff to notify patients and other staff with a preplanned message related to closure.

4. Sheltering in place within the center may occur with
    a. inclement weather (noted that patients cannot leave in a safe manner).
    b. A fire which occurs in a portion of the building,
    c. an external emergency noted by the EMS regional director, (active shooter or wild animal outside the building and in the region).
5. Sheltering in place will occur
6. Any given time, there are patients which need monitoring or active care.
    a. General Anesthesia Patients will require average of 1-3 hours recovery pending age of patient and procedure.
    b. MAC patients will require an average of 1-2 hours recovery pending age of patient and level of anesthesia provided.
    c. Local Anesthesia procedure will require an average of 30-60 minutes postop.
7. The OR and Procedure rooms as well as some portions of the pt. recovery rooms are located in a one-hour fire area. This will allow staff to move patients to appropriate safe spaces for recovery prior to discharge. If the patients are in areas which are not fire rated, they will be moved.
    a. All patients receiving postop care will have access to required supplies including Oxygen, suction and pharmaceutical products. In the event that any of the emergency supplies are

compromised, patients will be transferred to another facility and will follow previously noted transfer information.

Prior to housing any patients in the building during a small, controlled fire (even if the patients are housed in a safe fire rated zone), staff will receive validation from the emergency responders and fire chief that housing the patients is appropriate. Constant analysis will occur, and transfer will be implemented anytime that staff believe it is appropriate to implement emergency protocols or at a time when there is a loss of critical services (utility, med gas, suction, electricity).

8. REENTRY AFTER EVACUATION

1. In case of fire, the fire chief or regional Fire Marshal/inspector will determine when the emergency is over and if it is safe to reenter the building.
2. In case of evacuation due to other emergency events, the appropriate competent authority will communicate to Administrator that emergency is over, and it is appropriate to return to normal services.
    a. The Administrator will communicate with staff, providers, governing board and any joint venture facility that the emergency is over, and it is safe to return to work.

9. SECURITY DURING EMERGENCY

1. Since emergency personnel may require access to premises, the Center cannot be secured by locking.
    a. If the emergent event occurs after hours the local Fire Department and/or authorities will have access to the facility.
2. The center will use a telemonitoring system for security with a third-party security vendor in place which will receive all alarms and notify the authorities related to fire or activation of the security alarm system. The Administer will be notified anytime that the emergency system is activated. The third-party vendor has the ability to provide continuous monitoring of the emergency events.
3. The Administrator will be able to access any emergency monitoring using remote access though internet or established automated Apps.
4. Only persons authorized to be inside building or premises will be allowed during an emergency event.
    a. Staff called to the center will present appropriate center ID for access to the building. The business office lead will attest to all persons entering the building. Staff will be notified prior to arrival appropriate door location if returning to the center.
5. See media reporting needs and access noted in section 4

11. BIOHAZARD, BIOLOGICAL AGENTS, CHEMICAL AGENTS RISK

b. See Appendix I for chemical Risk Assessment

Chemical Agents – Resource Summary

Chemical agents can injure or kill in a number of ways. They can be inhaled, absorbed through the skin or infested. Anytime a condition is suspicious of exposure to toxic chemicals it should be reported, and the patient taken to a facility that has decontamination abilities.

Indicators of a presence of a dangerous chemical include, but are not limited to the following:

- An unusual number of dead animals, birds, or fish in the area
- Persons exhibiting unexplained rashes, blisters, or wheals
- Mass casualties all exhibiting similar symptoms such as disorientation, difficulty breathing, or convulsions
- The presence of unusual or oily liquid droplets found on surfaces
- Discolored or dead vegetation in a recognizable pattern or over a large area
- Unexplained or unusual odors such as garlic, almonds, new mown grass, peaches or others out of character with the surroundings
- Low-lying clouds or mists that do not conform to the current weather pattern
- Unusual metal debris

Refer to the chart for *Chemical Agents and their Effects* to identify signs and symptoms.

Biological Agents – Resource Summary

There are two main types of biological agents that might be involved in a disaster/emergency event.

- **Pathogens** are living organisms and include bacteria, parasites and viruses
- **Toxins** are poisonous substances produced by living organisms. They are not dependent on a living host to survive and can be hundreds of times more deadly than the organism that produced them.

Refer to the chart for *Biological Agents and Their Effects* to identify the most likely to used and the signs and symptoms for each.

Radioactive and Nuclear Materials – Resource Summary

Signs and symptoms of Radiation Exposure include:

Decontamination of persons exposed to radiation:

- Removal and isolation of all clothing
- Bathing with copious amounts of soap and hot water

Decontamination of equipment and facilities exposed to radiation will require the services of contractors specializing in this type of decontamination.

Radiation Sickness, also known as Acute Radiation Syndrome (ARS) is a serious illness that occurs when the entire body (or most of it) receives a high dose of radiation.
People may get ARS if:

- The radiation dose is high
- The radiation is able to reach internal organs
- The person's entire body, or most of it, receives the dose
- The radiation is received in a short period of time, usually within minutes

Signs and symptoms of Radiation Exposure include nausea, vomiting and diarrhea. These symptoms will start within minutes to days after the exposure and last minutes to several days. The symptoms may "come and go." The person may feel healthy for a short time before becoming ill again. At this time, the symptoms will include:

- Loss of appetite
- Fatigue
- Fever
- Nausea
- Vomiting
- Diarrhea
- Possibly seizures and coma

Victims may also have skin damage that will be exhibited within a few hours. These include:

- Swelling
- Itching
- Redness resembling a bad sunburn
- There may or may not be hair loss

Decontamination of persons exposed to radiation:

- Removal and isolation of all clothing
- Bathing with copious amounts of soap and hot water
- Decontamination of equipment and facilities exposed to radiation will require the services of contractors specializing in this type of decontamination.

Chemical Agents and Their Effects

Agent Name	Agent Type	Physical Properties	Physiological Effects	Relative Rate of Action[1]
Phosgene	Choking	Fresh cut hay odor; heavy gas	Coughing and choking, followed by chest tightness, nausea, tearing, vomiting, and headaches. Death due to fluid accumulation in the lungs.	Immediate irritation in high concentrations, and delayed reaction (several hours) in low concentrations.
Hydrogen Cyanide	Blood	Almond odor; highly volatile gas	If high concentration–	Very rapid; incapacitation

			violent convulsions after 20–30 seconds, breathing stops in one minute; cardiac failure within a few minutes.	within minutes and death within 15 minutes.
Mustard	Blister	Possible garlic odor, medium volatility, oily liquid	Blisters or irritation to skin, eyes and lungs	Delayed onset (4-6 hours)
Sarin	Nerve	Colorless/odorless, low volatile liquid	Difficulty breathing, miosis [a], blurred vision, headache and nausea leading to respiratory distress, convulsions and eventually death.	Rapid (within minutes)
VX	Nerve	Colorless/odorless, low volatility, oil liquid	Difficulty breathing, miosis [a,] blurred vision, headache and nausea leading to respiratory distress, convulsions and eventually death.	Relatively rapid (within 30 minutes)

Information obtained from http://www.labsafety.com/refinfo/ezfacts/ezf227.htm on 7-31-08.

Biological Agents and Their Effects

Disease (Common Name)	Causative Agent	Physiological Effects	Time to Effect[1]
Anthrax	*Bacillus anthracis*	Mild fever and fatigue, worsening to severe respiratory disorders, high fever and excessively rapid pulse rate. Death can occur within 5–12 days of exposure if left	1-5 days

		untreated. Pulmonary anthrax is fatal more than 90% of the time.	
Plague	*Yersinia pestis*	Fever, headache and rapid heart rate, followed by pneumonia and hemorrhaging of the skin and mucous membranes. Untreated plague pneumonia fatalities approach 100% but early treatment can reduce mortality to as low as 5%.	2-3 days
Smallpox	*Variola major*	Sudden onset of fever, malaise, headache, severe backache and prostration; after 2–4 days fever falls, and rash appears; scabs form and fall off at the end of the fourth week.	10-14 days
Ricin	*Ricinus communis* (castor bean plant)	Initial symptoms include high fever, pain, cough and shortness of breath; after several days' severe dehydration and a decrease in urine/blood pressure. If death has not occurred in 3–5 days, the victim usually recovers.	Several hours

c. See Appendix I for chemical Risk Assessment