



Development of Standards and Guidelines for Healthcare Surge during Emergencies

Existing Facilities

EXISTING FACILITIES

1 **NOTE:** This document was developed with input from a broad group of stakeholders representing
2 constituent organizations with diverse perspectives and technical expertise. The purpose of
3 eliciting a wide range of input was to ensure the information contained in this document was as
4 comprehensive and as sound as possible.
5

6 **Although the individuals referenced and the organizations they represent have provided many**
7 **constructive comments, information and suggestions, they were neither asked nor did they agree**
8 **to endorse the conclusions or recommendations represented here or in subsequent iterations.**
9

10 Introduction

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12 Providing healthcare during a large scale public health emergency presents significant challenges for
13 healthcare facilities, licensed healthcare professionals, and communities. During emergency events,
14 healthcare systems must convert quickly from their existing patient capacity to “surge capacity” - a
15 significant increase beyond usual capacity - to rapidly respond to the needs of affected individuals. The
16 demands of the emergency may prevent compliance with the existing healthcare standards. Just as
17 California has healthcare standards for use with a normal operations, it is essential that California provide
18 guidelines that identify the extent to which existing standards can be flexed or waived for healthcare
19 delivery during emergencies.
20

21 Surge planning for the healthcare system is a substantial and complex challenge. In a time of significant
22 disaster, a successful plan must provide flexibility to address capacity (volumes of patients) and
23 capabilities (types of illnesses) that emerge above baseline requirements. The issues addressed are
24 diverse and include standards of practice during an emergency, liability of hospitals and licensed
25 healthcare professionals, reimbursement of care provided during an emergency, operating alternate care
26 sites, and planning considerations for surge operations at individual hospitals.
27

28 Upon completion of this project, stakeholders will have access to a *Standards and Guidelines Manual* that
29 will serve as a reference manual on existing statutory and regulatory requirements identifying what will be
30 flexed or modified under different emergencies; *Operational Tools* that include forms, checklists and
31 templates to facilitate and guide the adoption and implementation of statutory and regulatory
32 requirements outlined in the *Standards and Guidelines Manual*; and a *Training Curriculum* outlining
33 intended audience, means of delivery and frequency of training that will enable adherence to the policies
34 and overall readiness of the healthcare delivery system.
35

36 The deliverables will serve as the basis for planning and operations of healthcare facilities, providers and
37 communities during an unexpected increase in demand for healthcare services. The deliverable will
38 focus on eight areas: (1) Declaration and Triggers; (2) Existing Facilities; (3) Alternate Care Sites; (4)
39 Personnel; (5) Supplies, Pharmaceuticals and Equipment; (6) Funding Sources; (7) Administrative; and
40 (8) Population Rights.

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1 Executive Summary

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94 In a mass casualty event the ill, injured and worried well will seek care wherever possible: in hospitals,
95 community clinics, physician offices, outpatient treatment centers, and alternate care locations. Planning
96 for a response to surge in demand for healthcare services needs to take into account the capacity of
97 local, regional and state facilities. While a biological event might require isolation of patients, a chemical,
98 radiological, or a nuclear event would require decontamination capabilities at the healthcare facilities.

99 Given the stress such events can exert on a healthcare system, planning and preparation for such events
100 will be at local, regional and state levels and integrated across a continuum of healthcare entities. The
101 local, state and federal governments have a critical role to play by providing operating support, access to
102 resources, incident response structure and above all a legal and compliance framework that is flexible.
103 Declaration and waivers afford providers (personnel and facilities) the required protection to provide care.

104

105 The focus of this document is existing healthcare facilities. According to Health and Safety code section
106 1250, a health facility is defined as "any facility, place, or building that is organized, maintained, and
107 operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including
108 convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of
109 these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or
110 longer..." Health and Safety code section 1250, defines a clinic as "an organized outpatient health facility
111 which provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to
112 patients who remain less than 24 hours, and which may also provide diagnostic or therapeutic services to
113 patients in the home as an incident to care provided at the clinic facility."

114

115 Though the licensing framework distinguishes between health facility (hospitals, etc.) and clinics, this
116 separation should not form the basis for healthcare surge planning. The expert panel recommended that
117 an operations perspective is required when planning for response to mass casualty events.
118 Consideration needs to be given to healthcare assets within the community's direct control.

119

120 Based on this principle, an existing facility for the purposes of this document includes hospitals,
121 ambulatory centers, surgery centers, community clinics, rural health clinics, nursing homes, skilled
122 nursing facilities, home healthcare centers, hospice care centers, physician offices, laboratories, and
123 radiology centers; facilities that currently provide human medical care inclusive of organizational assets
124 such as an administrative buildings and medical office buildings under the organization's direct control
125 where expanded capacity can be utilized.

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127 This document is an operational and a regulatory planning guide for existing facilities. The contents in this
128 guide are assembled in three sections:

129

130 Section I: Standard of care. This section defines Standard of Care during a healthcare surge. It also
131 provides guidance around the regulations/standards, waivers and available liability protection for facilities
132 that provide care during healthcare surge.

133

134 Section II: Surge Capacity. This section provides guidelines and operational tools for surge capacity and
135 capability planning. The section also reviews standards/regulations, waivers and available liability
136 protection for expanding patient care areas. Topics covered in this section include: concepts of
137 community based planning, strategies to create surge capacity, role of outpatient treatment centers and
138 role of Veterans Hospital Administration.

139

140 Section III: Facility Operations. This section provides guidelines and operational tools for key components
141 of the preparedness and response phases. The section also reviews standards/regulations and available
142 liability protection for facility operations. The topics covered in this section include: emergency
143 management standards, continuity of business operations, security planning, hazardous waste

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144 management, decontamination, infectious waste management, infection control, and mass fatality
145 management.

146

147 Additionally, the appendices contain several tools: to enable planners in pre-event planning and to enable
148 personnel in post-incident response. Appendices for Surge Capacity section are denoted as Appendix SC
149 and those for Facility Operations section are denoted as Appendix OPS.

2 Standard of Care

150

151 This section covers the discussion, literature review and definition of Standard of Care during a
152 healthcare surge. The expert panel developed the new definition from the Standard of Care definition
153 under normal circumstances. Standard of Care during a Healthcare Surge is defined as: "the degree of
154 skill, diligence and reasonable exercise of judgment in furtherance of optimizing population outcome
155 during a healthcare surge event that a reasonably prudent person or entity with comparable training
156 experience or capacity would have used under the circumstances"

157

158 In addition to several recommendations from the expert panel, the section covers regulations,
159 standards, waivers, and liability protection associated with Standard of Care including scope of
160 services, non-traditional treatment means, prioritization, and patient management.

161

2.1 What is Standard of Care?

162

163

164 Standard of Care in California is defined by the scope of practice each provider is licensed to provide.
165 It provides a framework to identify the professional responsibilities of licensed personnel and permit
166 individual licensed personnel to be rationally evaluated, to ensure that it is safe, ethical and consistent
167 with the professional practice of the licensed profession in Californiaⁱ. Standard of Care is a legal
168 concept that not only encompasses the diagnosis and treatment of patients but overall management of
169 patients as well. Per Jury Instructions, Standard of Care is defined as:

170

171 *A practitioner must use "the degree of skill and diligence in the care and treatment of his patient that a*
172 *reasonably prudent doctor in the same field of practice for specialty in this state would have used under*
173 *the circumstances of this case".*ⁱⁱ

174

175 The law requires that licensed healthcare personnel, when caring for patients, adhere to the customary
176 skill and care that is consistent with good medical practice. Diligence implies compliance with laws and
177 regulations (for example, licensing requirements). Standard of Care covers all aspects of treatment -
178 from the administering of proper medications to performing open-heart surgery.

179

180 Under normal conditions, current standards of care might be interpreted as employing appropriate
181 health and medical resources to improve the health status and/or save the life of each individual
182 patient. However, according to a report by, Health Systems Research Inc., *Altered Standards of Care*
183 *in Mass Casualty Events*; an AHRQ¹ Publication, April 2005) in the aftermath of a mass casualty event,
184 the demand for care provided in accordance with normal conditions (current standards) would exceed
185 system resources resulting in a healthcare surge. Therefore, it is critically important to identify, plan,
186 and prepare for making the necessary adjustments in current health and medical care standards to
187 ensure that the care provided in response to a healthcare surge results in as many lives being saved
188 as possible.

189

190 The report further states that currently no universally accepted definition of Standard of Care during a
191 mass casualty event exists. Joint Commission refers to such standards as "graceful degradation" under
192 which care and access to caregivers may become rationed. Per the AHRQ report, *Altered Standards*
193 *of Care*" is referred to: "as a shift to providing care and allocating scarce equipment, supplies, and
194 personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving
195 individuals." According to the report, examples of shift in care include:

196

- 197 ■ "Triage efforts that will need to focus on maximizing the number of lives saved. Instead of
198 treating the sickest or the most injured first, triage would focus on identifying and reserving
immediate treatment for individuals who have a critical need for treatment and are likely to

¹ The Agency for Healthcare Research and Quality

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- 199 survive. The goal would be to allocate resources in order to maximize the number of lives
200 saved. Complicating conditions, such as underlying chronic disease, may have an impact on
201 an individual's ability to survive.
- 202 ▪ Triage decisions that will affect the allocation of all available resources across the spectrum of
203 care: from the scene to hospitals to alternate care sites. For example, emergency department
204 access may be reserved for immediate-need patients; ambulatory patients may be diverted to
205 alternate care sites (including nonmedical space, such as cafeterias within hospitals, or other
206 nonmedical facilities) where "lower level" hospital ward care or quarantine can be provided.
207 Intensive or critical care units may become surgical suites and regular medical care wards may
208 become isolation or other specialized response units.
 - 209 ▪ Needs of current patients, such as those recovering from surgery or in critical or intensive care
210 units; the resources they use will become part of overall resource allocation. Elective
211 procedures may have to be cancelled, and current inpatients may have to be discharged early
212 or transferred to another setting. In addition, certain lifesaving efforts may have to be
213 discontinued.
 - 214 ▪ Usual scope of practice standards that will not apply. Nurses may function as physicians, and
215 physicians may function outside their specialties. Credentialing of providers may be granted on
216 an emergency or temporary basis.
 - 217 ▪ Equipment and supplies that will be rationed and used in ways consistent with achieving the
218 ultimate goal of saving the most lives (e.g., disposable supplies may be reused).
 - 219 ▪ Not enough trained staff. Staff will be scared to leave home and/or may find it difficult to travel
220 to work. Burnout from stress and long hours will occur, and replacement staff will be needed.
221 Some scarce and valuable equipment, such as ventilators, may not be used without staff
222 available who are trained to operate them.
 - 223 ▪ Delays in hospital care due to backlogs of patients. Patients will be waiting for scarce
224 resources, such as operating rooms, radiological suites, and laboratories.
 - 225 ▪ Providers that may need to make treatment decisions based on clinical judgment. For example,
226 if laboratory resources for testing or radiology resources for x-rays are exhausted, treatment
227 based on physical exam, history, and clinical judgment will occur.
 - 228 ▪ The psychological impact of the event on providers. Short- and long-term stress management
229 measures (e.g., Critical Incident Stress Management programs) are essential for providers and
230 their families.
 - 231 ▪ Current documentation standards that will be impossible to maintain. Providers may not have
232 time to obtain informed consent or have access to the usual support systems to fully document
233 the care provided, especially if the health care setting is damaged by the event.
 - 234 ▪ Backlog in processing fatalities. It may not be possible to accommodate cultural sensitivities
235 and attitudes toward death and handling bodies. Numbers of fatalities may make it difficult to
236 find and notify next of kin quickly. Burial and cremation services may be overwhelmed.
237 Standards for completeness and timeliness of death certificates may need to be lifted
238 temporarily."

239
240 While the examples suggest how clinical practices might shift, the definition of Altered Standards of
241 Care does not explore the liability and compliance issues that would arise out shift in care provided. To
242 address the lack of legal dimension in the definition of care during healthcare surge, the expert panel
243 chose to modify the Standard of Care definition (Jury instructions). As a first step, the expert panel
244 identified principles supporting the new definition, followed by development of a definition for care
245 provided during healthcare surge and finally, offered recommendations to support an effective
246 response to healthcare surge.

247 Guiding Principles

- 249 • The Adjusted or Altered Standard of Care during a healthcare surge will be "the" Standard of
250 Care available and should be termed "Standard of Care during a Healthcare Surge".
- 251 • The Standard of Care definition, under normal conditions, adapted for large number of victims as
252 opposed to individual patients, would apply to healthcare surges.

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- The definition should broaden the scope of caregivers and afford protection to not just licensed personnel but also volunteers and facilities.

Standard of Care during a Healthcare Surge: "the degree of skill, diligence and reasonable exercise of judgment in furtherance of optimizing population outcome during a healthcare surge event that a reasonably prudent person or entity with comparable training experience or capacity would have used under the circumstances"

- The "under the circumstances" clause in the definition provides some protection to healthcare providers (facilities, personnel and volunteers) during a healthcare surge as long as there is evidence to support that there was no negligence, appropriate steps were taken (planning, periodic training, relevant documentation, etc.) and that there was reasonableness demonstrated.

Recommendations

- The state should consider developing patient prioritization guidelines for healthcare facilities. The guidelines would enable:
 - Equitable, fair and ethical allocation of resources between various types of patients (for example, existing vs. disaster patients, patients with co-morbidities, etc.)
 - Appropriate use of resources by defining criteria for transfer of patient between levels of care and/or discharge.
 - Patient prioritization in accordance with Standard of Care during Healthcare Surge as defined earlier.
 - Coordination of field and facility triage. (Note: Training of responding medical personnel in field triage protocols should be considered.)
- Risk communications and public education programs should be initiated before an incident and such programs should be incorporated in pre-event planning activities of the community. The information provided should set expectations for the Standard of Care that will be available during a healthcare surge and include appropriate guidance for all age groups and populations.

The expert panel also suggested that the state should explore if protocol-based care might have advantages over independent medical judgment during a healthcare surge. Some of the suggested advantages of protocol-based care are:

- Consistent protocols offer defensibility against liability and allow healthcare providers to focus on providing care to populations.
- Protocols enable determining how to deviate from the norm without the healthcare provider experiencing repercussions. Protocols would also address triage and rationing of supplies.
- Development of protocols at the state level would ensure that the protocols are equitable to the populations.

Since the goal of Standard of Care during a Healthcare Surge is to optimize population outcomes, one key planning element to be considered is the training needs of responding medical personnel. Training should focus on behavioral adjustments - from delivering as much care as needed for each patient to applying predefined prioritization, delivery of care and discharge guidelines for populations.

2.2 Regulations and Standards

As discussed earlier, during a healthcare surge usual Standard of Care will not apply. This will mean that facilities will not be able to comply with certain regulatory/standards requirement. This section starts with a review of current regulatory/standards requirement for facility scope of services and treatment means, and available waivers/liability protection. This is followed by a review of current regulatory/standards requirement for patient prioritization and management, and available waivers/liability protection.

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308 2.2.1 Scope of Services and Treatment Means: Compliance Requirements

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Healthcare providers will be faced with extenuating circumstances during which they will have to provide patient care services for which they may not be licensed or have to treat patients using “non-traditional” treatment means. As a result, scope of practice for personnel and scope of services at facilities will require to be flexed. While the "Personnel" workgroup addresses "scope of practice" issues, the discussion below focuses on several statutory requirements that outline the types of services that facilities provide:

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- On a federal level, Medicare Conditions of Participation, Sections 482.21 through 482.45 list the basic hospital functions that must be met in order to participate in the Medicare program. These functions include provision of: a quality assessment and performance improvement program, medical staff, nursing services, medical record services, pharmaceutical services, radiologic services, laboratory services, food and dietetic services, utilization review, physical environment, infection control, discharge planning, and organ, tissue, and eye procurement. Sections 482.51 through 482.57 further lists the services that hospitals have the option, but are not mandated, to provide including: surgical services, anesthesia services, nuclear medicine services, outpatient services, emergency services, rehabilitation services and respiratory care services.
- On a state level, CCR 22 §70011 defines a general acute care hospital's basic services as: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. For skilled nursing facilities (CCR 22 §72301), basic services include: physician, skilled nursing, dietary, pharmaceutical and an activity program. Intermediate care facilities (per CCR 22 §73301) are to provide physician, intermittent nursing, dietary, pharmaceutical and an activity program. Primary care clinics (per CCR 22 §75026) are to provide only those services for which it is organized, staffed and equipped. Intermediate care facilities for the developmentally disabled (per CCR 22 §76301) are to provide patients with a developmental program, health support, food and nutrition, and pharmaceutical services. For intermediate care facilities for the developmentally disabled – habilitative (CCR 22 §76853), basic services include active treatment, health support, food and nutrition, recreational and pharmaceutical services. And correctional treatment centers (per CCR 22 §79597) are to provide patients with physician, psychiatrist, psychologist, nursing, pharmaceutical, dentist, and dietary services.
- Title 22 has specific licensing requirements for supplemental services and special services; CCR 22 §70301 Supplemental Services Approval Required and , CCR 22 §70351 Special Permit Required.
- Health and Safety Code Section 1418.6, No long-term health care facility shall accept or retain any patient for whom it cannot provide adequate care. This means that long-term health care facilities have been prohibited from accepting or retaining any resident for whom they cannot provide adequate care.

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In addition to the statutory requirements outlined above, patients have an overarching right to receive information regarding their treatment. When Standard of Care during a Healthcare Surge is implemented at facilities, it is a possibility that the treatment patients receive would be considered “non-traditional”. In this instance, facilities’ responsibility to notify patients of their treatment remains in effect, perhaps even more so. Therefore, early preparation and notification ahead of a disaster would be prudent.

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- Under CCR 22 §70707(b)(5) hospitals are required to adopt and post a written policy on patients' rights which includes the right to receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

370 2.2.2 Scope of Service and Treatment Means: Waivers and Liability 371 Protection:

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373 Facilities need to be aware of the existing waivers for scope of services:

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- Per the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (HR 3448), the Secretary of Health and Human Services or the Assistant Secretary of Preparedness and Response (ASPR) has the authority to flex the Conditions of Participation upon request by the Governor during a state of emergency.
 - With respect to the state regulations governing facilities' provision of basic services, Health and Safety Code §1276(b) and CCR 22 §70129 provide hospitals with a program flexibility provision and allow DHS the authority to flex existing requirements such as those discussed above. This provision allows the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use has the prior written approval of the department or the office, as applicable. The approval of the department or office shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the department or office regarding the exception, as applicable.
 - To the extent that invoking program flexibility provisions for each facility type (CCR §70129 for general acute care hospitals, 72213 for skilled nursing facilities, 73227 for intermediate care facilities, and 71127 for acute psychiatric hospitals) would not adequately allow facilities to provide services for which they are not licensed or to provide non-traditional treatment means would require invoking Government Code §8571. The Governor – under Government Code §8571 – has the authority during a state of war emergency or a state of emergency to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.
 - Program flexibility exists for CCR 22 §70301 Supplemental Services Approval Required - CCR 22 §70307, and CCR 22 §70351 Special Permit Required - CCR 22 §70363.

410 Current legislation also provides facilities with liability protection, including:

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- *Government Code §8659* states that any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local

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415 emergency at the express or implied request of any responsible state or local official or
416 agency shall have no liability for any injury sustained by any person by reason of such
417 services, regardless of how or under what circumstances or by what cause such
418 injuries are sustained; provided, however, that the immunity herein granted shall not
419 apply in the event of a willful act or omission.

420
421 • *Civil Code §1714.5* which deems that there shall be no liability on the part of one,
422 including the state of California, county, city and county, city or any other political
423 subdivision of the state of California, who owns or maintains any building or premises
424 which have been designated as a shelter from destructive operations or attacks by
425 enemies of the United states by any disaster council or any public office, body, or
426 officer of this state or of the United states, or which have been designated or are used
427 as mass care centers, first aid stations, temporary hospital annexes, or as other
428 necessary facilities for mitigating the effects of a natural, manmade, or war-caused
429 emergency, for any injuries arising out of the use thereof for such purposes sustained
430 by any person while in or upon said building or premises as a result of the condition of
431 said building or premises or as a result of any act or omission, or in any way arising
432 from the designation of such premises as a shelter, or the designation or use thereof
433 as a mass care center, first aid station, temporary hospital annex, or other necessary
434 facility for emergency purposes, except a willful act, of such owner or occupant or his
435 servants, agents or employees when such person has entered or gone upon or into
436 said building or premises for the purpose of seeking refuge, treatment, care, or
437 assistance therein during destructive operations or attacks by enemies of the United
438 states or during tests ordered by lawful authority or during a natural or manmade
439 emergency. No disaster service worker who is performing disaster services ordered
440 by lawful authority during a state of war emergency, a state of emergency, or a local
441 emergency, as such emergencies are defined in Section 8558 of the Government
442 Code, shall be liable for civil damages on account of personal injury to or death of any
443 person or damage to property resulting from any act or omission in the line of duty,
444 except one that is willful.

445
446 • *Civil Code §1714.6* states that the violation of any statute or ordinance shall not
447 establish negligence as a matter of law where the act or omission involved was
448 required in order to comply with an order or proclamation of any military commander
449 who is authorized to issue such orders or proclamations; nor when the act or omission
450 involved is required in order to comply with any regulation, directive, or order of the
451 Governor promulgated under the California Emergency Services Act. No person shall
452 be prosecuted for a violation of any statute or ordinance when violation of such statute
453 or ordinance is required in order to comply with an order or proclamation of any
454 military commander who is authorized to issue such orders or proclamations; nor shall
455 any person be prosecuted for a violation of any statute or ordinance when violation of
456 such statute or ordinance is required in order to comply with any regulation, directive,
457 or order of the Governor promulgated under the California Emergency Services Act.
458 The provisions of this section shall apply to such acts or omissions whether occurring
459 prior to or after the effective date of this section.

460
461 These protections only provide relief at the state level and for state-run programs and hence
462 the recommendation of the expert panel was to afford similar protection at a federal level.

463
464 Clinical Laboratory Improvement Act (CLIA)

465
466 • As it relates to a facility's ability to setup a laboratory during a healthcare surge (for
467 example, during a pandemic influenza outbreak), the CLIA statutes are very
468 prescriptive, and prohibit any place from receiving or testing human specimens unless
469 it is CLIA certified (application, assurances of compliance, survey, etc). A CLIA waiver
470 still requires pre-approval based on an application, and limited scope of testing (42

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471 USC 263a(d)(2).) Since the effect of this necessitates pre-approval, it does not appear
472 possible to secure a waiver prior to a declared emergency.

473
474 There are two suggested options: have a CLIA waiver packed prepared and ready for
475 submission in the event of a declared emergency. This would expedite things on the
476 facility's end, but would still require time for federal processing to approve and issue
477 the waiver. A second option would be to request via the Governor to the Secretary of
478 HHS, a temporary suspension of the requirements under CLIA to obtain a Certificate or
479 a certificate of waiver to perform simple laboratory examinations and procedures.
480 There is authority under 42 USC 247d for the Secretary to take whatever action is
481 appropriate in the event of a public health emergency.
482

483 2.2.3 Prioritization and Management of Patients: Compliance 484 Requirements

485
486 Standard of Care during a healthcare surge will necessitate managing patients in a manner
487 that will save as many lives as possible. There are several regulatory/standards requirements
488 that relate to managing patients:
489

- 490 • Perhaps the most applicable statutory requirement with respect to the prioritization of
491 patients is the Examination and Treatment for Emergency Medical Conditions and
492 Women in Labor Act, or EMTALA (42 U.S.C. 1395dd), which states that hospitals must
493 provide individuals who come to the emergency department with an appropriate
494 medical screening examination to determine whether or not an emergency medical
495 condition exists.

496
497 Upon verifying that the patient does have an emergency medical condition, the hospital
498 must then provide either within the staff and facilities available at the hospital, for such
499 further medical examination and such treatment as may be required to stabilize the
500 medical condition, or for transfer of the individual to another medical facility. If an
501 individual at a hospital has an emergency medical condition which has not been
502 stabilized, the hospital may not transfer the individual unless the individual – after
503 being informed of the hospital's obligations and of the risk of transfer – in writing
504 requests transfer to another medical facility; or a physician has signed a certification
505 that based upon the information available at the time of transfer, the medical benefits
506 reasonably expected from the provision of appropriate medical treatment at another
507 medical facility outweigh the increased risks to the individual and, in the case of labor,
508 to the unborn child from effecting the transfer; or if a physician is not physically present
509 in the emergency department at the time an individual is transferred, a qualified
510 medical person (as defined by the Secretary in regulations) has signed a certification;
511 and the transfer is an appropriate transfer. A certification shall include a summary of
512 the risks and benefits upon which the certification is based.

- 513
514 • As it relates to triage of patients during a healthcare surge, The Joint Commission's
515 Environment of Care stipulates the following Standard: EC.4.18 - The organization
516 establishes strategies for managing clinical activities during emergencies: The
517 fundamental goal of emergency management planning is to protect life and prevent
518 disability. The manner in which care, treatment and services are provided may vary by
519 type of emergency. However, certain clinical activities are so fundamental to safe and
520 effective care that the organization should determine how it will re-schedule or manage
521 patient clinical needs even under the most dynamic situations or in the most austere
522 care environments. (Note, these standards will be effective January 1, 2008)

523
524 The emergency triage process will typically result in patients being quickly treated and

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525 discharged, admitted for a longer stay, or transferred to a more appropriate source of
526 care. It is especially important to identify and triage patients whose clinical needs are
527 outside of the usual scope of service of the organization. A catastrophic emergency
528 may result in the decision to keep all patients on the premises in the interest of safety,
529 or conversely may result in the decision to evacuate all patients because the facility is
530 no longer safe. Planning for clinical services must address these situations
531 accordingly.
532

- 533 • Certain circumstances could warrant the use of patient restraints for the safety of the
534 patient, other patients and staff. Regulations that apply include:
535
 - 536 ○ Welfare and Institutions Code, 5150: When any person, as a result of mental
537 disorder, is a danger to others, or to himself or herself, or gravely disabled, a
538 peace officer, member of the attending staff, as defined by regulation, of an
539 evaluation facility designated by the county, designated members of a mobile
540 crisis team provided by Section 5651.7, or other professional person
541 designated by the county may, upon probable cause, take, or cause to be
542 taken, the person into custody and place him or her in a facility designated by
543 the county and approved by the state Department of Mental Health as a facility
544 for 72-hour treatment and evaluation.
545
546 Such facility shall require an application in writing stating the circumstances
547 under which the person's condition was called to the attention of the officer,
548 member of the attending staff, or professional person, and stating that the
549 officer, member of the attending staff, or professional person has probable
550 cause to believe that the person is, as a result of mental disorder, a danger to
551 others, or to himself or herself, or gravely disabled. If the probable cause is
552 based on the statement of a person other than the officer, member of the
553 attending staff, or professional person, such person shall be liable in a civil
554 action for intentionally giving a statement which he or she knows to be false.
555
 - 556 ○ California Administrative Code, Title 13, Section 1103.2 - Ambulance
557 Emergency Care Equipment and Supplies: Any equipment or supplies carried
558 for use in providing emergency medical care must be maintained in clean
559 condition and good working order. (a) Essential equipment and supplies to be
560 carried shall include as a minimum: (2) Straps to secure the patient to the
561 stretcher or ambulance cot, and means of securing the stretcher or ambulance
562 cot in the vehicle.
 - 563 ○ Health and Safety Code, Section 1798.6: (a) Authority for patient health care
564 management in an emergency shall be vested in that licensed or certified
565 health care professional, which may include any paramedic or other
566 prehospital emergency personnel, at the scene of the emergency who is most
567 medically qualified specific to the provision of rendering emergency medical
568 care. If no licensed or certified health care professional is available, the
569 authority shall be vested in the most appropriate medically qualified
570 representative of public safety agencies who may have responded to the
571 scene of the emergency. (b) If any county desires to establish a unified
572 command structure for patient management at the scene of an emergency
573 within that county, a committee may be established in that county comprised of
574 representatives of the agency responsible for county emergency medical
575 services, the county sheriff's department, the California Highway Patrol, public
576 prehospital-care provider agencies serving the county, and public fire, police,
577 and other affected emergency service agencies within the county. The
578 membership and duties of the committee shall be established by an
579 agreement for the joint exercise of powers under Chapter 5 (commencing with
580

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581 Section 6500) of Division 7 of Title 1 of the Government Code. (c)
582 Notwithstanding subdivision (a), authority for the management of the scene of
583 an emergency shall be vested in the appropriate public safety agency having
584 primary investigative authority. The scene of an emergency shall be managed
585 in a manner designed to minimize the risk of death or health impairment to the
586 patient and to other persons who may be exposed to the risks as a result of
587 the emergency condition, and priority shall be placed upon the interests of
588 those persons exposed to the more serious and immediate risks to life and
589 health. Public safety officials shall consult emergency medical services
590 personnel or other authoritative health care professionals at the scene in the
591 determination of relevant risks.

- 592
- 593 ○ In addition to the above regulations, CCR, Title 22, Sections 1000075 &
594 1000159 apply.
 - 595
 - 596 ○ Guidance on policy and procedures associated with patient restraints can be
597 obtained from San Diego County Division of Emergency Medical Services -
598 Policy Procedure Protocol (Pg 48), July 2002. The document can be
599 accessed via: [http://www2.sdcounty.ca.gov/hhsa/documents/EMS-
600 TreatmentProt2004Rev6_30_04Part3.pdf](http://www2.sdcounty.ca.gov/hhsa/documents/EMS-TreatmentProt2004Rev6_30_04Part3.pdf)
601

602 2.2.4 Prioritization and Management of Patients: Waivers and Liability 603 Protection:

- 604
- 605 • Although 42 USCA §1320b-5 grants the Secretary of Health and Human Services the
606 authority to temporarily waive or modify application of federal program requirements,
607 with respect to EMTALA, the only portion that has been waived (as it was during
608 Hurricane Katrina in 2005) have been the sanctions for a transfer of an individual who
609 has not been stabilized if the transfer arises out of the circumstances of the
610 emergency.

611

612 To date, no waivers for the program requirement itself have been developed nor has
613 there been a general immunity protection developed for violation of a federal regulation
614 during a disaster. Note, as of May 7, 2007, according to federal Register, Department
615 of Health and Human Services - Centers for Medicare & Medicaid Services, 42 CFR
616 Parts 411, 412, 413, and 489 Medicare Program; Proposed Changes to the Hospital
617 Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule :
618 "On December 19, 2006, Congress enacted the Pandemic and All-Hazards
619 Preparedness Act, Pub. L. 109-417. Section 302(b) of Pub. L. 109-417 makes two
620 specific changes that affect EMTALA implementation in emergency areas during an
621 emergency period. Specifically section 302(b)(1)(A) of Pub. L. 109-417 amended
622 section 1135(b)(3)(B) of the Act to state that sanctions may be waived for the direction
623 or relocation of an individual for screening where, in the case of a public health
624 emergency that involves a pandemic infectious disease, that direction or relocation
625 occurs pursuant to a state pandemic preparedness plan. In addition, sections
626 302(b)(1)(B) and (b)(1)(C) of Pub. L. 109-417 amended section 1135(b)(3)(B) of the
627 Act to state that, if a public health emergency involves a pandemic infectious disease
628 (such as pandemic influenza), the duration of a waiver or modification under section
629 1135(b)(3) of the Act (relating to EMTALA) shall be determined in accordance with
630 section 1135(e) of the Act as that subsection applies to public health emergencies. In
631 this proposed rule, we are proposing to make changes to the EMTALA regulations to
632 conform them to the sanction waiver provisions of section 302(b) of Pub. L. 109-417."
633 The proposed rule can be accessed at:

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634 <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-1920.pdf>

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- 638 • On a state level, limited liability protection is available through Health and Safety Code §1317 which states that no health facility, its employees, physician, dentist, clinical
639 psychologist or podiatrist shall be liable in any action arising from refusing to render
640 emergency care if based on a determination, exercising reasonable care, the person is
641 not suffering from an emergency medical condition, or the health facility does not have
642 the appropriate facilities or qualified personnel available to render those services. The
643 same applies to any “rescue team” if resuscitation efforts are attempted and in good
644 faith.
 - 645 • *Government Code §8659* which states that any physician or surgeon (whether licensed
646 in this state or any other state), hospital, pharmacist, nurse, or dentist who renders
647 services during any state of war emergency, a state of emergency, or a local
648 emergency at the express or implied request of any responsible state or local official or
649 agency shall have no liability for any injury sustained by any person by reason of such
650 services, regardless of how or under what circumstances or by what cause such
651 injuries are sustained; provided, however, that the immunity herein granted shall not
652 apply in the event of a willful act or omission.
 - 653 • Currently The Joint Commission standards cannot be flexed

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656
657 The expert panel recommended that regulatory and compliance framework needs to be flexible so that in
658 the event of a healthcare surge, declaration of waivers leads surge response and affords healthcare
659 providers the required flexibility and compliance/liability protection to provide care. Specifically:
- 660 • Expanding *Government Code §8659* to include all existing facilities as defined in this
661 guide.
 - 662 • Expanding *Government Code §8659* to include liability protection for facilities where
663 volunteers present at facilities through informal channels. For example, for volunteers
664 that are not sourced through ESAR-VHP², instead those that directly present at
665 facilities. Another option would be to federalize such volunteers, which means that
666 such volunteers would be considered employees of the federal government sourced
667 through Department of Health Services.
 - 668 • During most healthcare surge events, facilities will experience surge before a formal
669 emergency is declared. In order to protect facilities, waivers accompanying the
670 declaration should be retroactive to experience of surge.
 - 671 • Waivers should not specific to a certain set of regulations (for example, Title 22), but
672 should be broad, yet appropriate for the circumstances. Facilities require a
673 mechanism by which they can determine what level of care should be provided and
674 what regulations should be complied with based on the type of declaration.
 - 675 • Governor's request for waiver of federal requirements must be initiated for local as well
676 as state emergencies.
 - 677 • Waiver should be for suspension of regulations as well as enforcement.
 - 678 • Beyond the waivers discussed in this manual, state should make available a list of
679 specific laws and regulations that can and cannot be waived during a healthcare surge
680 (for example, list of sections of Title 22 that might not be waived). In addition, waiving
681 certain regulations might not be sufficient since providing care during a healthcare
682 surge is likely to violate other related regulations. Facilities require specific guidance
683 that provides them the necessary means to operate outside of license.
 - 684 • Counties need to establish a formal surge mechanism which will have a measure of
685 presumption or automatic confirmation that facilities are free to provide care during
686 healthcare surges. Another option to consider would be a stand-by prior program flex

² Emergency System for Advance Registration of Volunteer Health Professionals

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687 approval conditioned upon declaration of disaster and compliance with as much as
688 possible under the circumstances.

689

690 The occurrence of a healthcare surge will require significant changes in the way in which health and
691 medical care is delivered. The panel of experts was certain in its view that if the healthcare system is to
692 optimize population outcomes, planning, education, and training efforts should be focused on the
693 development and implementation of appropriate protocols for Standard of Care during a Healthcare
694 Surge.

3 Surge Capacity

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Mass casualty events create demand for healthcare services, or a healthcare surge, that often exceed the infrastructure of the affected community. The concept of a surge forms the basis of preparedness and planning efforts for mass casualty events. It is important, therefore, to define Surge Event and Surge Capacity as referenced in this guide.

A Surge Event is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment determines, subsequent to a significant event or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services. The local official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local healthcare jurisdiction/operational area medical and health status.

Surge Capacity is the patient care capacity under the control of existing healthcare organizational asset base which can be flexed to comply with the Standard of Care for a Healthcare Surge arising out of emergencies. "Healthcare Emergency consists of an unpredictable or unavoidable occurrence at unscheduled intervals relating to healthcare delivery, requiring immediate action"ⁱⁱⁱ (Industrial Welfare Commission Order).

Healthcare surge **is not** the frequent emergency department overcrowding experienced by healthcare facilities (for example, Friday/Saturday night emergencies). It **is also not** a local casualty event that might overcrowd nearby facilities but have little to no impact on the healthcare delivery system. Healthcare surge as referenced in this guide specifically relates to mass casualty or catastrophic events that overwhelm the healthcare delivery system.

Medical surge capacity refers to the ability to evaluate and care for a markedly increased volume of patients - one that challenges or exceeds normal operating capacity within the Standard of Care during a healthcare surge event^{iv}. The medical surge capacity is not necessarily limited by the scope of license.

Medical surge capability is descriptive of the types of services that can be offered/provided to patients during times when the health care system is experiencing a surge of patients^v. Medical surge capability encompasses the ability to manage patients requiring care in light of the supplies, resources and personnel available at the time

This section provides recommendations, guidelines and operational tools for surge capacity and capability planning. The key recommendation from the expert panel was that surge capacity planning should be a community based initiative where all the healthcare and non-healthcare assets in the community collaborate and share information, knowledge and resources. Topics covered include: concepts of community based planning, strategies to create surge capacity, role of outpatient treatment centers and role of Veterans Hospital Administration. The section also reviews regulations, standards, waivers and liability protection for expanding patient care areas. The appendix for this section contains several tools, specifically, sample mutual aid MOUs for healthcare facilities, facility capacity and patient census report for surge capacity reporting, and samples of patient transfer and evacuation forms.

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3.1 Community Based Surge Capacity and Capability

The concepts, ideas and content in this section are based on the discussions of the expert panel and references from a report by The CNA Corporation, *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies*, August 2004.

Currently, patient care during emergencies or disasters is provided primarily at community-based hospitals, integrated healthcare systems, private physician offices, and other point-of-service medical facilities. The delivery of care is based on individual facility's preparedness, capacity and capability. However, this approach to response during a healthcare surge is sub-optimal from a population outcome perspective as well as from a scarce resource utilization perspective. In a mass casualty incident, healthcare facilities may lack the necessary resources and/or information to individually provide optimal patient care.

According to the report, "research has shown that most individual healthcare facilities possess limited surge supplies, personnel, and equipment, and that vendors or anticipated "backup systems" for these critical assets are often shared among local and regional healthcare facilities. This "double counting" of resources diminishes the ability to meet individually projected surge demands across multiple institutions" during a healthcare surge.

These community healthcare assets, therefore, must collaboratively develop community surge capacity and capability. This does not, however, preclude or diminish the need for individual healthcare facilities to have a comprehensive emergency management plan that addresses mitigation, preparedness, response, and recovery activities. However, efforts must extend beyond optimizing internal emergency management plans and focus on integrating with other healthcare and non-healthcare assets in the community, public and private. For example, communities should consider developing Memorandum of Understanding (MOU) for transfer of patients from hospitals to skilled nursing facilities (SNF). If SNFs and nursing homes can support the hospital or even hold their own then it will save a lot of hospital beds for the victims during a healthcare surge. Refer to Appendix SC³ 1 for Alameda County's MOU with SNFs and rehabilitation facilities to voluntarily coordinate mutual aid services during a disaster. Similarly, during a Pandemic Influenza, Home Health Care will play a critical role, especially when such patients are either infected or when hospitals are overwhelmed. Community based planning to define the role of home health care and availability of personnel to support such care will enable communities to better respond to an outbreak. Community based planning would allow existing healthcare resources in the public and private sectors as well as other non-healthcare assets to be optimally leveraged. Advantages of community based planning include, shared costs and funding, regulatory/standards compliance, purchasing coalitions, and shared knowledge. To encourage community based planning the government could consider tax breaks for participating members.

One of the challenges in creating a community surge capacity is the possible lack of buy-in from medical clinics, private physician offices, and other healthcare and non-healthcare assets. Because the private medical community is diverse, there are differences in capacity, capability, and constraints to implementing these processes. It is important to recognize that many community healthcare assets do not have the management infrastructure or personnel necessary to establish complex processes for incident preparedness and response. Thus, it is imperative that larger healthcare facilities in the community take a leadership role to initiate and maintain communications, develop trust and make the community planning effort inclusive.

The community based surge capacity and capability is composed of healthcare facilities and non-healthcare facilities to form a unified entity in a defined geographic area. During a surge, a unified entity facilitates effective communications and consistent information sharing with local government. While the community assets retain their management autonomy during surge response, they

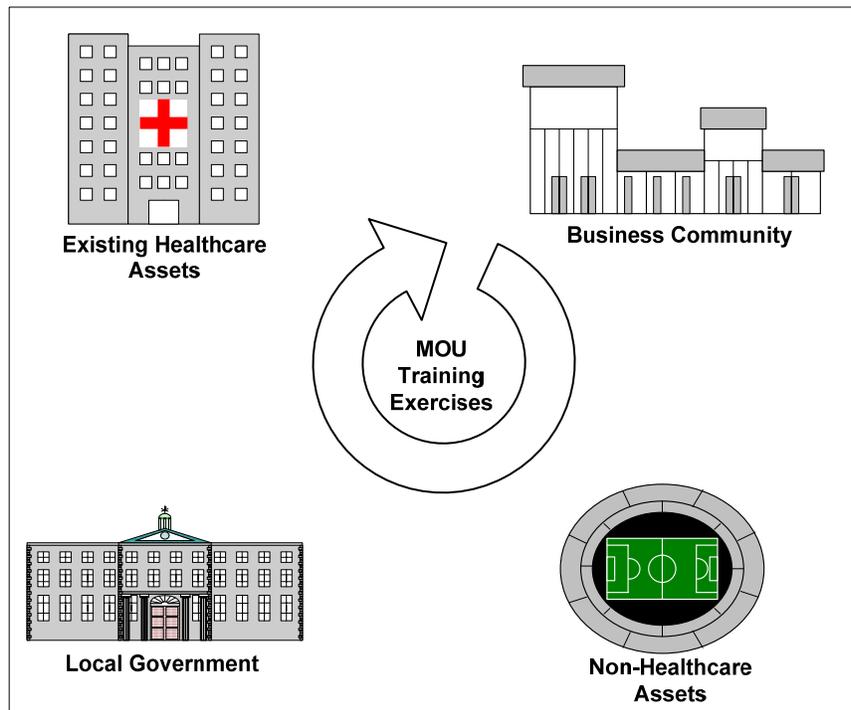
³ SC = Surge Capacity

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coordinate and participate in information and asset sharing. A critical component of community based surge capacity and capability response is mutual aid—the sharing of personnel, facilities, equipment, or supplies. Since not all healthcare facilities, especially smaller hospitals and non-hospital facilities, participate in Health Resources and Services Administration (HRSA) funded programs, mutual aid become critical these clinics to be able to successfully participate in community based response plans. Mutual aid provides surge capacity and capability that is immediately operational, reliable, and cost-effective. Sample mutual aid agreements have been attached in the Appendix section. Refer to Appendix SC 2 for Alameda County Hospital Mutual Aid Agreement, MOU, and Appendix SC 3 for Memoranda of Understanding - Clinics and Clinic Association of Los Angeles County (Draft). The MOU in Appendix SC 3 indicates that the Community Clinic Association of Los Angeles County (CCALAC) has been designated as a Disaster Resource Center (DRC) for the community health centers and clinics within the County of Los Angeles. The DRC program addresses surge capacity through preparedness activities that enhances response during a disaster and as a resource for equipment, supplies and pharmaceuticals. The DRC’s have a regional emergency management plan for use in the event of a disaster. This plan coordinates efforts with the county as a whole on how medical and health needs will be met. Each DRC serves as a resource for their assigned facilities. They take the lead in planning, training and communication. Once the mutual aid process is established and documented, participating members need to be trained and educated on how to request/receive support and account for assets shared.

Community Based Surge Capacity & Capability



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3.1.1 Community Participants

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An important element of the community based capacity and capability is inclusion and integration of non-healthcare entities in the community. Below is a checklist of community members to consider for community based planning:

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	Community Participant	Role
<input type="checkbox"/>	Local Emergency Medical Services Authority	Local implementing arm of the Emergency Medical Systems Authority.
<input type="checkbox"/>	Law Enforcement and Fire	Emergency first responders
<input type="checkbox"/>	Public works & local Utility Companies	Essential services
<input type="checkbox"/>	Communication Companies	Communication needs
<input type="checkbox"/>	Major employers and business community, especially big-box retailers	Essential supplies and services
<input type="checkbox"/>	Area Airports	Transportation
<input type="checkbox"/>	Red Cross/Salvation Army and other non-profit organizations	Volunteers and Supplies Aid
<input type="checkbox"/>	National Guard and Military Establishments	Transportation and infrastructure support
<input type="checkbox"/>	Chamber of Commerce	Business community support
<input type="checkbox"/>	Board of Realtors	Help coordinate additional space for healthcare facilities
<input type="checkbox"/>	City Unified School District and Community Colleges	Alternate Care Sites
<input type="checkbox"/>	Public transportation	Transportation
<input type="checkbox"/>	Faith based organizations	Translation and funeral services
<input type="checkbox"/>	Private security firms	Security services
<input type="checkbox"/>	Mortuaries	Funeral services
<input type="checkbox"/>	Neighborhood emergency response centers	Volunteers

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The community based capacity and capability may include healthcare and non-healthcare assets from multiple jurisdictions. This may be desirable especially in rural areas, where health and medical assets are scattered. Since rural isolated facilities cannot rely on receipt of supplies, medications and durable medical equipment from Strategic National Stockpile in a timely manner, they have an even greater need to form a community based capacity and capability especially with private sector.

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3.1.2 Community Based Surge Capacity and Capability Standards

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The Joint Commission's Environment of Care provides guidance on standards for community based surge capacity and capability. These standards will be effective January 1, 2008

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- EC.4.11: The organization plans for managing the consequences of emergencies.

840

An emergency in a health care organization or in its community can suddenly and significantly affect demand for its services or its ability to provide those services. The organization's Emergency Management Program defines a comprehensive approach to identifying risks and mobilizing an effective response within the organization and in collaboration with essential response partners in the community.

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- EC.4.12: The organization develops and maintains an emergency operations plan.

842

A successful response relies upon planning around the management of six critical areas: communications; resources and assets; safety and security; staffing; utilities; and clinical activities. While the Emergency Operations Plan can be formatted in a variety of ways, it must address these six critical functions to serve as a blueprint for managing care and safety

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EXISTING FACILITIES

854 during an emergency.

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856 Some emergencies can escalate unexpectedly, or strain not only the organization but the
857 entire community. An organization cannot mitigate risks, plan thoroughly, and sustain an
858 effective response and recovery without preparing its staff and collaborating with the
859 community, suppliers and external response partners. Such an approach will aid the
860 organization in developing a scalable response capability, and in defining the timing and
861 criteria for decisions involving sheltering in place, patient transfer, facility closings, or
862 evacuation.

863

- 864 • EC.4.14: The organization establishes strategies for managing resources and assets during
865 emergencies.

866

867 During emergencies healthcare organizations that continue to provide care, treatment and
868 services to their patients must sustain essential resources, materials, and facilities. The
869 emergency operation plan should identify how resources and assets will be solicited and
870 acquired from a range of possible sources, such as vendors neighboring healthcare
871 providers, other community organizations, state affiliates, or a regional parent company.

872

873 The organization establishes processes to collaborate with health care organizations outside
874 of the community in the event of a regional or prolonged disaster that requires resources and
875 assets from outside the immediate geographic area.

876

877 The organization establishes processes to receive and care for evacuees from other
878 communities consistent with the organization's role in the state or local emergency operations
879 plan.

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881 3.2 Surge Capacity Strategies

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883 According to a report by, Health Systems Research Inc., *Altered Standards of Care in Mass Casualty*
884 *Events*; an AHRQ Publication, April 2005) and The Recommendations of the state Expert Panel on
885 Inpatient and Outpatient Surge Capacity, *Guidelines for Managing Inpatient and Outpatient Surge*
886 *Capacity*, state of Wisconsin, November 2005, if a facility determines they are experiencing a
887 healthcare surge they are to use the following guidelines to assess and prepare for the need to
888 increase patient care capacity:

- 889 • Rapid discharge of emergency department (ED) and other outpatients who can continue their
890 care at home safely
- 891 • Cancellation of elective surgeries and procedures, with reassignment of surgical staff members
892 and space
- 893 • Reduction of the usual use of imaging, laboratory testing, and other ancillary services
- 894 • Transfer of patients to other institutions in the state, interstate region, or nationally.
- 895 • Facilitation of home-based care for patients in cooperation with public health and home care
896 agencies
- 897 • Facilities should consider cohorting surge capacity patients rather than spread them out. This
898 cohorting will also be necessary for pediatric and adolescent patients.
- 899 • Specifically for hospitals:
 - 900 ○ Expansion of critical care capacity by placing select ventilated patients on monitored or
901 step-down beds; using pulse oximetry (with high/low rate alarms) in lieu of cardiac
902 monitors; or relying on ventilator alarms (which should alert for disconnect, high pressure,
903 and apnea) for ventilated patients, with spot oximetry checks
 - 904 ○ Conversion of single rooms to double rooms or double rooms to triple rooms if possible
 - 905 ○ Designation of wards or areas of the facility that can be converted to negative pressure or
906 isolated from the rest of the ventilation system for cohorting contagious patients; or use of

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- 907 these areas to cohort those health care providers caring for contagious patients to
908 minimize disease transmission to uninfected patients
- 909 ○ Use of cots and beds in flat space areas (e.g., classrooms, gymnasiums, lobbies) within
910 the hospital for non-critical patient care
 - 911 ○ Avert elective admissions at tertiary hospitals and discharge patients to rehab or a SNF
912 or to home healthcare.
 - 913 ○ Obstetrics (OB) is to be considered as a “clean” unit (no infectious patients should be
914 placed in OB), but may be filled with other “clean” patients only as a last resort.
 - 915 ○ Any unit that is used for immuno-suppressed patients should be treated in the same way
916 as the OB unit and thus should not be counted as inpatient surge capacity beds.
 - 917 ○ Nursery beds are not to be considered as potential inpatient surge capacity beds even for
918 infants, since these beds are used only for neonates <28 days. If an infant with an
919 infectious disease or with trauma is brought in, the infant is to be placed in pediatrics
920 (PEDS).

921
922 Facilities need to identify wings, areas and spaces that could be opened and/or converted for use as
923 patient/inpatient treatment areas. These potential treatment areas included such areas or spaces as:

- 924 ● Waiting Rooms
- 925 ● Wings previously used as inpatient areas that can be reopened
- 926 ● Conference Rooms
- 927 ● Physical Therapy Gyms
- 928 ● Medical Office Buildings
- 929 ● Parking Lots
- 930 ● Temporary shelters on facility premises (including cots in tents)

931
932 Obviously, there is a hierarchy among these rooms as to which would best and first be used as
933 patient/inpatient surge capacity treatment areas. This selection of areas to be used for surge capacity
934 can best take place when the facility has an understanding of the intensity of the incident and the
935 resulting number of surge patients that it may receive. Collaboration and the establishment of alert
936 protocols with Emergency Medical Services, First Responders and the Emergency Operations Center
937 (EOC) will provide facilities with the necessary information to implement the appropriate number of
938 patient/inpatient surge capacity.

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941 3.2.1 Surge Capacity and Triage

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943 There are two planning aspects that can augment surge capacity, the "what" and the "where".
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945 3.2.1.1 The What

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947 The "what" relates to the pre-event planning of sorting patient care capacity based on triage color
948 codes (red, yellow, green or black). Thus, a facility's surge capacity plan should consider identifying
949 which patient care areas can best serve the needs of a type of patient.

- 950
951 Surge capacity could be initially designated by the following triage color codes:
- 952 ● RED patient care areas are to be designated for the care of patients in need of immediate care.
953 These RED patient care areas, which need to be similar to ED rooms with the required gases and
954 equipment. Examples of such rooms are Post Anesthesia Care Unit PACU and Intensive Care
955 Unit (ICU) rooms or, if necessary, a medical/surgical room.
 - 956 ● YELLOW patient care areas are to be designated for the care of patients, whose treatment can
957 be delayed. These are medical/surgical areas that are in close proximity to existing
958 medical/surgical rooms and also in close proximity to ancillary services and supplies.

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- 959 • GREEN patient care areas are to be designated for care of patients that are ambulatory and thus
960 their injuries may be of a minor nature. GREEN patients could be directly transported to
961 outpatient treatment centers
- 962 • BLACK patient care areas are to be designated for the palliative or comfort care of patients and
963 may be rooms that are more distant from the core acute care service areas.
964

965 Note, as in the field, all these patients will need to be constantly re-triaged. The color designation may
966 change several times for these patients^{vi}.
967

968 3.2.1.2 The Where

969 The "where" enables employing the right amount and types of resources based on the needs of the
970 victims. An applicable model to look at would be the one used by military medical departments. The
971 Health Service Support on Battlefield doctrine employs Echelons of Care. The term echelon is used to
972 describe the phased system of health care delivery in the Theater of Operations (such as from the
973 forward line of troops (FLOT) Echelon I, back to the continental United states (CONUS) Echelon V).
974 Each higher echelon reflects an increase in medical capability while it retains the capabilities found in
975 the lower echelons. At Echelon I, the medic makes medically substantiated decisions on the field
976 (including triage decisions) as well as provides emergency medical treatment, while at Echelon V,
977 facilities are staffed and equipped to provide care for all categories of casualties.
978

979 Employing Echelons of care, to field triage would ensure that victims are routed to the right types of
980 care areas, from field to community clinics, surgery centers, acute care hospitals or even to hospice
981 care centers and thus employing only appropriate level and amounts of scarce resources. A detailed
982 discussion of Echelons of Care can be found at:

983 https://ccc.apgea.army.mil/sarea/products/textbook/Web_Version/chapters/chapter_13.htm#Unit%20level
984
985
986

987 3.2.2 Discharge Planning and Case Management

988 Need for patient care capacity becomes more critical 24 hours after the incident. This will require
989 managing patients and discharging them as soon as it is medically appropriate.
990

991 It is recommended, during a healthcare surge, a discharge committee of the Operations Section
992 leaders from the Incident Command System be formed. Suggested role for the committee are Inpatient
993 Unit Leader, Outpatient Unit Leader, Casualty Care Unit Leader and Mental Health Unit Leader. The
994 committee would assist physicians in the discharge of their patients. Some physicians may be reluctant
995 to discharge their patients early and will need the support of both facility administration and their
996 physician peers to understand that the discharge of their patient(s) is medically appropriate under
997 surge conditions^{vii}. The facilities should periodically report capacity status, and types of patients
998 presenting in a format defined by the Operational Area (OA). As a sample, refer to Appendix SC 4 for
999 Facility Capacity and Patient Census Report.
1000

1001 The emergency plan of the facility should provide for the transfer of patients to other facilities as
1002 deemed necessary by the event producing the surge. Emergency Departments are to divert patients to
1003 alternative triage sites, urgent care clinics or primary care clinics, reserving the ED for life-threatening
1004 emergencies.
1005

1006 Per Sacramento County Healthcare Facilities Mutual Aid Memorandum of Understanding
1007 March 28, 2007, patient-accepting healthcare facilities assume the legal and financial responsibility for
1008 transferred patients upon arrival into the patient-accepting healthcare facility.
1009
1010

EXISTING FACILITIES

1011 "The patient-transferring healthcare facility is responsible for coordinating through Emergency Medical
1012 Services (EMS) or Medical Health Operational Area Coordinator (MHOAC) the transportation of
1013 patients to the patient-receiving healthcare facility. The patient-receiving healthcare facility's senior
1014 administrator or designee will designate the point of entry for the receiving healthcare facility. Once
1015 admitted, that patient becomes the patient-receiving healthcare facility's patient and under care of the
1016 patient-receiving healthcare facility's admitting physician until discharged, transferred or reassigned.
1017 The patient-transferring healthcare facility is responsible for the transferring of extraordinary drugs or
1018 other special patient needs (e.g., equipment, blood products) along with the patient if requested by the
1019 patient-receiving healthcare facility." The expert panel recommended that the patient-transferring
1020 facility is obligated to accept the patient when the accepting facility is ready to return the patient. Refer
1021 to Appendix SC 5 for a simple Facility Transfer Summary Form. A Skilled Nursing and Rehabilitation
1022 Patient Evacuation and Tracking Form can be found in Appendix SC 6.

1023 3.3 Role of Clinics and other Outpatient Facilities

1024
1025 Community clinics, including Indian health clinics operated by tribal government entities, have a
1026 significant role in providing medical care to underserved urban and rural communities. While their
1027 capabilities are limited, they are likely to be significant points of convergence for ambulatory patients
1028 seeking care because:

- 1029 ▪ "Victims often seek medical care in settings they are familiar with, such as a personal
1030 physician's office;
- 1031 ▪ When medical surge demands severely challenge hospitals, patients may seek care at other
1032 healthcare facilities;
- 1033 ▪ Some victims' treatment requirements may be adequately managed in these smaller settings;
1034 and
- 1035 ▪ Certain events, such as a biological agent release, may be prolonged in duration and generate
1036 patients that can be safely evaluated in these settings, thus relieving some of the burden on
1037 larger healthcare facilities". (The CNA Corporation, *Medical Surge Capacity and Capability: A
1038 Management System for Integrating Medical and Health Resources During Large-Scale
1039 Emergencies*, August 2004)

1041 According to California Emergency Medical Services Authority, *California Disaster Medical Response
1042 Plan*, January 24, 2007, the use of off site facilities, such as freestanding Outpatient Surgery Centers,
1043 for treatment of specified injuries (orthopedic or abrasion/lacerations which require more than first aid)
1044 will free up necessary resources at the hospital. Increasingly, licensing, accreditation, and funding
1045 agencies require community clinics to develop disaster response plans and perform hazard
1046 vulnerability assessments.

1047
1048 Urgent care centers, dialysis clinics, and other non-hospital facilities also provide essential medical
1049 services. Following a catastrophic disaster these facilities, along with community clinics, have several
1050 potential response roles and responsibilities:

- 1051 ▪ Protection of staff and patients.
- 1052 ▪ Stabilization of casualties who are injured on site or converge to the facility.
- 1053 ▪ Maintaining continuity of care to ambulatory patient base
- 1054 ▪ Creating a surge capacity resource for the treatment of stable, low priority incident and/or non-
1055 incident patients
- 1056 ▪ Creating a venue to establish specialty disaster services, such as blood donation stations,
1057 worried well centers, and mental health services.
- 1058 ▪ Participation, consistent with the organization's mission, capability and role as planned and
1059 provided for in the local system, in the OA's medical and health response.
- 1060 ▪ If unable to provide services, referring both usual patients and disaster victims to appropriate
1061 alternative sources of medical care.
- 1062 ▪ In addition to keeping the facility open, provide assistance with recruiting medical personnel or
1063 volunteers to augment staff at other health care facilities or service sites.

EXISTING FACILITIES

- 1064 ▪ Supporting OA medical response through language services and outreach and information
- 1065 dissemination to limited-English proficient and isolated communities.
- 1066 ▪ Rapid restoration of function to provide services to its usual patient population.
- 1067

1068 To meet these responsibilities, non-hospital facilities should:

- 1069 ▪ Develop and exercise disaster plans for internal and external emergencies both separately and
- 1070 simultaneously.
- 1071 ▪ Train staff in disaster operations including operating under Incident Command System (ICS).
- 1072 ▪ Establish communication and coordination links with their MHOAC and as specified in local plans.
- 1073 ▪ Prepare their facilities by mitigating non-structural hazards
- 1074

1075 California Primary Care Association's The Community Clinic & Health Center Emergency Operations

1076 Plan Template, 2004, provides extensive guidance to community clinics in the development of their

1077 emergency management plans and programs. The template contains sections for mitigation,

1078 preparedness, response and recovery. The appendix section contains extensive tools that enable

1079 planners to develop their emergency operations plan. The document can be accessed at:

1080 <http://www.emsa.ca.gov/hbppc/hbppc.asp>. The next update to the plans is expected to include

1081 Pandemic Influenza planning and an MOU template (see the draft version of the MOU template in

1082 Appendix SC 3)

1083

3.3.1 Outpatient Surge Capacity

1084

1085 Of all the literature reviewed, The Recommendations of the state Expert Panel on Inpatient and

1086 Outpatient Surge Capacity, *Guidelines for Managing Inpatient and Outpatient Surge Capacity*, state of

1087 Wisconsin, November 2005, provides the most insightful and pertinent guidance for outpatient surge

1088 capacity planning. According to the report, hospitals which are located near clinics, freestanding or

1089 hospital affiliated, have the opportunity to designate the clinic area as a triage area, a mass prophylaxis

1090 site, a holding area for minor injuries, a community support area, and a childcare area. If the clinic is

1091 not affiliated with the particular hospital, an important part of comprehensive emergency planning would

1092 be to develop agreements, memoranda of understanding or contracts detailing the roles of the clinic

1093 and hospital in the event of natural disaster, pandemic or other surge situation.

1094

1095

1096 Each hospital is to have a plan whereby it can direct GREEN patients for care and treatment. Hospitals

1097 in a surge incident will be overwhelmed, especially the Emergency Department. The hospital will be

1098 challenged with the management of RED, YELLOW and BLACK patients. A strategy to reduce

1099 overcrowding at hospitals would be to direct GREEN patients from the field and through the media to

1100 Outpatient Treatment Sites. Various outpatient centers such as ambulatory centers, surgery centers,

1101 community clinics, rural health clinics, and physician offices, are to be identified as Outpatient

1102 Treatment Sites.

1103

1104 Physicians and their staff, who normally work in these outpatient centers, will be able to staff these

1105 areas. Considerations for Outpatient Treatment Sites:

- 1106 1. Physicians and staff will have training on the deployment of their office as an Outpatient Treatment
- 1107 Site. Majority of current training material is hospital centric. For clinics and outpatient centers to
- 1108 effectively operationalize their emergency plans, training specific to their needs should be
- 1109 developed.
- 1110 2. These facilities will have limited supplies and equipment and a plan for supplying and re-supplying
- 1111 Outpatient Treatment Sites needs to be addressed
- 1112 3. These sites will serve not only the victims of the incident, but also the GREEN “normal sick and
- 1113 injured”, who will not be able to be treated in the ED
- 1114

1115 The community based surge capacity plan, to be developed in collaboration with the hospital and the

1116 community is to include protocols to deploy these Outpatient Treatment Sites after business hours and

1117 on weekends and holidays and also for extended periods of time (as long as there are patients in need

1118 of care).

EXISTING FACILITIES

1119
1120 Critical to the success of the deployment of these outpatient treatment sites will be a system to call up
1121 the physicians and staff and notify them of the need to deploy the site, especially outside normal
1122 business hours. In some locations, there are no clinics or other suitable sites adjacent or near to the
1123 hospital that can serve as these outpatient treatment sites. In these cases, the community will need to
1124 determine which locations on campus can best be utilized as these sites, since the goal is still to
1125 maintain the ED for RED and YELLOW patients.
1126

1127 Since GREEN patients will be directed to report to these sites from the “field” and will also be
1128 redirected to these sites from the hospital, it is important that these sites be able to become operational
1129 along with community's other healthcare resources.
1130

1131 Below is the Outpatient Treatment Site Matrix that can serve as a planning tool to assist the community
1132 in determining what outpatient centers may serve as treatment sites for GREEN patients and also the
1133 “normal sick and injured”, who do not need immediate ED care and treatment:
1134

Outpatient Treatment Site Matrix	
Type of Patient/Injury/Illness	Name and Location of Outpatient Center
Pediatric Patients	
OB Patients	
Lacerations	
Broken Bones	
Patients in Need of Medical Evaluation	
Cardiac Symptoms	
Psychiatry	
Eye Injury	
Other	

1135
1136 Since clinics and outpatient centers will play a critical role during a Pandemic Influenza, the expert
1137 panel recommended that a similar matrix be developed for Pandemic Influenza or other infectious
1138 diseases.
1139

1140 3.4 Role of Veterans Affairs (VA) Hospitals

1141
1142 As of May 2007 the specific missions of VA healthcare are to:
1143

- 1144 1. Provide medical care to veterans
- 1145 2. Conduct health professional education and training
- 1146 3. Conduct research that benefits veterans
- 1147 4. Provide contingency support to the Department of Defense (DoD) and the civilian health care
1148 system during times of disaster or national emergency
1149

1150 General Considerations for VA health care priorities:

1151 The explicit language in 38 U.S.C. § 8111A and the legislative history of 38 U.S.C. § 1785 indicate that
1152 during declared major disasters and emergencies and activation of NDMS, the highest priority for
1153 receiving VA care and services goes to service-connected veterans, followed by members of the armed
1154 forces receiving care under section 8111A, and then by individuals affected by a disaster or emergency
1155 described in section 1785.
1156

1157 When faced with individuals needing emergency medical treatment, VHA practitioners prioritize based
1158 on medical need. Life-threatening conditions are treated prior to less severe or routine
1159 conditions. This may require deferring routine or elective care for higher priority veterans in order to

EXISTING FACILITIES

1160 treat medical emergencies. This prioritization based on need is not dictated by a specific statute or
1161 regulation. Rather, it is derived from the general authority granted to the Secretary and to health care
1162 providers to provide “needed care” to veterans. Thus, during a disaster or an emergency, VA has
1163 flexibility and discretion in determining what constitutes needed care.

1164
1165 The ability of the VA to respond to requests for services and taskings may be impacted by the need to
1166 respond to local and regional conditions and by VA’s primary mission of providing medical care to
1167 veterans as well as maintain the safety of patient, employees and visitors.

1168
1169 Care to non-VA beneficiaries in a disaster or emergency [38 U.S.C. § 1785]
1170 The Secretary is authorized to provide hospital care and medical services to non-VA beneficiaries
1171 responding to, involved in, or otherwise affected by a disaster or emergency. Section 1785 codifies
1172 VA’s existing obligations under the National Response Plan, including VA’s obligations under the
1173 Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. §§ 5121, et seq.), and during
1174 activation of the National Disaster Medical System (42 U.S.C. § 300hh-11). Regulations to implement
1175 this authority are currently under development.

1176
1177 Care to non-VA beneficiaries in a disaster or emergency [38 U.S.C. § 1785]
1178 In a disaster or emergency declared by the President under the Stafford Act, VA can be directed to
1179 utilize its authorities and resources in support of state and local assistance efforts. This is generally
1180 done through a request for tasking or sub-tasking under the auspices of the National Response Plan.

1181
1182 During non-Stafford Act Incidents of National Significance, the Financial Management Support Annex
1183 of the National Response Plan describes a process for signatories of the NRP to provide needed
1184 support to one another on a reimbursable basis. The Memorandum of Agreement detailing this
1185 process is set forth in the Financial Management Support Annex. The general authority for providing
1186 this assistance is the Economy Act (31 U.S.C. § 1535).

1187
1188 VA’s general authority to share health care resources [38 U.S.C. § 8153; VHA Directive 1660.1,
1189 Enhanced Health Care Resources Sharing Authority – Selling]
1190 To secure health-care resources which otherwise might not be feasibly available, the Secretary may,
1191 make arrangements, by contract or other form of agreement for the mutual use of health-care
1192 resources between VA Health-care facilities and any health-care provider, or other entity or
1193 individual. Health care resources includes hospital and ambulatory care, mental health services,
1194 medical/surgical services, exams, treatment, rehab, preventive health care, prosthetics, administrative
1195 resources, medical equipment, and the use of space.

1196
1197 Further information regarding VA’s policies regarding treating non-veterans during a disaster is
1198 available under Appendix B-2 of VA’s Pandemic Influenza plan at:

1199 http://www.publichealth.va.gov/flu/documents/VAPandemicFluPlan_2006-03-31.pdf
1200

1201 3.5 Regulations and Standards

1202
1203 During a healthcare surge, patient care capacity will be expanded to setup care areas for influx of large
1204 number of patients. This will mean that facilities will not be able to comply with certain
1205 regulatory/standards requirement. This section starts with a review of current regulatory/standards
1206 requirement for facility licensed capacity, followed by a review of current regulatory/standards
1207 requirement for use of non-clinical areas for clinical purposes and ends with available waivers/liability
1208 protection.

1210 3.5.1 Expanding a Facility’s Licensed Capacity: Compliance Requirements

1211

EXISTING FACILITIES

- 1212
- 1213
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- Current regulations (CCR 22 §70809) state that no hospital shall have more patients or beds set up for overnight use than the approved licensed capacity except in the case of justified emergency when temporary permission may be granted by the Director or his designee. Beds not used for overnight stay such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in X-ray or laboratory departments are not included in the approved licensed bed capacity.

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Temporary permission may be granted by the Department of Health Services Licensing & Certification Office (DHS L&C) upon the facility's submittal, and DHS L&C district office approval, of an application (All Facilities Letter AFL 06-33 Attachment A – DHS L&C Temporary Permission for Increased Patient Accommodations Request Review and Approval Sheet).

- 1225
- 1226
- 1227
- 1228
- 1229
- 1230
- Patient accommodation regulations for skilled nursing facilities, intermediate care facilities, and acute psychiatric hospitals may be found at CCR 22 §72607, 73609, and 71609 respectively. However, similar guidance (i.e., and All Facilities Letter) for other facilities to increase patient accommodations and their capacity in response to a surge, should be developed.

1231 3.5.2 Using Non-Clinical Areas for Clinical Purposes: Compliance

1232 Requirements

1233

1234

1235

1236

1237

Guidance for how a facility may use its space and whether they may be converted, for example from a non-clinical area to a clinical area, is provided by both regulatory requirements and industry standards.

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- 1239
- 1240
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- 1253
- Per CCR 22 §70805, spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department. Although this regulation pertains specifically to general acute care hospitals, space conversion regulations for skilled nursing facilities, intermediate care facilities and acute psychiatric hospitals may be found at CCR 22 §72603, 73605 and 71605 respectively.
 - Additionally, the National Fire Protection Association (NFPA) standards (19.1.1.4.4) stipulate that for existing health care occupancies, a change from one health care occupancy sub-classification to another shall require compliance with the requirements for new construction. With respect to existing ambulatory health care facilities, sections of facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (1) they are not intended to serve ambulatory health care occupants for purposes of treatment or customary access by patients incapable of self-preservation and (2) they are separated from areas of ambulatory health care occupancies by construction having a fire resistance training of not less than 1 hour. (NFPA standards 21.1.2.1)

1254 3.5.3 Existing Waivers

1255

1256

1257

1258

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1264

Health and Safety Code §1276(b) and CCR 22 §70129 provide hospitals with a program flexibility provision and allow DHS the authority to flex existing requirements such as those discussed above. This provision allows the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use has the prior written approval of the department or the office, as applicable. The approval of the department or office shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the department or office regarding the exception, as applicable.

EXISTING FACILITIES

1265
1266 To the extent that invoking program flexibility provisions for each facility type (CCR §70129 for
1267 general acute care hospitals, 72213 for skilled nursing facilities, 73227 for intermediate care
1268 facilities, and 71127 for acute psychiatric hospitals) would not adequately allow facilities to expand
1269 their licensed capacity, or to use non-clinical areas for medical care during a surge would re
1270 quire invoking Government Code §8571. The Governor – under Government Code §8571 – has
1271 the authority during a state of war emergency or a state of emergency to suspend any regulatory
1272 statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or
1273 regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment
1274 Insurance Code, where the Governor determines and declares that strict compliance with any
1275 statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the
1276 effects of the emergency.

1277
1278 At this time, there is no known process to flex NFPA standards.
1279

1280 3.5.4 Liability Protection

1281
1282 Current legislation already provides facilities with liability protection, including:
1283

- 1284 • Government Code §8659 which states that any physician or surgeon (whether licensed in this
1285 state or any other state), hospital, pharmacist, nurse, or dentist who renders services during
1286 any state of war emergency, a state of emergency, or a local emergency at the express or
1287 implied request of any responsible state or local official or agency shall have no liability for
1288 any injury sustained by any person by reason of such services, regardless of how or under
1289 what circumstances or by what cause such injuries are sustained; provided, however, that the
1290 immunity herein granted shall not apply in the event of a willful act or omission.
1291
- 1292 • Civil Code §1714.5 which deems that there shall be no liability on the part of one, including
1293 the state of California, county, city and county, city or any other political subdivision of the
1294 state of California, who owns or maintains any building or premises which have been
1295 designated as a shelter from destructive operations or attacks by enemies of the United
1296 states by any disaster council or any public office, body, or officer of this state or of the United
1297 states, or which have been designated or are used as mass care centers, first aid stations,
1298 temporary hospital annexes, or as other necessary facilities for mitigating the effects of a
1299 natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof
1300 for such purposes sustained by any person while in or upon said building or premises as a
1301 result of the condition of said building or premises or as a result of any act or omission, or in
1302 any way arising from the designation of such premises as a shelter, or the designation or use
1303 thereof as a mass care center, first aid station, temporary hospital annex, or other necessary
1304 facility for emergency purposes, except a willful act, of such owner or occupant or his
1305 servants, agents or employees when such person has entered or gone upon or into said
1306 building or premises for the purpose of seeking refuge, treatment, care, or assistance therein
1307 during destructive operations or attacks by enemies of the United states or during tests
1308 ordered by lawful authority or during a natural or manmade emergency. No disaster service
1309 worker who is performing disaster services ordered by lawful authority during a state of war
1310 emergency, a state of emergency, or a local emergency, as such emergencies are defined in
1311 Section 8558 of the Government Code, shall be liable for civil damages on account of
1312 personal injury to or death of any person or damage to property resulting from any act or
1313 omission in the line of duty, except one that is willful.
1314
- 1315 • Civil Code §1714.6 which states that the violation of any statute or ordinance shall not
1316 establish negligence as a matter of law where the act or omission involved was required in
1317 order to comply with an order or proclamation of any military commander who is authorized to
1318 issue such orders or proclamations; nor when the act or omission involved is required in

EXISTING FACILITIES

1319 order to comply with any regulation, directive, or order of the Governor promulgated under
1320 the California Emergency Services Act. No person shall be prosecuted for a violation of any
1321 statute or ordinance when violation of such statute or ordinance is required in order to comply
1322 with an order or proclamation of any military commander who is authorized to issue such
1323 orders or proclamations; nor shall any person be prosecuted for a violation of any statute or
1324 ordinance when violation of such statute or ordinance is required in order to comply with any
1325 regulation, directive, or order of the Governor promulgated under the California Emergency
1326 Services Act. The provisions of this section shall apply to such acts or omissions whether
1327 occurring prior to or after the effective date of this section.
1328

1329 However, these protections only provide relief at the state level and for state-run programs and
1330 thus, the recommendation would be to afford similar protection at a federal level. In addition, the
1331 expert panel recommended:

- 1332 • Expanding Government Code §8659 to include all existing facilities as defined in this guide.
- 1333 • While a local office can declare a local emergency, Government Code 8571 (Government
1334 Code §8571 – has the authority during a state of war emergency or a state of emergency to
1335 suspend any regulatory statute, or statute prescribing the procedure for conduct of state
1336 business, or the orders, rules, or regulations of any state agency, including subdivision (d) of
1337 Section 1253 of the Unemployment Insurance Code, where the Governor determines and
1338 declares that strict compliance with any statute, order, rule, or regulation would in any way
1339 prevent, hinder, or delay the mitigation of the effects of the emergency) would not apply
1340 under such circumstances. Thus facilities must be provided permission ahead of time to flex
1341 patient care areas and move patients from licensed units to non-licensed part of
1342 organizational asset.
- 1343 • From a pre-event planning perspective there is an opportunity to get licensed "surge beds".
1344 Another option to consider would be to have surge specific language incorporated in the
1345 current regulations.

4 Facility Operations

1346

1347

1348 According Emergency Medical Services Authority of California, *Hospital Incident Command System*
1349 *Guidebook*, August 2006, an Emergency Management Program is defined as "a program that
1350 implements the organization's mission, vision, management framework, and strategic goals and
1351 objectives related to emergencies and disasters. It uses a comprehensive approach to emergency
1352 management as a conceptual framework, combining mitigation, preparedness, response, and recovery
1353 into a fully integrated set of activities. The "program" applies to all departments and organizational units
1354 within the organization that have roles in responding to a potential emergency. (Adapted from NFPA
1355 1600, 2004 and the VHA Guidebook, 2004)

1356

1357 As discussed in the previous section, community based capacity and capability planning includes
1358 participation of all of community's assets. This does not, however, preclude or diminish the need for
1359 individual healthcare facilities to have a comprehensive emergency management plan that addresses
1360 mitigation, preparedness, response, and recovery activities.

1361

1362 Each facility is expected to develop its own emergency management plan. While this section is not
1363 intended to serve as a template for an emergency management plan, it does provide guidelines and
1364 operational tools for key components of the preparedness and response phases. The section also
1365 reviews regulations, standards, waivers and liability protection for facility operations and some of the
1366 key recommendations from the expert panel. Topics covered in this section include: emergency
1367 management standards, continuity of business operations, security planning, hazardous waste
1368 management, decontamination, infectious waste management, infection control, and mass fatality
1369 management. The appendix for this section contains several tools, specifically, list of emergency
1370 preparedness tools and access links, Incident Command System, business continuity plan template,
1371 standard operating procedure template for equipment, plant and utilities, standardized security
1372 assessment/vulnerability tool, lockdown policy and procedure sample, mass fatality factsheet, and
1373 facility damage report (limited and comprehensive assessment).

1374

4.1 Emergency Management Standards

1375

1376

1377 Emergency management standards provide a structure for development of emergency management
1378 plans. Below is a review of emergency management standards that apply to healthcare facilities.

1379

4.1.1 The Joint Commission's Environment of Care:

1380

1381 The Joint Commission's Environment of Care provides guidance on standards for emergency
1382 management. These standards will be effective January 1, 2008.

1383

- 1384 • EC.4.11: The organization plans for managing the consequences of emergencies.

1385

1386 An emergency in a health care organization or in its community can suddenly and
1387 significantly affect demand for its services or its ability to provide those services. The
1388 organization's Emergency Management Program defines a comprehensive approach to
1389 identifying risks and mobilizing an effective response within the organization and in
1390 collaboration with essential response partners in the community.

1391

- 1392 • EC.4.12: The organization develops and maintains an emergency operations plan.

1393

1394 A successful response relies upon planning around the management of six critical areas:
1395 communications; resources and assets; safety and security; staffing; utilities; and clinical

EXISTING FACILITIES

1396 activities. While the Emergency Operations Plan can be formatted in a variety of ways, it
1397 must address these six critical functions to serve as a blueprint for managing care and safety
1398 during an emergency.
1399

1400 Some emergencies can escalate unexpectedly, or strain not only the organization but the
1401 entire community. An organization cannot mitigate risks, plan thoroughly, and sustain an
1402 effective response and recovery without preparing its staff and collaborating with the
1403 community, suppliers and external response partners. Such an approach will aid the
1404 organization in developing a scalable response capability, and in defining the timing and
1405 criteria for decisions involving sheltering in place, patient transfer, facility closings, or
1406 evacuation.
1407

1408 Refer to Appendix OPS⁴ 1 for a list of Emergency Preparedness Tools.
1409

4.1.2 OSHA

1410 29 CFR 1910.38 Emergency Action Plans; corresponding Cal/OSHA reference - CCR Title 8, Sec 3220
1411 a. Application. An employer must have an emergency action plan whenever an OSHA
1412 standard in this part requires one. The requirements in this section apply to each such
1413 emergency action plan.
1414 b. Written and oral emergency action plans. An emergency action plan must be in writing,
1415 kept in the workplace, and available to employees for review. However, an employer with
1416 10 or fewer employees may communicate the plan orally to employees.
1417 c. Minimum elements of an emergency action plan. An emergency action plan must include
1418 at a minimum:
1419 c.1. Procedures for reporting a fire or other emergency;
1420 c.2. Procedures for emergency evacuation, including type of evacuation and exit route
1421 assignments;
1422 c.3. Procedures to be followed by employees who remain to operate critical plant operations
1423 before they evacuate;
1424 c.4. Procedures to account for all employees after evacuation;
1425 c.5. Procedures to be followed by employees performing rescue or medical duties;
1426 c.6. The name or job title of every employee who may be contacted by employees who need
1427 more information about the plan or an
1428 c.6.1. explanation of their duties under the plan.
1429 d. Employee alarm system. An employer must have and maintain an employee alarm
1430 system. The employee alarm system must use a distinctive signal for each purpose and
1431 comply with the requirements in 1910.165.
1432 e. Training. An employer must designate and train employees to assist in a safe and
1433 orderly evacuation of other employees.
1434 f. Review of emergency action plan. An employer must review the emergency action plan
1435 with each employee covered by the plan;
1436 f.1. When the plan is developed or the employee is assigned initially to a job;
1437 f.2. When the employee's responsibilities under the plan change; and
1438 f.3. When the plan is changed.
1439
1440

4.1.3 Centers For Medicare & Medicaid Services - Condition of Participation

1441 • §482.11 Condition of Participation: Compliance with federal, state and local Laws
1442
1443
1444

⁴ OPS = Operations

EXISTING FACILITIES

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- §482.41 Condition of Participation: Physical Environment - The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.
 - §482.42 Condition of Participation: Infection Control - The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

1455 Waivers: Yes, but only if waived by the Secretary of Health and Human Services or Assistant
1456 Secretary of Preparedness Response (ASPR) under the National Preparedness for Bioterrorism
1457 and Other Public Health Emergencies Act. CMS may waive life safety code requirements if an
1458 unreasonable hard ship on a facility so long as the waiver does not adversely affect the health
1459 and safety of the patients.
1460

1461 4.1.4 CCR 8 3220 - Emergency Action Plan

- 1462
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- 1467
- Scope and Application. This section applies to all emergency action plans. The emergency action plan shall be in writing, except as provided in the last sentence of subsection (e)(3) of this section, and shall cover those designated actions employers and employees must take to ensure employee safety from fire and other emergencies.

1468 4.1.5 Incident Command System

1469

1470 According to the California Governor's Office of Emergency Services (OES) website
1471 (http://acs.oes.ca.gov/Pages/acs_definitions.html), "The ICS (Incident Command System) is a long
1472 proven system of handling field response activities in emergencies. It provides essential management
1473 using these aspects: common terminology, modular organization, integrated communications, a unified
1474 command structure, consolidated action plans, manageable span-of-control, predesigned incident
1475 facilities and comprehensive resource management."
1476

1477 The expert panel recommended that non-hospital healthcare facilities adopt an Incident Command
1478 System methodology for emergency organization structure and management. Appendix OPS 2
1479 provides a version of the Incident Command System, designed by Collaborating Agencies Responding
1480 to Disasters (CARD), that non-healthcare facilities may use.
1481

1482 The Hospital Incident Command System (HICS) is a methodology for using an Incident Command
1483 System (ICS) in a hospital/healthcare environment. According to the California Emergency Medical
1484 Services Authority's (EMSA) website, "HICS is an incident management system based on ICS that
1485 assists hospitals in improving their emergency management planning, response, and recovery
1486 capabilities for unplanned and planned events. HICS is consistent with ICS and the National Incident
1487 Management System (NIMS) principles. HICS will strengthen hospital disaster preparedness activities
1488 in conjunction with community response agencies and allow hospitals to understand and assist in
1489 implementing the 17 Elements of the hospital-based NIMS guidelines. HICS products include a
1490 Guidebook and planning and training tools" and can be accessed at:
1491 <http://www.emsa.ca.gov/hics/hics.asp>
1492

1493 While this guide refers to the Incident Command System as an emergency organization structure and
1494 management system so as to make it relevant for a larger audience (all healthcare facilities), it is
1495 intended that the reader will apply the appropriate emergency management system that exists for their
1496 facility/entity type. For example, a hospital planner may refer to HICS when the Incident Command
1497 System is noted in this guide.

EXISTING FACILITIES

1498 4.2 Business Continuity Planning

1499
1500 Business Continuity Planning involves formulating an action-plan that enables an organization to
1501 perform its routine day-to-day operations in the event of an unforeseen incident. The Joint
1502 Commission's Environment of Care Standards requires facilities to address continuity of business
1503 operations as part of their emergency operations plan (EOP). National Fire Protection Association
1504 (NFPA) Standard 1600, Disaster/Emergency Management and Business Continuity Programs
1505 (<http://www.nasttpo.org/NFPA1600.htm>), has gained international recognition and consensus between
1506 the public and private sectors. The 9/11 Commission recommends that the NFPA 1600 Standard be
1507 adopted by the private sector. The 9/11 Commission further recommends that insurance and credit-
1508 rating industries look closely at a company's compliance with the NFPA Standard in assessing its
1509 insurability and creditworthiness. The Commission believes that compliance with the NFPA Standard
1510 should define the standard of care owed by a company to its employees and the public for legal
1511 purposes. NFPA standards are voluntary, open to public comment and are developed through
1512 consensus processes by technical committees.

1513
1514 NFPA 1600 standard articulates the generic elements of these programs and serves as the basis for
1515 emergency management program evaluation and accreditation system in use by state, local and tribal
1516 governments. This Standard also applies to healthcare facilities, especially hospitals. The 2005
1517 revision to NFPA 99, Standard for Health Care Facilities, Chapter 12 - Health Care Emergency
1518 Management, incorporated the "program" emphasis of NFPA 1600, serving to differentiate an
1519 "emergency management program" for health care systems from the current emphasis by other facility
1520 standards on an "emergency management plan." Chapter 12 in NFPA 99 establishes minimum criteria
1521 for health care facility emergency management in the development of a program for effective disaster
1522 preparedness, response, mitigation, and recovery.

1523
1524 The purpose of the Business Continuity function is to focus on certain aspects of health care facility
1525 operations and service delivery that must not be interrupted. The continuity planning process should
1526 cover these main areas:

1527
1528 Business Planning - determines which aspects of the healthcare facility's operations are the most
1529 critical to its ability to provide care. This preliminary analysis phase assesses the potential risk and
1530 impact on the facility operations, identifies recovery requirements and lists alternative strategies. The
1531 planning team must analyze the different departments that comprise the company's business. Identify
1532 and prioritize the departments and functions that are most critical to the business's survival.

1533
1534 Technical Support - determines the feasibility of the plan from a technical standpoint and ensures that
1535 the different departments, which may have been put at an off-premises site, have the equipment and
1536 technical support to provide care. Details of the functions that must be carried out must be provided,
1537 both prior to and following a disaster, to minimize the loss and improve the chances of quick recovery.

1538
1539 Implementation - ensures that facility personnel will be able and willing to implement the plan. The plan
1540 should take personnel rotation into account, to avoid the situation where only one person knows about
1541 the equipment or other needs of the departments and their processes.

1542
1543 Maintenance and Testing - the Business Continuity Plan is a dynamic document that must reflect the
1544 continuing changes in daily operations of the facility. Constant testing and adjusting are needed in
1545 order to ensure its continued viability.

1546
1547 When determining the necessity for a Business Continuity Plan, facility size should not be a factor,
1548 since business resumption is as critical to a medical office as it is to a large hospital.

1549 The overall purpose of planning is to:

- 1550 ▪ Resume vital operations within a specified time after the incident occurs
- 1551 ▪ Return to normal operations as soon as practical and possible
- 1552 ▪ Train personnel and familiarize them with emergency operations.

EXISTING FACILITIES

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The checklist below summarizes additional areas to consider when developing a Business Continuity Plan:

Additional areas to consider when developing a Business Continuity Plan	
<input type="checkbox"/>	Clear definition of individual responsibilities, including who has the authority to initiate the Business Continuity Plan procedures
	Instruction on when, where and how to use the backup site including, but not limited to:
<input type="checkbox"/>	<ul style="list-style-type: none"> ▪ Procedures for establishing Information Systems processing in an alternate location including arrangements for office space
<input type="checkbox"/>	<ul style="list-style-type: none"> ▪ Replacement equipment
<input type="checkbox"/>	<ul style="list-style-type: none"> ▪ Telecommunications
<input type="checkbox"/>	<ul style="list-style-type: none"> ▪ Supplies
<input type="checkbox"/>	<ul style="list-style-type: none"> ▪ Transportation
<input type="checkbox"/>	<ul style="list-style-type: none"> ▪ Housing
<input type="checkbox"/>	<ul style="list-style-type: none"> ▪ Sanitary facilities
<input type="checkbox"/>	<ul style="list-style-type: none"> ▪ Food and water
<input type="checkbox"/>	Notification to personnel at the selected backup site
<input type="checkbox"/>	List of contacts with work, home, cellular phone, and pager numbers
<input type="checkbox"/>	Identification of vital system software documentation at the backup site.
<input type="checkbox"/>	Procedures for retrieving and restoring medical record information and data from the off-site storage facility
<input type="checkbox"/>	List of vendor contact personnel
<input type="checkbox"/>	Site of remote storage and related information
<input type="checkbox"/>	Current listing of hardware and software
<input type="checkbox"/>	Backup equipment requirements (contracts, compatibility, timeliness, availability)
<input type="checkbox"/>	Interim procedures to be followed until systems are restored, and procedures for catching up when systems are back in operation
<input type="checkbox"/>	Evaluation of maximum outage tolerable for each major system and a restoration priority listing indicating the order in which to restore systems
<input type="checkbox"/>	Verify that a copy of the Business Continuity Plan is stored off-site.

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The plan should consider various types of disasters and varied durations of operations interruption. It should detail the actions to be taken based on the level of damage, rather than an individual type of loss. Appendix OPS 3 provides a sample template for Business Continuity Plan. The template contains key elements to be included in the Business Continuity Plan. The elements include, critical personnel and entity contact information, roles and responsibilities, critical vendor contact information, critical recovery functions, minimal resource requirements for the functions, dependent activities/entities of the function, vital records information, alternate site requirements for business relocation, emergency notification protocols, security strategies, designated plan coordinator and review date.

In addition to continuity of business operations, development of standard operating procedures for key activities of Equipment, Plant and Utilities should be considered. It is essential to involve facility engineering personnel in the patient management planning processes in order to ensure maintenance of a safe facility environment for both hospital personnel and our patients. Areas within the expertise of

EXISTING FACILITIES

1571 engineering that must be included in the planning process are: alarm systems, electrical backup power,
1572 elevators-vertical transport, HVAC, room/hood exhaust, steam distribution, internal transport system,
1573 medical gases system, roads and grounds, waste and debris, and water delivery/potability.
1574 Development of these procedures is critical to the recovery of business operations. The standard
1575 operating procedure tool in Appendix OPS 4 can be used for Equipment, Plant and Utilities.

1576
1577 Note: The Joint Commission - Environment of Care - EC.4.17 - The organization establishes strategies
1578 for managing utilities during emergencies.

1579
1580 Involving engineering in the planning and disaster management process will ensure that mission critical
1581 engineering systems essential to maintaining facility integrity will be properly monitored and preserved.
1582 The expert panel recommended developing waivers for moving from an existing facility to another
1583 healthcare asset that doesn't meet the required standards (qualified immunity).
1584

1585 4.3 Security Planning

1586
1587 The Joint Commission's Environment of Care provides guidance on security planning. These standards
1588 will be effective January 1, 2008

1589
1590 EC.4.15 - The organization establishes strategies for managing safety and security during
1591 emergencies.

1592
1593 Controlling the movement of individuals into, throughout and out of the organization during an
1594 emergency is essential to the safety of patients and staff, and to the security of critical supplies,
1595 equipment and utilities. The organization determines the type of access and movement to be allowed
1596 by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility
1597 suppliers, and other individuals when emergency measures are initiated. Factors influencing access
1598 and movement vary depending upon the type of emergency and local conditions (ie. the decision by
1599 the organization to shelter staff families, the allowance for or prohibition against firearms, mutual aid
1600 agreements with nearby facilities or vendors, etc.)

1601
1602 During an emergency, the campus or immediate environment around the organization may be under
1603 the authority of the local police or sheriff serving the larger community. Access to and from the
1604 organization on local roads and interstates could be subject to local, state or even federal control. As
1605 an incident evolves, this responsibility and authority may shift from one agency to another. For this
1606 reason, it is important that the Emergency Operations Plan includes reference to any existing
1607 community command structure to provide for on-going communication and coordination with this
1608 structure. In the absence of such a command structure, the organization maintains direct contact with
1609 the agencies charged with community security.

1610
1611 Emergency Medical Services Authority of California, *Hospital Incident Command System Guidebook*,
1612 August 2006, provides guidance for security planning. Due to its applicability in the context of existing
1613 facilities, this section has been borrowed from the guidebook. Certain passages have been modified to
1614 provide appropriate context for this guide.

1615
1616

1617 4.3.1 Lock-Down vs. Restricted Visitation

1618
1619 Each incident will have its own security-related issues. In the past, no consideration was given to the
1620 facility being a secondary or especially a primary target for a harm event. Facilities cannot afford that
1621 passive approach any longer. "Gang violence," employee or patient-related violence, and terrorism are
1622 pressing reasons why facility security must be taken seriously and comprehensive planning and

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1623 training conducted. Refer to Appendix Ops 5 for Standardized Security Assessment / Vulnerability
1624 Tool.

1625
1626 The decision to restrict access must be made early into the event by the Incident Commander in
1627 conjunction with other senior personnel such as the Security Branch Director. If access is to be
1628 restricted, then implementing the decision should immediately be carried out according to the EOP.
1629 Announcing the security restrictions to the staff and public should be immediate, followed by assigned
1630 personnel rerouting pedestrian and vehicular traffic and doors being locked, either manually or
1631 electronically (Access Control Unit). Locked doors should ideally be monitored to ensure no
1632 compromise occurs. Internal and external signage indicating the doors are NOT to be opened (and,
1633 where appropriate, redirecting would-be entrants) should be posted as soon as possible. Such signage
1634 can be created in advance and stored, ideally, by doors for rapid deployment. It is crucial to involve life-
1635 safety engineers/personnel in planning and response to ensure adequate egress in the event of a fire
1636 or other internal emergency.

1637
1638 Heightened surveillance procedures may need to be implemented including inspecting suspect
1639 packages; closer scrutiny of personnel at checkpoints, including verification that each individual,
1640 including staff, is wearing a proper identification badge; and assigning properly protected personnel at
1641 patient arrival points, including the decontamination sector if activated (Crowd Control Unit). Certain
1642 areas such as the emergency department, pharmacy, and Facility Incident Command Center (for
1643 example, Hospital Command Center) should receive enhanced security support. Steps may need to
1644 include restricting staff entry into certain areas because of security concerns, unsafe conditions, or
1645 because no additional staff is required. For a lockdown policy and procedure sample refer to Appendix
1646 Ops 6

1647

1648 4.3.2 Supplemental Security Staffing

1649
1650 Supplemental personnel may be needed to assist the on-duty Security staff, depending on the type and
1651 length of the incident. This need may be met by calling personnel in from home, reassigning other non-
1652 Security personnel to select tasks, and requesting help from local law enforcement (Law Enforcement
1653 Interface Unit). Planning should address when law enforcement will be able to assist and how they will
1654 be integrated into facility operations and the Incident Command System. Their deployment
1655 assignments and pertinent response procedures, including rules of engagement, should be discussed
1656 upon their arrival along with what support they will require (e.g., personal protective equipment, phone
1657 access). In addition to using local law enforcement to supplement staffing shortfalls, consideration
1658 should be given to having a contingency contract(s) with local or national private security firms to
1659 provide trained personnel during an emergency. Planning should address the deployment, supervision,
1660 and needed support for these personnel along with associated utilization expenses.

1661

1662 4.3.3 Traffic Control

1663
1664 Depending on the situation, victims will likely be arriving by private autos accompanied by quickly
1665 escalating numbers of family and friends. The media will also be arriving at some point and requesting
1666 special parking locations for their outside interviewing and "live shots." The gravity of the situation may
1667 warrant inspecting all of these vehicles as they enter the campus; this will require additional personnel
1668 and the equipment needed to do the inspection (Traffic Control Unit). For facilities sharing campuses
1669 with other healthcare facilities, the decision-making associated with campus security should be done in
1670 a collaborative manner and employ optimal communication practices.

1671

1672 Traffic patterns may need to be revised to optimize EMS and other emergency vehicle arrivals. The
1673 area in front of the emergency department should be kept clear along with areas assigned for
1674 decontamination. All available parking areas should be opened and consideration given to suspending
1675 gate-entry systems and fee payments.

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1676
1677 Planning should address situations such as abandoned vehicles, including those with possible
1678 chemical contamination, and how they should be removed from outside the emergency department and
1679 other critical locations. It should also be anticipated that law enforcement may request vehicle
1680 information (tag number make and model of the car, and location) for the patients being seen.

1681
1682 As time goes on, vendor deliveries may need special inspections, alternative routing, or cancellation.
1683 The implications of all of these actions should not be taken lightly and will require careful planning and
1684 coordination.
1685

1686 4.3.4 Personal Belongings Management

1687
1688 Routine daily procedures for managing patients' personal belongings may need to be modified. The
1689 arrival of a large number of patients may present challenges in rapidly and accurately cataloguing and
1690 securing belongings. Contaminated patient belongings will require special care to avoid cross-
1691 contamination as well as to preserve the chain of custody if the incident was deliberate. Thus, it is
1692 important that incident plans comprehensively address how all patient belongings will be secured as
1693 well as the process for determining when and how they will be returned to the rightful owner (Security
1694 Branch).
1695

1696 4.3.5 Chain of Custody Considerations

1697
1698 For suspicious incidents, specific chain-of-custody procedures must be followed. The EOP should
1699 outline a fundamental strategy of basic objectives and steps. These procedures ideally will address
1700 everything from handling a patient's personal effects to packaging and transfer of laboratory
1701 specimens. local law enforcement should be consulted when developing these procedures to ensure
1702 the outlined steps are consistent with accepted practice. During an incident it will be important for the
1703 Security Branch to identify what procedures are to be employed and to quickly disseminate easily
1704 understood instructions
1705

1706 4.4 Hazardous Waste Management

1707
1708 Veterans Health Administration Center for Engineering & Occupational Safety and Health in their
1709 *Emergency Management Program Guidebook*, 2002, provide extensive guidance around hazardous
1710 waste management (<http://www1.va.gov/emshg/apps/emp/emp.htm>). This section has been borrowed
1711 from the Emergency Management Program Guidebook.
1712

1713 Key OSHA Hazardous Materials Regulations

- 1714 • Subpart H - Hazardous Materials (1910.101-.126)
 - 1715 ○ 1910.120 - Hazardous Waste Operations and Emergency Response (HAZWOPER) and
 - 1716 Appendices A-E.
 - 1717 • Subpart I - Personal Protective Equipment (1910.132-.139 and App. B)
 - 1718 ○ 1910.132 - General Provisions
 - 1719 ○ 1910.133 - Eye and Face Protection
 - 1720 ○ 1910.134 - Respiratory Protection (and App. A-D)
 - 1721 ○ 1910.136 - Occupational Foot Protection
 - 1722 ○ 1910.138 - Hand Protection
 - 1723 • Subpart Z - Toxic & Hazardous Substances (1910.1000-.1450 App. B)
 - 1724 ○ 1910.1200 - Hazard Communication (and App. A-E)
- 1725

EXISTING FACILITIES

1726 OSHA 1910.120 - Hazardous Waste Operations and Emergency Response (HAZWOPER) regulation
1727 applies to facilities in at least three scenarios: when facilities have an internal release of a hazardous
1728 substance which requires an emergency response; when facilities respond as an integral unit in a
1729 community-wide emergency response to a release of hazardous substance; and, if a facility is a RCRA
1730 (Resource Conservation and Recovery Act)-permitted Treatment, Storage and Disposal Facility
1731 (OSHA, 1991).

1732
1733 The term “emergency” is dependent upon several factors, including the hazards associated with the
1734 substance, the exposure level, the potential for danger and the ability to contain the substance. OSHA
1735 does not require that facilities receive accident victims, but if the victim were part of an emergency
1736 involving hazardous substances and facility personnel needed to decontaminate, HAZWOPER would
1737 apply (OSHA, 1992).

1738
1739 The role of facility personnel in the safe decontamination of victims has been further clarified in the
1740 OSHA publication “Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty
1741 Incidents Involving the Release of Hazardous Substances,” released in December 2004
1742 (http://www.osha.gov/dts/osta/bestpractices/html/hospital_firstreceivers.html). In this document
1743 OSHA outlines the minimal level of personal protective equipment recommended for healthcare
1744 employees decontaminating victims presenting to a non-contaminated medical facility.

1745
1746 The Environmental Protection Agency (EPA), as part of EPCRA, has stated that the agency will not
1747 pursue enforcement actions for environmental consequences of necessary and appropriate actions,
1748 such as decontamination, during the phase of an emergency response where an imminent threat to
1749 human health and life is present. However, once this phase passes, every attempt should be made to
1750 contain the runoff and dispose of it properly. All healthcare facilities implementing hospital
1751 decontamination programs must include procedures for runoff containment and management in the
1752 hospital decontamination plan. EPA’s website has extensive guidelines for hazardous waste storage,
1753 disposal, transportation, and treatment. The guidance can be accessed at:
1754 <http://www.epa.gov/epaoswer/osw/hazwaste.htm>

1755
1756 Key aspects to consider in the development of the standard operating procedure for decontamination
1757 include event recognition, activation, management, primary triage, patient registry and collection of
1758 personal property, decontamination, secondary triage, logistics for treatment, public information and
1759 post-incident actions. Healthcare facility decontamination training programs should follow NFPA
1760 Standard 473, Professional Competence of EMS Personnel Responding to a Hazardous Materials
1761 Incident.

1762
1763 Emergency first responders, at the site of the release, are covered under OSHA’s Standard on
1764 Hazardous Waste Operations and Emergency Response (HAZWOPER), or the parallel Cal/OSHA
1765 state Plan standards (Title 8 CCR, Section 5192-E), and depending on their roles, some facility
1766 employees also are covered by the standard.
1767

1768 4.5 Decontamination

1769
1770 The Hospital and Healthcare System Disaster Interest Group and The California Emergency Medical
1771 Services Authority, have developed *Patient Decontamination Recommendations For Hospitals*, July
1772 2005. The document provides recommendations for protecting healthcare providers and managing
1773 patients in the event of a hazardous materials exposure. Specific algorithms for different contamination
1774 events have been included in the guide. The guide can be accessed at:

1775 <http://www.emsa.ca.gov/aboutemsa/emsa233.pdf>. Some of the recommendations include:

- 1776
1777 1. Facilities must regularly assess the risks to the community and perform a hazards vulnerability
1778 analysis. The level of equipment and staff protection must be based on this analysis.

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2. Facilities are encouraged to establish relationships and notification procedures with appropriate local agencies (e.g. local EMS and public health) in order to:
 - o Ensure communication between the field and facility to allow for preparation.
 - o Ensure that properly trained and equipped field/pre-facility responders decontaminate patients in the field in order to protect the facility as much as possible.
 - o Understand the local protocols and capabilities for field decontamination of patients.
 - o Ensure proper notification of an event to appropriate local agencies.
 3. The primary role of a facility in a hazardous materials event is to triage, treat, decontaminate and medically screen patients as necessary.
 - o An influx of contaminated patients will overwhelm any facility and therefore facilities must work collaboratively with the community and local government to meet the challenges of a surge of contaminated patients.
 - o Facilities must be prepared for potentially contaminated patients who self-refer and present to the facility.
 - o Additional planning considerations may include:
 - Establishing a “fast track” decontamination line for patients with severe or life threatening symptoms, delivering basic life saving treatment during decontamination if time and situation allow. Note the exception for Radiological decontamination in which emergency treatment takes precedence over Radiological decontamination.
 - Establishing a separate decontamination area for patients that require secondary and /or technical decontamination if primary decontamination is not adequate.
 - Establishing a separate “lane” for patients arriving by EMS transport that have been decontaminated on scene so that these patients can be quickly assessed for adequacy of decontamination and be triaged to medical screening more quickly.

4.6 Infectious Waste Management⁵

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- The Public Health and Hospital Preparedness - Public Health and Hospital Preparedness, state of Wisconsin, *Wisconsin Hospital Emergency Preparedness Plan (WHEPP)*, Version 3, provides guidelines for infectious waste management. According to the report, in a mass casualty event, the potential for overloading the waste handling capacity of the facilities is greatly increased. Because of this potential, each participant facility is to develop protocols in addition to existing waste management protocols that address the challenges associated with the increased volume of infectious waste.
1. Greater quantities of materials suitable for containing biological agents or infectious organisms will be needed. These materials are to include but not limited to:
 - a. Biohazard labeled bags
 - b. Sharps containers
 - c. Liquid handling containers
 - d. All other associated supplies materials
 2. Facilities are to list the supplies with supporting information that shows:
 - a. The quantity normally on hand
 - b. An estimate of how long these supplies will last for an inpatient population level determined by the facility.
 3. If the existing inventory of materials or usage rate compromises patient care or waste containment needs, the facility is to obtain additional material:
 - a. If an Emergency Operation Center (EOC) is not activated, contact other participant facilities and request the materials needed.

⁵ Awaiting final review comments from California Department of Health Services, Medical Waste Program

EXISTING FACILITIES

- 1829 b. If the EOC is activated, contact the EOC and request the materials needed. The EOC
1830 may obtain materials from:
1831 i. Participant facilities
1832 ii. Other known sources
1833 iii. The state of California by submitting a request for materials from the Centers for
1834 Disease Control (CDC), "Vendor Managed Inventory Program"

Waste Storage:

- 1835
1836 1. Facilities are to consult with their medical waste disposal vendors for details of the vendor's ability
1837 to provide continued waste disposal services during a mass casualty emergency.
1838 2. Facilities are to consult with their County/Tribal Emergency Management office for protocols for
1839 storage of infectious waste during a mass casualty incident.
1840 3. Infectious waste may need to be stored under refrigeration (<42°F) to limit nuisance conditions.
1841 a. If the EOC is not activated, facilities are to contact the County/Tribal Emergency
1842 Management office to obtain refrigerated storage.
1843 b. If the EOC is activated, facilities are to contact the EOC to obtain refrigerated storage.
1844 4. Separation of infectious waste from the solid waste stream is to be maintained.
1845 5. Combined waste streams are to be handled as infectious waste.
1846 6. Chemical and radiological wastes must be separated and segregated from infectious waste in
1847 order to avoid dual contamination.
1848 7. Waste stored on the premises of the facility must be secure to prevent access by unauthorized
1849 persons and to prevent accidental spread of contamination.
1850 8. The designated storage area for infectious waste must display the appropriate 'bio-hazard'
1851 symbols.
1852 9. Refrigerated storage areas need to be located away from external air intakes or they need to be
1853 maintained with negative airflow
1854

1855 The regulations for medical waste management can be found in California's Medical Waste
1856 Management Act (Division 194, Part 14 of the Health and Safety Code). During events when waste
1857 volumes increase significantly, participating facilities are to comply with established institutional plans
1858 as required by the California Department of Health Services' Medical Waste Management Act. Per
1859 Section 117960(i) of the Medical Waste Management Act (MWMA) an emergency action plan is
1860 required. Indicate in the emergency action plan the actions to be taken in the event of a disruption of
1861 service as a result of a natural disaster or an equipment failure. Existing federal and state waste
1862 disposal regulations and statutes are to be followed as these events unfold. Facilities are also to
1863 contact local governmental agencies to determine local regulations. Accurate record keeping is to be
1864 maintained as set forth in various sections of MWMA.
1865

4.7 Infection Control

1866
1867 The Public Health and Hospital Preparedness - Public Health and Hospital Preparedness, state of
1868 Wisconsin, *Wisconsin Hospital Emergency Preparedness Plan (WHEPP)*, Version 3, provides
1869 guidelines for Infection Control. These guidelines have been adapted for California and reproduced
1870 below.
1871

Definitions

1872
1873
1874
1875 "Isolation rooms" are defined (California Mechanical Code Section 414.0) as negative air pressure
1876 airborne isolation rooms (hereinafter, "NPAir") with a minimum of 12 air exchanges per hour and direct
1877 exhaust to the outside, which is located at least 7 ft above roof and more than 25 feet from an air
1878 intake and from areas where people may pass. If air cannot be exhausted directly to the outside more
1879 than 25 feet from an air intake and from areas where people may pass, then air should be filtered
1880 through an appropriately installed and maintained HEPA filter. These rooms should be appropriately
1881 alarmed (CMC 414.0) and tested monthly (and daily when in use) to verify negative airflow.
1882

EXISTING FACILITIES

1883 "Pre-identified room": In facilities that do not have "NPAir" that meet the above criteria, an enclosed
1884 private room(s) should be pre-identified for "isolating" patients with fever and rash illnesses to minimize
1885 exposure to other patients and staff (e.g., an examination room at the end of a hallway). A
1886 transportation route from the Emergency Department to this pre-identified room also is to be
1887 established.

1888
1889 Infection Control Guidelines

1890 1. California Building Code requires each facility is to have one negative pressure isolation room per
1891 35 patient beds.

1892 2. Ten percent of staffed beds, above All minimum recommendations, are to be Negative Pressure
1893 Surge Capacity (NPSC), if feasible. The definition of NPSC is:

1894
1895 a. A building, portion of a building, or individual rooms where patients suspected or
1896 confirmed to have an airborne transmitted infectious disease can be temporarily isolated
1897 during an emergency situation.

1898 b. Because NPSC usually will have less than the required 12 Air Changes per Hour (ACH)
1899 the "trigger" to use these rooms is:

1900 1. An outbreak of airborne transmitted disease

1901 2. All available All rooms are in use

1902 3. The facility informs the local health department that NPSC is being
1903 implemented and provides the local Health Department (LHD) with the
1904 following information:

1905 a. The number of patients involved

1906 b. The signs and symptoms

1907 c. The origin of the patients

1908 d. Other pertinent information

1909

1910 c. The criteria for NPSC rooms or areas are:

1911 1. Individual patient rooms must be negative in air pressure to the adjacent
1912 corridor.

1913 2. Temporary areas must be negative in air pressure to all adjacent areas.

1914 3. Each room or area must have a minimum of six ACH.

1915 4. These air changes must be exhausted outside the building (preferred) or if this
1916 is not possible, the re-circulated air stream must be HEPA-filtered.

1917

1918 d. Investment in developing NPSC is not recommended if a facility does not have (all) of the
1919 following clinical services.

1920 1. ICU Services

1921 2. 24/7 ventilator/respiratory support

1922 3. 24/7 laboratory support

1923 4. 24/7 respiratory care staff

1924

1925 e. With or without the minimum recommended All or NPSC, each facility is to have a plan to
1926 manage an increased number of patients with suspected or confirmed airborne
1927 transmitted infections and other communicable diseases. The plans are to include:

1928 1. Protocols to transfer patients to another facility

1929 2. Patient cohorting, once the disease is conformed

1930 3. Opening rooms and/or areas that are NPSC or can provide isolation needs.

1931

1932 Minnesota Department of Health, Emergency Preparedness, Response and Recovery website has an
1933 "Airborne Infectious Disease Management" guide. The guide was written to assist hospitals in
1934 developing strategies for temporary negative pressure isolation and provides instruction on the use of
1935 equipment used for airborne infectious disease management. Preventative maintenance schedules
1936 and a sample log for measuring particle counts are included for performance improvement planning.
1937 The guide can be found at:

1938 http://www.health.state.mn.us/oep/training/bhpp/docs/AirborneWeb2_07Linked.pdf

EXISTING FACILITIES

1939
1940 Note: Guidelines from other states do not necessarily comply with California laws, regulations and
1941 standards. These references have been provided for informational purposes only.
1942

1943 4.8 Mass Fatality Management

1944
1945 When a mass casualty event occurs, normal public or hospital mortuary facilities may be overwhelmed
1946 to deal with prolonged mortuary work, forensic examinations and other associated activities. For a
1947 mass fatality factsheet, refer to Appendix OPS 7. Per, Minnesota Department of Health, Disaster
1948 Mortuary Emergency Response Team (D-MERT) Plan, a temporary morgue may need to be
1949 established if the number of dead exceed the resources of the local mortuaries. Potential temporary
1950 morgue sites could be:

- 1951 ▪ National Guard Armories
- 1952 ▪ Schools with gymnasiums (without wooden floors)
- 1953 ▪ Airport hangars
- 1954 ▪ Warehouses
- 1955 ▪ Reception halls
- 1956 ▪ County fair grounds

1957
1958 Considerations for Temporary Morgue Site:

- 1959 ▪ Proximity to disaster site
- 1960 ▪ Electricity
- 1961 ▪ Hot and cold running water
- 1962 ▪ Restrooms
- 1963 ▪ Adequate office space
- 1964 ▪ Ventilation
- 1965 ▪ Large open area of sufficient size to accommodate the number of dead to be cared for
- 1966 ▪ Area for securing valuables
- 1967 ▪ Parking
- 1968 ▪ Secure from public

1969
1970 Minnesota Department of Health, Disaster Mortuary Emergency Response Team (D-MERT) Plan
1971 (<http://www.health.state.mn.us/terrorism.html>) provides detailed guidance on setting up temporary
1972 morgues.

1973
1974 Additional guidance can be found at Mass Fatality Response Plan, Office Of The Coroner Parish Of
1975 East Baton Rouge: <http://ci.baton-rouge.la.us/Dept/OEP/plan/annexu/Appendix2.pdf>.

1976
1977 Note: Guidelines from other states do not necessarily comply with California laws, regulations and
1978 standards. These references have been provided for informational purposes only.
1979

1980 4.9 Regulations and Standards

1981
1982 During a healthcare surge facilities might be damaged and be required to operate in a degraded
1983 environment. This will mean that facilities will not be able to comply with certain regulatory/standards
1984 requirements. This section starts with a review of current regulatory/standards requirement for
1985 structural safety of healthcare facilities and available liability protection. The next section outlines
1986 Cal/OSHA's guidance for healthcare surge and applicable regulations.
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1988

EXISTING FACILITIES

4.9.1 Structural Safety of Healthcare Facilities: Compliance Requirements

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- The California Building Standards Code (CCR 24, Part 2, Volume 1, Section 102) states that all buildings or structures that are regulated by this code that are structurally unsafe or not provided with adequate egress, or that constitute a fire hazard, or are otherwise dangerous to human life are, for the purpose of this section, unsafe. Any use of buildings or structures constituting a hazard to safety, health or public welfare by reason of inadequate maintenance, dilapidation, obsolescence, fire hazard, disaster, damage or abandonment is, for the purpose of this section, an unsafe use.
- Per Health and Safety Code §129990, the Office of statewide Health Planning and Development (OSHPD) has the authority to order the vacating of any building or structure found to have been in violation of the adopted regulations of the office and may order the use of the building or structure discontinued within the time prescribed by the office upon the service of notice to the owner or other person having control or charge of the building or structure. Any owner or person having control so served shall, upon request made within 15 days of the written notice, be entitled to a hearing pursuant to Section 11506 of the Government Code.
- Specific to the determination of seismic safety of healthcare facilities, Health and Safety Code 129680 (a) It is the intent of the Legislature that hospital buildings that house patients who have less than the capacity of normally healthy persons to protect themselves, and that must be reasonably capable of providing services to the public after a disaster, shall be designed and constructed to resist, insofar as practical, the forces generated by earthquakes, gravity, and winds. In order to accomplish this purpose, the office shall propose proper building standards for earthquake resistance based upon current knowledge, and provide an independent review of the design and construction of hospital buildings.

4.9.2 Liability Protection

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- Government Code §8659 which states that any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission.
- Civil Code §1714.5 which deems that there shall be no liability on the part of one, including the state of California, county, city and county, city or any other political subdivision of the state of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United states by any disaster council or any public office, body, or officer of this state or of the United states, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or as other necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United states or during tests

EXISTING FACILITIES

2043 ordered by lawful authority or during a natural or manmade emergency. No disaster service
2044 worker who is performing disaster services ordered by lawful authority during a state of war
2045 emergency, a state of emergency, or a local emergency, as such emergencies are defined in
2046 Section 8558 of the Government Code, shall be liable for civil damages on account of
2047 personal injury to or death of any person or damage to property resulting from any act or
2048 omission in the line of duty, except one that is willful.
2049

2050 • Civil Code §1714.6 which states that the violation of any statute or ordinance shall not
2051 establish negligence as a matter of law where the act or omission involved was required in
2052 order to comply with an order or proclamation of any military commander who is authorized to
2053 issue such orders or proclamations; nor when the act or omission involved is required in
2054 order to comply with any regulation, directive, or order of the Governor promulgated under
2055 the California Emergency Services Act. No person shall be prosecuted for a violation of any
2056 statute or ordinance when violation of such statute or ordinance is required in order to comply
2057 with an order or proclamation of any military commander who is authorized to issue such
2058 orders or proclamations; nor shall any person be prosecuted for a violation of any statute or
2059 ordinance when violation of such statute or ordinance is required in order to comply with any
2060 regulation, directive, or order of the Governor promulgated under the California Emergency
2061 Services Act. The provisions of this section shall apply to such acts or omissions whether
2062 occurring prior to or after the effective date of this section.
2063

2064 However, these protections only provide relief at the state level and for state-run programs and hence
2065 the recommendation was that similar protections should be requested at a federal level.
2066

2067 ▪ Government Code §8571 grants the Governor with the authority, during a state of war
2068 emergency or a state of emergency, to suspend any regulatory statute, or statute prescribing
2069 the procedure for conduct of state business, or the orders, rules, or regulations of any state
2070 agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where
2071 the Governor determines and declares that strict compliance with any statute, order, rule, or
2072 regulation would in any way prevent, hinder, or delay the mitigation of the effects of the
2073 emergency.”
2074

2075 ▪ Additionally to the extent that Government Code §8659 and Civil Codes §1714.5 and 1714.6
2076 do not sufficiently protect facilities from liability, the recommendation is that liability protections
2077 be developed, or current protections be expanded, to ensure that facilities are not held liable so
2078 long as they can show reasonable efforts to preserve safety for both its patients and staff.
2079

2080 ▪ Finally, the expert panel recommended that facilities need to manage liabilities, not solve it.
2081 Facilities should create plans that guide decision making around operating or abandoning a
2082 degraded environment. Facilities should develop a list of “fatal deficiencies/flaws” that would
2083 trigger immediate evacuation. Plans should identify an organizational person to perform an
2084 immediate assessment. Appendix OPS 8 provides a Facility Damage Report (Limited
2085 Assessment) tool that is to be completed by the organizational assessment person in
2086 consultation with California Department of Public Health, Licensing and Certification Program
2087 Office. Appendix OPS 9 provides a Facility On Site Damage/Operability Report which is a
2088 comprehensive assessment performed by California Department of Public Health, Licensing
2089 and Certification Program officer onsite.
2090

2091 4.9.3 Cal/OSHA Guidance:

2092 Cal/OSHA provided the following guidance as it relates to healthcare personnel safety during a mass
2093 casualty event.
2094

2095 1. The #1 priority or one of the first priorities, in responding to a healthcare surge should be to
2096 protect the health and safety of the workforce. The underlying issues around safeguarding
2097

EXISTING FACILITIES

- 2098 their safety must be addressed or else there won't be a workforce to respond to the surge.
2099
2100
2101 2. Health and safety planning has to be an integral part of any disaster planning and
2102 preparedness else there may be a resulting, secondary catastrophe. Facilities should develop
2103 an employee health and safety checklist, which should be incorporated in the emergency
2104 management plans.
- 2105 3. U.S. Department of Labor - Occupational Safety & Health Administration's, *Worker Safety*
2106 *and Health Support Annex* provides guidelines for implementing worker safety and health
2107 support functions during potential or actual Incidents of National Significance. This annex
2108 describes the actions needed to ensure that threats to responder safety and health are
2109 anticipated, recognized, evaluated, and controlled consistently so that responders are
2110 properly protected during incident management operations. The annex can be accessed at:
2111 http://www.osha.gov/SLTC/emergencypreparedness/nrp_work_sh_annex.html
2112
- 2113 4. Although Cal/OSHA regulations are not waived, Cal/OSHA is flexible and aims to work with
2114 facilities. Enforcement of the requirements is handled through the Incident Command
2115 System (ICS), under which the focus is not on citation (or issuance of tickets for violations).
2116 Cal/OSHA would shift from enforcement to "compliance assistance mode". The key driving
2117 principle for Cal/OSHA is not the violation but the hazard involved with violating the standard.
2118
- 2119 5. Cal/OSHA expects that facilities have a health & safety plan that addresses the following:
2120
 - 2121 ▪ Infection control
 - 2122 ▪ Life safety
 - 2123 ▪ Emergency action plan
 - 2124 ▪ Control of hazardous substances
 - 2125 ▪ Personal protective equipment (PPE)
 - 2126 ▪ Fatigue
 - 2127 ▪ Heat stress
 - 2128 ▪ Provision of sanitary facilities

4.9.3.1 OSHA and Cal/OSHA Requirements

- 2129
2130
2131
 - 2132 ▪ As it relates specifically to healthcare facilities' obligation to maintain a safe working
2133 environment for its employees and volunteers, CalOSHA regulations (Labor Code 6400(a) and
2134 6401) state that every employer shall furnish employment and a place of employment that is
2135 safe and healthful for the employees therein; and that every employer shall furnish and use
2136 safety devices and safeguards, and shall adopt and use practices, means, methods,
2137 operations, and processes which are reasonably adequate to render such employment and
2138 place of employment safe and healthful. Every employer shall do every other thing reasonably
2139 necessary to protect the life, safety, and health of employees.
 - 2140 ▪ Federal OSH Act of 1970, Section 5 – "A. Each employer – a. shall furnish to each of his
2141 employees employment and a place of employment which are free from recognized hazards
2142 that are causing or are likely to cause death or serious physical harm to his employees; b. shall
2143 comply with occupational safety and health standards promulgated under this Act. B. Each
2144 employee shall comply with occupational safety and health standards and all rules, regulations,
2145 and orders issued pursuant to this Act which are applicable to his own actions and conduct."
2146
 - 2147 ▪ Cal/OSHA CCR 8 §3203(a)(6). Effective July 1, 1991, every employer shall establish,
2148 implement and maintain an effective Injury and Illness Prevention Program (Program). The
2149 Program shall be in writing and, shall, at a minimum: (6) Include methods and/or procedures
2150 for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely
2151 manner based on the severity of the hazard: (A) When observed or discovered; and, (B) When
2152 an imminent hazard exists which cannot be immediately abated without endangering

EXISTING FACILITIES

- 2153 employee(s) and/or property, remove all exposed personnel from the area except those
2154 necessary to correct the existing condition. Employees necessary to correct the hazardous
2155 condition shall be provided the necessary safeguards.
2156
- 2157 ▪ Labor Code 90.5. (a) It is the policy of this state to vigorously enforce minimum labor
2158 standards in order to ensure employees are not required or permitted to work under
2159 substandard unlawful conditions or for employers that have not secured the payment of
2160 compensation, and to protect employers who comply with the law from those who attempt to
2161 gain a competitive advantage at the expense of their workers by failing to comply with
2162 minimum labor standards.
2163
 - 2164 ▪ Labor Code 6307. The division [California Division of Occupational Safety and Health] has the
2165 power, jurisdiction, and supervision over every employment and place of employment in this
2166 state, which is necessary adequately to enforce and administer all laws and lawful standards
2167 and orders, or special orders requiring such employment and place of employment to be safe,
2168 and requiring the protection of the life, safety, and health of every employee in such
2169 employment or place of employment.
2170
 - 2171 ▪ Labor Code 6401. Every employer shall furnish and use safety devices and safeguards, and
2172 shall adopt and use practices, means, methods, operations, and processes which are
2173 reasonably adequate to render such employment and place of employment safe and healthful.
2174 Every employer shall do every other thing reasonably necessary to protect the life, safety, and
2175 health of employees.
2176
 - 2177 ▪ Labor Code 6400. (a) Every employer shall furnish employment and a place of employment
2178 that is safe and healthful for the employees therein. (b) On multiemployer worksites, both
2179 construction and non-construction, citations may be issued only to the following categories of
2180 employers when the division has evidence that an employee was exposed to a hazard in
2181 violation of any requirement enforceable by the division: (1) The employer whose employees
2182 were exposed to the hazard (the exposing employer). (2) The employer who actually created
2183 the hazard (the creating employer). (3) The employer who was responsible, by contract or
2184 through actual practice, for safety and health conditions on the worksite, which is the employer
2185 who had the authority for ensuring that the hazardous condition is corrected (the controlling
2186 employer). (4) The employer who had the responsibility for actually correcting the hazard (the
2187 correcting employer). The employers listed in paragraphs (2) to (4), inclusive, of this
2188 subdivision may be cited regardless of whether their own employees were exposed to the
2189 hazard. (c) It is the intent of the Legislature, in adding subdivision (b) to this section, to codify
2190 existing regulations with respect to the responsibility of employers at multiemployer worksites.
2191 Subdivision (b) of this section is declaratory of existing law and shall not be construed or
2192 interpreted as creating a new law or as modifying or changing an existing law.
2193

EXISTING FACILITIES

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5 APPENDICES

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- Appendix SC refers to appendices for Surge Capacity
- Appendix OPS refers to appendices for Facility Operations

EXISTING FACILITIES

2200 Appendix SC 1: Skilled Nursing and Rehabilitation Facilities 2201 Mutual Aid Agreement and Memorandum of Understanding

2202
2203 Skilled Nursing and Rehabilitation Facilities - Mutual Aid Agreement
2204 MEMORANDUM OF UNDERSTANDING

2205 2206 I. Scope and Applicability 2207

2208 The participants agree that in the event of a declared or undeclared event affecting hospital
2209 services as a result of natural, man-made or technological causes or a mass casualty incident
2210 (hereinafter "Disaster") which exceeds the effective response capabilities of the impacted health care
2211 facility or facilities of any other Participant, the affected Participant may request assistance from the
2212 other Participants as is more generally set forth herein.
2213

2214 In the event of Disaster, an affected participant should first contact the other Participants. If the
2215 disaster is broader than the Participants determine they can handle by working together, they will
2216 contact the Alameda County Emergency Medical Authority, their city government Office of Emergency
2217 Services, and other agencies as appropriate. The Participants will use the guidelines established
2218 herein to coordinate the care and services necessary to deal with the Disaster.
2219

2220 Each Participant shall agree to take all appropriate actions during a Disaster without regard to
2221 race, color, creed, national origin, age, sex, gender orientation, religion, or handicap to assist all
2222 Participants as necessary. No Participant shall be required to provide treatment, care, medical
2223 supplies, equipment, services or personnel over and above that which is necessary to meet its own
2224 needs, existing or anticipated, or beyond its own resources.
2225

2226 In the event that the affected Participant is unable to continue patient care for some or all of its
2227 patients, the other Participants agree to act as receiving facilities for these patients.
2228

2229 Each Participant agrees to follow the guidelines set forth herein to the extent possible. There
2230 shall be no cause of action or basis of liability for breach of this Memorandum of Understanding by any
2231 participant(s) against any other Participant(s).
2232

2233 This Memorandum of Understanding is not intended to replace each facility's Disaster Plan or
2234 to adversely affect existing transfer agreements between facilities, but is intended to support those
2235 plans and agreements. Each Participant shall incorporate this Memorandum of Understanding into its
2236 disaster plan consistent with the principles agreed to herein.
2237

2238 II. GUIDELINES

2239 A. EMERGENCY TREATMENT

2240 Each Participant agrees to provide assistance, as available within its reasonable
2241 capabilities, including:

- 2242 1) Accepting as many casualties / patients as resources permit.
- 2243 2) Accepting as many transfers as resources permit.
- 2244 3) Providing emergency treatment / care within the capabilities of the facility.
- 2245 4) Providing emergency physician and medical support services.
- 2246 5) Providing diagnostics services
- 2247 6) Assisting in placing casualties / transfers.
- 2248 7) Facilitating transportation as available and requested by other Participants
- 2249 8) Notifying the Participants when vacancies no longer exist
2250

2251 Skilled Nursing and Rehabilitation Facilities
2252 Mutual Aid Agreement - MEMORANDUM OF UNDERSTANDING
2253 Adapted from Final Guidelines developed by New Hampshire Hospital Association and Draft
2254 Guidelines from Vermont Hospital Association

EXISTING FACILITIES

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- 9) Providing a copy of the medical record for patient transferred / received.
- 10) Providing other medical services that may be necessary and requested.

B. EMERGENCY MEDICAL SUPPLIES AND EQUIPMENT

A Participant shall provide emergency medical supplies and equipment within resource capabilities.

C. COST OF SERVICES, EQUIPMENT AND PERSONNEL

A Participant receiving services, equipment, and personnel will replace or reimburse the cost of same to Participant providing services, equipment, and personnel.

D. ADMINISTRATIVE SERVICES

A Participant will provide the following administrative services for themselves and will assist other Participants by:

- 1) Maintaining a current listing of all casualties or transfers made to and from the Participants facility.
- 2) Maintaining a current listing of all discharges, their assigned areas and locations.
- 3) Maintaining a current listing of all deaths at the Participant's facility.
- 4) Notifying the other Participants when patients or personnel can be returned to their facility.
- 5) Furnishing other information or record keeping, as may be requested or deemed necessary by the Participant.

Consider also requiring:

- 6) Maintaining a record of all treatment administered, including medical supplies, and charges made.
- 7) Notifying attending physicians of the disaster and disposition of their patients.
- 8) Contacting family members of patients/personnel and informing them of the disposition of each.

E. COMMUNICATION SERVICES

In the event the Participants' normal lines of communication are disrupted, other Participants, as feasible, will:

- 1) Monitor Emergency Department 800 MHz radios and HAM radios for emergency information transmitted.
- 2) Communicate among themselves and with Alameda County EMSA and Department of Public Health and local hospitals.
- 3) Notify local fire, police, and other municipal services.
- 4) Request support from state, local, or Department of Public Health emergency operations centers based on levels of activation and type of assistance needed.

Skilled Nursing and Rehabilitation Facilities
Mutual Aid Agreement - MEMORANDUM OF UNDERSTANDING
Adapted from Final Guidelines developed by New Hampshire Hospital Association and Draft
Guidelines from Vermont Hospital Association

EXISTING FACILITIES

III. EFFECTIVE DATE, FUTURE AMENDMENT AND CONSTRUCTION

2308
2309
2310 This Memorandum of Understanding shall become effective on **July 1, 2007, through June 2012**. A
2311 Participant may terminate its participation in this Memorandum of Understanding by giving a sixty (60)
2312 day written notice to the other Participants of its intentions to so terminate.

2313
2314 This Memorandum of Understanding shall be reviewed periodically to ensure that it meets the
2315 requirements of the Participants.

2316
2317 This Memorandum of Understanding is in no way meant to affect any of the Participants' rights,
2318 privileges, titles, claims, or defenses provided under federal or state law or common law.

2319
2320
2321
2322 IN WITNESS WHEREOF, we have set our hands and seals to the date below written.

2323
2324
2325 _____
2326 Health Care Institution

2327
2328
2329 _____
2330 Administrator

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2332
2333 _____
2334 Date

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2353 Skilled Nursing and Rehabilitation Facilities
2354 Mutual Aid Agreement - MEMORANDUM OF UNDERSTANDING
2355 Adapted from Final Guidelines developed by New Hampshire Hospital Association and Draft
2356 Guidelines from Vermont Hospital Association

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EXISTING FACILITIES

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Appendix SC 2: Alameda County Hospital Mutual Aid Agreement, MOU

DRAFT: For Discussion Purposes Only
Alameda County
Hospital Mutual Aid Agreement
MEMORANDUM OF UNDERSTANDING

I. Scope and Applicability

The participants agree that in the event of a declared or undeclared event affecting hospital services as a result of natural, man-made or technological causes or a mass casualty incident (hereinafter "Disaster") which exceeds the effective response capabilities of the impacted health care facility or facilities of any other Participant, the affected Participant may request assistance from the other Participants as is more generally set forth herein.

In the event of a Disaster, an affected participant should first contact the other Participants. If the disaster is broader than the Participants determine they can handle by working together, they will contact the Alameda County Emergency Medical Authority, their city government Office of Emergency Services, and other agencies as appropriate. The Participants will use the guidelines established herein to coordinate the care and services necessary to deal with the Disaster.

Each Participant shall agree to take all appropriate actions during a Disaster without regard to race, color, creed, national origin, age, sex, gender orientation, religion, or handicap to assist all Participants as necessary. No Participant shall be required to provide treatment, care, medical supplies, equipment, services or personnel over and above that which is necessary to meet its own needs, existing or anticipated, or beyond its own resources.

In the event that the affected Participant is unable to continue patient care for some or all of its patients, the other Participants agree to act as receiving facilities for these patients.

Each Participant agrees to follow the guidelines set forth herein to the extent possible. There shall be no cause of action or basis of liability for breach of this Memorandum of Understanding by any participant(s) against any other Participant(s).

This Memorandum of Understanding is not intended to replace each facility's Disaster Plan or to adversely affect existing transfer agreements between facilities, but is intended to support those plans and agreements. Each Participant shall incorporate this Memorandum of Understanding into its disaster plan consistent with the principles agreed to herein.

II. GUIDELINES

A. EMERGENCY TREATMENT

Each Participant agrees to provide assistance, as available within its reasonable capabilities, including:

- 1) Accepting as many casualties/patients as resources permit.
- 2) Accepting as many transfers as resources permit.
- 3) Providing emergency treatment/care within the capabilities of the facility.
- 4) Providing emergency physician and medical support services.
- 5) Providing diagnostic services.
- 6) Assisting in placing casualties/transfers.
- 7) Facilitating transportation as available and requested by other Participants.
- 8) Notifying the Participants when vacancies no longer exist.
- 9) Providing a copy of the medical record for patient transferred/received.
- 10) Providing other medical services that may be necessary and requested.

EXISTING FACILITIES

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B. EMERGENCY MEDICAL SUPPLIES AND EQUIPMENT

A Participant shall provide emergency medical supplies and equipment within resource capabilities.

C. COST OF SERVICES, EQUIPMENT AND PERSONNEL

A Participant receiving services, equipment and personnel will replace or reimburse the cost of same to Participant providing services, equipment and personnel.

D. ADMINISTRATIVE SERVICES

A Participant will provide the following administrative services for themselves and will assist other Participants by:

- 1) Maintaining a current listing of all casualties or transfers made to and from the Participant's facility.
 - 2) Maintaining a current listing of all discharges, their assigned areas and locations.
 - 3) Maintaining a current listing of all deaths at the Participant's facility.
 - 4) Notifying the other Participants when patients or personnel can be returned to their facility.
 - 5) Furnishing other information or record keeping, as may be requested or deemed necessary by the Participant.
- Consider also requiring:*
- 6) Maintaining a record of all treatment administered, including medical supplies, and charges made.
 - 7) Notifying attending physicians of the disaster and disposition of their patients
 - 8) Contacting family members of patients/personnel and informing them of the disposition of each.

Consider adding the following Section:

E. COMMUNICATION SERVICES

In the event the Participants' normal lines of communication are disrupted, other Participants, as feasible, will:

- 1) Monitor Emergency Department 800 MHz radios and HAM radios for emergency information transmitted.
- 2) Communicate among themselves and with the Alameda County EMSA and Department of Public Health using Nextel direct connect telephones.
- 2) Notify local fire, police and other municipal services.
- 3) Provide emergency communication equipment, if available, to the affected municipal services and/or Partner hospitals.
- 4) Request support from state, local or DPH emergency operations centers based on levels of activation and type of assistance needed.

III. EFFECTIVE DATE, FUTURE AMENDMENT AND CONSTRUCTION

This Memorandum of Understanding shall become effective on _____(Date). A Participant may terminate its participation in this Memorandum of Understanding by giving a sixty (60) day written notice to the other Participants of its intentions to so terminate.

This Memorandum of Understanding shall be reviewed periodically to ensure that it meets the requirement of the Participants.

EXISTING FACILITIES

2469 This Memorandum of Understanding is in no way meant to affect any of the Participants' rights,
2470 privileges, titles, claims, or defenses provided under federal or state law or common law.

2471

2472 IN WITNESS WHEREOF, we have set our hands and seals that dates below written.

2473

2474 _____
Health Care Institution

2475

2476 _____
Chief Executive Officer

2477

2478 _____
Date

2479

2480 Attest:

2481 **Draft / October 2006**

2482

2483 Source: Adapted from Final Guidelines developed by New Hampshire Hospital Association and Draft
2484 Guidelines from Vermont Hospital Association

2485

EXISTING FACILITIES

2486 Appendix SC 3: Memoranda of Understanding - Clinics and Clinic 2487 Association of Los Angeles County (Draft)

2488 2489 **Memoranda of Understanding (MOU) between _____ and the** 2490 **Community Clinic Association of Los Angeles County (CCALAC)** 2491

2492 The aftermath of a large-scale terrorist event and its consequences on the fabric of society are almost
2493 unimaginable. Designing a healthcare capability to care for thousands of patients or victims when the
2494 local system is overwhelmed poses a daunting task. Los Angeles County, as a recipient of the
2495 National Bioterrorism Hospital Preparedness Program (NBHPP) Grant must work with healthcare
2496 entities to address this issue. The mission of the NBHPP is to ready hospitals and supporting
2497 healthcare systems to deliver coordinated and effective care to victims of terrorism and other public
2498 health emergencies.

2499
2500 The Community Clinic Association of Los Angeles County has been designated as a Disaster
2501 Resource Center for the community health centers and clinics within the County of Los Angeles. This
2502 concept is intended as a starting point to develop plans, relationships and procedures for responding to
2503 a terrorist event. Outcomes associated with this program, specific to community health centers, include
2504 the following:

- 2505
2506 ▪ Provide a coordinated strategy for community clinic disaster planning within Los Angeles County.
- 2507
2508 ▪ Enhance community clinic internal disaster planning and external cooperation with other clinics and
2509 hospitals in a geographical area. This planning will address the development of an all hazards
2510 approach to disaster preparedness.
- 2511
2512 ▪ Enhance disaster capability for community clinics through the provision of appropriate supplies &
2513 equipment; and improved communication to provide efficient and effective triage and/or treatment to
2514 victims of a terrorist event or other public health emergency.

2515 2516 **Eligibility and Requirements for Community Clinic Participation** 2517

2518 The CCALAC recognizes that not all community clinics will want to or be able to make the commitment
2519 outlined in this MOU for disaster preparedness. Because a commitment to disaster planning is
2520 necessary in order to assure appropriate use of the purchased supplies and equipment, the CCALAC
2521 bioterrorism workgroup has established eligibility requirements for the participating clinics: Each clinic
2522 must:

- 2523 1) Identify an on-site disaster coordinator who participates in the CCALAC Bioterrorism work-
2524 group;
 - 2525 2) Implement a current disaster plan that will be modified, as necessary by site, to maintain
2526 alignment with the model plan developed by the CPCA consortia group of which CCALAC is
2527 a member.
 - 2528 3) Participate actively in the disaster training set up by CCALAC in coordination with LA County
2529 EMS for current and new staff;
 - 2530 4) Engage in internal disaster drills, at least quarterly, to assess readiness in a variety of
2531 hazards;
 - 2532 5) Participate in an annual external disaster drill;
 - 2533 6) Maintain disaster supplies/equipment/information in a centralized location and replace
2534 expired/damaged supplies on a rotational basis;
 - 2535 7) Maintain all disaster equipment in working order; and
 - 2536 8) Commit to the participation of at least the Medical Director and one other clinician to the Los
2537 Angeles County and/or state alert system network.
- 2538

EXISTING FACILITIES

2539 Meeting these eligibility requirements will enable clinics to participate in the following receivables.
2540 The sustainability of this program is dependent on continued funding from the federal government
2541 through the Health Resources and Services Administration NBHPP.

2542

2543 **Clinic Receivables**

2544

2545 Each clinic, committed to meeting the above criteria will have the following support in their disaster
2546 planning efforts:

2547

2548 • **Support staffing** – reimbursement for personnel involved in ordering, establishing, and
2549 maintaining the medical/surgical supplies, PPE & equipment that are being cached & coordinating
2550 the education of all personnel. The clinic will be reimbursed an amount that depends on the
2551 number of clinics participating in this program.

2552

2553 • **Medical/Surgical supplies** – Each participating clinic shall have a medical surgical supplies
2554 cache that will be purchased by CCALAC. Clinic shall store, secure and maintain cache. Clinic
2555 shall establish a stock rotation plan to minimize expiration of supplies. Any item that cannot be
2556 rotated will be replaced at time of expiration. These items will be purchased in bulk to receive
2557 better pricing and distributed to participating clinics. Each clinic will receive approximately
2558 \$1500.00 worth of supplies The exact amount depends on the number of clinics participating in
2559 this program.

2560

2561 The use and deployment of these supplies will be under the direction of the Emergency Medical
2562 Services (EMS) Agency, in their role as the Medical and Health Disaster Coordinator for the
2563 County of Los Angeles. If any or all of the identified supplies are needed outside of the individual
2564 clinic's geographical area, the County will make arrangements and provide the necessary
2565 transportation ensuring delivery to the impacted area.

2566

2567 • **Personal Protective Equipment (PPE)** – Each participating clinic shall have a PPE cache that
2568 will be purchased by CCALAC. Clinic shall store, secure and maintain cache. The purchased
2569 PPE equipment will meet level C recommendations and also contain an N95 respirator which
2570 needs to be fit-tested for size requirements. This equipment will be distributed after the clinic's
2571 identified key person is trained in correct use of such equipment and secures fit testing
2572 information on all individuals who may receive the PPE. Each clinic trainer will be provided with
2573 training resources to facilitate a train the trainer approach. The number of PPE kits that each
2574 clinic will receive will depend on the number of clinics agreeing to participate in this program.

2575

2576 • **HEAR Radios or other communication technology** – CCALAC will coordinate with EMS a plan
2577 for purchase and installation of the HEAR radio or a similar device, as feasible and desired, at
2578 participating clinic sites. CCALAC will facilitate, in cooperation with EMS, the training of
2579 appropriate personnel.

2580

2581 • **Walkie-Talkies** – Each participating clinic agrees to put into place a policy and procedure for
2582 maintaining security of this equipment and agrees to replace the equipment that may be lost or
2583 stolen. It is anticipated that at least two walkie-talkies will be purchased for designated clinics.

2584

2585 • **Education & Training** – Each participating clinic will send all appropriate staff to training
2586 sessions coordinated by CCALAC/on-site disaster coordinator. With the support of the LA County
2587 EMS, as needed. The program name, date, speaker and participating staff will be sent to
2588 CCALAC. The clinic will be reimbursed up to a specified amount to be determined once the
2589 number of participating clinics is known.

2590

2591 • **Flip-charts** - CCAALC will coordinate the development, printing and distribution of disaster flip
2592 charts to all participating clinics. These charts will facilitate a quick and current reference to an all
2593 hazards approach to disaster preparedness and implementation. Each clinic will identify the

EXISTING FACILITIES

2594 number needed and be responsible for their appropriate placement. CCALAC will develop a train
2595 the trainer program for key clinic personnel. The clinic will document education of personnel in the
2596 information contained in the flip charts and send this information to CCALAC.

2597
2598

2599

2600 _____
Executive Director

_____ Executive Director CCALAC

2601

2602

2603 _____
Representative to Bioterrorism Workgroup

_____ Director Clinical Programs

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2605

2606 _____
Representative Title

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2608

2609 _____
Date

_____ Date

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2612 Source: California Primary Care Association

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EXISTING FACILITIES

Appendix SC 4: Facility Capacity and Patient Census Report

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Facility Name _____ Town/City _____ Date _____
Time _____ Person Completing Report _____ Phone _____

#	Type of Unit	Expanded Bed Capacity		Potentially Available Beds	
		A	B	C	D
		Reg	Neg Press	Reg	Neg Press
1.	Medical / Surgical (Include GYN)				
2.	Perinatal (exclude Newborn / GYN)				
3.	Pediatric				
4.	Intensive Care				
5.	Coronary Care				
6.	Acute Respiratory Care				
7.	Burn				
8.	Newborn Nursery				
9.	Intensive Care Newborn Nursery				
10.	Rehabilitation Center				
11.	Chemical Dependency Recovery Hospital				
12.	Acute Psychiatric				
13.	Skilled Nursing				
14.	Intermediate Care				
15.	Intermediate Care / Developmentally Disabled				
16.	Other (specify)				
17.	Total Inpatient beds				
18.	Surgical Suites				
19.	Emergency Department				
20.	Outpatient Services (Surgicenter, Endoscopy, etc.)				
21.	Pain Clinic				
22.	Dialysis				
23.	Urgent Care				
24.	Swing bed or attached Nursing Home				
25.	Rehabilitation				
26.	Other (specify)				
27.	Other (specify)				
28.	Other (specify)				
29.	Total Outpatient beds				

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Note: Inpatient Bed categories based on Office of statewide Health Planning & Development (OSHDP), The state Utilization Data File of Hospitals

Adapted from Public Health and Hospital Preparedness - Public Health and Hospital Preparedness, state of Wisconsin, *Wisconsin Hospital Emergency Preparedness Plan (WHEPP)*, Version 3.

EXISTING FACILITIES

Appendix SC 6: Patient Evacuation Tracking Form

SKILLED NURSING AND REHABILITATION - Patient Evacuation Tracking Form

Please Print

PATIENT INFORMATION – To be completed prior to patient movement from the Unit/Department.

Patient Name: _____ Department/Unit/Room/Bed Number: _____

Attending Physician: _____ Isolation Type: _____ Reason: _____

Holding/Staging Area Patient Sent To:

RED (High Acuity) YELLOW (Mid-Acuity) GREEN (Low Acuity)

Patient ID Band Confirmed: Yes By (name): _____ No N/A

This Portion of Form Completed by (name): _____

Section 1: PATIENT CONDITION/PHYSICIAN CERTIFICATION

A. Patient Condition: (check one of the following) Diagnosis _____

The patient has been stabilized such that within reasonable medical probability, no material deterioration of the patient condition or the condition of the unborn child(ren) is likely to result from transfer.

The patient's condition has not stabilized.

B. Reason for Transfer:

High level of care Service not available Patient request MD request Other

C. Benefits of Transfer:

Availability of specialized facilities, services or personnel Availability of diagnostic/therapeutic equipment

Other: _____

D. Risks of Transfer:

Additional time delay in receiving treatment Potential deterioration of medical condition

Other: _____

Section 2: TRANSFER REQUIREMENTS

A. Receiving hospital: _____ Contact (Non-MD): _____ Time: _____

Telephone number: _____

B. Transportation vehicle: Ambulance Other: _____

Level of Care ALS BLS RN RT CCT Other: _____

C. Copies of medical record sent: _____ V/S

15 min of xfer Sent Rcvd Sent Rcvd Patient Belongings (within

H&P Nursing notes Sent with patient T

Orders X-ray Sent with family P

Progress notes EKG Other: _____ R

5150 Form Lab work _____ BP

Transfer Form (original)

RN Signature: _____ Transfer Date: _____

Transfer Time: _____

EXISTING FACILITIES

268 **Section 3: HOLDING/STAGING AREA** – to be completed upon arrival into and departure from
 268 Holding/Staging Area.
 269 A. Location of Holding/Staging Area: _____
 269 B. Time arrived at Holding/Staging Area: _____ Received by (name): _____
 269 Time departed Holding/Staging Area: _____ Destination: _____
 269 C. Transportation Mode: Ambulance Other (specify type of vehicle): _____
 2694 Vehicle Identification (unit #, etc.): _____ This Portion of Form Completed by (name): _____

269 **Section 4: TRANSPORT** – to be completed by transportation crew
 269 (Not applicable to outpatients or patients being discharged)
 269 A. Accompanied By (hospital staff name): _____
 269 B. From (Sending Facility): _____
 269 _____ Time Depart: _____
 270 C. To (Receiving Facility): _____ Time Arrive: _____
 2701 This Portion of Form Completed by (name): _____

270 **Section 5: RECEIVING FACILITY** – to be completed at time of arrival
 270 (Not applicable to outpatients or patients being discharged)
 270 A. Time Arrived: _____ Initial Care Location (reception area, ICU, etc.): _____
 270 This Portion of Form Completed by (name): _____

270 NOTE: Check **Transfer Requirements** section and indicate items received.
 270 **Top Copy** – to accompany Patient – Receiving Facility to return completed top copy to Sending Facility
 270 **Middle Copy** – to be retained by Receiving Facility
 2709 **Bottom Copy** – to be retained by Sending Facility

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 2712 Source: Alameda County Hospital Safety and Emergency Managers, Jan 2007

EXISTING FACILITIES

Appendix OPS 1: Emergency Preparedness Tools

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1. As part of provider regulations and guidance, the Department of Health and Human Services and the Centers for Medicare and Medicaid Services have developed a Survey & Certification - All Hazards Emergency Preparedness & Response Plan. The plan is a healthcare facility checklist for effective emergency planning. The checklist can be access via CMS' webpage at: http://www.cms.hhs.gov/SurveyCertEmergPrep/03_ProviderRegulationsandGuidance.asp#
 2. A project funded by the Health Resources and Services Administration (HRSA) and developed under Agency for Healthcare Research and Quality (AHRQ) has developed such a tool. The tool helps assess the readiness of hospitals and other health care facilities for chemical, biological, radiological, nuclear, and explosive (CBRNE) events. The tool can be found at: <http://www.ahrq.gov/prep/cbrne/>
 3. The Department of Human Health and has developed a Pandemic Influenza Plan Supplement 3 Healthcare Planning. The plan contains a checklist to help hospitals assess their current level of readiness to deal locally with an influenza pandemic. The tool can be accessed at: <http://www.hhs.gov/pandemicflu/plan/sup3.html#app2>
 4. The Department of Health and Human Services and the Centers for Disease Control and Prevention have developed the following checklist to help medical offices and ambulatory clinics assess and improve their preparedness for responding to pandemic influenza. The tool can be accessed at: <http://www.pandemicflu.gov/plan/pdf/medofficesclinics.pdf>
 5. The Los Angeles County Public Health Bioterrorism Preparedness and Response Program's website has a detailed manual called "Bioterrorism Information and Treatment Guidelines for Hospitals and Clinicians". The manual seeks to provide a comprehensive resource for clinical personnel to become educated on various aspects of biological, chemical, and radiological terrorism and to serve as an emergent guide book on what to do and where to seek information in the event of an attack. Information on the bioterrorism preparedness effort can be found on the website www.labt.org, as well as details on how individual clinicians can become involved. The manual can be found at: <http://www.labt.org/pdf/Terrorism%20Agent%20Information%20and%20Treatment%20Guidelines%20for%20Hospitals%20and%20Clinicians.pdf>
 6. Employers are responsible for providing a safe and healthful workplace for their employees. In the event of an influenza pandemic, employers will play a key role in protecting employees' health and safety as well as in limiting the impact on the economy and society. The Occupational Safety and Health Administration (OSHA) has developed a pandemic influenza planning guidance based upon traditional infection control and industrial hygiene practices. The guidance can be found at: <http://www.osha.gov/Publications/OSHA3327pandemic.pdf>
 7. Hospital Incident Command System (HICS) is a methodology for using Incident Command System (ICS) in a hospital/healthcare environment. According to EMSA's website, "HICS is an incident management system based on the ICS, that assists hospitals in improving their emergency management planning, response, and recovery capabilities for unplanned and planned events. HICS is consistent with ICS and the National Incident Management System (NIMS) principles. HICS will strengthen hospital disaster preparedness activities in conjunction with community response agencies and allow hospitals to understand and assist in implementing the 17 Elements of the hospital-based NIMS guidelines. HICS products include a Guidebook and planning and training tools" and can be accessed at: <http://www.emsa.ca.gov/hics/hics.asp>
 8. California Primary Care Association's The Community Clinic & Health Center Emergency Operations Plan Template, 2004, provides extensive guidance to community clinics in the

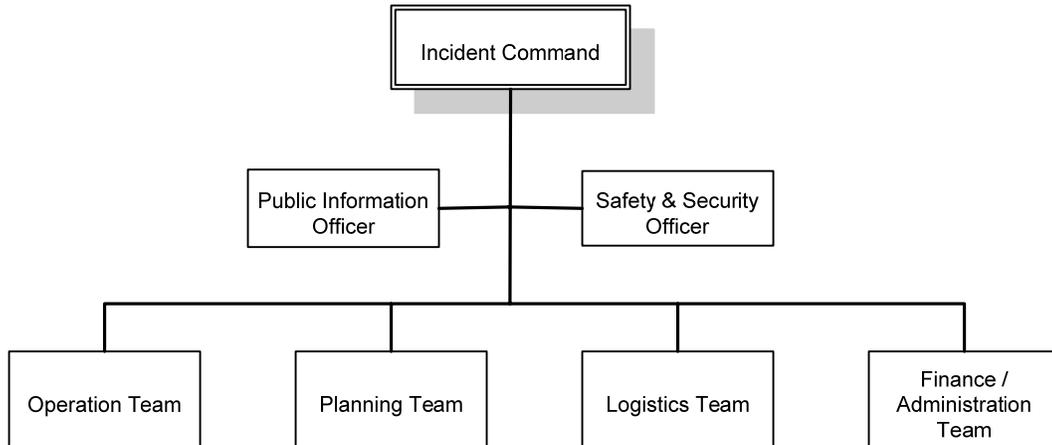
EXISTING FACILITIES

2768 development of their emergency management plans and programs. The template contains
2769 sections for mitigation, preparedness, response and recovery. The appendix section contains
2770 extensive tools that enable planners to develop their emergency operations plan. The
2771 document can be accessed at: <http://www.emsa.ca.gov/hbppc/hbppc.asp>. The next update to
2772 the plans is expected to include Pandemic Influenza planning and an MOU template (see the
2773 draft version of the MOU template in Appendix SC 3)
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EXISTING FACILITIES

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Appendix OPS 2: CARD version of Incident Command System



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- Incident Command: Leads the response; appoints and empowers team leaders; sets tone and standards for response. Encourages teamwork and communications.
- Depending upon the situation the Incident Command might appoint Command Staff
 - Public Information Officer: Works with the media and distributes messages to the public and local community.
 - Safety and Security Officer: Focuses on the safety of all people responding to the incident.
- Management Functions
 - Operation Team: Handles key actions including first aid, search and rescue, fire suppression and securing the site.
 - Planning Team: Gathers information, thinks ahead and keeps all team members informed and communicating.
 - Logistics Team: Finds, distributes, and stores all necessary resources (supplies and people) to respond appropriately.
 - Finance/ Administration Team: Tracks all expenses, claims and activities and is the record keeper for the incident.

It is important to understand that ICS is a management system—not an organizational chart. Depending upon the size of the organization or the type of incident, one person may play more than one role.

Source: Collaborating Agencies Responding to Disasters (CARD), www.FirstVictims.org

EXISTING FACILITIES

Appendix OPS 3: Business Continuity Plan Template

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Section 1: Critical contact information

Critical Personnel and Entities*

Position	Name	Work Phone	Cell Phone	Home Phone	Personal e-mail	Site and Alternate Site Responsibilities
Critical Position #1:						
Alternate:						
Critical Position #2:						
Alternate:						
Critical Position #3:						
Alternate:						
Critical Position #4:						
Alternate:						

*Note, entities could include governmental agencies

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Critical Vendors

Vendor	Location	Contact	Work Phone	Cell Phone
Vendor Name				
Alternate Contact:				
Comments:				
Vendor Name				
Alternate Contact:				
Comments:				
Vendor Name				
Alternate Contact:				
Comments:				
Vendor Name				
Alternate Contact:				
Comments:				

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EXISTING FACILITIES

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Section 2: Functions and recovery objectives

Functions	Recovery Objectives
1. Function 1	
2. Function 2	
3.	
4.	
5.	

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Section 3: Minimum Resource Requirements

Minimum Resource Requirements		
	Minimum	Full Function
Function 1		
- Space Requirements		
- Equipment Requirements		
- Supplies Requirements		
- Essential Services Required		
- Personnel Requirements		
Function 2		
- Space Requirements		
- Equipment Requirements		
- Supplies Requirements		
- Essential Services Required		
- Personnel Requirements		

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Section 4: All agencies, divisions and vendors upon which function is dependent

Function	Dependent Activity/Entity	BCP in place?	Comments
Function 1		Y/N	
Function 2		Y/N	
		Y/N	

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EXISTING FACILITIES

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Section 5: Vital Records

Name/#	Description	Location

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Section 6: Alternate Site for function

Special Alternate Facility Requirements:

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Section 7: Emergency notification protocols (includes designee and communication mode)

- 1. During work hours
- 2. During non-work hours

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Section 8: Security strategies for each function

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2855

Section 9: Designated Plan Coordinator

Name	Work Phone	Pager or Cell	Home Phone	Personal Email

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2857
2858
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Section 10: Review Date

Source: Adapted from Enterprise Business Continuity Planning, Department of Administrative Services, State of Oregon.

EXISTING FACILITIES

2861 Appendix OPS 4: Standard Operating Procedure Template for 2862 Equipment, Plant and Utilities

- 2863 1. Description of the Threat/Event
- 2864
- 2865 2. Impact on Mission Critical Systems
- 2866
- 2867 3. Operating Units and Key Personnel with Responsibility to Manage this Threat/Event.
- 2868
- 2869 4. Mitigation/Preparedness Activities of the Threat/Event.
 - 2870 a. Hazard Reduction Strategies and Resource Issues
 - 2871 b. Preparedness Strategies and Resource Issues.
 - 2872
 - 2873
- 2874 5. Response/Recovery from the Threat/Event.
 - 2875 a. Hazard Control Strategies.
 - 2876 b. Hazard Monitoring Strategies
 - 2877 c. Recovery Strategies
 - 2878
- 2879 6. Internal and External Notification Procedures by Entity Type
- 2880
- 2881 7. Specialized Staff Training
- 2882
- 2883 8. Review Date.
- 2884

2885 Source: Veterans Health Administration Center for Engineering & Occupational Safety and Health in their
2886 Emergency Management Program Guidebook, 2002, provide extensive guidance around hazardous
2887 waste management (<http://www1.va.gov/emshg/apps/emp/emp.htm>).

EXISTING FACILITIES

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Appendix Ops 5: Standardized Security Assessment / Vulnerability Tool

#	Security Assessment / Vulnerability Tool	Yes	No	If No,		
				Why / Action Plan	By Whom	By When
1	The facility has a security plan, which includes, but is not limited to designated security staff...					
2	...additional security staff who can be deployed					
3	... security staff have vests for identification purposes					
4	... security staff have designated assignments					
5	...security staff have periodic training					
6	...security staff have job action sheets					
7	...security staff have protocols to provide security staffing in a sustained disaster					
8	The facility has a "lockdown" protocol.					
9	The facility has a protocol for the identification of physicians and staff who will enter the facility during a lockdown.					
10	The facility has a protocol for the identification of others such as fire, law enforcement, public health, etc. who will enter the facility during a lockdown.					
11	The facility has established a plan to set up a security perimeter and has the cooperation of law enforcement in the establishing and enforcement of this perimeter.					
12	There are designated ingress and egress routes into and out of the facility.					
13	The facility has a plan to establish a patient triage center at the security perimeter.					
14	The security plan includes signage that is ready to be posted.					
15	The facility has a plan to call-in security staff.					
16	Traffic flow patterns have been established in cooperation with law enforcement.					
17	The facility has public address systems to communicate with potential crowds outside the facility.					
18	Security knows where to direct media.					
19	Security has a log for all persons entering the facility through the security perimeter at which people log in time of entrance and time of departure.					
20	There is a protocol developed in collaboration with law enforcement on when and how to search persons or their belongings and who will be responsible for this function.					
21	There is a plan for communications with and among security personnel.					
22	There is a plan for armed security personnel.					

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Source: Adapted from California Primary Care Association, *The Community Clinic & Health Center Emergency Operations Plan Template*, 2004.

EXISTING FACILITIES

Appendix Ops 6: Lockdown Policy and Procedure Sample

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I. PURPOSE

To provide procedures and guidance when the need to lockdown the facility exists for any reason. This type of situation could involve mass contamination, picketing, demonstrations, acts of violence, sit-ins, passive resistance, civil disobedience, gang activity, or other disturbances.

II. POLICY

The primary goal in a lockdown situation is to isolate and control access to the facility while caring for the safety of the patients, visitors, staff, and property.

III. RESPONSIBILITIES

A. LAW ENFORCEMENT

Management of a civil disturbance itself will be accomplished by law enforcement.

B. SECURITY

Security staff, augmented if necessary, will conduct the internal response in the event of a need for lockdown and will take measures to control access to and from the facility, whenever possible.

C. STAFF

Will separate themselves, if at all possible, from any involvement in a civil disturbance.

IV. PERSONNEL

All staff members

V. PROCEDURES

A. GENERAL – CIVIL DISTURBANCE

1. Regardless of how peaceful the intent or how righteous the cause of a civil disturbance, because of the strong emotional nature of the issues involved, these manifestations on many occasions end in rioting, violence, and destruction/looting of property.

2. Based on the nature of the disturbance, it will be managed by security staff until the decision is made that management of the situation requires the activation of the Facility Incident Command System.

3. Upon becoming aware of a civil disturbance situation, the facility administrator or senior administrative person in the facility will be notified immediately.

B. MASS CONTAMINATION

1. Contaminated individuals/equipment entering the facility building may require the total closure of operations of all or part of the facility.

2. In a mass contamination situation, only individual or equipment which are KNOWN to be free of contamination will be allowed in the building

C. ACTIVATION/NOTIFICATION

1. The decision to initiate lockdown will be made by the Administrator, if available, based on information provided by security and other staff members. In accordance with the policy established in the Emergency Management Plan, the following individuals, in order of position rank, may initiate lockdown in the absence of the Administrator:

EXISTING FACILITIES

- 2947 a. Administrator-On-Call
2948 b. Appropriate Administrative Directors
2949 c. Safety Officer or designee
2950 d. Emergency Management Chairperson
2951 e. Operations Supervisor during off hours and weekends

2952
2953 2. Announcement/Notification

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2955 a. Upon specific guidance from the Administrator or designee, the operator will announce the civil
2956 disturbance three times via the public address system. The proper announcement is:

2957
2958 **<<Code Name for Lockdown>> “Nature and Location of Disturbance”**

2959
2960 Repeat the statement every 15 minutes for the first hour, or as often as the
2961 Incident Commander directs.

2962
2963 b. When directed by the Incident Commander, the operator will contact the appropriate law
2964 enforcement office and request immediate assistance.

2965
2966 c. The operator will contact <<Facility Name>> Relations at the phone numbers provided for that
2967 purpose.

2968
2969 d. When so directed by the Incident Commander or the senior administrative
2970 individual in the facility, the All Clear will be announced of the public address
2971 system as follows:

2972
2973 **“<<Code Name for Lockdown>>, Location, ALL CLEAR” (three times)**

2974
2975 3. Upon announcement of lockdown, the Incident Command Center and other designated
2976 portions of the Incident Command System organization will be activated. This will normally
2977 include as a minimum, a portion of the Planning Section and the Public Information Officer.

2978 D. SECURITY OPERATIONS

2979
2980 1. In the case of a civil disturbance, the senior Security representative present will immediately
2981 assess the situation and provide that information to the Administrator or Incident Commander if
2982 has already been initiated.

2983
2984 2. In the case of a mass contamination situation, the Infection Control Coordinator, or designated
2985 clinical staff member will assess the situation and recommend appropriate action.

2986
2987 3. If required security augmentation will be initiated either through recall of off duty security,
2988 appointing other available staff to perform security duties, or by obtaining augmentation from
2989 security companies.

2990
2991 4. Security will immediately commence locking all exterior doors and will advise staff to close
2992 ground floor window coverings if possible.

2993
2994 5. A Single Entry Point will be established. Staff guarding other exterior doors will be instructed to
2995 not allow anyone in or out of those doors. A security representative or other designated individual
2996 will allow individuals with legitimate reason into and out of the Single Entry Point based on the
2997 situation. In the case of mass contamination, only those individuals KNOWN to be free of
2998 contamination will be allowed in the building.

2999
3000 6. A security officer will be stationed in the primary treatment area (Emergency Department or
3001 Urgent Care).
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EXISTING FACILITIES

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7. If anyone exits the building, a staff or security member must ensure the door is firmly closed and locked after the individual.

8. Security representatives will provide escorts for staff members to and from the parking areas. In the case of mass contamination, anyone leaving the building, to include security representatives, must be determined to be free of contamination before being allowed to reenter the building.

E. COMMAND CENTER OPERATIONS

1. All information from local law enforcement, fire department and other sources will be provided to the Incident Command Center.

2. Actions to be taken will be based on the evaluation of this information.

3. The Incident Commander will determine what information will be disseminated to facility staff.

4. The Public Information Officer will coordinate all releases of information to the media.

5. In the case of mass contamination, the decontamination procedures will be initiated.

6. In the event the disturbance is in one of the area's prisons and/or jails and the facility is to receive a large number of prisoners to be treated, plans will be developed to set aside an area for these patients which are under guard to preclude interfering with other facility operations.

7. In the event of an extended disturbance causing all or part of the staff to remain in the facility, provisions will be made for housing and feeding these individuals.

F. FACILITY OPERATIONS

1. Patients, visitors, and staff will be moved from the immediate area of the disturbance if at all possible.

2. In patient care areas, access will be limited to staff and others authorized by the Incident Commander to be in those areas.

3. Based on guidance provided by the Incident Commander, visiting hours may be reduced or eliminated and any visitors will be strictly controlled.

4. Staff will be informed to avoid the area and to not involve themselves in the disturbance.

G. POST CRISIS MANAGEMENT

After cancellation of the lockdown, a debriefing by a crisis intervention team and/or mental health professionals should be provided as needed for all individuals involved in managing the disturbance.

EXISTING FACILITIES

LOCKDOWN CHECKSHEET

- 3055
3056
3057 Mission: The primary goal in a lockdown situation is to isolate and control the situation while caring for the
3058 safety of the patients, visitors, staff, and property.
3059
3060 ___ Personnel discovering the lockdown situation will promptly notify their supervisor who will pass the
3061 information to the Administrator or designee.
- 3062 ___ Staff will not become involved, if possible, in any manner with the civil disturbance.
- 3063 ___ Isolate the situation by locking all exterior doors to your unit and closing all ground floor windows.
- 3064 ___ Do not allow any entry or exit from other than through the Single Entry Point, which will be
3065 controlled by Security
- 3066 ___ Only individual KNOWN to be free of contamination will be allowed to enter the building in a mass
3067 contamination event.
- 3068 ___ If exiting the building, request an escort to and from the parking lot areas.
- 3069 ___ Allow law enforcement to quell the civil disturbance.
- 3070
3071 Source: This policy and procedure sample was adapted from CODE CD - Lockdown for Scripps Mercy
3072 Hospital.

EXISTING FACILITIES

Appendix Ops 7: Mass Fatality Fact Sheet

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Health Impacts

- The health risk to the general public from large numbers of dead bodies is negligible
- Drinking water must be treated to avoid possible diarrhoeal diseases
- Body handlers should follow universal precautions for blood and body fluids, wear gloves, and wash their hands

Body Storage

- Refrigerated containers provide the best storage, if available
- Temporary burial in trench graves can be used if refrigeration is not available

Body Identification

- Visual recognition or photographs of fresh bodies are the simplest forms of non-forensic identification and should be attempted after all natural disasters
- If resources and comparative data are available, simpler methods can be supplemented by forensic techniques (dental, fingerprint, and DNA analysis)

Body Disposal

- Communal graves may be necessary following large disasters
- Bodies should be buried in one layer to facilitate future exhumation
- Graves should be clearly marked

Coordination

- A named person/organization should have an agreed mandate to coordinate the management of dead bodies

Preparedness

- Mass fatality plans should be included in national and local disaster preparedness activities
- Systematic documentation about how the dead are managed in future disasters is needed to learn from them

Communications

- Close working with the media is needed to avoid misinformation and to promote the rights of the survivors to see their dead treated with dignity and respect

Source: *Mass Fatality Management following the South Asian Tsunami Disaster: Case Studies in Thailand, Indonesia, and Sri Lanka*, Oliver W. Morgan, Pongruk Sribanditmongkol, Clifford Perera, Yeddi Sulasmi, Dana Van Alphen, Egbert Sondorp, 2006

EXISTING FACILITIES

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3115

Appendix Ops 8: Facility Damage Report (Limited Assessment)

Facility Name & Type _____ Address: _____ Date and Time report given: _____ Census _____ Contact Person: _____ Title/Location: _____ Preferred Contact Method: _____ Preferred Contact Number: _____
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3116

Complete the worksheet through interview or fax to facility completion and return ASAP.			
#	answer:	questions:	comments:
1	Y/N Partial	Can you provide essential patient care? (Routine as well as management of injuries or disaster related conditions if any)	
2	Y/N Partial	Is your facility intact? (Structural integrity intact, no obvious damage, access to all areas)	
3	Y/N Partial	Are essential services intact? (Power, water, gas, communication)	
4	Y/N Partial	Do you have adequate staff, supplies And equipment for the next 72 hours? (Food, water, medicines, O2, hygiene, fuel)	
5	Y/N Unsure	Can you function without assistance for the next 72 hours?	

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If “partial” or “no” answer to any question, ask provider to describe their plan and include that info in report to headquarters. If facility is preparing to evacuate, ask for patient list and evacuation destination (s) and enter info on Facility Transfer Summary. Report a summary of findings to headquarters Disaster Preparedness Coordinator and/or Field Branch Chief.

Source: California Department of Public Health, Licensing and Certification Program, Emergency Preparedness & Response Plan

EXISTING FACILITIES

3125 Appendix Ops 9: Facility On Site Damage/Operability Report
 3126 (Comprehensive Assessment)

3127 Facility Name: _____ Date of Visit: _____
 3128 Address: _____ Evaluator Names: _____
 3129 City: _____

3130 Overall Damage Assessment:
 3131 (See OSHPD Placards*) GREEN YELLOW RED

3132 AVAILABLE VACANT BEDS MALE FEMALE

3133 PATIENT EVACUATION ORDERED BY: _____ TITLE _____

3134 TYPE OF EVACUATION: TOTAL PARTIAL

3140

BUILDING	YES	NO
PARTIAL COLLAPSE		
TOTAL COLLAPSE		
PHOTOS TAKEN		

COMMUNICATIONS	YES	NO
EXTERNAL		
INTERNAL		
ELEVATORS OPERATIONAL		

3142

WATER AVAILABILITY	YES	NO
FROM UTILITY		
DRINKING WATER		
HOT WATER		

BUILDING SYSTEMS	YES	NO
ELECTRICITY		
EMERGENCY POWER		
FUEL RESERVE		
HEAT/ COOLING		
SEWAGE DISPOSAL		

3143

SUPPLIES	YES	NO
FOOD		
MEDICATIONS		
LINEN		
OTHER SUPPLIES		

STAFF AVAILABILITY	YES	NO
ADMINISTRATION		
NURSING		
DIETARY		
HOUSEKEEPING		

3144 EVALUATOR COMMENTS AND DIAGRAM (IF NECESSARY):
 3145 _____
 3146 _____
 3147 _____
 3148 _____
 3149 _____
 3150 _____
 3151 _____

3152 Recommend Referral To: _____

3153 *Green: Habitable, minor or no damage,
 3154 Yellow: Damage which represents some degree of threat to occupants
 3155 Red: Not habitable, significant threat to life safety
 3156 Source: California Department of Health Services, Licensing and Certification, Emergency
 3157 Preparedness & Response Plan
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References

ⁱ Adapted from Medical Board of California, Division of Licensing, Standard of Care for California Licensed Midwives. *Midwifery Standards of Care* (September 15, 2005). http://www.mbc.ca.gov/MW_Standards.pdf

ⁱⁱ Virginia Jury Instructions, Civil Instruction No. 35.000. Steven D. Gravely, Troutman Sanders LLP. *Altered Standards of Care: An Overview*.
http://www.vdh.state.va.us/EPR/pdf/Health_and_Medical_Subpanel.pdf

Note: In The Supreme Court Of The State Of Hawaii, In the Matter of the Publication and Distribution of the Hawai'i Standard Civil Jury Instructions, Instruction No. 14.2: Standard Of Care:

"It is the duty of a [physician/nurse/specialty] to have the knowledge and skill ordinarily possessed, and to exercise the care and skill ordinarily used, by a [physician/nurse/specialty] practicing in the same field under similar circumstances. A failure to perform any one of these duties is a breach of the standard of care".

ⁱⁱⁱ Industrial Welfare Commission Order No. 5-2001 Regulating Wages, Hours And Working Conditions In The Public Housekeeping Industry (Definitions): http://www.dir.ca.gov/IWC/WageOrder5_010102.html

^{iv} Adapted from: The CNA Corporation, *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies*, August 2004

^v Humboldt County Dhhs Public Health Branch, *Surge Plans for Hospitals*.

^{vi} Adapted from: The Recommendations of the state Expert Panel on Inpatient and Outpatient Surge Capacity, *Guidelines for Managing Inpatient and Outpatient Surge Capacity*, state of Wisconsin, November 2005

^{vii} Adapted from: The Recommendations of the state Expert Panel on Inpatient and Outpatient Surge Capacity, *Guidelines for Managing Inpatient and Outpatient Surge Capacity*, state of Wisconsin, November 2005