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HARVARD

SCHOOL OF PUBLIC HEALTH

Emergency Preparedness and Response
Exercise Program



MDPH HOSPITAL EVACUATION TOOLKIT

VII. EMERGENCY RECEIVER GUIDANCE



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INTRODUCTION

Purpose of the Emergency Receiver Guidance

If one hospital is forced to evacuate all or a significant portion of its inpatient population, the evacuation event will undoubtedly create significant challenges for the other hospitals in its Region. Whether from the Regional effects of a loss of an Emergency Department, thereby diverting ambulances and other walk-in patients towards other area Emergency Departments, or from the disruptions to inpatient admissions caused by a major influx of transferred patients, a hospital evacuation is always a Regional emergency event that requires more than just the evacuating hospital to use its emergency plans to manage the incident well. This Emergency Receiver Guidance describes the possible actions that neighboring hospitals (“Emergency Receivers”) may take to help support the evacuating hospital and avoid creating a secondary disaster in their own institutions.



EMERGENCY RECEIVER GUIDANCE

Activation of the Hospital EOP

Upon learning that another hospital in the Region is evacuating, all neighboring hospitals should be encouraged to activate their hospital's EOP, at least in a limited fashion. Information from the evacuating hospital may be sporadic, limited, and dynamic. Rapid responses to requests for assistance may be required. The leadership and communications structures activated within a hospital's EOP will facilitate smoother communications with the evacuating facility and better situational awareness in the receiving institution. In addition, should the receiving hospital accept large numbers of transferred patients from the evacuating institution, significant coordination of administrative and clinical efforts will be required to avoid major disruptions to the Emergency Department and inpatient care areas as transferred patients arrive.

Designation of a Receiving Area and/or Team(s)

Despite the best efforts of the sending institution to manage the evacuation process, evacuated patients may arrive at a receiving hospital with some deterioration in their clinical status, with incomplete clinical data, and/or have diagnoses or conditions that are different than expected. Many patients will arrive feeling the emotional impact of the incident and will be frightened and stressed. Many receiving hospitals may not be comfortable accepting rapidly transferred patients directly into specific inpatient care beds without an initial brief clinical evaluation, while others may do so but require an immediate evaluation by a clinical team to review the patient's current status and diagnoses.

Receiving hospitals may be tempted to request that all evacuated patients be transferred to the Emergency Department for this clinical evaluation, but in general this should be discouraged.

Hospital Emergency Departments are typically crowded on a daily basis, and an additional Influx of transferred inpatients would severely exacerbate this crowding and limit the ability of the Emergency Department to care for new, ill patients. Further, since the evacuating hospital's Emergency Department will be closed, it is likely that all neighboring hospital Emergency Departments will see increases in volume.

Receiving hospitals should instead designate an alternate clinical location in their institutions for the receipt of transferred patients, if those patients will not be transferred directly to inpatient beds. This alternate location should be able to support registration of new patients, conduct basic medical care and emergency resuscitation if needed, and be staffed with the appropriate personnel to speed patients into their ultimate inpatient locations.

- *Regional preparation allowed undamaged hospitals to function as receiving hospitals for those severely impacted by Superstorm Sandy. Hospitals that did not prepare were unable to support a regional emergency and the community at large. Some advance preparations include^{1, 2}:*
- *Proactive management of inpatient census (discharging 10% to 25% of pre-event census, cancellation of elective surgeries)*
- *Augmentation of clinical and administrative staff (staffed to 150% of projected need)*
- *Planning for employees to remain on site for 72 hours (meals & sleeping quarters provided)*
- *Suspension of elective procedures*
- *Securing additional supplies in advance of storm*



Whether transferred patients are sent to a specially designated receiving area, or directly to their inpatient beds, hospitals should be encouraged to create and use rapid response teams of physicians and nurses who will meet patients immediately on arrival and begin the difficult process of reviewing the patient's care to date and initiating further clinical interventions if needed. Because of occasional differences among hospitals in the services to which patients are admitted, this team should have immediate available access to specialty expertise, should questions or issues arise.

Credentialing of Personnel from Other Facilities

The evacuation of a facility poses a significant burden on surrounding hospitals. The varied reasons for facility evacuations mean that the surge experienced by receiving facilities could last for a significant amount of time. However, regardless of the length of the evacuation and subsequent surge, receiving facilities would likely benefit from the ability to incorporate outside personnel in to their staff. Facilities should develop plans on how to rapidly and/or temporarily credential outside personnel to augment their own staff in these scenarios. To the extent possible, regions and coalitions should undertake efforts to standardize credentialing documentation requirements across institutions in order to expedite the credentialing process during an emergency.



Elements of a Receiver Hospital's Patient Receiving Plan

- 1) Activate EOC/EOP
 - a. Consider implementing mass casualty plan in ED if the affected hospital is nearby
 - b. Consider implementing medical surge plan to create additional available beds
- 2) Establish internal communication throughout the hospital
 - a. Limit outreach by floors/units
 - b. Clarify internal communication structure
- 3) Establish external communication with affected hospital and regional partners
- 4) Assess available bed space and ability to surge
- 5) Ready hospital for the arrival of evacuated patients
 - a. Discharge patients
 - b. Discharge location/staging
 - c. Transfer patients internally
 - d. Setup arrival location for EMS
 - e. Establish meet and greet/screening/triage/assessment/registration team
 - i. Team should have immediate life-saving capability
 - ii. Team should include escorts for arriving EMS crews to direct them to receiving units
 - f. Identify resource shortages
 - i. Beds
 - ii. Clinical staff
 - iii. Pharmaceuticals
 - iv. Medical equipment
 - v. Dietary resources
 - vi. Non-clinical staff (security, engineers, interpreters)
 - vii. Confirm readiness and reassess as patients arrive
- 6) Continue services for discharged patients
 - i. Organize staging / discharge area
 - ii. Monitor health
 - iii. Coordinate transportation
 - iv. Locate discharge operations far from intake/receiving
- 7) Receive evacuated patients
 - a. Avoid Emergency Department if/when possible using direct admitting process
 - b. Establish screening triage/re-triage process for sending patients to new areas/ED
 - c. Register patients as they arrive
 - d. Reassess available beds and identify beds that are:
 - i. Occupied
 - ii. Occupied and pending transfer (estimated time of transfer)
 - iii. Occupied and pending discharge (estimated time of discharge)
 - iv. Available
 - v. Surge bed space that will become available (estimated time of availability)



SECTION VII REFERENCES

1. Adalja A, Watson M, Bouri N, Minton K, Morhard R, Toner E. Absorbing citywide patient surge during Hurricane Sandy: a case study in accommodating multiple hospital evacuations. *Ann Emerg Med.* 2014 Jul; 64(1): 66-73.
2. Diglio M, Benedetto NA, Raneri J. Along came Sandy. How NYC REMSCO helped coordinate the evacuation of 6000-plus patients during Superstorm Sandy. *JEMS.* 2013 May; 38(5): 32-8.