Emergency Management Preparedness

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INTRODUCTION

Disasters often strike without warning, and their effects can be devastating. Some disasters are the result of natural events, while others are caused by human error. In healthcare, disasters are categorized as either internal events that occur within the medical facility or external events that occur outside of the facility.

When a disaster strikes, public service agencies, emergency response agencies, and other officials will rapidly mobilize to help the injured and the broader community in general. Because saving lives in a disaster is paramount, medical professionals must be included in all phases of disaster planning as well as in the immediate response to these events.

PURPOSE/OVERALL GOAL

This module is intended to serve as a single educational unit for healthcare workers responsible for patient care in a variety of settings. The primary focus relates to emergency preparedness for a hospital or acute-care setting, and the roles and responsibilities of each worker. It is important to note that specific disaster plans vary across organizations, and each person is responsible for familiarizing him/herself with the plan(s) for the location in which they are working.

This module focuses on the unique expertise and knowledge that medical professionals must have in order to assist in disaster mitigation and planning. Without a comprehensive disaster plan in place, time is lost and lives are threatened. A carefully created disaster preparedness plan is an institution’s most critical defense in an emergency.

COURSE OBJECTIVES

After completing this module, the learner should be able to:
1. Explain what constitutes an external or internal disaster
2. Understand national standards and guidelines related to disaster planning
3. Describe how an institution develops a Disaster Preparedness Plan
4. Define the role of healthcare workers in the event of a disaster
5. Explain the importance of conducting emergency preparedness drills
6. Describe general safety procedures for common disasters

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WHAT CONSTITUTES A DISASTER?

According to the World Health Organization, a disaster is a “sudden ecological phenomenon of sufficient magnitude to require external assistance.” The American College of Emergency Physicians describes a disaster as “when the destructive effects of natural or man-made forces overwhelm the ability of a given area or community to meet the demand for healthcare.”

While there may be different definitions, healthcare workers must be prepared to handle a disaster and other problematic events occurring inside or outside their walls.

- An external disaster is an event that impacts a facility when the demand for services goes beyond the available resources.
- An internal disaster is an event that happens within the facility that poses a threat to interrupt the environment of care.

Disaster events may be categorized as Class A, Class B, and Class C, according to type and severity.

Class A: Natural Disasters
- Earthquakes
- Floods
- Tornadoes
- Hurricanes
- Blizzards
- Other serious weather conditions

Class A: External Disasters/Medical Emergencies
- Chemical exposure
- Epidemic of disease (biological)
- Explosions
- Fire
- Large-scale poisoning
- Multiple-victim accidents (car, bus, train, plane crashes)
- Terrorism
- Nuclear fallout
- Riots and other civil disturbances
- Structural collapse
- Toxic radiation

Class B: Internal Disasters/Medical Emergencies
- Disease epidemics
- Large-scale food poisoning
- Large-scale infections
Class C: Internal Disasters/Non-Medical Emergencies

- Explosions
- Fire
- Multi-administrator deaths
- Terrorist threats
- Bomb threats
- State Board of Health declared emergency
- Strikes
- Union activity
- Malpractice suit or accusation against facility or physician on staff
- Power failure
- Major mechanical failure
- Internet- or computer-related issues involving patient records
EMERGENCY MANAGEMENT PREPARATION

As a healthcare worker, you should know and understand your institution’s disaster preparedness plan, as well as standards set forth by The Joint Commission (TJC) and the widely accepted Hospital Incident Command System (HICS) guidelines relating to disaster planning.

The circumstances triggering a disaster preparedness plan include:

- Severe natural events such as earthquakes, hurricanes, floods, blizzards, or heat waves
- Human-caused emergencies such as transportation crashes, industrial explosions, terrorist activities, or infectious disease epidemics such as influenza

When a disaster occurs, you will be challenged to provide care in difficult situations including:

1. Loss of essential services, such as electricity, water, or the supply chain
2. Loss of infrastructure, including damage to facilities or electronic information
3. Shortage of workers due to transportation loss, worker or worker family illness/injury, or unwillingness to report to work
4. Size of the affected population, requiring triage at a community level
5. Sudden increase in the number of patients, significantly over your facility’s capacity and/or with serious injuries or other extreme patient conditions
6. The need to perform patient care at an alternate facility not equipped for patient care

In situations such as these, there can be severe consequences if changes are not made in care practices. Essential decisions about allocation of resources should be made at a system level, by the facility in which you work or the community-wide incident command structure.

As a healthcare worker, you are responsible for giving the best possible care to patients within the available resources. Understanding the latest standards, and the role you play, is vital.
It is important for you to familiarize yourself with the latest standards, so you will be prepared in case of disaster. Research indicates that facilities with assigned leaders in case of emergencies can more effectively respond to disaster situations.

The Joint Commission’s elements of performance require the organization to:

- Identify a leader to oversee emergency management
- Consider input from staff at different levels when evaluating exercises and responses to events
- Review of the organization’s emergency management plan, performance, and responses to actual events by the facility’s senior leaders to facilitate improvement

According to The Joint Commission (TJC), an effective emergency management plan includes four key principles:

1. **Mitigation** – Make plans ahead of time to lessen the severity and impact of an emergency.
2. **Preparation** – Build needed organizational capacities, including supplies and equipment, agreements with vendors, staff orientation and training, planning processes, and organization-wide drills.
3. **Response** – Define actions staff would take when confronted by an emergency, such as reporting to prearranged locations. Plan for a warning and notification process, priority-setting, and liaison with other organizations.
4. **Recovery** – Take steps to restore essential services and resume normal operations; plan for staff support and community response.

In response to TJC requirements, the Columbia University School of Nursing’s Center for Health Policy developed, for the American Nurses Association, the following 11 core competencies for healthcare workers in the event of a disaster.

As a healthcare worker, you should be able to:

1. Describe your expected role in an emergency response in the specific practice setting as part of the institution or community response.
2. Respond to an emergency event within the incident or emergency management system of the practice, institution and community.
3. Recognize an illness or injury as potentially resulting from exposure to a biologic, chemical, or radiologic agent possibly associated with a terrorist event.
   - Recognize uncommon presentations of common diseases and distinguish these from common presentations of uncommon diseases that may be related to a terrorist event or emerging infectious disease.
   - Recognize emerging patterns or clusters of unusual presentations.
4. Institute appropriate steps to limit spread, including infection control measures, decontamination techniques and use of appropriate personal protective equipment.
5. Report identified cases or events to the public health system to facilitate surveillance and investigation using the established institutional or local communication protocol.
6. Initiate patient care within your professional scope of practice and arrange for prompt referral appropriate to the identified condition(s).
7. Use reliable information sources (e.g., infection control department, state or local public health agency, Centers for Disease Control and Prevention) for current referral and management guidelines.

8. Provide reliable information to others (e.g., institutional administration, other patients) as relevant to the specific practice site and emergency response protocol.

9. Communicate risks and actions taken clearly and accurately to patients and concerned others.

10. Identify and manage the expected stress/anxiety associated with emergency events, making referrals for mental health services if needed.

11. Participate in post-event feedback and assessment of response with the local public health system and take needed steps to improve future response.
THE HOSPITAL INCIDENT COMMAND SYSTEM (HICS) PLAN

The Hospital Incident Command System (HICS) management plan meets TJC standards and offers a simplified, predictable management structure for:

- Communicating during disasters
- Predefining management positions, such as Incident Commander and Section Chiefs
- Clarifying the chain of command and reporting channels
- Helping to improve communication within the facility and at other participating facilities
- Providing standardized forms for consistent documentation

The HICS plan suggests the following leadership roles.

1. Incident Commander – Responsible for calling together the Disaster Preparedness Committee when a crisis event occurs
2. Section Chiefs – Responsible for logistics, planning, finance, and operations
3. Branch Directors – Responsible for directing unit leaders in their specific areas; the Director reports to the designated Section Chief
4. Unit Leaders – Responsible for communications, transportation, materials and supplies, nutritional needs, situational status, the labor pool, medical staff, nursing staff, medical needs (including triage), and more; the Unit Leader reports to a designated Director
5. Area Officers – Responsible for specific assignments such as Public Information Officer (PIO), Safety/Security Officer, Liaison Officer, Patient Tracking and Information Officer

Whether your institution develops its own plan or follows HICS, the Disaster Preparedness Committee should include representatives from the following areas:

- Medical staff (ER physician or trauma surgeon)
- Administration (includes risk manager)
- Operating room
- Nursing staff
- Emergency department
- Security/Safety
- Communications
- Public relations
- Medical records and admissions
- Engineering/maintenance
- Laboratory
- Radiology
- Respiratory therapy
- Linen services
- Environmental services (housekeeping)

No Disaster Preparedness Plan can be effective without appropriate and organization-wide communication. Once a plan is developed, all staff should be notified and educated accordingly. Additionally, if allowed to be part of the review process, their input can be helpful.
DEVELOPING A DISASTER PREPAREDNESS PLAN

To prepare for internal and external emergencies or disasters, the Disaster Preparedness Committee should consider the following when developing a plan:

1. Determine potential disasters
Disaster Preparedness Committee members should prepare for any type of disaster, but it is imperative that they determine which type has the greatest potential to affect their facility.

2. Assess resources within the institution
Committee members should determine their facility’s capabilities, potential problems, and other concerns during a disaster. Consider the following questions:
   - Is there an emergency water source readily available?
   - If a triage area is established outside of the facility, are there adequate power sources in the designated area, including an emergency generator?
   - Will the air handlers have water if the local water supply is damaged?
   - How will water be rationed?
   - How will food be provided?
   - How will communications be performed, both internally and externally?
   - What is the back-up air, oxygen, electrical, and emergency generator status throughout the facility?

The Committee should assess:
   - Whether there are sufficient supplies to maintain the facility through the first 72 hours post-disaster
   - Current staff information regarding phone numbers, addresses, emergency contact numbers
   - The use of proper personnel identification (ID) to ensure the staff will be permitted to cross security/disaster area lines

Different scenarios should be considered to help identify shortcomings before an actual situation is experienced. The institution should consider establishing mutual aid or written agreements with other healthcare facilities and vendors in the community, as well as in adjoining communities, to provide personnel, supplies, equipment, transportation, pharmaceuticals, or whatever else may be needed during an external disaster.

3. Outline key elements
Committee members should determine the chain of command during a disaster and the communication process, both internally and externally. They should develop a process to manage patient triage, patient care and evacuation procedures, equipment management and transfer, patient identification, records management, security issues, and public information, as well as the steps to take toward recovery from emergency situations of all kinds.
4. Chain of command
Most medical facilities have a Safety Director in place. This person is responsible for overseeing the development, implementation, and monitoring of the facility’s disaster plan, and should play a key role as a member of the Disaster Preparedness Committee.

The Safety Director’s responsibilities usually include:

- Implementing plans following a disaster based upon the space, supplies, and security of the facility in case of a bomb threat, natural disaster, fire, chemical spill, hostage situation, power outage, or utility failure
- Establishing policies for notifying proper authorities outside the facility regarding an emergency
- Developing protocol for notifying personnel upon implementation of the emergency preparedness plans
- Defining responsibilities of personnel during disaster and emergency situations, and assignments to reflect staffing patterns
- Developing policies for providing communications during disasters and emergencies, and policies for alternative sources of essential utilities
- Developing policies and procedures for evacuation of the facility if it cannot continue to support adequate patient care and treatment, and identifying an alternate care site
- Integrating the facility’s role with community emergency preparedness plans
- Developing policies for identifying available facilities for radioactive or chemical isolation and decontamination
- Developing policies and procedures for managing patients during disasters or emergencies, including the scheduling, modification, or discontinuation of services as well as control of patient information and admission, transfer, and discharge of patients
- Promoting orientation programs and continuing education on emergency preparedness plans for all personnel
- Implementing emergency preparedness plans semi-annually, in response to an emergency or planned drill.

5. Communication
In preparation for a disaster, another key position is the Incident Commander, responsible for gathering the Disaster Preparedness Committee together at a moment’s notice.

As a team, the Committee members then take control of the situation by delegating responsibilities to predetermined Section Chiefs, Directors, Unit Leaders, and Area Officers, who are responsible for either directing teams or other specific duties.

The Committee must be able to effectively communicate with one another, with all staff, the public, and other medical facilities in times of disaster.

6. Patient management
Healthcare delivery has changed over the years. Many patients are receiving healthcare at home instead of at a hospital or long-term care facility. In times of disaster, this can present a challenge.
In order for emergency preparedness agencies to properly evacuate patients, the hospital or home health agency should have the ability to provide patients’ locations and their specific needs as quickly as possible. Local emergency preparedness agencies can assist in developing plans for home health situations.

Home health agencies must have a disaster plan, as required by both The Joint Commission and the Community Health Accreditation Program (CHAP). Many communities have designated special shelters for temporary care until patients can be relocated or moved back into their homes.

7. Patient transfers
A Transportation Officer should be assigned to make sure patients can be safely transferred either within the facility in cases of internal disaster or to another facility in cases of external disaster. As an example, the following is a general guideline regarding patient transfer during and after an earthquake.

Within your facility:
1. Move all patients to a central area.
2. Issue extra blankets to all patients and keep them warm.
3. Close all curtains or shades in the central area to protect against exposure to broken glass.
4. Close all doors to the central area including outer fire and smoke barrier doors.
5. Avoid using open flame devices.
6. Gather flashlights and extra batteries.
7. Reassure patients and explain measures being taken to promote their safety.
8. Should transfers of patients to other facilities be necessary, follow the guidelines set forth in your institution’s policies and procedures.

8. Evacuation procedures
If evacuation is necessary following an internal disaster, patients should be relocated to a secure place within the facility, designated by the emergency response team. Patients and personnel should remain in the secured area until an “All Clear” has been given. Avoid using elevators.

Department heads, supervisors, or other predetermined area officers should assign one staff member in each of their areas to remove patient charts (if paper charts are in use). All such records should be taken to an area designated by the person in charge.

Officers are also responsible for assuring that exit routes are safe. One person must remain at the assembly area to assure that everyone remains in the area. No one should be allowed to return to the building until “All Clear” has been announced.

Once evacuation has occurred, law enforcement and designated search teams should search the premises. Once the search is completed or has been terminated by the search commander, all employees participating in the search should leave the premises and return to the assembly area designated during the evacuation process unless otherwise instructed.
9. Availability of equipment
During a disaster, the availability of equipment is essential to the survival of patients in an internal event and to the community in an external event. In preparation, know where the following items are located so they can be gathered as quickly as possible:

1. Keys – Environmental services personnel may know where all keys are kept.
2. Blankets – Additional blankets may be obtained from Environmental Services.
3. Portable Oxygen Tanks – Check the Emergency Room, Supply areas and Respiratory Therapy Department.
4. Carts (for transporting supplies) – Usually found in the following areas:
   - Ambulatory Care Unit
   - Emergency Room
   - Surgery
   - Radiology
   - Ultrasound
   - EKG/Stress Test Room
5. Miscellaneous items – This includes bandages, dressings, compresses, suture materials, sterile scrub brushes, normal saline, antimicrobial skin cleanser, waterless hand cleanser, gloves, fracture immobilization, splinting and casting materials, backboards, rigid stretchers, non-rigid transporting devices, oxygen-ventilation-suction devices, and advance life support equipment (i.e., chest tube, airway, major suture trays).

10. Patient Identification and Information
One person or the Patient Identification/Information Officer should be responsible for patient identification practices during a disaster. In brief, this person is responsible for keeping a list of patients, their location within the facility, and their condition.

11. Records
A Records Officer should be assigned to lead an effort to obtain patient records in time of disaster. That way, there is a greater likelihood that medical records and medical equipment can be transferred to another facility if necessary.

If your facility has a computerized charting system, the information can be quickly and easily downloaded onto an external drive or immediately backed up to a server, while hard copies of charts must be gathered and carried out.

12. Security
A Safety/Security Officer should be assigned to make sure no unauthorized persons enter the building following an internal disaster. This helps to provide security for staff, patients, visitors, and property. This officer is also responsible for ensuring that any activity that takes place at the medical facility is done with the highest level of safety considerations.

13. Public Information
Staff members answering telephones should not give out information concerning a disaster to any caller, unless authorized to do so. Similarly, publicity should be avoided as much as possible. For example, in the case of a bomb threat, publicity tends to generate additional threats.

Only the Administrator or his/her designee should answer questions asked by the media, and should provide information only on a need-to-know basis.
14. Recovery
Many disaster plans fail to include information regarding the disaster recovery phase. However, recovery is extremely important. And planning for it begins before a disaster ever happens.

In preparation for recovery, experts recommend that facilities start with a complete inventory of their assets, including buildings and equipment. When new buildings are built, additions are made, major renovations occur within the facility, or any other addition or improvement occurs, photographs or videos should be taken to build a historical file that can be presented to an insurance agent post-disaster.

For insurance claims, pictures present the actual condition prior to any damage. Do not forget to photograph any damage prior to its removal or clean up.
CONDUCTING DRILLS

Testing emergency preparedness plans before a disaster strikes allows everyone in your organization to learn what to do if a disaster occurs, and helps to reveal potential problems so they can be corrected before they are ever tested in a real disaster.

All staff should participate in basic emergency preparedness training and drills. This includes:
- How to report and respond to an emergency
- How to obtain assistance
- How to obtain equipment
- How to communicate if the facility loses normal communication methods

In addition, your facility should identify staff with key roles and responsibilities in the disaster plan and train them as to their responsibilities. It is also suggested that local assistance agencies be part of the drill when possible.

It is important to note that The Joint Commission requires facilities to conduct at least two disaster drills a year. According to TJC, these drills must occur at least four months apart. These drills are further required to include all departments and legal agencies that would be involved in a real emergency.

Drills must include practice treatment and transportation exercises. The emergency plan and staff must be evaluated once a year.

Once the Disaster Plan has been reviewed and finalized, it must be maintained. Conducting periodic drills helps maintain the plan.

In addition, the plan should be revised periodically to allow for changes that have occurred in the community that may affect implementation of the plan. Examples of these include the opening and closings of schools in the area, openings and closings of other hospitals and medical facilities in the area, and community expansion or decline.
THE IMPORTANCE OF AREA COORDINATION

In an emergency of any magnitude, you aren’t just dealing with your institution and its administrators, but with fire departments, police, emergency disaster services such as the Red Cross and Salvation Army, and many other community assistance services and agencies.

Creating, maintaining, and practicing a Disaster or Emergency Plan requires a high level of coordination between your institution and those services and agencies. Designated individuals at your institution should be charged with staying in touch with community assistance agencies and services that are set up to help in a disaster.

Area coordination is necessary, especially in larger events that affect a wider base of the population both inside and outside your institution’s walls. For example, in case of fire, both the fire department and police are usually involved. According to federal guidelines, the fire department must be notified regardless of the size or type of fire.

These agencies can be helpful with the exchange of information. For example, if communications in your facility go down, the fire and police departments are equipped with portable communications devices. They can provide a necessary link in the flow of information.

Outside agencies can also be helpful in evaluating your institution’s Disaster or Emergency Plan when involved in drills.
GENERAL SAFETY PROCEDURES FOR COMMON DISASTERS

The following are general guidelines to follow in cases of the most commonly experienced disasters in the healthcare environment. These are meant only as general guidelines. You should review your institution’s Disaster or Emergency Plan for detailed instructions.

1. Fires

Fire emergencies are one of the most serious situations that can occur in a healthcare environment. Healthcare professionals are exposed to many fire hazards in their workplace that have potential to harm patients, visitors, and coworkers if not handled appropriately. Having a plan in place regarding fire can save lives.

Many healthcare institutions use the R.A.C.E. system when fire breaks out. The word ‘RACE’ provides a convenient way for all staff members to remember what to do in case of a fire.

- **R** = Rescue Patients and Employees in Immediate Danger
  The first step in the R.A.C.E. procedure is to rescue patients and employees in immediate danger. ‘R’ can also stand for remove all patients and employees in immediate danger. All healthcare professionals should know the evacuation route in their area, as well as their facility’s policies and procedures for evacuating patients. Follow these procedures quickly and calmly.

- **A** = Activate the Fire Alarm
  The second step of the R.A.C.E. procedure is to activate the fire alarm. ‘A’ can also stand for alarm. If you are the first to discover the fire and the fire alarm has not been activated, immediately activate the alarm. Follow your facility’s policies and procedures for notifying appropriate personnel about the fire.

- **C** = Confine/Contain the Fire
  The third step of the R.A.C.E. procedure is to confine/contain the fire. The purpose of closing doors and containing the fire is to limit the fire’s access to oxygen. Close all doors to patient and storage rooms and make sure that the fire doors have automatically closed. Closing all doors helps prevent the spread of the fire to other areas.

- **E** = Extinguish the Fire
  The final step in the R.A.C.E. procedure is to extinguish the fire. If the fire is small and contained, you can extinguish it by covering it with nonflammable materials or by using the correct type of fire extinguisher. Use the fire hoses available in your facility only if you have been properly trained to do so. Otherwise, evacuate everyone and wait for the fire department to extinguish the fire.

2. Earthquakes

Almost every area of the world is at risk for earthquakes. In fact, several million earthquakes occur each year globally, ranging from barely perceptible quakes to those severe enough to destroy entire cities and countrysides.

During an earthquake, the main concern for healthcare facilities is loss of power, especially those facilities that are geographically isolated. In case of earthquake, the following serves as a general guideline for operational procedures:
During the quake:
The first rule of thumb is: don’t panic. If inside, remain inside, where you are the safest. The greatest
danger from falling debris is just outside a doorway and near outer walls. Instruct patients, coworkers,
and visitors to move into the hallways. If time does not permit this, instruct all persons to take cover
under beds, tables, or against inside walls. Remind them to stay away from windows and glass.

During an earthquake, you should never use an open flame, such as candles and matches. If you are
outside, move away from the building and utility wires. Once in the open, stay there until the shaking
stops.

After the quake:
Here are the steps you should take once the shaking stops:
1. Check for injuries.
2. Follow treatment procedures as instructed.
3. Don’t use open-flame devices until the building has been inspected for broken gas lines and has
   been declared safe.
4. Check utilities, but don’t turn them on until the building has been declared safe.
5. If you smell gas, open windows and shut off the main gas valve.
6. Don’t use telephones, except for emergencies.
7. If the building or any portion of it has been damaged, don’t allow anyone entrance until an “All
   Clear” has been issued.
8. Be mindful of fires caused by earthquakes. They can be more dangerous than the earthquake
   itself, because equipment and water lines may be destroyed or immobilized. During and after an
   earthquake, be especially watchful for fires, leaking gas lines, and the like, and report them
   immediately. Should a fire occur, procedures MUST be followed as outlined in your facility’s Fire
   Safety Plan, unless otherwise instructed.

3. Bomb Threats
According to federal guidelines, should a bomb threat be received by phone, the nurse or other
healthcare professional taking the call should immediately institute the following procedures and
complete a “Record of Bomb Threat”:
1. Remain calm. Don’t panic.
2. Keep the caller on the line as long as possible.
3. Record, as near as possible, every word spoken by the person calling.
4. Listen for any strange or unusual background noises such as music playing, motors running,
   traffic sounds, etc., which might be helpful in providing clues to determine where the call was
   made from.
5. Determine whether the voice is male or female, familiar or unfamiliar, and listen for any
   accents, speech impairments, nervousness, etc.
6. Record as much information as you can. You may not be able to get everything, but gather as
   much as possible.

Immediately after the caller hangs up, contact the Switchboard Operator and relay as much information
as possible. This person should contact the Police Department and then make the following
announcement over the intercom: “Attention please. Code 50 is now in effect.” (The Switchboard
Operator will use whichever code is appropriate for your facility. All healthcare employees should be
familiar with their facility’s code system.)
The Switchboard Operator will then contact the following and relay the information received:

- Fire Department
- Facility Administrator and/or CEO
- Chief Nursing Officer and/or Director of Nursing Services
- Safety Director
- Director of Environmental Services
- Maintenance Supervisor

Only authorized law enforcement officials will remain in the building during the removal of any suspicious object(s), and such agencies will direct the removal as quickly as possible. Once the search has been completed, an “All Clear” should be announced after a confirmation has been obtained from the police department or fire department stating the building has been searched and nothing found.

4. Riots
Planning for civil disturbances or riots **MUST** be a part of your preparedness plan. If a civil disturbance breaks out, the first thing you need to do is to secure the facility entrance nearest the location of the occurrence and notify security. Also, notify your supervisor, who in turn should notify appropriate administrators and law enforcement agencies.

In a situation of civil disturbance, the most important things to remember are to:

- Remain calm and get the facts and reason for the demonstration
- Meet and talk with the leader of the demonstration
- Make no promises or concessions without administrative authority
CONCLUSION

With an Emergency Management Plan in place, a medical facility or hospital can be properly and adequately prepared for any disaster, either internal or external. Without one, the organization is at high risk for confusion, unnecessary chaos, and even loss of life when disaster occurs.

The key for institutions to effectively manage and react to a disaster is to practice their preparedness using mock situations and periodic drills, which are requirements of The Joint Commission.

Nurses and other healthcare workers are responsible for the safety of their patients. By understanding their role in their institution’s disaster plan, they can help to enhance the level of safety for patients, visitors, coworkers, and themselves.

REFERENCES: