

2

SOME IMPORTANT CONSIDERATIONS FOR MAKING YOUR HOSPITAL EMERGENCY PLAN

2.1 Aim of Hospital Disaster/Emergency Management Plan:

The aim of a hospital disaster plan is to provide prompt and effective medical care to the maximum possible, in order to minimize morbidity and mortality resulting from any MCI.

2.2 Objectives and goals of a Hospital Emergency Plan:

The main objective of a hospital emergency/disaster plan is to optimally prepare the staff and institutional resources of the hospital for effective performance in different disaster situations.

The hospital disaster plans should address not only the mass casualties which may result from MCI that has occurred away from the hospital, but should also address the situation where the hospital itself has been affected by a disaster – fire, explosion, flooding or earthquake.

In case of MCI away from the hospital and not affecting the hospital the further goals are:

To control a large number of patients and manage the resulting problems in an organized manner,

- ✓ By enhancing the capacities of admission and treatment.
- ✓ By treating the patients based on the rules of individual management, despite there being a greater number of patients.
- ✓ By ensuring proper ongoing treatment for all patients who were already present in the hospital.
- ✓ By smooth handling of all additional tasks caused by such an incident.
- ✓ To provide medications, medical consultation, infusions, dressing material and any other necessary medical equipment.

In case of incidents affecting the hospital itself the further goals of the plan would be:

To protect life, environment and property inside the hospital from any further damage –

- ✓ By putting into effect the preparedness measures.
- ✓ By appropriate actions of the staff who have to know their tasks in such a situation.
- ✓ By soliciting help from outside in an optimal way.
- ✓ by re-establishing as quickly as possible an orderly situation in the hospital, enabling a return to normal work conditions.

2.3 Principles of a Hospital Disaster Plan

- **Predictable:** The hospital disaster plan should have a predictable chain of management.
- **Simple:** The plan should be simple and operationally functional.
- **Flexible:** (Plan should have organizational charts)
The plan should be executable for various forms and dimensions of different disasters.
- **Concise:** (Clear definition of authority)

The plan should specify various roles, responsibilities, work relationships of administrative and technical groups.

➤ **Comprehensive:** (Compatible with various hospitals)

It should be comprehensive enough to look at the network of various other health care facilities along with formulation of an inter-hospital transfer policy in the event of a disaster.

➤ **Adaptable:** Although the disaster plan is intended to provide standard procedures which may be followed with little thought, it is not complete if there is no space for adaptability.

➤ **Anticipatory:** All hospital plans should be made considering the worst case scenarios.

➤ **Part of a Regional Health Plan in Disasters:** A hospital cannot be a lone entity making its plans in isolation. The hospital plans have to be integrated with the regional (district/taluka/block) plan for proper implementation.

2.4 How to proceed for making Emergency Plan for your hospital?

To make the proceedings easier it is recommended that the hospital administrators embark upon disaster planning using a phase plan. The hospital emergency planning can be divided into three phases:

1) Pre disaster phase

- a) Planning: Most of the assessment and planning is done in the pre disaster phase, the hospital plans are formulated and then discussed in a suitable forum for approval.
- b) The disaster manual: The hospital disaster plan should be written down in a document form and copies of the same should be available in all the areas of the hospital.
- c) Staff education and training: It is very important for the staff to know about and get trained in using the hospital disaster/emergency manual. Regular staff training by suitable drills should be undertaken in this phase.

2) Disaster Phase

- a) Phase of activation: Alert and notification of emergency.
- b) Activation of the chain of command in the hospital.
- c) Operational phase: This is the phase in which the actual tackling of mass casualties is performed according to the disaster/emergency plan.
- d) Phase of deactivation: An important phase of the hospital emergency plan when the administration/ command of the hospital is satisfied that the influx of mass casualty victims is not continuing to overwhelm the hospital facilities.

3) Post Disaster Phase

This an important phase of disaster planning where the activities of the disaster/ emergency phase are discussed and the inadequacies are noted for future improvements.

2.4.1 Pre Disaster Planning

Most of the planning of hospital emergency plans is done in pre disaster phase. It is recommended that all hospitals providing emergency care to patients start planning for the worst at the earliest. It is always good to have a ready working plan before next emergency strikes.

2.4.1.1 Hospital Disaster Management Committee

Formation of a disaster/emergency committee is the first step for making a disaster plan for the hospital. Most of the hospitals already have such hospital management committee; therefore, an emergency/

disaster management committee can be carved out from such already existing committees. The members of the disaster management committee should be from following basic facilities of the hospital.

Who should be in the committee?

The hospital administration:-

- ✓ The director/principal/dean/head of institution/medical superintendent.
- ✓ Member/members from hospital management board.
- ✓ The chiefs/heads of various clinical departments supporting the emergency services; e.g., casualty and emergency services, orthopedics, general surgery, medicine, neurosurgery (if present), cardio-thoracic surgery (if present), anesthesia.
- ✓ The chiefs/heads of various ancillary departments e.g., radio-diagnosis, transfusion medicine/ blood bank, laboratory services/pathology, forensic medicine.
- ✓ The chief nursing superintendent/matron.
- ✓ The finance department.
- ✓ The stores and supplies department.
- ✓ The hospital engineering department.
- ✓ The public relation and liaison office.
- ✓ The chief of security of the hospital.
- ✓ The sanitation department.
- ✓ Hospital kitchen/dietary services.
- ✓ The social welfare department (if present).
- ✓ Hospital unions.

2.4.1.2 Central Command structure (Incident command system) for your hospital

In order to ensure effective control and avoid duplication of action there should be a unified command system which should be based on the individual hospital hierarchical chain. The advantages of ICS are many. It has predictable chain of management; flexible organization charts allowing flexible response to specific emergencies; prioritized response checklists; accountability of position function; improved documentation; a common language to promote communications and facilitate outside assistance; cost effective emergency planning within the hospital.

Although this sort of chain of command is ideal to avoid chaos in emergency situations, it is seen that there is a strong opposition to formation of any such hierarchical command system by the physicians and hospital personnel. Nevertheless all doctors including the administrator should emphasize that such a command system would come into affect only at the time of mass casualty incident and would close down on withdrawal of disaster alert. Therefore all hospital personnel including doctors should respect the command hierarchy during emergencies and disasters.

Any command system may be used by the hospital but the most important rule is to make organizational chart. Each position on the chart should be function based and not position or individual based. An individual can be assigned more than one position on the chart, so a person might have to perform multiple tasks until additional support comes.

Sample organizational chart for different hospitals are given in Annexure D,E&F, Delineate the jobs according to your command system the disaster/emergency management plan describes many jobs which may need to be performed in an emergency, but how people are assigned to jobs or the jobs to people depends on

different circumstances existing in different hospitals. Therefore, the jobs delineated according to the command systems depend on the administrator or leaders of that particular hospital.

The titles used in a disaster/emergency plan are carried by functions and not individual people/designation.

2.4.1.3 Job Cards

Action sheets or job cards are basis of a successful disaster/emergency management plan. These sheets should be made for each and every position in the organizational chart of the command system. The job cards should be detailed; Stored safely (in disaster manual); Colour coded and laminated. Some sample jobs cards are attached as Annexure G

2.4.1.4 Plan activation of different areas of hospital

The areas which should find a mention in a hospital emergency plan are:

- ✓ Command centre.
- ✓ Communications office/paging/hotline area/telephone exchange.
- ✓ Security office/police picket (chowki).
- ✓ Reception and triage area.
- ✓ Decontamination area (if needed).
- ✓ Minor treatment areas.
- ✓ Acute care area (emergency department).
- ✓ Definitive care areas (OTs, wards).
- ✓ Intensive treatment area and activation of High Dependency Units (HDUs)
- ✓ Mortuary.
- ✓ Holding area for relatives/non-injured.
- ✓ Area for holding media briefings (separate media/PRO/spokesperson room).
- ✓ Area for holding patients in case a part of the hospital is evacuated.

All these areas should be mapped on the outlay map of the hospital. The normal capacities of the existing areas should be mentioned on these maps. Enhanced admission of patients requires an enlargement of suitable spots, if necessary even by changing their function.

2.4.1.5 Disaster beds/ how to increase bed capacity in emergencies?

The newly arriving patients would require admission for definitive treatment therefore plans should be there to increase the bed capacity when needed. This can be achieved by the following actions:

- ✓ Discharge elective cases.
- ✓ Discharge stable recovering patients.
- ✓ Stop admitting non emergency patients.
- ✓ Convert waiting/non-patient care areas into makeshift wards.

2.4.1.6 Planning of public information and liaison

We live in the age of mass and multimedia. Every news and information source will seek access to the latest and most up to date information. In most cases there is absence of clear and credible information. This leads to media speculations and increases the stress and pressure of the incident, especially on hospital and its staffs. The disaster committee should designate one person from the hospital for regular media/ press briefing.

One of the areas in the hospital should be designated as media room where media persons can be accommodated for controlled access to information.

Media always gets its information – the better way is controlled one.

2.4.1.7 Planning for security of hospitals in emergency situation

During emergency situation the hospital is the focus of not only the patients being brought in but a lot of other persons including relatives, by-standers, media etc. They more often than not block the entrance and other areas hampering the smooth functioning of the hospital. It is therefore recommended that all hospitals should have some security arrangements even in non disaster phases. The hospital security should be operational at a very early stage of disaster. Some of the duties recommended are

- Work in close coordination with local police
- Maintain order within and outside the hospital
- Direct traffic so as not block the free access of patient carrying vehicles to and outside the hospital
- Protect key installation of the hospital (Emergency Department, Hospital Working areas, Power Station/Generators, Water Tanks/Water Supply etc.)
- Restrict and strictly control access to the hospital
- Direct the entry for authorized persons to appropriate areas (ambulances to emergency, relatives to waiting area, media to media room etc.)
- Protect hospital personnel and patients,
- All hospital personnel should carry Identity cards

2.4.1.8 Logistics planning

i) Planning for communications (within and outside the hospital)

Communications is one of the main problems in major emergencies and disasters. Information transfer has to be reduced to most important facts only. Multiple means of communications should be planned to communicate with hospital staffs and administrator. The currently available communication networks which should be looked into for availability in the hospital are;

- internal telephone exchange (for the hospital)
- landline phones
- private mobile/cellular phones
- mobile/cellular phones in closed user group (CUG) for hospital staffs only provided by the hospital
- Loudspeakers/ public address system
- Wireless sets for security and ambulance personnel
- The communications room

An area should be identified as communication room within the hospital and all internal and external communications must be made from here. This communication room should be in continuous contact with the command centre/control room.

All important numbers of hospital personnel, police, district functionaries of administration other nearby hospitals etc. should be clearly mentioned in the disaster manual and a copy of this manual should also be present in the communication room/ telephone exchange.

On getting the go ahead from the control room the disaster message should be flashed/ communicated to all the numbers.

ii) Transportation (To and from the site/ other hospitals)

Transportation is necessary in emergency situation mainly to bring the patients from the site of mass casualty incident to the hospital. Transport is also required to transfer patients to other hospitals if the facilities at the hospital in question are overwhelmed or is unable to perform its functions due to internal damage.

The transport room/driver room should also have a telephone or any other means of communication like wireless to remain in touch with the control room.

iii) Stores planning

What is a disaster store?

It is recommended that adequate stores of linen, medical items, surgical items should be kept separately in the Emergency/Casualty and should be marked the "Disaster Store". The activation of this store is done only after the Disaster has been notified by the appropriate authorities.

As immediate measures the buffer stocks earmarked for the Casualty/Emergency Services should be utilized till the fresh stocks are replenished from main Hospital stores/ disaster stores.

Close liaison is kept between the Stores In – Charge and the Hospital administration (Central command). Any requirements to the Operational Areas/Treatment areas are conveyed to the Command Center.

Sample Stock Inventory for Disaster Stores is given as Annexure J

iv) Personnel Planning – Medical and Non-Medical

Medical Staffs:

In addition to the members of clinical staff, Para and preclinical disciplines (if present in the facility) should render their services in managing the casualties. Duty roster for standby staffs should be available in the control room/Command center, Nursing Staffs:

The Nursing Superintendent should be able to prepare a list of nursing staffs who may be made available at a short notice. The nursing personnel officer should be also able to mobilize additional nursing staffs from non-critical areas.

Other Staffs:

Duty roster (including those on standby duty) of all ancillary medical services (e.g. Radiology, Laboratory, Blood Bank) and also other hospital services (e.g. house keeping, sanitation, stores, pharmacy, kitchen etc.) should be available with the duty officer/ hospital administrator.

Volunteers:

The role which volunteers will assume in the course of a disaster should be predetermined, rehearsed, coordinated and supervised by the regular senior staff of the health facility.

Reserved Staff:

In cases of large scale disasters the recommendations are made for community participation and reserve staff concept.

Preparedness will be enhanced by development of a community-wide concept of "reserve staff" identifying physicians, nurses and hospital workers who are (1) retired, (2) have changed careers to work outside of healthcare services, or (3) now work in areas other than direct patient care (e.g., risk management, utilization review). While developing the list of candidates for a community-wide "reserve staff" will require limited resources, the reserve staff concept will only be viable if adequate funds are available to regularly train and update the reserves so that they can immediately step into roles in the hospital which allow regular hospital staffs to focus on incident casualties.

Hospital preparedness can be increased if state medical councils, working through the State Medical Services, develop procedures allowing physicians licensed in one system of medicine to practice in another under defined emergency conditions.

v) Financial Planning

An important aspect of any management plan is the financial management. It is recommended that the disaster plans are made in close association with the financial advisors of the hospital/institution. This will make them more cost effective and avoid unnecessary and repeated expenditure.

2.4.1.9 Operations Planning

The incident commander after notification of the hospital disaster activates and alerts the in-charges of different important areas of the hospital. The in-charges of various facilities in turn notify and alert the staff (medical / nursing / others staff) working in these areas to immediately reach the area and carry out their functions. The in-charges also call up the reserved staff which is not on duty to be ready in case they are needed.

• *Essential Medical/Non-Medical Staff Activation (In different Areas)*

1) Reception and Triage Area

This area is the first area of contact between hospital personnel and the incoming patients. This area should be manned by

- Registration officer on the registration desk
- Triage Doctors/Nurses
- Adequate number of doctors in the emergency room/ casualty
- Adequate no. of stretchers/trolley bearers
- Hospital attendants

Initial registration and Triage should be done in this area.

- Triage criteria for disasters and the patients will be color coded according to the kind of treatment they deserve e.g.

ONE - Immediate Resuscitation (RED)

TWO - Potentially Life Threatening Injuries (YELLOW)

THREE - Walking Wounded (GREEN)

FOUR - Dead (BLACK/WHITE) (Annexure H)

(2) Decontamination Area (If needed in NBC Disasters)

(3) Acute Care Area (Emergency Department) Responsible person – casualty medical officer/ doctor in-charge emergency services

(4) Definitive Care areas (Operation Theaters, Wards)

Responsible person – zcy services.

(5) Intensive Treatment Area Activation (HDU/ICU'S)

Responsible person – Head of Anaesthesiology/ Critical Care/ Medicine.

(6) Minor Treatment Areas

The Staffs mainly nursing staffs and hospital attendants who are familiar with first aid, splinting and dressings can be sent to the Minor treatment areas and thus saving the Medical staffs for more intensive and resuscitation areas

(7) Holding Area for Relatives/Non-Injured

A hospital staff member will stay with the family members. (Social Services will be assigned here after reporting to the Command Center and other personnel assigned as needed) A list of the visitor's names in association with the patient they are inquiring about should be kept. Volunteers may be needed to escort visitors within the facility.

- **Essential Nursing Staff Activation**

To be done by the Matron / Chief Nursing Superintendent of the hospital in association with Deputy Nursing Superintendents and other nursing administrators.

- **Essential Ancillary Services (Lab, Radiology, Pharmacy)**

- (1) Laboratory Services

Department Head or designee will call in their own personnel as needed after reporting to Command Center. Call personnel from nearby hospitals and clinics as necessary. Have arrangements made to obtain additional blood, equipment and supplies from area agencies.

- (2) Radiology Services

Department Head or designee will: Call any or all personnel needed. Arrange for extra supplies to be brought in if needed. Coordinate flow of work and delegation of work areas. Other members of the Radiology staff will: Perform all x-ray exams/ CT scans/ Ultrasounds etc. as needed and assigned.

- (3) Blood Bank:

- (4) Mortuary Services (Care for the dead)

Mortuary should be situated away from the main entrance of the hospital. It should be adequately staffed with Senior Forensic Specialist/any designee appointed for that purpose. Patients pronounced DEAD ON ARRIVAL (DOA) should be tagged with a Disaster Tag and body should be sent to mortuary. The Emergency Department should also notify about all deaths to the Command Control room. Bodies should be stored in the alternate morgue area if the capacity of mortuary to store bodies is overwhelmed. Mortuary Personnel will remain with bodies until removed by Mortuary In-Charger. After bodies have been identified, the information will be filed on the Disaster Tag and Medical Records notified as to the identification of the patient. The bodies may be removed via a separate gate of the hospital with the knowledge of the Mortuary in-Charge. A complete record of all bodies must be maintained along with the name of the agency removing them, e.g., police, fire department, hearse, etc.

Be sure appropriate paperwork is filled out.

- **Other Ancillary Services**

- (1) Hospital Dietary Services (Kitchen)

Department head or designee will call in their own personnel as needed after reporting to Command Center. Prepare to serve nourishments to ambulatory patients, in-house patients and personnel as need arise. Utilize additional areas for extra eating space. Be responsible for setting up menus in disaster situation and maintain adequate supplies.

- (2) Sanitation Services

Adequate sanitation services within and around the hospital should be ensured by the hospital administration.

- (3) Hospital Laundry and Sterile Supply

The hospital administration should ensure adequate supply of clean hospital linen, sterile dressing and sterile supply of instruments to the essential areas of the hospital.

(4) Essential Services

Water: Adequate provision should be made to meet the additional requirement of water. Planning should also be done for alternative sources of water such as storage tanks or tube well which can provide water in case of possible breakdown in the normal system of supply.

Light and Power: Provision should be made for standby generators to provide light and power to essential areas of the hospital like Emergency Department, Operation Theatres, ICUs etc.

2.4.1.10 Phase of Staff Education and Training

Once the Disaster Plan is ready the next phase would be the education and training of the staff of the hospital about the plan and specific roles of each staff member in case of a disaster.

- Concept of Common Language in Disaster Situation

The initial chaos of any disaster scenario in a hospital can be minimized by proper training of the hospital staff about their roles and responsibilities in case of a MCI/Disaster so that, everyone knows his/her job and work continues in an orderly fashion without confusion

- Introduction of Disaster Management Training to Hospital Leadership

A presentation made to all administrators, department heads and managers regarding the implementation of the Hospital Disaster Plan into the facility's emergency response plan will help solidify support in all areas of the hospital. This program should be a combination of education and public relations. Managers should be made to feel that they are all an integral part of the new system. Interested managers can be recruited to become part of a train the-trainer class.

- Introductory Lessons for all Hospital Staff

An orientation and education program is required for personnel who participate in implementing the emergency preparedness plan. Education should address the following

1. Specific roles and responsibilities during emergencies,
2. The information and skills required to perform duties during emergencies
3. The backup communication system used during disasters and emergencies, and
4. How supplies and equipment are obtained during disasters or emergencies;

- **Disaster Drills**

As a part of the emergency management plan, every hospital is required to have a structure in place to respond to emergencies. This structure is routinely tested during drills. The evaluation modules for hospital disaster drills are designed to be a part of that testing. Viewed in this way, hospital disaster drill evaluations can provide a learning opportunity for all who participate in a planned drill. The disaster drill evaluation modules present topics for evaluation in a systematic manner. They should be used to identify strengths and weaknesses in hospital disaster drills, and the results gained from evaluation should be applied to further training and drill planning. Although the evaluation modules can be used to identify improvement in repeated drills, they are not intended to be used to make final or complete judgments about whether a hospital passes or fails in its planning and training endeavors. The value of this approach is to identify specific weaknesses that can be targeted for improvement and to promote continuing efforts to strengthen hospital disaster preparedness.

- **Table Top drills**

Table Top Exercise is a paper drill intended to demonstrate the working and communication relationships of functions found within the disaster organizational plan. The exercise is intended primarily for the administrators, managers and personnel who could conceivably be placed into an officer's position upon activation of the disaster plan.

- **Partial evacuation/Non-evacuation Drills**

Hospital evacuation may become a necessity if the hospital itself becomes a victim of any disaster. Such situations need to be foreseen and proper planning has to go into how to evacuate and which areas of the hospitals need to be evacuated first in case of an internal disaster.

(Appendix: I) gives an idea about the evacuation plans of the hospital.

- **Revision of Hospitals Disaster/Emergency Plan**

Continuous revisions should be made in the Hospital Disaster Management Plan taking leads from the regular disaster drills in the hospital. This would refine the plan and cover up the deficiencies faced in the Drill Phase.

- **Continuing Staff Education**

2.4.2 Phase of Disaster

2.4.2.1 **Disaster Activation** – Alert and Mobilization Phase (plans for alerting the disaster committee, staff, other facilities via phones/paging and mobilizing resources to appropriate activated areas) Several critical events must occur in this phase:

- **The Hospital Administration must appoint an Incident Commander.**

- a. The Incident Commander must not be expected to carry out any patient care, logistical, security, or other activities, but must be free to command and coordinate the overall disaster response.
- b. The Hospital Administration must choose the most competent person to be Incident Commander. (Competence in the context of coordinating a hospital during a disaster.) An Emergency Department physician with Emergency Medical Services and disaster experience would be ideal, but the Incident Commander need not be a physician, nurse, or administrator. (For example, if a security chief from another hospital just happens to be visiting, and has managed many hospital disasters before, the Hospital Administration could appoint him as Incident Commander.) The Incident Commander inherits authority directly from the Hospital Administration.
- c. The hospital Incident Commander's job is to direct all aspects of the hospital's participation in the disaster operation. The effectiveness of the hospital is his responsibility.

- **Incident Staff**

- A. The purpose of the Incident Staff (comprised of Command and General Staff) is to provide the hospital IC with enough manpower to meet all his or her responsibilities in conducting the disaster relief operation. This frees him or her to carry out the IC's primary functions of overall supervision, development and implementation of strategic decisions, approving the requesting and releasing of resources, and liaison with the Hospital Administration and any other participating agencies. For a small disaster operation, the hospital IC may discharge some or all of the Incident Staff duties himself or herself, but a large disaster operation might have an Incident Staff numbers of which can vary.
- B. A Staff consisting of the seven positions most appropriate for a medium-sized disaster by grouping all hospital-related ICS functions into these seven positions. The seven positions in an ideal incident command system as are follows:

- **The operations chief:** The operations chief is overall in-charge of all patient care activities and supervises the following areas:

- a. **Medical Care**

Emergency Department

In patient areas

Surgical services

Critical care units

b. **Ancillary Services**

Laboratory Services

Radiology Services

Pharmacy Services

Mortuary Services

c. **Human Services**

Psychological Support

Social Work Support

- **The Logistics chief:** The logistics chief is overall in-charge of all support services of the hospital and supervises the following areas:
 - a. Communication systems
 - b. Transportation
 - c. Dietary Services
 - d. Stores
 - e. Sanitation, Water and Power Supply
- **The planning chief:** The planning chief is overall in-charge of the manpower planning and is responsible for making immediate as well as extended rosters of the following staff:
 - a. Medical Staff
 - b. Nursing Staff
 - c. Group 'C' and 'D' Staff
- **The public information officer/ Public Relations Officer:** The public information officer is responsible for dissemination of all the information, medical or otherwise, to the relatives coming to the hospital as well as to the media.
- **The Liaison Officer:** The liaison officer is responsible for maintaining a close liaison with the other agencies providing rescue and relief to the victims of MCI/ Disaster. His work is liaison with the following agencies:
 - a. The Police
 - b. The Ambulance Services
 - c. The Defence Medical Services
 - d. Railways or others agencies providing medical relief
 - e. Others hospitals in the network/ Area
 - f. Blood Banks or other ancillary medical services in the area
- **The Security and Fire Officer:** The security and fire officer is responsible for activating and alerting all the security staff within the hospital and mobilizing them to areas like hospital gate, emergency department etc. where they are needed most.
- **The Finance Officer:** The Finance Officer is responsible for allocation of emergency funds and facilitating emergency purchases if and when needed in the course of the disaster.

An important concept embodied in the Incident Command System is that of span of control. The ideal maximum span of control is five; this means that each member in the command structure should supervise no more than five others. (The functional imperative of this principle, for any management problem, is: when things get too complex, delegate.) It is not essential to unfold the whole incidence command structure of the hospital in all disaster. Depending upon the time of the day and the level of disaster the positions mentioned in the incidence command structure can be taken over by the staffs working in the hospital that time. Multiple roles can be performed by a single person till the time other people arrive to support the existing staff. Sample incident command system charts are provided as Annexure D,E&F

- **Different types of hospital Responses**

- a) **In-Hospital Response Phase (small multi-casualty incident, using only main Em. Dept. patient Care)**

During this phase, extra resources are brought to areas such as the ICU's, OT, and Emergency Department, and some elective operations may be postponed, but otherwise hospital operations proceed much as normal.

Even if the situation presents with many patients, it is advisable to start in the Small Multi-Casualty Incident Phase, because it is only a slight extension of normal operations, and can be started without difficulty.

Later on the incident commander can order more staff to reach the hospital and help out in both direct patient care activities as well as support activities.

- b) **Additional Area/Out of Hospital Support Phase (Large multi casualty incident using additional areas of the hospital as overflow zones. Also utilizing other definitive care areas of the hospital like the OT's, ICU, HDU's, Pediatric/ Maternal facilities)**

During this Phase, the number of patients disrupts normal functioning; the Emergency Department is no longer able to handle the patient load, even with extra resources. Other emergency patient care areas must be opened. This requires assigning extra nurses, physicians, and support personnel to the area, and establishing command and communication links to the area for adequate coordination.

The Emergency Department may be able to decongest by postponing care for trivial problems (sore throats, children with fever etc.) and take more serious patients.

- c) **Damage to Hospital Phase (Structural Assessment Plans, Damage Control Plans and Evacuation Plans are activated)**

- d) **Catastrophic Disaster in City Phase (e.g. Earth quake/ Serial Bombings, hundreds of patients coming to hospital – Inter-hospital Transfer Protocol Plans come into force) If a particular Hospital is tasked with caring for hundreds of patients, hospital must be able to extend the hospital's resources out to nearby areas that can handle large numbers of patients During such an extended operation, we would have to some degree, merge our Incident Staff with that of the city, in order to form a Unified Command and to allow proper coordination.**

- **Disaster Deactivation (Demobilization phase)**

Disaster Deactivation or declaring the disaster to be over is also a very important step in the hospital emergency plan. The decision to deactivate the hospital emergency plan should be taken after proper assessment of the situation by the incident commander and other hospital administrator. The deactivation should not be too early (premature) or too late. It is very difficult to reactivate the emergency plan once it has been declared over because staff fatigue sets in which is difficult to overcome.

2.4.2.2 Post Disaster Debriefing - Importance of debriefing exercises as a part of Planning cannot be stressed further. Debriefing is a process in which the Disaster Committee sits down after the Disaster has been deactivated and tries to figure out how things went. It can be best described as a critical self review of one hospital's own performance during a disaster. What went right is taken cognizance of and what went wrong is further incorporated into the disaster plans