

# EMERGENCY MANAGEMENT PLANNING CRITERIA FOR HOSPITALS

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The following minimum criteria are to be used when developing Comprehensive Emergency Management Plans (CEMP) for all hospitals. These criteria will be used as the approval guidelines for the county emergency management agencies, pursuant to Chapter 252, Florida Statutes. The criteria also serve as the suggested plan format for the CEMP, since they satisfy the basic emergency management plan requirements of s. 395.1055, Florida Statutes, and Chapter 59A-3, Florida Administrative Code.

These criteria are not intended to limit or exclude additional information that hospitals may decide to include in their plans in order to satisfy other requirements, or to address other arrangements that have been made for emergency preparedness. Any additional information which is included in the plan will not be subject to approval by county emergency management personnel, although they may provide informational comments.

This form **must** be attached to your facility's comprehensive emergency management plan upon submission for approval to the county emergency management agency. Use it as a cross reference to your plan, by listing the page number and paragraph where the criteria are located in your plan on the line to the left of each item. This will ensure accurate review of your hospital's plan by the county emergency management agency

Criteria and upload portal is available on the Emergency Management website:  
<http://www.seminolecountyfl.gov/health>

### \*\*\*\*\*IMPORTANT SUBMITTAL INFORMATION\*\*\*\*\*

1. All plans **must** be submitted on-line through the Healthcare Upload Portal;
2. It must be in PDF, doc, or docx format;
3. It cannot be password protected;
4. Criteria showing page numbers, Contact Sheet and Review Acknowledgement must be included before the basic plan.
5. Plans must be submitted as one document with all supporting documentation inserted after the basic plan. Use identifiers (blank page with title of next section) between each section to separate the annexes/appendixes/MA Agreements/Floor plans etc;
6. All pages must be numbered; annexes / appendixes should be numbered separately.
7. The **fire plan** must be a separate appendix, and include the approval letter from the fire marshal.



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*\* ITALIZED ITEMS ARE BEING REQUESTED BY THE OFFICE OF EMERGENCY MANAGMEMENT\**

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## *CEMP TABLE OF CONTENTS (Example)*

- I. Introduction
- II. Authorities and References
- III. Hazards Analysis
- IV. Concept of Operations
  - A. Direction and Control
  - B. Notification
  - C. Evacuation
  - D. Re-entry
  - E. Sheltering
- V. Information, Training and Exercise
  - A. Trainings and Exercises Schedule
    - 1. Calendar / schedule showing drills and exercises for 12 months

### Appendices

- A. Roster of employees and companies with key disaster roles
  - 1. List positions of all staff with disaster roles
  - 2. List of emergency service provider
- B. Agreements and Understandings
  - 1. Transportation, host facility, pharmacy, water, food
- C. Evacuation Route Maps
  - 1. Map of evacuation routes and description to receiving facility
- D. Support Materials
  - 1. Any additional material to support the plan: (SOP, supply list, menu, floor plans)
  - 2. Facility Approved Fire Safety Plan

### EM Requirements

- 1. Contact Information Form
- 2. Facility Acknowledgement Plan Review Form
- 3. Location map of facility

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## **I – INTRODUCTION**

A. Provide basic information concerning the hospital, to include:

- \_\_\_\_\_ 1. Name of hospital,  
address,  
telephone number,  
emergency contact telephone number,  
fax number.  
*Email address (if applicable)*
  
- \_\_\_\_\_ 2. Year the hospital was built,  
type of construction,  
date of any subsequent construction.
  
- \_\_\_\_\_ 3. Name of administrator,  
administrator address,  
administrator phone number.  
*Email address*
  
- \_\_\_\_\_ 4. Name and title of person(s) who developed this plan.
  
- \_\_\_\_\_ 5. Organizational chart with key management positions identified.
  
- \_\_\_\_\_ Identify the Safety Liaison Officer (per 2011 Florida Statute 408.82)  
*Email address*
  
- \_\_\_\_\_ DOH – EMResource (per Section 408.821(4), Florida Statutes)
  
- \_\_\_\_\_ B. Provide an introduction to the plan which describes its purpose, time of  
implementation, and the desired outcome that will be achieved through the planning  
process. Also provide any other information concerning the hospital that has bearing on  
the implementation of this plan.

## **II - AUTHORITY**

- \_\_\_\_\_ A. Identify the hierarchy of authority in place during emergencies.  
Provide an organizational chart, if different from A5 above.

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## III – HAZARDS ANALYSIS

- \_\_\_\_\_ A. Describe the potential hazards that the hospital is vulnerable to such as hurricanes, tornadoes, flooding, fires, and hazardous materials incidents from fixed facilities or transportation accidents, proximity to a nuclear power plant, power outages during severe cold or hot weather, etc.
  
- B. Provide site-specific information concerning the hospital to include:
  - \_\_\_\_\_ 1. Location Map
  
  - \_\_\_\_\_ 2. Number of hospital beds
    - \_\_\_\_\_ Maximum number of patients on site
    - \_\_\_\_\_ Average number of patients on site
  
  - \_\_\_\_\_ 3. Type of patients served by the facility, including but not limited to:
    - \_\_\_\_\_ Patients requiring special equipment or other special care such as
    - \_\_\_\_\_ Oxygen
    - \_\_\_\_\_ Dialysis
  
  - \_\_\_\_\_ 4. Identification of hurricane evacuation zone the hospital is in.
  
  - \_\_\_\_\_ 5. Identification of which flood zone the hospital is in as identified on the Flood Insurance Rate Map.  
To obtain flood zone information contact Seminole County Building & Zoning Department at 407-665-7335 or online at <http://gis2.seminolecountyfl.gov/InformationKiosk/>
  
  - \_\_\_\_\_ 6. Proximity of the hospital to a railroad or  
\_\_\_\_\_ major transportation artery (to identify possible hazardous materials incidents)
  
  - \_\_\_\_\_ 7. Identify if hospital is located within the 10 mile or 50 mile emergency planning zone of a nuclear power plant.

## IV - CONCEPT OF OPERATIONS

This section of the plan defines the policies, procedures, responsibilities and actions that the hospital will take before, during and after any emergency situation. At a minimum, the facility plan needs to address: direction and control; notification; and, evacuation and sheltering.

### A. Direction and Control

- \_\_\_\_\_ 1. Identify, by position title, who is in charge during an emergency and one alternate, should that person be unable to serve in that capacity.
  
- \_\_\_\_\_ 2. Identify the chain of command to ensure continuous leadership and authority in key positions.
  
- \_\_\_\_\_ 3. State the procedures to ensure timely activation and staffing of the hospital in emergency functions.

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- \_\_\_\_\_ 4. State the operational and support roles for all established positions within the hospital. This will be accomplished through the development of Standard Operating Procedures, which must be available for review.
  
- \_\_\_\_\_ 5. State the procedures to ensure the following needs are supplied. Since hospitals must plan for both internal and external disasters, the plan should take into consideration self sufficiency, dependence upon other sources, and a contingency plan in case of community-wide disasters.
  - \_\_\_\_\_ a. Food, water, and other essential supplies.
  - \_\_\_\_\_ b. Emergency power capacity. If natural gas, identify alternate means should loss of power occur which would affect the natural gas system. **Per NFPA 99 2005, Type 1 Essential Electrical System (EES) required**
  - \_\_\_\_\_ c. What is the capacity of the emergency fuel system?
  
- \_\_\_\_\_ 6. Provisions for continuous staffing until the emergency has abated.

### **B. Notification**

Procedures must be in place for the hospital to receive timely information on impending threats and the alerting of hospital decision makers, staff and patients of potential emergency conditions.

- \_\_\_\_\_ 1. Explain how the hospital will receive warnings.
  
- \_\_\_\_\_ 2. Explain how key staff will be alerted.
  
- \_\_\_\_\_ 3. Describe the procedures and policy for reporting to work for key workers.
  
- \_\_\_\_\_ 4. Explain how patients will be alerted, and the precautionary measures that will be taken.
  
- \_\_\_\_\_ 5. Identify alternative means of communication should the primary system fail.
  
- \_\_\_\_\_ 6. Identify procedures for notifying those areas or facilities to which patients will be moved or relocated.
  
- \_\_\_\_\_ 7. Identify procedures for notifying families that patients have been moved or relocated.

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## **C. Evacuation**

Hospitals must plan for both internal and external disasters. Although facilities must be prepared for the possibility of relocating patients to another facility, there are instances when moving patients to another part of the hospital is appropriate. The following criteria should be addressed to allow the hospital to respond to both types of evacuation.

- \_\_\_\_\_ 1. Describe the policies, roles, responsibilities and procedures for moving and relocating patients.
- \_\_\_\_\_ 2. Identify the individual responsible for initiating the hospital's evacuation procedures.
- \_\_\_\_\_ 3. Identify any transportation arrangement made through mutual aid agreements or understandings that will be used to move or relocate patients. If transportation is coordinated through a central agency, i.e., county EOC, please explain.
  - \_\_\_\_\_ a. In addition, If there is a "transportation shortfall" in the area, please explain how the problem is addressed under current limitations
- \_\_\_\_\_ 4. Describe logistical arrangements for transporting support services, including: moving medical records, medicine, food, water, and other necessities. If this is arranged through a coordinating agency, i.e., county EOC, please explain.
- \_\_\_\_\_ 5. Identify locations where patients will be moved or relocated, if they are pre-determined. If relocation is coordinated through a centralized agency, i.e., county EOC, please explain.
- \_\_\_\_\_ 6. Identify evacuation routes that will be used, including secondary routes if the primary route is rendered impassable.
- \_\_\_\_\_ 7. Specify the amount of time it will take to successfully move or relocate patients.
- \_\_\_\_\_ 8. What are the procedures to ensure hospital staff will accompany relocated patients?
  - \_\_\_\_\_ a. If staff will not be accompanying patients, what measures will be used to ensure their safe arrival (i.e., who will render care during transport).
- \_\_\_\_\_ 9. Identify how patients will be tracked once they have been relocated. If patients are considered discharged at the time of relocation, please explain.
- \_\_\_\_\_ 10. Establish procedures for responding to family inquiries about patients who have been moved or relocated.
- \_\_\_\_\_ 11. Establish procedures for ensuring all patients are accounted for and are out of the facility.
- \_\_\_\_\_ 12. Determine at what point to begin the pre-positioning of necessary medical supplies and provisions.

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## **D. Re-entry**

Once a hospital has been evacuated, procedures need to be in place for allowing patients to re-enter the facility.

- \_\_\_\_\_ 1. Identify who is the responsible person(s) for authorizing re-entry to occur.
- \_\_\_\_\_ 2. Identify procedures for inspecting the hospital to ensure it is structurally sound.
- \_\_\_\_\_ 3. Explain how patients will be transported back to the hospital following relocation. If patients will not be re-admitted, please explain the criteria that will be used to make this determination.

## **E. Sheltering**

If the hospital will be accepting patients from an evacuating hospital, the plan must describe the procedures that will be used once the evacuating hospital's patients arrive.

- \_\_\_\_\_ 1. Describe the receiving procedures for patients arriving from an evacuating hospital.
- \_\_\_\_\_ 2. Identify the means for providing, for a minimum of 72 hours, additional food, water, and medical needs of those patients being hosted.
- \_\_\_\_\_ 3. Identify how the hospital will notify AHCA if it exceeds its licensed operating capacity.
- \_\_\_\_\_ 4. Describe procedures for tracking additional patients within the hospital.

## **V. INFORMATION, TRAINING AND EXERCISES**

This section shall identify the procedures for increasing employee and patient awareness of possible emergency situations and provide training on their emergency roles before, during and after a disaster.

- \_\_\_\_\_ A. Identify how key workers will be instructed in their emergency roles during non-emergency times.
- \_\_\_\_\_ B. Identify training schedule for all employees and identify who will provide the training.
- \_\_\_\_\_ C. Identify the provisions for training new employees regarding their disaster related roles.
- \_\_\_\_\_ D. Identify a schedule for exercising all or portions of the disaster plan on a semi-annual basis.
- \_\_\_\_\_ E. Establish procedures for correcting deficiencies noted during training exercises.

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## APPENDICES

The following information is required, yet placement in an annex is optional, if the material is included in the body of the plan.

A. Roster of employees and companies with key disaster related roles.

- \_\_\_\_\_ 1. List the positions of all staff with disaster related roles.
- \_\_\_\_\_ 2. List the name of the company, contact person, telephone number and address of emergency service providers such as transportation, emergency power, fuel, water, police, fire, Red Cross, etc.

B. Agreements and Understandings

- \_\_\_\_\_ 1. Provide copies of any **mutual aid agreement** entered into pursuant to the fulfillment of this plan. This is to include reciprocal host hospital agreements, transportation agreements, current vendor agreements or any other agreement needed to ensure the operational integrity of this plan.

C. Evacuation Route Map

D. Support Material

- \_\_\_\_\_ 1. Any additional material needed to support the information provided in the plan.
- \_\_\_\_\_ 2. Copy of the facility's fire safety plan that is approved by the local fire department.

## *FACILITY CONTACT INFORMATION*

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Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Facility Type: \_\_\_\_\_

Location Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Facility Phone: \_\_\_\_\_ Emerg. Phone Number: \_\_\_\_\_

Facility Email: \_\_\_\_\_

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**Administrator/Owner Contact:**      **New Contact** \_\_\_\_\_      **Contact Update** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ X \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Office E-Mail: \_\_\_\_\_

Alt. E-Mail (optional): \_\_\_\_\_

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**Alternate Administrator Contact:**      **New Contact** \_\_\_\_\_      **Contact Update** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ X \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Office E-Mail: \_\_\_\_\_

Alt. E-Mail (optional): \_\_\_\_\_

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**Safety Liaison Officer Contact:**      **New Contact** \_\_\_\_\_      **Contact Update** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ X \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Office E-Mail: \_\_\_\_\_

Alt. E-Mail (optional): \_\_\_\_\_

***All information is required***

# FACILITY CEMP ANNUAL REVIEW ACKNOWLEDGEMENT

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FACILITY NAME: \_\_\_\_\_

FACILITY TYPE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ Zip: \_\_\_\_\_

I certify the facility's Comprehensive Emergency Management Plan (CEMP) and the facility's fire plan have been updated and all employees have been trained on their roles and responsibilities during an emergency and given the opportunity to review the CEMP.

This CEMP is exercised on an annual basis with all employees who have a disaster role and any deficiencies found during an exercise have been corrected and the plan updated with all emergency personnel made aware of any new procedures or changes.

Please **initial** by each one:

- \_\_\_\_\_ DOH EMSsystems: The information in the DOH EMSsystem has been updated
- \_\_\_\_\_ Weather Radio: The facility has a NOAA weather radio monitored at all times
- \_\_\_\_\_ Alert Seminole: The facility is signed up for Alert Seminole to receive emergency information

\_\_\_\_\_  
Signature of Administrator / Director / Owner **AND/OR**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Assistant Administrator/Manager **AND/OR**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Safety Liaison

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

*At least one signature is required*