23

PRINCETON Community Hospital	
POLICY NAME: **EMERGENCY OPERATIONS PLAN**	POLICY #: 73.19H (EC)
DEPARTMENT: Hospital Wide	PAGE: Page 1 of 22 EFFECTIVE: 1-21-14
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I. STATEMENT OF PURPOSE

The purpose of the Emergency Operations Plan is to coordinate the "Critical Six" functions of communications, resources and assets, safety and security, staff responsibilities, utilities management and patient clinical and support activities of Princeton Community Hospital during an emergency.

II. SCOPE

The Emergency Management Plan applies to all employees and departments in the hospital and other sites owned by the hospital.

III. RATIONALE

Although the emergencies encountered by Princeton Community Hospital have many causes, the effects on the "Critical Six" functions encountered and the required response effort may be similar. Therefore, this All-Hazards approach will support a general response capability that is also scalable in order to address a range of emergency situations of different cause, duration and scale. In addition, specific response policies, as well as the utilization of HICS and The Emergency Management Plan, remain an integral aspect of the response effort and its inherent adaptability to other emergencies and events outside of normal daily operations that Princeton Community Hospital may experience.

IV. PROCEDURE

A. Aspects of the Emergency Operations Plan for PCH include, but are not limited to the following:

1. **PCH leadership, including Medical Staff, participates in the development and maintenance of the EOP.**
Implementation: The Emergency Operations Plan is developed, maintained, and reviewed with the involvement of the Princeton Community Hospital leadership, including the involvement of the medical staff. Leadership reviews and approves all plans, and both leadership and medical staff are involved in maintenance of the plan through event and drill reporting in the EOC and quarterly Board of Directors reports.

2. **PCH develops and maintains a written EOP that describes the response procedure to follow when emergencies occur. The response procedures address specific emergencies but can also be adapted to other emergencies PCH may encounter including maintaining or expanding services, conserving resources, curtailing**

services, supplementing resources from outside the local community and evacuation aspects.
Implementation: The PCH Emergency Operations Plan with hazard specific policy direction is designed to maximize the hospital's effectiveness in emergency response to internal and external hazards and to guide employees and respondents in their efforts. The outlined break down of the "Critical Six functions" that follows, along with an All-Hazards approach in the HICS and its associated operational periods and information / processes encountered during mitigation, preparedness, response and recovery efforts, is utilized to aid in any size event and any other emergencies that may be encountered. Unless otherwise stated in specific response policy, the Incident Command Center will be located in the Administrative Boardroom with alternate Command Center location in Education Classroom 1 & 2. The Labor / Credentialing Pool will be located in Education Classroom 3. All news and media coming to PCH are to be directed to the most northern tabled section of the cafeteria. The HICS kit, consisting of vests, Job Action Sheets (JAS), flashlights x 4, laminated HICS model and detailed PCH model, Disaster Key Personnel recall listing and resource Coordinator/Supervisor cell phone listing is kept in the Administrative Boardroom.

3. **This EOP identifies PCH capabilities and establishes response procedures for when the hospital cannot be supported by the local community for at least 96 hrs in the six critical areas.**
Implementation: The following is a listing of capabilities and response procedures broken down into the Six Critical functions for when PCH cannot be supported by the local community for 96 hours.

Communications would not be adversely affected due to the redundancies in place for internal and external applications

Resources and Assets would not be adversely affected due to existing abilities to operate greater than 96 hours without support in regards to food, water and patient care supplies.

Safety and Security would not be adversely affected due to existing abilities in facility lock-down and responder identification processes.

Staff Responsibilities would not be adversely affected due to existing and established HICS roles during emergency events.

Utilities Management would be adversely affected in regards to emergency generator power which would cease operating past approximately 58 hours on full load due to insufficient fuel. With this in mind, leadership would direct the delivery points of emergency power and curtail services as necessary in order to create partial generator loads which would lengthen operating times. Leadership will also direct the transfer and evacuation of patients to local and regional facilities and established alternate care sites as possible in the 24-36 hour operating time frame.

Patient Clinical and Support Activities would be affected, but not in an adverse manner, during events non-supportable by the local community. Elective patient care services and non-essential to patient, family and staff care areas in the hospital may not be operating or may be operating in a limited manner, thereby disrupting normal operations behaviors and actions.

4. **This EOP describes recovery strategies and actions designed to restore systems that are critical to providing care/treatment/services after an emergency.**

Implementation: Strategies and actions designed to restore systems that are critical to providing care/treatment/services during the recovery period include, but are not limited to the following;

– Incident Command and General staff will utilize the HICS Job Action Sheets which will provide direction during the de-mobilization phase of the event. The Incident Commander will determine when space, equipment and other resources are sufficiently restored to permit resumption of normal operations. PCH leadership will continue the oversight of remaining recovery operations once normal operations resume. The Emergency Preparedness Coordinator will manage the "Hotwash" and event evaluation for follow-up by the Environment of Care Committee and facility Leadership.

– Information Services will ensure the restoration of normal operations communications including telephone and intra / internet applications via established IS recovery procedures.

– Materials Management will ensure the restocking and inventory usage of emergency carts and all supply materials for which they oversee. Pharmacy will ensure the restocking and inventory usage of all medication related supplies. Food and Nutrition services will ensure the restocking and inventory of all food related supplies. Environmental Services will assist in the conversion and cleaning of areas utilized during the emergency back to normal operations state.

– Security Services will remove signage and barriers to allow traffic, internally and externally, to return to normal.

– Health Information Management will ensure the conversion of disaster tags to medical records and capture patient treatment information for the medical record.

– Plant Operations will ensure the continuation and/or restoration of all key utilities, such as power, water, ventilation, medical gas, suction, HVAC and elevator services.

– Patient care and related activities will resume to normal operations services under established policies and procedures, facility leadership and chain of command.

– All staff will return to their respective normal duties as they are de-mobilized and the event de-escalates to normal operations while Department managers ensure that department specific actions of full demobilization and recovery are completed.

5. **This EOP describes processes for initiating and terminating the**

response and recovery phases and includes under what circumstances these phases are activated.
Implementation: Specific Emergency Management policies and the HICS provide the processes for initiating and terminating the response and recovery phases and associated circumstances that impact both phases. The Incident Commander, in coordination with the Planning Section Chief and Command Staff, establishes operating periods, (Immediate - 0 to 2 hrs, Intermediate - 2 to 12 hrs, Extended >12 hrs, and Demobilization/Recovery) with objectives, for each event.

6. **This EOP identifies the individual(s) who has the authority to activate the response and recovery phases of the emergency.**
Implementation: The authority to activate the response phase of emergencies faced by PCH falls upon the CEO/AOC and/or Nurse Leader at that time and they will assume the Incident Commander HICS position. The authority to activate the recovery phase of emergencies responded to by PCH falls upon the Incident Commander acting at that time of the operational period. The Incident Commander will determine when space, equipment, and other resources are sufficiently restored to permit resumption of normal operations.

7. **This EOP identifies alternative sites for care, treatment and service that meets the needs of PCH patients during emergencies.**
Implementation: During events of which the Emergency Department is not able to be utilized for Priority 1, 2 and 3 influx patients, the Day Surgery/T&D area will be utilized. Alternative sites for care, treatment and services to meet the needs of PCH patients during emergencies include, but are not limited to the following:
- HealthSouth Rehabilitation Center
- Bluefield Regional Medical Center
- WV Region I MSCC facilities
- areas designated by the Mercer County Emergency Management Office and / or Mercer County Health Department

8. **When PCH experiences an actual emergency, implementation of its response procedures related to care/treatment/services for its patients occurs.**
Implementation: The response procedures initiated for care/ treatment/services of PCH patients include the following codes;
-- "Minor-D external" is utilized for an influx of patients
-- "Minor-D internal" is utilized for interruption of essential services
-- "NBC" is utilized for nuclear, biological or chemical incidents (accidental or terrorist related) (internal or external designation)
-- "Black" is utilized for a hostage situation
-- "Yellow" is utilized for a bomb threat
-- "Lock Down" is utilized for missing / abducted person and is also utilized during Code NBC activation or other events in which the facility is closed to normal traffic
-- "Dr. White" is utilized for disruptive pt/visitor/staff events
-- "99" is utilized for fire events

There is no designated code for evacuation procedures. During the need for evacuation, partial or complete, the strategy is communicated by the Incident Commander and the existing evacuation policy utilized. "Plain English" communications of these codes will occur with outside agencies.

B. Princeton Community Hospital prepares for how it will *communicate* during emergencies by, but not limited to, the following:

1. **Notify staff when emergency response procedures are initiated.**
Implementation: Staff are notified when emergency response procedures are initiated by the announcement of codes performed by the PBX operator, upon direction of the proper authority and procedures. Codes should be announces as "Code_____" three times. A Disaster Key Personnel recall list with preface page exists to initially gather the HICS Command and General Staff. The Incident Commander will then decide what additional staff if any, are to be called in. A full recall of staff is an option by the Incident Commander at any time dependant on existing knowledge, and magnitude of the event. Full recall staff notified by switchboard should report to the Labor Pool / Credentialing Unit opened in Classroom 3 for that event. Partial recall staff notified by department managers or designee will report where directed. Internet based Mass Notifications systems are also used to notify Key Personnel, staff, off-site campuses as well as HealthSouth Southern Hills, the Mercer Co. Office of Emergency Management and WV Region 1 MSCC members as applicable to the circumstances. Voice phone calls are made to the E-911 Center as applicable and are not a routine part of the web based Mass Notifications.

2. **Communicate information and instructions to the staff and physicians.**
Implementation: Information and instructions to staff and physicians occurs after the HICS Command and General Staff have ascertained pertinent event information and developed the incident objectives. Staff and physicians are updated as needed during each operational period.

3. **Notify External authorities that emergency response procedures are initiated.**
Implementation: External authorities are notified in "Plain English" of emergency response procedure initiation by the following, but not limited to, ways:
A – Mercer County 911 call center is contacted during Code Black and Code Yellow Events.
B – Medical Command / Regional Command / local EMS is notified and communicated with through the ER during all influx of patients events.
C - Bluefield Regional Medical Center is notified as needed and use of the disaster hotline number 304-327-6886 is available for ER to ER communications.
D – WV Region I MSCC facilities and other outside agencies as needed

E - Mercer County Emergency Manager is notified when the organization has enacted its Emergency Operations Plan.

4. **Communicate with external authorities during an emergency.**
Implementation: Communication with external authorities during an emergency is overseen and ensured by the HICS Incident Commander, Command and General Staff.

5. **Communicate with patients and family during emergencies and include notification when pts are relocated to alternative care sites.**
Implementation: Patients and families are communicated with during emergencies using "Plain English" by their assigned nurse or charge nurse. Notification of family regarding patient relocation to alternate care sites will be done post-transfer.

6. **Communicate with the community and/or media during emergencies.**
Implementation: Community and/or media communications are handled through the HICS Public Information Officer during emergency responses. All communications are handled through the Joint Information Office if established during the community event.

7. **Communicate with purveyors of essential supplies, services and equipment.**
Implementation: Communication with purveyors of supplies, services and equipment is ensured and overseen by the HICS Logistics Section Chief during emergencies.

8. **Communicate with the Mercer Co. LEPC and WV Region I MSCC of essential elements of their respective command structure, including names/roles of staff in the command structure and command center phone numbers.**
Implementation: During communications with the Mercer Co. LEPC and WV Region I MSCC, they are made aware of the PCH command structure, including names, roles of Command Staff, other key members and the command center phone numbers via the Liaison Officer and the Emergency Preparedness Coordinator. The County and Region have contact information with numbers for PCH in existing respective plans.

9. **Communicate with the Mercer Co. LEPC and WV Region I MSCC of essential elements of their respective command structure for emergency response.**
Implementation: Essential elements and any limitations of the command structure for emergency response by PCH during emergencies will be communicated to the Mercer Co. LEPC and WV Region I MSCC facilities via the Liaison Officer and the Emergency Preparedness Coordinator.

10. **Communicate with the Mercer Co. LEPC and WV Region I MSCC of resources and assets that could be shared in a emergency**

response.
Implementation: Resource and Assets that could be shared in an emergency response would be communicated with the Mercer Co. LEPC and Region I MSCC through contact with the Liaison Officer and the Emergency Preparedness Coordinator. Outlines of available services and resources are in existing plans.

11. **Communicate with the Mercer Co. LEPC and WV Region I MSCC of how and under what circumstances PCH will communicate names of patients and deceased patients.**
Implementation: Names of patients and deceased patients will be communicated with the Mercer Co. LEPC and WV Region I MSCC via the Public Information Officer as needed during events in which the Mercer County or Region I Emergency Plans are in effect. This is especially important during Mass Casualty Events, Mass Fatality Events, and Biological events.

12. **Communicate with the Mercer Co. LEPC and WV Region I MSCC of how and under what circumstances PCH will communicate patient information to third parties.**
Implementation: Patient information will be communicated with the Mercer Co. LEPC and WV Region I MSCC via the Liaison Officer as needed during events in which the Mercer Co. or Region I Emergency Plans are in effect. This is especially important during Mass Casualty Events, Mass Fatality Events and Biological events.

13. **Communicate with the Mercer Co. LEPC and WV Region I MSCC of how PCH will communicate with identified alternative care sites.**
Implementation: Communications with alternate care sites will occur primarily through telephone land line services. The HICS Logistics Section - Communication Unit will facilitate this action.

14. **PCH establishes back-up communication systems and technologies.**
Implementation: Back-up communication systems and technologies present at PCH include the following;
- UHF radios used daily by Plant Operations, Biomedical Services and Transport Staff. In addition, there are designated emergency UHF radios in Administration (1), Nursing Administration (1), Emergency Department (4) and Emergency Preparedness (1). Additional radios are allocated to Clinical areas as necessary.
- UHF radio in Emergency Room for EMS and Regional Command use
- Cellular phones
- 3 analog phones, separate from the VoIP, are present on the main campus:
    ER 304-487-7492
    Incident Command 304-431-5403
    Emergency Preparedness 304-431-5139
- Satellite phone
- Ham radio
- HICS form 213 (message form)

15. **PCH implements components of the EOP that require advance preparation to support communications during an emergency.**
Implementation: Components of the EOP that require advance preparation to support communications during an emergency include, but are not limited to, the following;
- normal daily operations UHF radios are maintained by the Plant Operations and Biomedical Services
- designated emergency UHF radios are checked monthly by the Emergency Preparedness office and consists of a > 4 hour battery life and transmission capability verification
- known cellular phone number listings are maintained by the Switchboard
- the satellite phone at PCH and HealthSouth is checked monthly by the Emergency Preparedness office and consist of transmission capability verification / a functional UPS test for both phones is done quarterly
- the HAM radio is checked monthly by the Emergency Preparedness office for transmission capability verification
- the Mercer Co. HEPC Emergency Telephone Hotline located in the Emergency Department is checked monthly by the Emergency Preparedness office for transmission capability verification along with the analog lines in the Incident Command and Emergency Preparedness Office.

Existing contact names, numbers, frequencies for communicating with local response partners are listed with the Mercer County Emergency Management plan, and its Annexes through the LEPC. Regional contact names, numbers, frequencies for communications are listed with the WV Hospital Disaster Preparedness MSCC Region I plan. The Emergency Preparedness Coordinator maintains these sources up to date. Local and regional numbers are also kept with the satellite and HEPC Hotline phones.

C. Princeton Community Hospital prepares for how it will manage *resources and assets* during emergencies by, but not limited to, the following:

1. **How PCH will obtain/replenish medication related supplies required throughout the response and recovery phases of an emergency.**
Implementation: PCH obtains/replenishes medication related supplies required during emergency response and recovery efforts through established Pharmacy Department mechanisms and HICS Medication Unit / Staging Manager / Operations Section Chief (as activated). Caches available through the SNS (Strategic National Stockpile) are available for request through, and will be managed by, the primary contact, PCH Pharmacy Director. A secondary contact Pharmacy staff member is established. Coordination with the HICS Command / General Staff, Mercer County and Region I agencies will occur whenever the SNS is activated.

2. **How PCH will obtain/replenish medical supplies and equipment required throughout the response and recovery, including PPE.**

Implementation: PCH obtains/replenishes medical supplies, equipment, PPE, during emergency response and recovery efforts through established Materials Management Department mechanisms and HICS Equipment/Supply Unit / Staging Manager / Operations Section Chief (as activated) which coordinate with the Logistics Section of the HICS. Caches available through Mercer Co. LEPC and Region I are available for request through, and will be managed by, the primary contact, Emergency Preparedness Coordinator. A secondary contact, ER Clinical Director is established. Coordination with the HICS Command / General Staff and established LEPC / Region I contacts will occur whenever cache utilization is needed.

3. **How PCH will obtain/replenish non-medical supplies needed throughout response and recovery.**
Implementation: PCH obtains/replenishes non-medical supplies during emergency response and recovery efforts through established Materials Management / Nutrition Services Department mechanisms and HICS Logistics Section. Local and Regional contacts, MOU's, service and support agreements are established. The HICS kit will be re-stocked and maintained by the Emergency Preparedness Coordinator.

4. **How PCH will share resources/assets with other health care organizations in Mercer County.**
Implementation: PCH will share resources/assets with other health care organizations in Mercer County as needed and as available. Coordination will occur externally with known LEPC and facilities contacts. Coordination will occur internally with the Emergency Preparedness office and HICS Command / General Staff.

5. **How PCH will share resources/assets with other health care organizations in WV Region I.**
Implementation: PCH will share resources/assets with other health care organizations in WV Region I as needed and as available. Coordination will occur externally with known Region I and facilities contacts. Coordination will occur internally with the Emergency Preparedness office and HICS Command / General Staff.

6. **How PCH will monitor quantities of resources/assets during an emergency.**
Implementation: PCH monitors quantities of resources/assets during an emergency through the HICS Logistics and Planning Sections.

7. **How PCH will transport patients/meds/supplies/equipment/staff to alternative site(s).**
Implementation: PCH transports patients/meds/supplies/equipment /staff to alternative site(s) in coordination with Regional Med-Com, the Mercer County Emergency Management Office, LEPC and WV Region I. Patients, with their medical record and related care items, will be transported primarily through the services of Princeton Rescue Squad. Supplies, equipment and staff are transported by way of facility vehicles

which are maintained through the HICS Logistics Section.

8. **How PCH will transfer pertinent information, including essential clinical and medication related information with patients to alternative sites.**
Implementation: PCH will transfer pertinent information, including essential clinical and medication related information with patients to alternative sites by way of nursing report, evacuation checklist and transfer form utilization. The patients medical record and related care items stays with the patient. Coordination internally is done through the HICS Operations and Planning Sections.

9. **How PCH implements the components of its EOP that require advance preparation to provide for resources and assets during emergencies.**
Implementation: Components of the EOP that require advance preparation to support the provision of resources and assets for an emergency include, but are not limited to, the following;
- Pharmacy Services maintains stock and inventory of medications
- Pharmacy Services maintains a working relationship with the WV Deputy SNS Director.
- Materials Management maintains stock and inventory of medical supplies, equipment, PPE and non-medical supplies
- Nutrition Services maintains stock and inventory of food supplies
- Emergency Preparedness Coordinator maintains inventory of grant purchased stock and inventory
- Emergency Preparedness Coordinator updates PCH leadership and EOC of resource and asset support as discussed in the Mercer Co. LEPC and the WV Region I Hospital Disaster Task Force (MSCC)
- Human Resources maintains PCH workforce information
- Administration oversees all associated contractual agreements and MOU's

D. Princeton Community Hospital prepares for how it will manage *safety and security* during emergencies by, but not limited to, the following:

1. **PCH arranges for internal security and safety.**
Implementation: PCH has a Security Department which provides 24/7 facility coverage through physical rounds, video surveillance, ID card use surveillance and "Dr White" buttons placed strategically throughout the facility. As needed, the HICs Operations Section – Security Branch oversees internal security and the HICS Safety Officer oversees safety during the event.

2. **PCH identifies roles of community security agencies.**
Implementation: PCH has identified roles and established a rapport with the Mercer County E-911 Center, Mercer Co. Sheriff's office, Princeton Police Department, WV State Police-Princeton Detachment, Athens Police Department, Bluefield Police Department and Wallace Security Agency. A formal change of command for Incident Commander,

HICS to ICS through local law enforcement is a possibility during law enforcement related events.

3. **PCH coordinates security activities with community security agencies.**
Implementation: PCH coordinates security activities with community agencies through direct E-911 and local police officials contact for "Code Yellow", "Code Black" and any other events as per Incident Command designations. The HICS Operations Section-Security Branch manages this cooperation.

4. **PCH manages hazardous waste and materials.**
Implementation: PCH manages hazardous waste and materials in the same manner as they occur during normal operations and as needed the Operations Section-Hazmat Branch will be activated.

5. **PCH provides for radioactive/biological/chemical isolation and decontamination.**
Implementation: PCH has a Memorandum of Understanding with the Princeton Fire Department for 3-line decontamination set-up and management during radioactive/biological/chemical events, external and internal. This is outlined in the Mercer County LEPC Hazardous Material Emergency Plan. Green Valley-Glenwood Vol. Fire Department is the back-up for PCH decontamination coverage. Isolation of patients post decontamination is possible with contact, airborne and reverse techniques. The HICS Operations Section-Hazmat Branch will manage and coordinate activities as needed otherwise for internal events. Self-Directed and Emergency Room Staff-Directed decontamination in the Emergency Room will be overseen by the department Clinical Director in coordination with the Emergency Preparedness Coordinator and facility Hazardous Materials and Waste Management program purveyor.

6. **PCH controls entrance into and out of the facility.**
Implementation: PCH controls entrance and exit in the facility by use of ID card lock release systems on all doors not regular public usage. Public use entrances and exits can, and are locked and monitored, during events such as "Code Lock-Down". Security is stationed in and controls public entrance into the ER. The ambulance entrance into the ER is controlled by ER nursing staff.

7. **PCH controls movement of individuals within the facility.**
Implementation: PCH controls the movement of individuals within the facility by use of the "Code Lock-Down" policy and the HICS Operations Section-Security Branch.

8. **PCH controls vehicles accessing the facility.**
Implementation: PCH controls vehicles accessing the facility by the use of Security Department staff, Plant Operations staff, Local Police/Fire/EMS, signage and physical barrier devices and the HICS Operations Section-Security Branch.

9. **PCH implements the components of its EOP that require advance preparation to support security and safety during emergencies.**
Implementation: Components of the EOP that require advance preparation to support security and safety for an emergency include, but are not limited to, the following;
- routine security rounds of hospital grounds by Security Department
- maintenance of barrier devices and signage by Security Department
- ID card use surveillance system maintenance by Security Department, Communication Department and Plant Operations
- Dr White button activation system maintenance by Security Department, Communication Department and Plant Operations
- ongoing coordination and contact information maintained with outside agencies through the PCH Safety Officer and Emergency Preparedness Coordinator.

E. Princeton Community Hospital prepares for how it will manage *staff* during emergencies by, but not limited to, the following:

1. **PCH identifies staff roles and responsibilities for the "Critical Six" functions during an emergency.**
Implementation: Through the utilization of the HICS and response specific policies direction, the following "Critical Six" functions are covered by the Command staff and as follows;
- Communications by Logistics Section – Service Branch
- Resources/Assets by Logistics - Planning Sections
- Safety and Security by Safety Officer - Operations Section – Security Branch
- Staff Responsibilities by Section Chiefs – Branch Directors – Unit Leaders
- Utilities Management by Operations Section – Infrastructure Branch
- Patient Clinical and Support by Operations – Planning – Logistics Sections

2. **PCH assigns staff to all essential staff functions.**
Implementation: PCH assigns staff to all essential functions through the utilization of the HICS and response specific policies directions.

3. **PCH identifies the individual(s) to whom staff report in the hospital's incident command structure.**
Implementation: PCH has identified the following individuals to whom staff report to during the HICS utilization as follows;
Incident Commander - Wayne Griffith / Adm. on call / Nursing Supervisor
Safety Officer - Richard Puckett
Public Information Officer - Richard Hypes
Liaison Officer - Kim Poe / Mark Pickett
Operations Chief - Rose Morgan
Planning Chief - Mark Pickett
Logistics Chief - Colleen Cox
Finance Chief - Frank Sinicrope

Branch Directors and Unit Leaders have also been designated and a copy of the full model is in the HICS Kit located in the Administrative Boardroom.

4. **PCH manages staff support needs (i.e., housekeeping, transportation and incident stress debriefing).**
Implementation: PCH manages staff support needs through the HICS Logistics Section – Support Branch and has a contracted Employee Assistance Program to aid in incident stress debriefing.

5. **PCH manages family support needs of staff (i.e., child and elder care/communication)**
Implementation: PCH manages family support needs of staff through the HICS Logistics Section – Support and Service Branches.

6. **PCH trains staff for their assigned emergency response roles**
Implementation: PCH trains staff for their assigned emergency response roles through, but not limited to, the following mechanisms;
- New employee orientation
- ICS-100 level course for all employees
- ICS-200, 700 and 800 level courses as designated
- Department specific orientation
- Event response and Drill critiques and their After Action Reports
- Yearly mandatory training
- Emergency preparedness skills fairs

7. **PCH communicates in writing with LIPs (physicians) regarding roles in emergency response and to whom he/she reports during an emergency.**
Implementation: PCH communicates in writing with LIPs regarding roles and reporting responsibilities during an emergency by way of, but not limited to, the following;
- PCH Bylaws Section 7.7-1 through 7.7-3
- HR policy 42.115 Disaster Volunteer Health Care Practitioners
- PC policy 73.03 Code Minor-D (influx off patients)
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8. **PCH identifies LIPs (physicians), staff and authorized volunteers during emergencies Note: ID could include ID cards, wrist bands, vests, hats or badges.**
Implementation: PCH identifies LIPs, staff and authorized volunteers during emergencies by, but not limited to, the following;
- employee name badges
- Human Resources generated name badges for volunteer LIPs
- HICS vests
- Medical Services vests
- Staff or civil authorities presenting without ID's must go through the Security Department, be positively identified then display new ID badge / name tag.

9. **PCH implements the components of its EOP that require advance**

preparation to manage staff during an emergency.
Implementation: Components of the EOP that require advance preparation to manage staff during an emergency include, but is not limited to, the following:

- updated workforce listings are sent to department managers and emergency preparedness office by the HR department
- PCH HICS model is kept up to date by the emergency preparedness office
- department managers ensure the ongoing training and education of staff
- PCH HICS Kit is kept up to date by the emergency preparedness office
- training occurs as outlined in above section E, part 6

F. Princeton Community Hospital prepares for how it will manage *utilities* during emergencies by, but not limited to, the following:

1. **PCH will provide electricity.**
Implementation: PCH provides electricity from two Appalachian Electric Power Co. sources. The primary source is from the New Hope sub-station. Should that source fail, the South Princeton source will automatically assume service within approximately 1 second. Should both sources fail, the emergency generators will assume power delivery to emergency outlets and designated patient care areas.

2. **PCH will provide water needed for consumption and essential care activities.**
Implementation: PCH provides water for consumption and essential care from the WV American Water Co. which provides the local area from tanks, totaling 1.5 million gallons, located less than 1 mile north of PCH on Gott Road and from the Bluestone Plant. Waterline service into PCH has redundancies. Back-up supplies of potable water are located in storage through the Materials Management and Nutrition Services departments. MOUs are in place with Pepsi for emergency needs beyond inventory maintained. Service agreements are in place with Seneca Medical and Reinhart.

3. **PCH will provide water needed for equipment and sanitary purposes.**
Implementation: PCH provides water for equipment and sanitary purposes from the WV American Water Co. which provides the local area from tanks, totaling1.5 million gallons, located less than 1 mile north of PCH on Gott Road and from the Bluestone Plant. Waterline service into PCH has redundancies. Back-up supplies of potable and non-potable water for equipment and sanitation needs are obtained through MOUs for water buffaloes available from the WV American Water Co. and the WVDOH, Princeton Fire Department and Green Valley Volunteer Fire Department.

4. **PCH will provide fuel required for building operations or essential**

transport activities.
Implementation: PCH provides fuel required for building operations and from existing local served natural gas which supplies the boiler plant. A diesel fuel tank supplies the emergency generators and also exists as a back-up for the boiler plant operations. PCH provides fuel for essential transport activities by way of local gasoline distributers.

5. **PCH will provide medical gas/vacuum systems.**
Implementation: PCH provides medical gases from primary storage on oxygen system has a primary and back-up tank located in the east parking lot. There is a tertiary back-up supply bank of H-cylinders in the "gas house" which automatically assumes service if needed. Capability exists to tie in a tanker at PCH also. There is a primary and back-up vacuum system at PCH.

6. **PCH will provide essential utilities: vertical/horizontal transport, HVAC and steam sterilization.**
Implementation: PCH provides vertical/horizontal transport by 10 elevators (4 traction–6 hydraulic). The patient transport cars are on emergency power. PCH provides HVAC primarily central air handling systems. Heating is provided via steam or hot water re-heats. Cooling is provided by a chilled water system. PCH provides steam sterilization in the Central Sterile Department.

7. **PCH implements the components of its EOP that require advance preparation to manage utilities during an emergency.**
Implementation: Components of the EOP that require advance preparation to manage utilities include, but are not limited to, the following;
- scheduled preventative maintenance by Plant Operations
- pre-determined re-order schedules
- maintaining up to date emergency contacts for back-up maintenance of utilities by Plant Operations department
- Building Automation System up-keep for automated plant op staff notification of pre-defined failures
- maintaining and creating MOUs and service agreements as needed

G. Princeton Community Hospital prepares for how it will manage *patient support activities* during emergencies by, but not limited to, the following:

1. **PCH will implement activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge.**
Implementation: PCH implements the following, but not limited to, patient scheduling activities during emergencies as needed;
- discontinuation of elective treatments
- cancellation of all non-emergency surgery

PCH implements the following, but not limited to, patient triage activities during emergencies as needed;
- triage for external influx of patients via EMS will occur at ER ambulance

entrance doors for the designation of Priority 1, 2, 3 or expectant/fatalities placement and comparison to field triage designation
- triage for external influx of patients via private vehicle will occur at regular ER triage station
- triage of patients for treatment, be they influx related or regular ER visit is coordinated so that all are seen accordingly and can be identified by use of the disaster triage tag/band for event related casualties

PCH implements the following, but not limited to, patient assessment activities during emergencies as needed;
- in-patients continue to be assessed as if normal operations
- event casualties are assessed fully utilizing the existing ER form upon arrival to designated treatment area
- admission assessment for all patients are as with normal operations
- existing in-patients are assessed for discharge capability

PCH implements the following, but not limited to, patient treatment activities during emergencies as needed;
- all non-elective treatment and care will continue for all in-patients
- specific ER rooms are designated for Priority Treatment areas
- responding staff are assigned to patient care based upon their individual skills and expertise
- order forms for event related casualties are in the Priority Packet
- In the event the ER cannot accommodate all patients, the Out-Patient Unit located in Day Surgery will be activated by the Medical Care Branch Director
- the Patient Registration Unit Leader will keep a list (HICS form 254) of patients received, treated and their disposition

PCH implements the following, but not limited to, patient admission activities during emergencies as needed;
- event casualty admission to nursing units will occur as possible
- event casualties treated in the ER and awaiting admission may be placed in the Out-Patient unit located in Day Surgery (PACU may be used if needed)
- event casualties that require minor surgical procedures and possibly treated and released within 24 hours will be admitted to Day Surgery

PCH implements the following, but not limited to, patient transfer activities during emergencies as needed;
- in-patients transferred to other internal nursing units will be no different from normal operation activities
- event casualties transferred from ER to internal units will be handled through the Transport Unit Leader and may have limited or no verbal reporting
- critical patients transported to Day Surgery will go via Trauma elevator
- stable patients transported to Day Surgery will go via regular elevator
- casualties transferred to other facilities from the ER or patients from other nursing units will follow all COBRA guidelines with designated transfer form utilization

PCH implements the following, but not limited to, patient discharge activities during emergencies as needed;

- The President of the Medical Staff and VP of Patient Care Services (Operations Section Chief) determine if discharges are necessary based on census and casualty numbers
- The President of the Medical Staff and VP of Patient Care Services (Operations Section Chief) implements the discharge plan as needed and evaluate those patients classified as possible discharges, will notify the attending physician and assume discharge responsibility as necessary.
- family may be asked to stay with in-patients designated as possible discharges so to facilitate transport via private vehicle
- event casualty discharges from ER are directed to the Parkview area of PCH to be reunited with family members and offered counseling and support services through volunteer hospital chaplain services

2. **PCH will implement evacuation: Horizontal/vertical (outside building) when environment cannot support care, treatment, and services.**
   Implementation: PCH will implement evacuation, be it horizontally, vertically or full building, to an alternate care site as needed, under the direction of the Incident Commander following the Evacuation Plan policy 73.02H (PC).

3. **PCH will identify a potential increase in demand for clinical services for vulnerable populations served by the hospital, such as patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions.**
   Implementation: PCH identifies potential increases in demand for clinical services for vulnerable populations served through existing Provisions of Care policies, the HICS Operations Section – Medical Care Branch and communications with Mercer County Emergency office and the local/regional Emergency Medical Services.

4. **PCH will manage personal hygiene and sanitation needs of its patients.**
   Implementation: PCH manages personal hygiene and sanitation of its patients through established Provisions of Care. In times where normal operations water is unavailable, hygiene and sanitation is addressed in policy IC64.23H Contamination of Potable Water and overseen by the HICS Operations and Logistics Sections.

5. **PCH will manage mental health service needs of its patients during an emergency.**
   Implementation: PCH manages mental health service needs of it patients during an emergency by established Provisions of Care, Behavioral Health Pavilion of the Virginias , Volunteer Pastoral Care and the Southern Highlands agency.

6. **PCH will manage mortuary services.**
Implementation: PCH manages mortuary services through the HICS Operations Section / Medical Care Branch. Personal effects are maintained with the body as possible. Mercer County Office of Emergency Management is notified for events which surpass the four (4) body storage capability at PCH. The Materials Management department maintains 14-20 cadaver bags. The Emergency Preparedness office has 48 body bags available and more available through the WV Region I MSCC Disaster Task Force. A BioSeal brand fatality containment system is available and stored in the morgue that can individually hold approximately 90 decedents at room temperature for up to 72 hours without degradation of the remains and maintain a level 4 containment.

7. **PCH will document and track patients' clinical information.**
Implementation: PCH documents and tracks patients clinical information through the EMS triage tags, PCH "Priority Packet" ER form and order sheets, existing Meditech EMR application and internally is overseen through the HICS Operations Section – Medical Care Branch and Planning Section – Situation Unit

8. **PCH will implement the components of its EOP that require advance preparation to manage patients during an emergency.**
Implementation: Components of the EOP that require advance preparation to manage patient support activities during an emergency include, but is not limited to, the following;
- Code Minor-D influx of patients drills
- restocking and regular inventory of materials used during response and drills which includes priority packets overseen by the ER Clinical Director
- Emergency Preparedness and Fire Safety skills fair quarterly which encompasses evacuation and is overseen by the Emergency Preparedness Coordinator and the Education Department
- Partnership in the Mercer Co. LEPC and WV Region I Hospital Disaster Task Force which assists in up to date information for the Emergency Services of PCH which includes special needs populations, municipal and emergency water, mental health, mortuary, patient tracking and documentation services.
- WV University sponsored Basic and Advanced Disaster Life Support (BDLS and ADLS) courses

H. Princeton Community Hospital prepares for how it will manage *disaster privileges* during emergencies by, but not limited to, the following:

1. **PCH will grant disaster privileges only when the EOP has been activated and the hospital is unable to meet immediate patient needs.**
Implementation: PCH grants disaster privileges as stated in Section 7.7-1 paragraph 2 of the Bylaws "If the Disaster Plan has been activated, and if available medical staff is insufficient to handle the

immediate patient care needs, the Chief Executive Officer, Chief of Staff, Medical Director or his or her designee(s) will activate the disaster privileges plan"

2. **PCH identifies in its Medical Staff bylaws those individual(s) responsible for granting disaster privileges to volunteer LIPs.**
Implementation: PCH identifies the individual(s) responsible for granting disaster privileges as stated in Section 7.7-2 item 3 of the Bylaws "The CEO, Chief of Staff, Medical Director, or designee may grant the disaster privileges"

3. **PCH determines how it will distinguish volunteer LIPs from other LIPs.**
Implementation: PCH distinguishes volunteer LIPs from staff LIPs as stated in line 4 under procedure in policy 42.115H - Disaster Volunteer Health Care Practitioners -"Volunteer practitioners will be issued temporary identification from the Human Resources Department."

4. **PCH assures the Medical Staff describes in writing how it oversees the performance of volunteer LIPs granted disaster privileges.**
Implementation: PCH has assured the Medical Staff describes in writing how it oversees the performance of volunteer LIPs granted disaster privileges as stated in Section 7.7-2 item 4 of the Bylaws "...Professional performance of volunteer practitioners who receive disaster privileges will be immediately overseen by direct observation of PCH physicians working with them, and will be followed up by clinical record review of a percentage of cases." And line 7 under procedure in policy 42.115H – Disaster Volunteer Health Care Practitioners – "The appropriate department director will oversee the professional practice of volunteer practitioners."

5. **PCH assures that before a volunteer LIP is considered eligible to function as a volunteer LIP, the hospital obtains his/her valid government-issued photo identification (i.e., a driver's license or passport) and <u>at least one of the following</u>:**

   - **Current hospital picture ID card that identifies professional designation**
   - **Current license to practice**
   - **Primary source verification of licensure**
   - **ID indicating member of a Disaster Medical Assistance Team (DMAT), (MRC), (ESAR-VHP), or other recognized state or federal organizations**
   - **ID granting authority to render patient care in emergency circumstances, such authority granted by a federal, state, or municipal entity**
   - **ID by LIP currently privileged by the hospital or a staff member with personal knowledge of the volunteer's ability to practice as an LIP.**

   Implementation: PCH obtains volunteer identification as stated

in Section 7.7-2 item 1 of the Bylaws. "Before a volunteer practitioner is considered eligible to function as a volunteer practitioner, the practitioner must submit a valid, government-issued photo identification and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation.
- A current license to practice
- Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), The Medical Reserve Corp (MRC), and Emergency System for advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response hospital group.
- identification indicating that the practitioner has been granted authority by a government entity to provide patient care, treatment, services, in disaster circumstances.
- Confirmation by a licensed independent practitioner currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioners ability to act as a licensed independent practitioner during a disaster."

PCH obtains volunteer identification as stated in line 5 under procedure of policy 42.115H - Disaster Volunteer Health Care Practitioners – " Volunteer practitioners will present appropriate and valid identification to the Human Resources department in the form of at least two of the following (primary source verification of licensure, certification or registration required for regulated professionals):

- current hospital picture ID
- current license, certification or registration
- ID indicating member of DMAT, MRC, ESAR-VHP, or other recognized state or federal organization or group
- ID granting authority to render patient care in emergency circumstances, such authority granted by a federal, state or municipal entity
- ID by current hospital member(s) with personal knowledge regarding volunteer practitioners qualifications

A Disaster Privileges Credentialing Form for Medical Staff is maintained in the Medical Staff Services Office. HICS form 253 (*Volunteer Staff Registration) is available for other volunteer practitioners and is maintained in the Logistics Section – Support Branch – Credentialing Unit.

6. **PCH Medical staff will, during a disaster, oversee the performance of volunteer LIP.**
Implementation: PCH Medical Staff oversees the performance of volunteer LIPs granted disaster privileges as stated in Section 7.7-2 item 4 of the Bylaws "...Professional performance of volunteer practitioners

who receive disaster privileges will be immediately overseen by direct observation of PCH physicians working with them, and will be followed up by clinical record review of a percentage of cases."

7. **PCH will determine within 72 hours if granted disaster privileges should continue.**
Implementation: PCH determines within 72 hours if granted disaster privileges should continue as stated in Section 7.7-3 of the Bylaws "A decision will be made within 72 hours related to the continuation of the disaster privileges initially granted based upon the scope of the disaster. Once the immediate situation is under control, the disaster privileges will be terminated. Termination of privileges granted in disaster does not entitle the practitioner to a hearing or other due process" and in line 8 under policy 42.115 – Disaster Volunteer Health Care Practitioners – "The hospital will make a decision based on information obtained regarding the professional practice of the volunteer practitioner within 72 hours related to the continuation of the disaster responsibilities initially assigned."

8. **PCH will assure that the primary source verification of licensure occurs as soon as emergency situation is under control/within 72 hours from time LIP presents, whichever comes first. If primary source verification of license cannot be completed within 72 hours, the hospital documents all of the following:**
   - **Reason(s) why it could not be performed within 72 hours of LIPs arrival**
   - **Evidence of LIPs ability to continue to provide care/tx/services**
   - **Evidence of hospital's attempt to perform primary source verification ASAP**

   Implementation: PCH assures the primary source verification of licensure and addresses any inability to verify license within 72 hours as stated in Section 7.7-2 item 5 of the Bylaws "The disaster privilege information shall be forwarded as soon as possible to the Medical Staff Services Office. Primary source verification of licensure will occur as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer practitioner presents to the hospital, whichever comes first. If primary source verification of volunteer practitioner cannot be completed within 72 hours of the practitioner
   arrival due to extraordinary circumstances, the hospital will document all of the following:
      - Reason(s) why it could not be performed within 72 hours of the practitioners arrival,
      - Evidence of the practitioners demonstrated ability to continue to provide adequate care, treatment and services.
      - Evidence of the hospitals attempt to perform primary source verification as soon as possible, if due to extraordinary circumstances, primary source verification of the license of the volunteer practitioner cannot be completed within 72 hours of the practitioners arrival, it is performed as soon as possible. (Note:

primary source verification of license is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges). A record of this information should be retained in the Medical Staff Services Office."

9. **PCH assures if primary source verification of licensure cannot be done within 72 hours, it is performed as soon as possible.** **Implementation:** PCH assures the primary source verification of licensure is done as soon as possible as stated in Section 7.7-2 item 5 piece c of the Bylaws " c, Evidence of the hospitals attempt to perform primary source verification as soon as possible, if due to extraordinary circumstances, primary source verification of the license of the volunteer practitioner cannot be completed within 72 hours of the practitioners arrival, it is performed as soon as possible. (Note: primary source verification of license is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges). A record of this information should be retained in the Medical Staff Services Office."

APPROVED BY:

Kevin W. Graham
Safety Officer — Date: 11/12/13

Richard A. Puckett, RN BSN
VP Quality and Performance — Date: 11/12/13

Wayne B. Griffith, FACHE
Chief Executive Officer — Date: 12/13/13

Fred St. John
President, PCH Board of Directors — Date: 1/21/14

COVER SHEET FOR POLICY / PLAN APPROVAL

(For detailed instructions, see Policy #2.8 H, "Use of Standard Policies and/or Procedures")

1. Title of Policy/Plan: Emergency Operations Plan 73.19

☐ New Policy/Plan
Submit complete document in both hard copy and electronic formats.

☒ Revised Policy/Plan
Strikeout passages being deleted (~~deleted~~); underline passages being added (added). Submit in both hard copy and electronic formats.

2. Statement of Purpose: The purpose of the Emergency Operations Plan is to coordinate the "Critical Six" functions of communications, resources and assets, safety and security, staff responsibilities, utilities management and patient clinical and support activities of Princeton Community Hospital during an emergency

3. Rationale: Although the emergencies encountered by Princeton Community Hospital have many causes, the effects on the "Critical Six" functions encountered and the required response effort may be similar. Therefore, this All-Hazards approach will support a general response capability that is also scalable in order to address a range of emergency situations of different cause, duration and scale. In addition, specific response policies, as well as the utilization of HICS and The Emergency Management Plan, remain an integral aspect of the response effort and its inherent adaptability to other emergencies and events outside of normal daily operations that Princeton Community Hospital may experience

Why needed?

4. Revisions made (if revised)

Pg 4 Procedure A-8: addition of "Minor-D internal" is utilized for interruption of essential services
Pg 5 Procedure B-1: addition of internet based mass notification tool usage / B-3: addition of contact to the mercer County Emergency Manager when the EOP is enacted.
Pg 7 Procedure B-14: addition of back-up analog phone locations/numbers / B-15 additon to same to monthly operational checks
Pg 11 Procedure D-5: addition of self directed and ER staff directed patient decontamination oversight
Pg 12 Procedure E-3: revisions of current HICS positions Command Staff names
Pg 14 Procedure F-2: update to current potable water service agreements
Pg 17 Procedure G-5: revision of behavioral medicine dept. to Behavioral Health Pavilion of the Virginias.
Pg 18 Procedure G-6: addition of BioSeal device availability for fatality containment, G-8 revision of bi-annual Fire Safety/E-Prep inservices to quarterly

5. Additional Input Provided by:

☐ Legal Counsel
☐ MEC
☒ Other: EOC approval 11-12-13

6. Submitted by: Mark S. Pickett RN

Title: Emergency Preparedness Coordinator / Education Instructor DATE: November 12, 2013

APPROVAL PROCESS

ALL POLICIES (including Medical Staff): All new/revised policies (a copy in final draft form and a copy showing revisions, if revised) are to be presented to the appropriate Vice President for review, who will then forward to the Chief Executive Officer (CEO) for final review and approval procedure. This cover sheet (to include statement of purpose, rationale, and reason for revisions, if revised) is to be attached. NOTE: In every instance, a copy of this cover sheet will be distributed to the PCHA, Inc. Board of Directors for informational purposes and approval, if required. The full policy will be made available to Board members on request.

MEDICAL STAFF POLICIES: All new/revised Medical Staff policies are to be submitted to the appropriate Medical Staff Department / Committee for review and further input prior to final approval. A copy of this cover sheet (to include statement of purpose, rationale, and reason for revisions, if revised) is to be forwarded to the Medical Executive Committee (MEC) for informational purposes and approval. The full document (with revisions) will be made available to the MEC for approval signatures. All new/revised policies (a copy in final form and a copy showing revisions, if revised) are then to be forwarded to the Chief Executive Officer (CEO) for the final review / approval procedure.

ALL HOSPITAL PLANS: All new/revised hospital plans will follow the same appropriate procedure described above.

Approval Signatures Required for Policy/Plan Documents: (to be included on signature page of document)

Department Manager:	All Departmental Policies/Plans
Administrative Supervisor:	All Departmental Policies/Plans
Medical Staff President:	All new / revised Medical Staff Policies/Plans
Chief Executive Officer:	All Policies and Plans
President of Board:	All Hospital Plans; all Policies pertaining to organizational performance for which the Board has accountability

--- OFFICE USE ONLY ---

Approved by: _____

Date: _____

Approved Policy/Plan Forwarded to: _____