



PLAN #: DIS:09

Children's National
Evacuation Plan
CODE BLACK
EOP Annex

September 13, 2012

**Children’s National Medical Center
Code BLACK - Evacuation Plan**

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Children's National Code BLACK Evacuation Plan

I. Purpose

The purpose of this plan is to ensure the safety and security of patients, personnel and visitors at Children's National through rapid and effective response to a situation requiring partial or total evacuation of Children's National or one of its facilities.

II. Scope

This document applies to main campus and off-campus buildings in situations that threaten either the health or life of individuals, or the structural integrity of the facilities.

III. Hospital Evacuation

A. Building Structure

If the evacuation of patients becomes necessary due to a fire or other type of incident, horizontal and/or vertical evacuation procedures will be used as appropriate, per the instructions in this plan. Hospitals are constructed with at least two smoke compartments on each level allowing occupants to 'defend in place' by horizontal evacuation to another smoke compartment as is the case with most fire situations. If necessary for the safety of occupants, vertical evacuation should be initiated as appropriate, moving occupants to a lower level or entirely from the building.

B. Authority to Activate Evacuation

The decision to evacuate vertically may be made by the nurse in charge at the scene as appropriate for the circumstances, the Executive Director of Safety & Emergency Management, Fire Response Team Commander, Hospital Incident Commander, Nurse Administrator on-call (NAOC), Administrative Manager (AD), CEO/designee, fire department or police department. The decision to evacuate horizontally may be made by any of the above, or by hospital personnel present at the scene as they deem appropriate to protect and save lives. The deciding authority must relay the decision to evacuate to Communications for overhead announcement. Clear overhead directions must be given directing persons to safe refuge areas.

C. Evacuation Categories

1. Ambulatory: Any patient or other person who is able to walk. Infants who can be transported in evacuation aprons or medsled baskets are in this category.
2. Wheelchair: Any patient or other person unable to walk who is able to sit up unassisted and be moved by wheelchair.
3. Non Ambulatory/Stretchers: Any patient or other person incapable of

walking or sitting during transport. These people must be moved lying down. Linen/sheet carry, Medsleds and Immobilizers are in this category.

D. Priority for Evacuation (ambulatory first, then wheelchair, then stretcher):

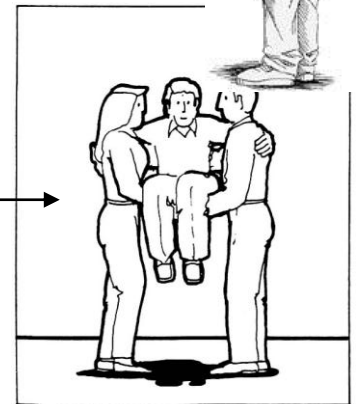
1. Ambulatory: Two employees should be assigned per group, one to lead the line and one at the end of the line. Children should be alternated between older and younger when possible, and instructed to hold hands and evacuate single file. One employee should stay with the group when they reach safety, the other employee can assist with further evacuation if appropriate.



Aprons can hold up to four infants, medsled baskets can hold two infants, nursing determines how many infants they can safely package based on the infant's status.

2. Wheelchair:

Two employees per patient must be used to evacuate wheelchair patients via stairways using the stair-carry method. **Stair-chair carry** entails two persons facing each other, grasp one another's elbows and form a "chair" with your forearms that the patient's back and knees can rest on, then proceed down the stairs. Make provision for another person to bring a wheelchair if possible so that the disabled person has mobility when evacuated.



If the patient remains in the wheelchair, use three employees (one behind the wheelchair grasping the handles, the other two in the lead, each one taking one wheel).



3. Non Ambulatory/Stretcher/Immobilizer: Two or three employees must be used to evacuate non ambulatory patients using doubled up linen and sheets when stretchers or Medsleds are not available. NOTE: Each nursing service director has determined the number and type of special evacuation equipment likely to be needed based upon their typical patient population. This equipment is stored on each unit for ready access at all times. Each unit is responsible for department-specific education and periodic checks to ensure their equipment is ready.

E. Horizontal Evacuation

Horizontal evacuation involves movement of patients, visitors and personnel in immediate danger to a safe area on the same floor. In the hospital, movement would be to an adjacent smoke compartment (blue, green, yellow, orange, East zone 1, etc.) beyond closed corridor doors.

1. Move patients who are closest to the danger first. **Mark rooms as evacuated by placing a pillow on the floor against room doors.**
2. Move remaining patients/personnel following the designated order of evacuation (ambulatory, wheelchair, stretcher).
3. Once a wheelchair patient has been evacuated, return the chair for use with the next patient needing assistance. Stretchers, immobilizers and aprons should also be returned after each patient is evacuated. If stretchers/chairs are unavailable, for large patients use the cradle drop method to place patients on a blanket which has been set on the floor, then pull the patient (head end first to protect the head) out along the floor to a safe location. For smaller patients use a three person corner carry. If blankets are unavailable, use sheets (double fold) or bedspreads.

F. Vertical Evacuation

Vertical evacuation is the second choice, used when horizontal evacuation is insufficient to protect lives. Depending upon the circumstances of the incident, vertical evacuation may be to one or two levels down, or it may be completely from the building. **DO NOT USE ELEVATORS.** Overhead announcements will be given to inform building occupants of the extent of evacuation.

1. Ambulatory patients should be lead down the nearest and safest stairways as previously described. Evacuation aprons and medsled basket infant carriers leave with this group.
2. Non ambulatory patients should be moved down stairways by means of emergency personnel carries, wheelchairs, medsleds or stretchers. The recommended stairway carries are the two-person stair-chair carry or the three-person/four-person blanket carries.

G. Total Evacuation

If total evacuation is declared, vertical evacuation procedures will be used.

1. Patient charts, medications, oxygen if needed, etc., must be taken with the patient (put in a bag on their stretcher, medsled, etc.).
2. The order of evacuation will be made by the Hospital Command Center and communicated to staff either overhead, via phones, radios, runners, etc., see the Base EOP, Communications.
3. The person in charge in each department must ensure that the following occurs:
 - a. Patient charts, medications, etc. are sent with them.
 - b. List of patients present is collected.
 - c. List of staff present is collected.
 - d. All rooms are fully evacuated.
 - e. Once evacuation is complete, charge person will account for all patients and personnel from their area at their predetermined MEETING PLACE.
 - f. Any missing persons will be immediately relayed to the Hospital Command Center.

H. Meeting Place and Accounting for Patients and Personnel

Each department/site shall congregate at a pre-arranged location upon building evacuation, manager or designee shall be responsible for the accounting of all staff and patients who have evacuated. Missing personnel must be promptly reported. Staff will remain at the meeting place until the "all clear" unless otherwise directed by management. If long term relocation is necessary, the Hospital Command Center will implement mutual aid agreements (MOUs) and DCEHC HIS as needed.

I. Provisions for Individuals With Handicaps

During any evacuation, staff must be alert to the potential that fellow staff (as well as patients and visitors) may require assistance due to physical, auditory or visual impairment and shall provide assistance as needed.

J. DC Emergency Healthcare Coalition Assistance

Children's is a member of the DC Emergency Healthcare Coalition (DCEHC). The DCEHC, upon notification via HMARS/ECIC, will activate their virtual command center (HCRT) to assist DC healthcare facilities during emergencies. DCEHC may provide support to DC healthcare facilities via alternate care beds, loan of equipment and/or supplies, sharing of personnel, sharing of available transportation resources as available. Members of Children's Administrator-on-Call group (Hospital Command Center staff) are responsible for interacting with DCEHC during emergency situations and must therefore be knowledgeable in use of the DCEHC website (HIS) resources. See Appendix for DCEHC tools on the

HIS. AOC personnel should contact Children's Executive Director of Safety & Emergency Management if additional training is needed in regard to these functions.

IV. Business Occupancy (Non-Hospital) Sites, ASC and LLC Evacuation

A. Building Structure

Non-hospital buildings and clinics are not required by Fire Code to have smoke compartments; therefore, horizontal evacuation must be complete evacuation out of the building. The exception to this is the Ambulatory Surgery Center and the LLC, each site has two smoke compartments, see site specific floor plans as appropriate.

B. Authority to Activate Evacuation

The decision to evacuate off-campus buildings may be made by the site manager or their designee, CEO/designee, Executive Director of Safety & Emergency Management, fire department or police department. Activation of the building fire alarm system is an automatic initiation of the building evacuation plan (exceptions are the ASC and LLC with two smoke compartments).

C. Building Evacuation

Evacuation categories, priority for evacuation, and evacuation procedures (except use of horizontal smoke compartments only for ASC/LLC), charge person accountability instructions (see I.A.7.c.), meeting place instructions and provisions for individuals with handicaps are the same as they are for the main campus hospital evacuation.

V. Termination of Code BLACK (ALL CLEAR)

The "all clear" is authorized by the following:

* Vertical evacuation - All Clear may be given by the Fire Department, Hospital Incident Commander/designee, Executive Director of Safety & Emergency Management, NAOC or AD.

* Horizontal evacuation - All Clear may be given by all of the above or the Fire Response Team Commander.

The person making the decision to terminate the evacuation order will relay the order to Communications, who will then emergency page 3 times overhead "Attention: ALL CLEAR for CODE BLACK".

VI. Interaction with Media and Event Management

A. Media Interaction - if involved

Public Relations will make accommodations for the media and provide PR support as appropriate to the situation. A security officer will be assigned to the media area to prevent the media from entering patient care areas. If the Hospital Command Center is activated the HCC will assign a Public Information Officer. All hospital employees are prohibited from discussing Code BLACK details with the media. In the event that the media approaches an employee, the employee will direct the media to Public Relations/the PIO immediately.

B. Event Management - Assessment of Response Activity

The Executive Director of Safety & Emergency Management will evaluate the hospital's responsiveness to the Plan and seek opportunities for improvement as appropriate.

C. Event Management - Stress and Crisis Counseling

Family Services will provide crisis intervention and supportive counseling for all personnel, patients and family members as needed.

VII. Activation of Memorandums of Understanding - Authority

The CEO/designee and/or the Hospital Incident Commander if the Hospital Command Center is stood up, has the authority to activate one or more MOUs.

VIII. Application of Disaster or Fire Plan - Response and Recovery

In the event of a fire, follow the Code Red (fire) Plan. In the event of a bomb/threat of a device deemed serious enough for evacuation, follow the Code White (bomb) Plan.

In the event that evacuation needs threaten to overcome the ability of the hospital to respond readily to the situation the appropriate disaster plan(s) may be put into effect, the Hospital Command Center (HCC) is activated and appropriate announcements made.

Should a situation requiring evacuation render Children's hospital facility unable to house all or part of its patient population, the Hospital Incident Commander may activate one or more of the hospital's Memorandums Of Understanding (MOU). Refer to Hospital Command Center MOUs for specific instructions on transportation, communication, continuity of care within each of the specific plan(s). Refer to the DCEHC HIS website for additional assistance and forms to use for response involving the Coalition (see also appendices to this Plan).

The Hospital Command Center will coordinate recovery operations should that be necessary. Follow HCC team member roles and responsibilities outlined in the plan. Short and long range recovery strategies may vary based upon the circumstances but patient and personnel safety will always be the first priority.

IX. Prevention and Mitigation Strategies

A. Prevention Strategies

Fire prevention and control strategies are designed to minimize the threat of evacuation due to a fire. Personnel are trained on the Code WHITE, Code RED, Code BLACK, Code GRAY, Code ORANGE (MCI), Code PURPLE, Code BROWN, Code GREEN, Code SILVER and Code COPPER plans during new employee orientation. Personnel working in sensitive areas or whose location requires department/site specific evacuation instructions receive additional department-specific training as appropriate.

B. Mitigation Strategies

Children's National was built with steel frame construction and followed architectural design specifications required at the time of construction. Education of staff and drills on evacuation plan response help to mitigate the effects of an event upon personnel and patients by training staff to respond quickly in disaster situations.

X. Evaluation / Appraisal of the Plan

The Code Black Plan will be reviewed and evaluated for effectiveness at least every three years by the Director of Safety & Emergency Management and the Safety & Emergency Management Committee. In addition, following any activation of the Code BLACK Plan (including drills) the plan will be reviewed and its effectiveness evaluated during critique of the event to ensure that all possible actions are being taken to provide for the safety of our patients, personnel and visitors.

Approved by: Safety & Emergency Management Committee

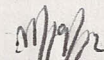
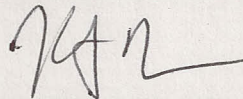
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Date

Leadership Council

10/31/12

Date



Kurt Newman, MD
President & CEO

Date

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Cross Reference:

CH:FS:14 Disaster Planning Policy; CH:DIS:03 Code Red Plan; CH:DIS:07 Code White Plan, CH:DIS:01 Code Orange (MCI) Plan, DC Emergency Healthcare Coalition (DCEMC) Healthcare Facility Evacuation Incident Specific Annex.