Emergency Operations Plan

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REFERENCES

1. County of Los Angeles DHS Employee Safety Handbook
2. County of Los Angeles DHS Policy #911, Attachment: Employee Responsibilities During Emergencies
3. County of Los Angeles DHS Policy #911: Role of DHS Employees in the Event of an Emergency
4. County of Los Angeles DHS Policy: Non-County Workforce Comprehensive Policy Statement (CPS)
5. Emergency Response Plan: Acute Care Surgery Emergency Response Plan for Mass Casualties
6. Emergency Response Plan: Department of Emergency Medicine
7. Emergency Response Plan: Food and Nutrition Services
8. Emergency Response Plan: Inpatient Psychiatric Services at Augustus F. Hawkins Mental Health Center
9. LAC+USC Area/Unit Orientation Checklist
10. LAC+USC Employee Monthly Education Program
11. LAC+USC Fire Life Safety / Emergency Preparedness Training
12. LAC+USC Fire Life Safety Manual
13. LAC+USC First Receiver Decon Team Manual
14. LAC+USC Medical Center Bylaws of the Attending Staff Association
15. LAC+USC Medical Center Facilities Management Procedure Manual # 401-408 (Utilities Policy & Procedures)
16. LAC+USC Medical Center Policy #511: Photo Identification Badges
17. LAC+USC Orientation/Reorientation Handbook

Emergency Operations Plan

Overview

PURPOSE
To establish operational procedures and guidelines for potential or actual emergencies that fall on a continuum of disruptive to disastrous that can adversely impact the organization's ability to provide care, or the environment of care itself, or that result in a sudden, significantly changed, or increased demand for the organization's services.

POLICY
This is an all-hazards emergency management plan. The plan is to be implemented at any time deemed necessary to manage an incident, for internal/external disasters, healthcare emergencies, patient surge, a multi-casualty / mass casualty incident (medical, trauma, or CBRNE), or when needs are greater than resources. This plan will remain in effect until that time that the event and its effects are resolved, and the medical center can return to normal operations.

DEFINITIONS
Disaster: an event that exceeds the capabilities of the response.

1. A disaster exists when need exceeds resources (Disaster = Needs > Resources).
2. A disaster exists when the number of patients and/or severity of illness or injury are such that normal daily operations are no longer possible.

Emergency: an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that result in a sudden, significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity.

Healthcare Emergency: an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care.

Multiple Victim Incident: an incident with 10 or less casualties on scene.

Multi-Casualty Incident: an incident with greater than 10 casualties on scene.

Mass Casualty Incident: an incident in which emergency medical services resources are overwhelmed by the number and severity of casualties.

Surge: a sizeable increase in demand for resources compared with a baseline demand. Components include Influx (volume, rate), Event (type, scale, duration), and Resource Demand (consumption, degradation).

Introduction

The Emergency Operations Plan (EOP) follows the four phases of emergency management: mitigation, preparedness, response, and recovery. These phases occur over time; mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.

Planning involves those activities that must be done in order to put together a comprehensive plan. Hospitals identify potential hazards, threats, and adverse events, and assess their impact on the care, treatment, and services they provide for their patients. This assessment is known as a *Hazard Vulnerability Analysis (HVA)* and is designed to assist hospitals in gaining a realistic understanding of their vulnerabilities in order to help them mitigate and prepare to respond to emergencies and their impact. Additionally, the hospital conducts an annual review of the objectives and scope of the EOP in order to identify relevant changes to the organization, community, and capability and support decision-making regarding how the facility responds to emergencies.

After the plan is in place, it is tested through staged emergency response exercises in order to evaluate its effectiveness. The hospital uses the lessons learned to improve the effectiveness of their response strategies. Adjustments to the EOP can then be made. Additionally, the plan addresses regulatory compliance specific to Emergency Management, i.e., CMS, the Joint Commission (TJC) which has deemed status for CMS, and CDPH.

The EOP is an "All Hazards" plan. Emergencies have many causes, and their effect on areas of the organization and the required response effort may be similar. This all-hazards approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

While no hospital can predict the nature of a future emergency or predict the date of its arrival, they can plan for managing the following critical areas of their organizations so that they can respond effectively regardless of the cause(s) of an emergency: communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities. When hospitals consider their capabilities in these areas, they are taking an "all hazards" approach to emergency management that supports a level of preparedness sufficient to address a range of emergencies, regardless of the cause.

This approach lays the foundation for developing emergency operations that are scalable to emergencies that may escalate in complexity, scope, or duration.

National Incident Management System (NIMS) Implementation for Healthcare Organizations

Homeland Security Presidential Directive HSPD-5: Management of Domestic Incidents calls for the establishment of a single, comprehensive national incident management system. The result was the National Incident Management System (NIMS), a systematic, proactive approach guiding departments and agencies at all levels of government, the private sector, and nongovernmental organizations to work seamlessly to prepare for, prevent, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location or complexity, in order to reduce the loss of life, property, and harm to the environment. NIMS represents a core set of doctrines, concepts, principles, terminology, and organizational processes that enables effective, efficient, and collaborative incident management. This consistency provides the foundation for utilization of NIMS for all incidents, ranging from daily occurrences to incidents requiring a coordinated Federal response. A basic premise of NIMS is that all incidents begin and end locally. The Federal government supports State, local, and tribal authorities when their resources are overwhelmed or anticipated to be overwhelmed. The intention of the Federal government in these situations is not to command the response, but rather to support the affected State, local, and tribal authorities.

HSPD-5 also requires that all Federal departments and agencies make adoption of NIMS by State, tribal, and local organizations a condition to receive Federal Preparedness Assistance. To that end, the U.S. Department of Health and Human Services (DHHS) requires that healthcare organizations implement NIMS in order to be eligible for preparedness funding through the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) grant program.

Homeland Security Presidential Directive HSPD-8: National Preparedness aims to strengthen the security and resilience of the U.S. through systematic preparation of proposed threats that pose the greatest risk to the security of the Nations. This preparedness is a shared responsibility across the entire nation, to include public and private partners. The ASPR HPP overarching goal is to ensure cooperative agreement funds are used to maintain, refine, and to the extent achievable, enhance the capacities and capabilities of their healthcare systems.

To assist HPP participating healthcare organizations, DHHS developed 11 NIMS Implementation Objectives which are categorized as follows: 1) adoption, preparedness: planning, preparedness: training and exercises, 2) communication and information management, and 3) command and management. As a recipient of HPP funding, LAC+USC Medical Center implements NIMS and documents the NIMS Implementation Objectives in the following table.

NIMS Implementation	
Objective	**Compliance**
Adoption	
1.) Adopt NIMS throughout the healthcare organization including all appropriate departments and business units.	▪ See Background: NIMS Implementation
2.) Ensure Federal Preparedness grants and cooperative agreements support NIMS Implementation (in accordance with the eligibility and allowable uses of the awards).	▪ The organization's Emergency Operations Plan (EOP) explains the use of ICS, particularly incident action planning and common communication plan. ▪ Reference: o Background o Emergency Operations: Incident Management o Emergency Operations: Communications
Preparedness: Planning	
3.) Revise and update emergency operations plans (EOPs), standard operating procedures (SOPs), and standard operating guidelines (SOGs) to incorporate NIMS and National Response Framework (NRF) components, principles and policies, to include planning, training, response, exercises, equipment, evaluation, and corrective actions.	▪ Plans incorporate NIMS objectives and NRF components. ▪ Plans document adoption of a standardized incident command system (ICS), for example, Hospital Incident Command System (HICS). ▪ EMP documents content and date of revisions to EOP or SOPs, including those made to address NIMS. ▪ Corrective Action/Improvement Plans document any changes made to plans, SOP, processes, training, exercise plans or resources which result from drills and actual events. ▪ Reference: ▪ Background ▪ Planning and Preparedness ▪ Emergency Operations [All Plans] ▪ Addendum
4.) Participate in interagency mutual aid and/or assistance agreements, to include agreements with public and private sector and nongovernmental organizations.	▪ The EOP references MOUs, mutual aid agreements, and/or arrangements between participating healthcare organizations, public health, emergency medical services agency, private sector, and NGOs. ▪ Reference: ▪ Background ▪ Emergency Operations: Communication ▪ Emergency Operations: Staff ▪ Emergency Operations: Essential Services and Resources ▪ Appendix I: Mutual Aid, Community Partners, and Coalition
Preparedness: Training and Exercises	
5.) Implement ICS-700: NIMS, An Introduction, ICS-100: Introduction to ICS and ICS-200: ICS for Single Resources training to appropriate personnel.	▪ Reference: ▪ Emergency Operations: Staff ▪ HCC Staff Training Roster ▪ HCC Staff Training Roster

NIMS Implementation	
Objective	**Compliance**
6.) Implement ICS-800 National Response Framework (NRF): An Introduction training to appropriate personnel.	▪ Reference: ▪ Emergency Operations: Staff ▪ HCC Staff Training Roster
7.) Promote and integrate, as appropriate, NIMS concepts and principles (i.e., the Incident Command System) into all healthcare organization-related training and exercises.	▪ Utilize and document use of HICS for disaster exercises and actual events. ▪ Document that drills and exercises test organization's ability to activate ICS, open their Hospital Command Center (HCC), develop and implement an Incident Action Plan (IAP), and communicate with community response partners. ▪ Develop an After-Action Report (AAR) and Corrective Action Plan. ▪ Reference: ▪ Emergency Operations: Incident Management: HICS and HCC Operations ▪ Emergency Operations: Staff ▪ Planning and Preparedness: Drills and Evaluation ▪ HCC Staff Training Roster
Communication and Information Management	
8.) Promote and ensure that hospital processes, equipment, communication, and data interoperability facilitate the collection and distribution of consistent and accurate information with local and state partners during an incident or event.	▪ Reference: ▪ Emergency Operations: Communications ▪ Emergency Operations: Essential Services and Resources ▪ Appendix I: Mutual Aid, Community Partners, and Coalition
9.) Apply common and consistent terminology as promoted in NIMS, including the establishment of plain language communications standards.	▪ Reference: Emergency Operations: Communications
Command and Management	
10.) Manage all emergency incidents, exercises, and preplanned (recurring/special) events with consistent application of ICS organizational structures, doctrine, processes, and procedures.	▪ Reference: ▪ Emergency Operations: Incident Management: HICS and HCC Operations ▪ Emergency Operations: Communications ▪ Planning and Preparedness: Drills and Evaluation
11.) Adopt the principle of Public Information, facilitated by the use of the Joint Information System (JIS) and Joint Information Center (JIC) ensuring that Public Information procedures and processes gather, verify, coordinate and disseminate information during an incident or event.	▪ The EOP describes management and coordination of public information with external entities, agencies and the public. ▪ Reference: Emergency Operations: Communications: System

State of California

The *California Office of Emergency Services (Cal OES): The Governor's Office of Emergency Services* is responsible for coordinating overall state agency response to major disasters in support of local government. The Agency is responsible for assuring the state's readiness to respond to and recover from all hazards (natural, manmade, war-caused emergencies and disasters) and for assisting local governments in their emergency preparedness, response, recovery, and hazard mitigation efforts.

For this purpose, the state is divided into six regions which are further grouped into the Coastal, Inland, and Southern regions. Los Angeles County is in Region 1 which is comprised of San Luis Obispo, Santa Barbara, Ventura, Los Angeles, and Orange Counties. Region 1 is part of the Southern Region which has its Regional EOC located in Los Alamitos at the Joint Forces Training Base.

When emergencies require resources that exceed the capabilities of local areas, Cal OES activates the *State Operations Center* (SOC) in Sacramento and the *Regional Emergency Operations Centers* (REOCs) in impacted areas to receive and process local requests for assistance. The REOCs are comprised of the *Operational Areas* (OA) which consist of a county or counties and all their political subdivisions.

In California, counties have been delegated the primary responsibility for designating a local EMS agency and assuring that EMS systems are developed and implemented. Additionally, California state law requires that during disasters, the County Sheriff is in charge of the County.

County of Los Angeles

Due to its size, Los Angeles County is its own Operational Area. If an event occurs which is beyond the capability of the local community such that it requires Operational Area support, the Sheriff's *Emergency Operations Bureau* (EOB) becomes the County *Emergency Operations Center* (EOC), and the Sheriff is in charge of the County (Operational Area). If this is a medical or health related disaster, the *Medical Alert Center* alters its mission to activate and manage the *Medical Coordination Center (MCC)* in coordination with the *Emergency Medical Services Agency* (EMSA). The MCC (as the Medical Branch) reports to the County EOC. This provides for the efficient coordination of information and resources to support response and recovery activities during a medical or health related event. The MCC is physically adjacent to the MAC, and a MAC representative is in the MCC.

During an emergency, LAC+USC reports to the EMSA via the MAC / MCC
. Communications includes our hospital status, capacity, event management, patient management, resources needed or that can be shared, and patient/victim tracking. The EMSA and all HPP hospitals, clinics, first providers in LA County participate in the ReddiNet for interoperable communication during disasters.

The Los Angeles County OA healthcare capabilities and resources include:

1. Ambulatory Surgery Centers: > 250
2. Clinics / Community Health Centers
    a. Community Clinic Association of Los Angeles County (CCALAC): 58 organizations
    b. CCALAC member and affiliate sites: > 300

3. Dialysis Centers: > 160
4. Disaster Resource Centers: 14
5. EMS Provider Agencies
    a. 32 Fire Departments (county, city)
    b. 36 private prehospital Provider Agencies
6. Home Health and Hospice: > 1300 agencies
7. Hospitals – Acute Care: 104
    a. Emergency Departments: 71
    b. MICN Base Stations: 22
    c. Trauma Centers: 14
    d. Burn Centers: 3
8. Long term Care / Skilled Nursing Facilities: 391

Additionally, capabilities include the following General Public Health Services:

1. Department of Animal Care & Control
2. Department of Children and Family Services
3. Department of Coroner
4. Department of Mental Health
5. Department of Public Social Services
6. Department of Public Health
7. Department of Health Services

The *Los Angeles County Department of Public Health* functions to protect health, prevent disease, and promote the health and well-being for all persons in Los Angeles County. It conducts its activities through a network of public health professionals throughout the community. Public health nurses make home visits to families with communicable diseases; epidemiologists investigate the sources of disease outbreaks; environmental health specialists ensure safe food, water, and housing; and all work with community coalitions to protect and improve health. Capabilities and resources include:

1. Acute Communicable Disease Control
2. Environmental Health
3. Medical Reserve Corps, Public Health Emergency Volunteer Network
4. On Call Public Health Physician
5. Public Health Emergency Rapid Response Teams
6. Radiation Management
7. Veterinary Health

The *Los Angeles County Department of Health Services* (DHS) is the second largest municipal health system in the nation. Through its integrated system of 4 hospitals, 19 health centers (the Ambulatory Care Network), an expanded network of community partner clinics, the College of Nursing and Allied Health, managed care services, and the Emergency Medical Services Agency. DHS annually cares for 670,000 unique patients and employs 19,000 staff.

The *Emergency Medical Services Agency* (EMSA), a division of the DHS, serves as the lead agency for the emergency medical services system in the County of Los Angeles and has the responsibility of coordinating the mitigation, preparation, and response of health-related disaster in the county. It is one of the largest EMS systems in the nation and, as one of the first to be developed, is known nationally and worldwide as a leader in the field of pre-hospital care. The system utilizes over 18,000 certified EMS personnel employed by fire

departments, law enforcement, ambulance companies, hospitals and private organizations to provide lifesaving care to those in need 24 hours a day, seven days a week.

The EMSA is responsible for:

1. Coordinating all system participants in its jurisdiction, encompassing both public and private sectors.
2. Planning, implementing, monitoring and evaluating the local EMS system. This includes establishing policies, addressing the financial aspects of system operation, and making provisions for collection, analysis, and dissemination of EMS related data.
3. Establishing operational policies and procedures
4. Designating EMS base hospitals and specialty care centers, such as trauma centers
5. Developing guidelines, standards and protocols for patient treatment and transfer
6. Implementing a prehospital ALS program
7. Certifying and accrediting prehospital medical care personnel
8. Approving EMS personnel training programs
9. Disaster Training and Readiness
10. L.A. County Disaster Healthcare Volunteers (DHV), the local Emergency System for Advance Registration of Healthcare Professionals (ESAR-VHP)

Assets and capabilities include:

1. Medical Alert Center
2. Mass Casualty Decon equipment
3. Medical and Pharmaceutical Disaster Caches
4. Mobile Medical System
5. Mobile Medical Alert Center Communications System

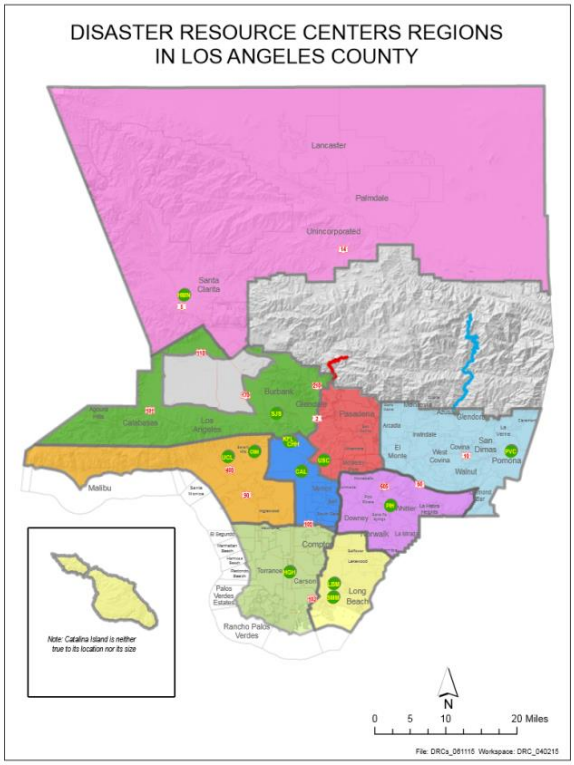
The *Medical Alert Center* (MAC) is a division of the EMSA and is available 24/7 for support. The MAC's role is to:

1. Coordinate patient transfer activities to all licensed acute care hospitals operated by the Los Angeles County Department of Health Services.
2. Coordination and support of multiple casualty incidents.
3. Coordinate of hyperbaric chamber team response and scuba diving incidents.
4. Coordinate placement of burn patients.
5. Coordinate trauma center destination for critically injured patients requiring helicopter transport from areas in Los Angeles County without a designated trauma center.
6. Coordinate inter-facility helicopter transfers requiring use of public EMS providers.
7. Management of the Hospital Emergency Administrative Radio (HEAR) and Rapid Emergency Digital Data Interface Network (ReddiNet).
8. Monitoring and document hospital diversion requests.
9. Activation and management of the DHS Department Operations Center.

Mutual-Aid, Community Partners, and Coalition

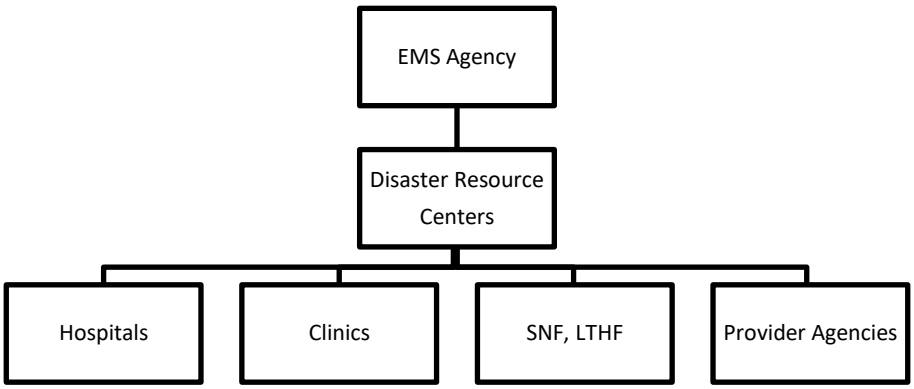
The County Board of Supervisors charged the EMS Agency with the oversight, administration, and implementation of the *ASPR Hospital Preparedness Program* (HPP) for Los Angeles County. Programs were developed to address stated critical benchmarks including hospital surge capacity, hospital isolation capability, healthcare volunteers (ESAR-VHP), Chempack, pharmaceutical caches, decontamination capacity, PPE (decon and isolation), behavioral health, trauma and burn care, communication and information technology, mutual aid, link to PH, education and training, and preparedness exercises. Additionally, the *County Disaster Healthcare Coalition* was started to build upon, maintain, and survive the cooperative and mutual-aid relationships created in this mass medical care model. The hospital-based programs of interest are as follows:

1. *First Receiver Decontamination Program*:
    a. Start Date: GY 1 (2003-4).
    b. Pilot program started by the EMSA to ready hospitals to be "First Receivers" for potential victims of a WMD (i.e., exposed to chemical, biological, or radiologic agents). Participating hospitals have Level C PPE and decon teams with personnel trained in First Receiver Decon Operations so that the facility, staff, and patients are protected, and victims can be treated as a result of a potential exposure.
    c. Participation: Voluntary. Levels of participation are "Basic" and "Expanded".

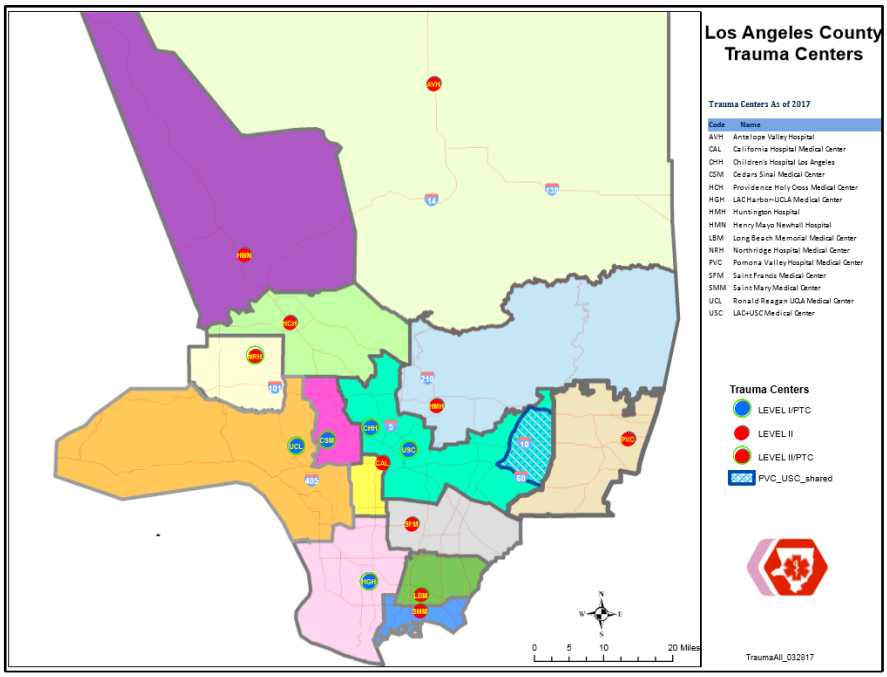


2. *Disaster Resource Center (DRC) Program*
    a. Start Date: GY 2 (2004-5).
    b. Pilot program started by the EMSA in which identified hospitals act as a "Disaster Resource Center" (DRC). Each DRC is assigned geographic / regional hospitals, clinics, and first responder agencies (their "umbrella") with whom they interface at the local level. The DRC, thus, has the following functions: they act as regional arms of the EMS Agency with respect to disaster planning and the local community; they are a conduit to gather and disseminate information, plans, and resources; they serve as regional distribution points for disaster medical/surgical supplies, equipment, and pharmaceuticals. The DRC's meet bimonthly with the EMS Agency to assess needs and create policies with respect to emergency and disaster response at a local and county level. Then each DRC meets bimonthly with their umbrella in their Regional Response Planning Committee. Each DRC maintains their respective *DRC Regional Response Plan* which incorporates county program policies, MOUs, and mutual aid with umbrella hospitals, clinics, SNF/LTHC, and first provider agencies.

c. Participation: Voluntary. All hospitals that participated in GY1 at the "Expanded" level were offered the opportunity to be a DRC. 11 hospitals initially designated; 13 to date.



3. *Trauma/Burns Surge Program*:
   a. Start Date: GY 3 (2005-6).
   b. Pilot program conceived by the EMSA and THAC to utilize the Trauma Centers (TC) as an asset to receive trauma and burn victims and a resource for trauma and burn medical/surgical supplies, equipment, and expertise. As a subcommittee of THAC, this group meets quarterly to assess the needs of and creates policies for the county with respect to emergency and disaster trauma and burns policies. These policies include:
      i. In the event of a mass casualty incident, all TCs must be able to accept 6 "Immediates".
      ii. In the event of a mass casualty burn incident, all TCs "Burn Receiving Centers" (BRC) and must be able to accept 20 burn victims for an indeterminate length of time.
   c. Participation: Must be a designated Trauma Center and participant in the NBHPP. There are 15 designated.



4. HPP Participation Countywide

Program/Hospital Type	Hospital Total
Basic	32
Expanded	32
Expanded/Trauma Center	5
DRC	3
Expanded/DRC/Trauma Center	9
Expanded/DRC/Trauma Center/Burn Center	1

5. HPP Deliverables Summary
   a. Participate in Coalition Activities:
      i. Host DRC Umbrella regional meetings (6/year)
      ii. Attend DRC Coordinator meetings (100%)
      iii. Attend Trauma Burns Surge meetings (100%)
      iv. Participate in exercises and drills in conjunction with county and community partners
      v. Participate in the annual Statewide Medical and Health Exercise
      vi. Respond to all EMS surveys
   b. Mutual Assistance
      i. Local Area, Operational Area, Region, and State
      ii. Participation is intrinsic to the HPP and MOA
      iii. Requested and coordinated through the EMSA, the Medical and Health Operation Area Coordinator for the County
      iv. Also see Regional Response Plan, Trauma Center Agreement, Burn Resource Center Agreement, Pediatric Surge Agreement
   c. Maintain Decon capability:
      i. Establish a Decon Team available 24/7
      ii. Establish a Respiratory Protection Program
      iii. Training: Conduct quarterly team meetings/exercises/training
      iv. Exercises: Conduct annual decontamination drill
   b. Staff Training:
      i. Disaster preparedness with emphasis on mass casualty incidents, WMD/terrorism, trauma, and burns
      ii. NIMS 11-point Implementation Activities (including ICS/HCC training for identified staff), *see Attachment 2* and below re: staff training.
      iii. Participation in the Annual Statewide Medical and Health Exercise
   c. Hospital Command Center
      i. Train HCC staff in HICS
      ii. Utilize whenever HCC is activated for exercise or real events
   d. Communications:
      i. Establish:
         1. ReddiNet
         2. HAM Radio capability
         3. Sat Phone capability
   e. Readiness Polls:
      i. ReddiNet
         4. Bio surveillance
         5. Facility Service Level Assessment
         6. HAvBED
         7. MCI
      ii. HAM Radio Capability
      iii. Satellite Phone Capability
   f. Emergency Notification System: implementation and regular testing, i.e., Everbridge

g. Joint Regional Intelligence Center (JRIC): Terrorism Liaison Officers, 2 per facility
h. Equipment / Supplies – secure, store, and maintain:
    i. Chempack
    ii. Pharmaceutical cache
    iii. Prepositioning of Antibiotics for First Receivers
    iv. DRC Med/Surg Supply Cache
    v. Burns Pharm / Supply Cache
    vi. Field Shelter / Trailers (set of 2)
    vii. Ventilators (23)
    viii. Evacuation equipment
    ix. Isolation equipment
    x. Technical Decon Showers
    xi. Security Enhancements
    xii. Truck
    xiii. HAM Radio
    xiv. Satellite Phone
    xv. 25kVa Portable Generator
    xvi. Radiation Monitors, Survey Meters
    xvii. Radiation Dosimeters
    xviii. MFI Racking System
    xix. Staxis Wheelchairs (Panflu Response Funds 2007)
    xx. Gurneys (5) Purchase (UASI 2008)
    xxi. Max-Air PAPRs (25) (Panflu Response Funds 2009)
i. Plans – develop and formalize:
    i. Business Continuity Plan
    ii. Evacuation / Shelter in Place Plan
    iii. Mass Fatality Incident Plan
    iv. Panflu Plan
    v. Prepositioning of Prophylactic Antibiotics for First Receivers Plan
    vi. Regional Response Plan
    vii. Surge Plan
    viii. Surge Plan – Pediatric

LAC+USC Medical Center

The LAC+USC Medical Center is part of the County of Los Angeles Department of Health Services and is composed of:

1. An acute care, full service, 692 bed in-patient facility including;
    a. Adult, Women's, Adolescent, Pediatric, Neonate, Jail, and Psychiatric inpatient wards
    b. Off-site Psychiatric inpatient ward > See below.
    c. 129 bed ED (General, Pediatric, Psychiatric, Jail)
    d. Burns Hospital (ACU, ICU, Clinic)
2. Full-service outpatient clinics located in 2 outpatient clinic towers.

<u>Regarding the Off-site Inpatient Psychiatric Services</u>

The off-site Augustus F. Hawkins (AFH) inpatient psychiatric wards are located at the Augustus F. Hawkins Mental Health Center (AFHMHC) which is part of the MLK Multi-Service Ambulatory Care Center (MLK MACC) located on the Martin Luther King, Jr. Medical Center Campus. These wards are only inpatient psychiatric wards for patients without acute or emergent medical conditions. This is not a 911 receiving facility.

The MLK MACC, under the authority of the DHS Ambulatory Care Network, is responsible for the campus. This is a unique situation in which the AFH wards/beds are licensed under LAC+USC, occupied by LAC+USC patients, and staffed by LAC+USC employees, but the facility falls is under the jurisdiction and control of MLK MACC.

In an emergency, AFH will follow their Augustus F. Hawkins ERP, the LAC+USC EOP, and the LAC+USC Fire / Life Safety Manual. For evacuation, AFH will follow the AFH ERP and the MLK MACC Evacuation Plan since AFH is a tenant occupying only one floor of the AFHMHC. Systems and Services are provided and supported by LAC+USC or MLK MACC for which they are responsible, respectively. LAC+USC has a low threshold for establishing the HCC to support incidents at AFH. Communication and collaboration between AFH, LAC+USC, and MLK MACC will be maintained.

Refer to the AFH ERP for specifics.

Assumptions

The following assumptions can be made for LAC+USC regarding disasters and emergency operations:

1. Disasters will occur. They are low probability, but high consequence. Effective preparedness and planning can reduce the impact on the quality of patient care.
2. The LAC+USC Medical Center will activate the Hospital Incident Command System (HICS) to manage all incidents, both pre-planned and emergencies.
3. The hospital will establish a Hospital Command Center (HCC) as the location to manage all incidents, both pre-planned and emergencies.
4. Emergency operations centralize management (via HICS and the HCC) and decentralize operations to those departments (units, services) usually responsible for a particular function.
5. Response is incident driven.
6. The capability to respond to an incident is dependent on the concept of demand vs. resources. The possibility that a new standard of care for patient care may exist and the incident will be managed to provide the best for the greatest number of people.
7. An incident or event, whether natural or man-made, has the potential to cause an immediate demand for healthcare services in excess of normal demand. Consequently, those immediately non-essential services or day-to-day functions not directly related to an emergency response may be suspended and efforts (including staff and resources) redirected for the duration of the emergency if necessary.
8. An event may threaten, destroy, or seriously damage structural and or nonstructural parts of the facility. Partial or total evacuation of patients may be necessary depending on the magnitude of the event(s).

Emergency Operations Plan

Planning and Preparedness

Note: the annual HVA hard copy is in EOP Binder, and the electronic copy is on MS Teams: LAC+USC Hospital Command Center.

Note: The Emergency Management Program Annual Review hard copy is in the EOP Binder, and the electronic copy is on MS Teams: LAC+USC Hospital Command Center.

Emergency Operations Plan

Drills and Evaluations

BACKGROUND

The organization conducts exercises to assess the Emergency Operations Plan's appropriateness, adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises are designed to stress the limits of the plan to support assessment of the organization's preparedness and performance. The drill designs reflect likely disasters and test the organization's ability to respond to the effects of emergencies on its capabilities to provide care, treatment, and services.

SYSTEM

1. Drills and Exercises
    a. The hospital conducts 2 exercises per year to test the EOP.
        i. 1 of the annual exercises must consist of an operations-based exercise as follows;
            1. Full-scale, community-based; or
            2. Functional, facility-based (when a community-based is not possible)
        ii. The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
            1. Full-scale, community-based exercise: or
            2. Functional, facility-based exercise: or
            3. Mock disaster drill; or
            4. Tabletop, seminar, or workshop that is led by a facilitator
        iii. Note: If the hospital activates their EOP in response to one or more actual emergencies, these emergencies can serve in place of the next planned emergency response exercise. The hospital must provide documentation.
    b. Each accredited freestanding outpatient care building (that provides patient care, treatment, or services) will conduct at least 1 operations-based or discussion-based exercise per year to test its emergency response procedures, if not conducted in conjunction with the hospital's emergency exercises.
    c. The planned exercises are based on:
        i. Likely emergency or disaster scenarios
        ii. Emergency operations plan, policies, and procedures
        iii. After action reports and improvement plans
        iv. The 6 critical areas (communication, resources and assets, staffing, patient care activities, utilities, safety and security)
    d. As with a real incident as described in the section "Emergency Operations", drills and exercises also utilize and document use of:
        i. NIMS/HICS
        ii. Hospital Command Center
        iii. Incident Action Plan
        iv. Communication
        v. After Action Reporting
    e. Drill and exercises include:
        i. The annual Statewide Medical & Health Exercise is a full-scale, multi-disciplinary, functional drill. LAC+USC participates along with the Los Angeles Operational Area. Included are approximately 100 volunteer victims.
        ii. Code Triage surge response exercises are conducted at least monthly in the Emergency Department.
        iii. A Regional Coalition First Receiver Decon Drill is conducted annually.

iv. A Power Shut Down Drill placing the entire facility and electric diesel generator backup power is conducted annually.
v. Ad hoc drills, exercises, tabletops.

2. Evaluation
    a. Exercises are evaluated by designated observers.
    b. Exercises and incidents have de-briefings and evaluations by those involved.
        i. Users identify observations, deficiencies, and opportunities for improvement.
    c. All emergency exercise and incident response activities are documented.
        i. The Emergency Management Committee, Incident Commander, and Planning Section Chief collaborate to generate the After-Action Report and Improvement Plans.

3. Improvement
    a. The deficiencies and opportunities for improvement, identified in the evaluation of all emergency response exercises and all responses to actual emergencies, are communicated Senior Leadership who are responsible for designated actions.
    b. The Emergency Operations Plan is modified based on its evaluation of emergency response exercises and responses to actual emergencies.

ATTACHED
After Action Reports

Note: After Action Report hard copies are in the EOP Binder, and electronic copies are on MS Teams: LAC+USC Hospital Command Center.

Emergency Operations Plan

Emergency Operations

POLICY

The Emergency Operations Plan (EOP) is activated via the hospital emergency code: Code Triage [Internal, External]. EOP activation then necessitates establishing the Hospital Command Center (HCC) and implementing the Hospital Incident Command System (HICS).

SYSTEM

1. **Authority**
    a. The following hospital staff have the administrative authority to activate the EOP and initiate a Code Triage Alert, Code Triage Internal, and Code Triage External:
        - Administrative Officer of the Day (AOD)
        - Chief Executive Officer (CEO)
        - Chief Medical Officer (CMO)
        - Chief Nursing Officer (CNO)
        - Chief Operations Officer (COO)
        - COO Alternates:
            - Associate Hospital Administrator II
            - Acting Associate Hospital Administrator II
            - Facilities Management Administrator [Director]
            - Medical Center Unit Administrator II
        - Emergency Management Officer (EMO)
        - House Supervisor in coordination with the AOD
        - House Supervisor if AOD unavailable

    b. The following hospital staff has the administrative authority to initiate a Code Triage External:
        - Base Station MICN in coordination with the DEM ANM and the DEM Team Leader Team Leader if > 10 victims are expected to arrive from an MCI.

2. **Notifications**
    a. Code Triage Alert
        i. Purpose:
            1. To alert staff of an event that could potentially impact the facility in order to prompt an elevated level of awareness and assessment.
            2. Does not activate the EOP.
        ii. Criteria:
            1. An event has occurred or may occur that can potentially impact patient care, business continuity, facility infrastructure, or environment of care.
            2. Code Decon
        iii. Recipients:
            - SEC, AOD, NOD, MOD, House Supervisor, Patient Flow Manager, DEM

    b. Code Triage Internal
        i. Purpose: EOP activation in response to <u>internal</u> event.
        i. Criteria:
            1. Any internal event that has or is expected to impact patient care, business continuity, facility infrastructure, or environment of care.
            2. Any time that the number of patients has or is predicted to overwhelm the capabilities of the ED or hospital.

3. Emergency Codes:
    - Code Red
    - Code Silver
    - Code Yellow (credible threat)
4. Consider for Emergency Codes:
    - Code Orange
    - Code Pink
    - Code Purple

ii. Recipients:
- All Staff, i.e., HCC Staff, SEC, AOD, NOD, MOD, House Supervisor, Patient Flow Manager, Nurse Managers, Service Chiefs, LASD, DEM ANM/EFC

c. Code Triage External

i. Purpose: EOP activation in response to an external event.

ii. Criteria:
1. Any external event that has or is expected to impact patient care, business continuity, facility infrastructure, or environment of care.
2. Any time that the number of patients has or is predicted to overwhelm the capabilities of the ED or hospital.
3. Any incident (medical or trauma) with > 10 victims expected to arrive
4. Consider for:
    - Code Decon
    - Healthcare Emergency, i.e., novel type or emerging infectious disease
    - Multi-Casualty Incident (medical, trauma, or CBRNE)
    - NEDOCS Level: Dangerously Crowded (black)

iii. Recipients:
- All Staff, i.e., HCC Staff, SEC, AOD, NOD, MOD, House Supervisor, Patient Flow Manager, Nurse Managers, Service Chiefs, LASD, DEM Staff

3. **Notification Procedure**

a. Call Telephone Office (x0, x94902, x111)

i. Request Page
1. Cisco phone speaker paging system
2. Overhead paging
3. Startel system

ii. Provide information
1. Name and administrative authority
2. Code Triage type: Internal, External

iii. Telephone Office will proceed with page: Code Triage Alert, Code Triage Internal, or Code Triage External

b. Call Enterprise Help Desk (x98000)

i. Request Everbridge Notification (all Code Triage types)
1. Provide:
    a. Name and administrative authority
    b. Code Triage type: Alert, Internal, External
    c. Event information
        i. Specific incident or hazard, if known
        ii. Location of incident
        iii. Number of casualties
        iv. Number of casualties expected to arrive

2. EHD will go to Everbridge>Notifications>Notification Template, locate the Code Triage type, input the event information, and send.

ii. Request Outlook 365 Broadcast Notification (for Internal or External)

1. Provide: Code Triage type: Internal, External

BACKGROUND

The facility manages all incidents (pre-planned, emergency, or disaster) utilizing the *Hospital Incident Command System v2014 (HICS*) which is the incident management system for hospitals under the *National Incident Management System (NIMS*) and is the standard for incident command throughout the United States. This system allows for a unified command structure, job responsibility, and common language consistent with governing agencies and other healthcare organizations within the community, county, region, state, and nation. This promotes efficient communication, coordination, and response. The guiding management principle of HICS IS "Management by Objectives": a problem encountered is evaluated, a plan to remedy the problem is identified and implemented, and the necessary resources are assigned. HICS centralizes management and decentralizes operations.

SYSTEM

III. Incident Management Timeline

1. Incident occurs.
2. Situation assessment.
3. Implement the EOP.
4. Activation and notification per protocol
5. HCC established.
6. HICS activated.
7. Command established.
8. IAP prepared and implemented.
9. Response-Evaluate-Corrective Actions
10. Demobilization
11. After Action Report Planning Activities
12. De-activation: Code Triage – All Clear
13. Response Evaluation
14. System Recovery

II. Hospital Command Center (HCC)

2. Location:
    a. HCC Primary: D&T 2F211 / B2F10
    b. HCC Back-up: IPT Conference Room C

3. Access
    a. HCC Primary: D&T 2F211
        i. Security Card Reader for HCC Staff
        ii. Key (Security)
    b. HCC Backup: IPT Conference Room C (keys to the room and the supply cabinet).
        i. Business hours: Executive Administration (Sylvia Perez, x94242)
        ii. After hours: LASD Dispatch Center (OPD 3P52, x91111) or Administrative Nursing Office (x96747)
        iii. Note: Establishing the HCC during an event has priority. Any meetings being held or scheduled in Conference Room C will be immediately put on hold and relocated per protocol.

4. Contact Numbers
    a. HCC Primary
        i. Phone (Cisco – primary digital): 409-1443
        ii. Other extensions: individual lines per each phone
        iii. Phone (Centrex – back up analogue): 441-4342
        iv. Fax: 441-4343
    b. HCC Back-up
        i. Phone (Cisco – primary digital): 409-1443
        ii. Other extensions: individual lines per each phone
        iii. Phone (Centrex – back up analogue): 21443
        iv. Fax: 441-8196

5. Set-up:
    a. Primary HCC: Turn-key.
    b. Back-up HCC
        i. Detailed instructions for the physical environment and procedure are located in a binder in Cabinet A (left side).
        ii. The cabinets contain:
            1. Command Vests with Job Action Sheets (JAS), HICS forms, clipboards
            2. Reference materials
            3. Phones
            4. Computers (desktops, laptops, accessories)
            5. Printer/fax machine, and stationary
            6. Information Systems should be contacted to assist with set-up (Help Desk: 409-8000).

III. Hospital Incident Command System

1. Establish Command
    a. The most capable/qualified HCC staff person assumes the role of incident commander (IC).
    b. Note: Authority can be passed to more qualified staff as additional support arrives.

2. Incident Briefing
    a. The IC briefs the HCC Staff on the incident.

3. Delegate Roles
    a. The IC appoints the Command and General Staff
    b. Section Chiefs appoint Branch Directors and Unit Leaders
    c. Note: See following tables for HICS positions and recommendations.

4. HICS Tools
    a. HICS Forms, Job Action Sheets, Incident Response Guides, HICS Guidebook
    b. Locations
        i. Intranet Homepage > Departments > Clinical Services > Emergency Management
        ii. HCC computers > Desktop > HICS File
        iii. HCC filing cabinet

5. Responsibilities:
    a. HCC Staff (All)
        i. Put on respective HICS vests
        ii. Read and use respective Job Action Sheets (JAS)
            1. Used continuously throughout event
            2. Should transfer to replacement and actions continued
        iii. Document using appropriate HICS Forms per JAS.

1. Fillable pdfs.
    a. Save to desktop as "Year-Month-Day Time HICSXXX"
2. Paper forms: If IT outage

iv. Staff responsible for delegated role until formally relieved
v. Staff to remain through to Response Evaluation

b. Command and General Staff
    i. Assure implementation of pertinent existing Medical Center and Service/Unit policies and response plans
    ii. Review pertinent HICS Incident Response Guidelines as needed.
    iii. Prepare, implement, and publish the *Incident Action Plan*. See below.
    iv. Evaluate *Sustainability* of Essential Capabilities.
        1. See section on Sustainability.

6. Incident Action Plan (IAP)
    a. Purpose: Formal Documentation that provides a common set of objectives for the HCC staff, enhances communication, provides a tool for evaluation of objectives and response effectiveness, and provides a written archive of actions
    b. Responsibility:
        i. Prepared by the Planning Section Chief
        ii. Approved by the IC.
        iii. Discussed by the Command and General Staff
    c. Procedure:
        i. Assess the Situation
        ii. Set the Operational Period
        iii. Determine overall priorities
        iv. Establish specific, measurable, attainable incident objectives
        v. Determine Branch / Section Objectives
        vi. Identify Needed Resources
        vii. Issue Assignments
        viii. Prepare and publish the IAP
            1. HICS Incident Action Plan (IAP) Quick Start: combinations of HICS 201, 202, 203, 204, 215A
        ix. Implement Actions
            1. Direct and monitor
        x. Reassess and Evaluate:
            1. Determine if objectives are being achieved, safe, effective, current & relevant
        xi. Initiate corrective actions and revise IAP as needed.

7. Demobilization
    a. Process begins as operations are returning to normal
    b. HCC staff to finalize all documents
    c. All documents submitted to Planning Section Chief

8. After Action Report (AAR) Planning Activities and Response Evaluation
    a. Initiated during Demobilization
    b. Completed after De-activation.
    c. Responsibilities
        i. All HCC Staff
            1. Provide objective, authoritative, and relevant data and observations
        ii. Planning Section Chief, Documentation UL, Emergency Manager
            1. Develop a report that provides a description of the incident or exercise in a narrative

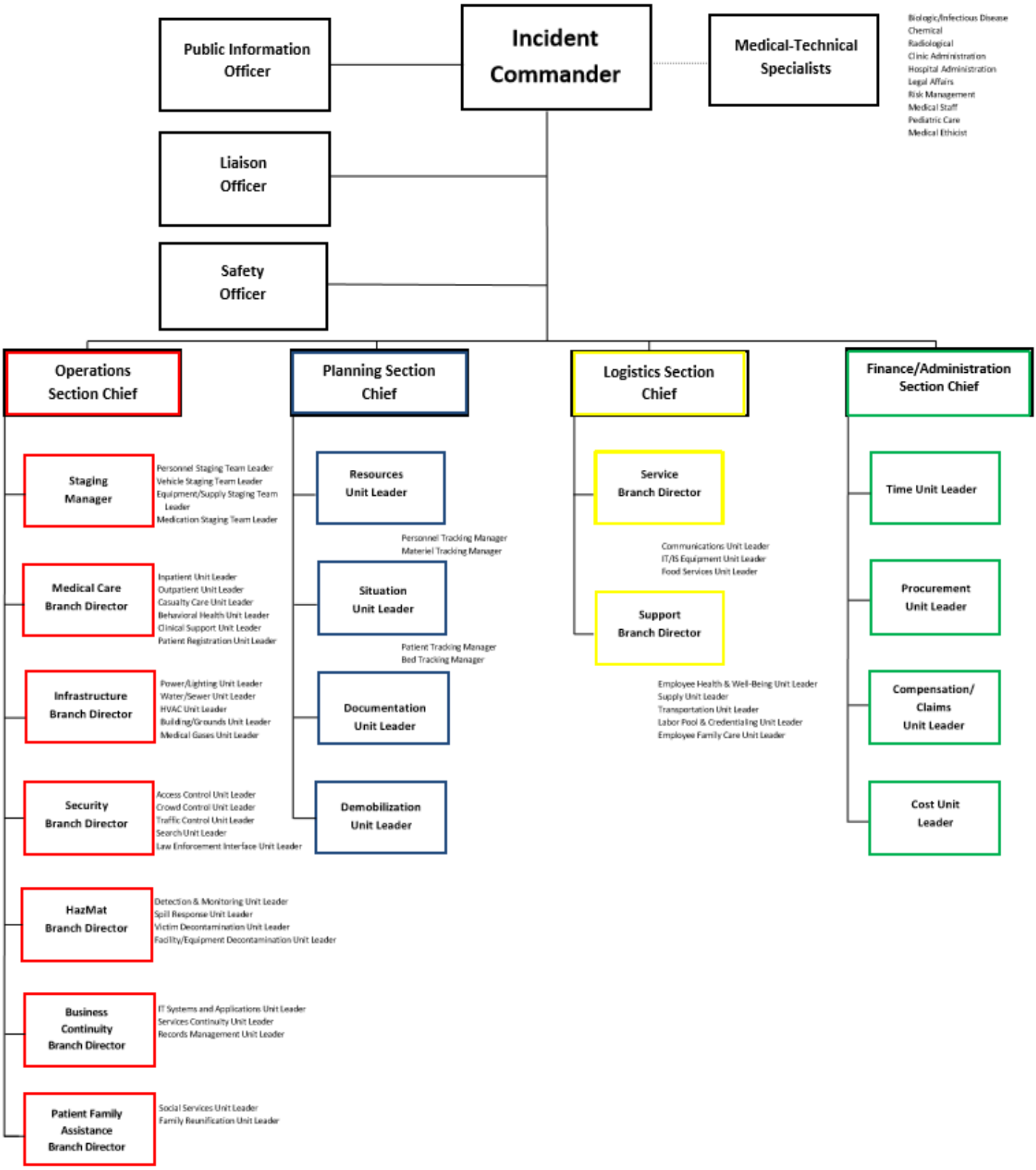
2. Describe objective issues, both positive and negative
3. Develop actionable recommendations to improve the response and recovery plans

9. De-activation: Code Triage All Clear
    a. Ends HCC functions
    b. Administrative authority: Incident Commander

10. System Recovery
    a. Depending on nature and effects of incident, system recovery may be immediate, short, or long-term
    b. Depending on nature and effects of incident, the HCC may or may not need to be established for short- or long-term recovery efforts.
    c. Assess financial costs. Seek reimbursement as indicated, e.g., FEMA.

ATTACHED
HIMT – Organizational Chart
HIMT – Potential Candidates for HIMT Positions

Hospital Incident Management Team



HOSPITAL INCIDENT COMMAND SYSTEM

HICS 2014

Table 1. Potential Candidates for HIMT Positions

HIMT Position	Hospital Position
Incident Commander	• Hospital Administrator/Administrator On Call • Nursing Supervisor • Chief Operating Officer • Chief Medical Officer • Chief Nursing Officer • Emergency Program Manager • Chief Executive Officer (CEO)
Public Information Officer (PIO)	• Hospital Public Information Officer (PIO) • Marketing Director • Patient Relations • Hospital Administrator/Administrator On Call • Safety Director • Chief Engineer
Safety Officer	• Safety Director • Security Chief • Building Engineer • Emergency Management Coordinator • Radiation Safety Officer • Employee Health • Infection Control • Risk Management • Industrial Hygienist
Liaison Officer	• Chief Executive Officer (CEO) • Emergency Management Coordinator • Risk Management • Chief Information Officer • Community Relations
Medical-Technical Specialist(s) **Medical-Technical Specialist(s)**	• Industrial Hygienist • Infectious Disease Specialist • Infection Preventionist • Epidemiology • Chief of Staff • Chief of Pediatrics • Radiation Safety Officer • Nuclear Medicine • Health Physicist • Structural Engineer • Outpatient Services Administrator • Chief of Trauma • Primary Care Director • Behavior Health Director

HOSPITAL INCIDENT COMMAND SYSTEM

4 – Hospital Incident Management Team

HIMT Position	Hospital Position
(continued)	• Legal Counsel • Risk Manager • Poison Control Director • Information Technology/Information Services (IT/IS) Director
Operations Section Chief	• Chief Operating Officer • Chief Medical Officer • Chief Nursing Officer • Nursing Supervisor • Emergency Management Coordinator
Planning Section Chief	• Strategic Planning • VP of Administration • Human Resources Director • Nursing Director • Chief Nursing Officer • Nursing Supervisor • VP of Facilities • Emergency Management Coordinator
Logistics Section Chief	• Chief Procurement Officer • Support Services Director • Supply Director • Chief Operating Officer • Facilities Director • Warehouse Director
Finance/Administration Section Chief	• Chief Finance Officer • VP of Finance • VP of Business Services • VP of Administration • Controller/Comptroller • Chief Information Officer

BACKGROUND

The hospital establishes English as the plain language communication standard and consistent terminology for use during emergencies. The hospital maintains reliable communications capabilities for the purpose of communicating response efforts to staff, patients, visitors and external organizations. The hospital establishes backup communications processes and technologies (for example, cell phones, landlines, bulletin boards, fax machines, satellite phones, Amateur Radio, text messages) to communicate essential information if primary communications systems fail.

The following are the standard, redundant, and emergency communications systems. Responsibility for these systems includes Information Systems, Telephone Office, Base Station, and OEM.

1. Telephone Office
    - Function
        i. Call Center
        ii. Directory
        iii. Paging Overhead
        iv. Paging via Cisco phone speaker system
        v. Paging via legacy pagers
        vi. Coordinates all Hospital Emergency Code Activations
        vii. Overhead Paging
    - Systems
        i. Startel Notification System
        ii. USA Mobility Paging System

2. Telephone System
    - Centrex
        i. Analogue lines (emergency red phones)
        ii. Digital lines (black, non-Cisco phones)
    - VoIP (voice over internet protocol)
        i. Cisco Call Manager (computer based, connectivity to AT&T)
        ii. Wired and wireless.

3. Internet-based Systems
    - E-mail
        i. Outlook Office365
    - Everbridge: L.A. County Medical and Health Notification System
        i. Notification system – includes polling, quota
        ii. Subscription paid for by DHS/EMSA
        iii. Includes all DHS employees
        iv. Contact IS Help Desk (98000): reference LAC+USC Everbridge

4. Intranet-based Systems
    - E-mail: Outlook Office365
    - Broadcast Notifications: Contact Is Help Desk (98000)

5. VMED28 (formerly Hospital Emergency Administration Radio) – 155.340.156.7 MHz
    - Location: Base Station
    - Function:

i. Communication for central dispatch, paramedic ambulances, and radio-equipped vans.
ii. Capability to transmit outside our complex and is to be used when other means of communication such as the ReddiNet and telephone are operational.

6. ReddiNet (Rapid Electronic Digital Data Information Network)
   - Location: Any PC, i.e., Base Station, HCC, House Supervisor, FAC
   - Function:
     i. Internet-based, Satellite transmission
     ii. Program providing regional hospital status to the Medical Alert Center which becomes the Medica Coordination Center (MCC) during a disaster. This includes information on facility damage, bed availability, staffing, regional tracking of transported patients, and resource requesting.
     iii. Participants: hospitals, clinics, first providers

   - Polling:
     i. Bio surveillance: Daily 0900
     ii. Facility Service Level Assessment: 2 x / month, emergency
     iii. HAvBED: Daily 0900, 2100
     iv. MCI: 2 x / month, emergency
     v. NDMS Hospital: Long Beach VA per HAvBED data

7. CWIRS (County-Wide Integrated Radio System)
   - Location: CEO, HCC
   - Function: Radio system that connects all county DHS facilities when other means of communication are non-functional.
   - Testing: Monthly via EMSA

8. HAM Radio – Amateur Radio Frequency 147.27 (Simplex)
   - Location: HCC
   - Function: last resort communications modality.
   - Operation
     i. ARES (Amateur Radio Emergency Service) Representative
     ii. Staff that are licensed Ham Radio Operator
     iii. Unlicensed staff may operate in catastrophic disaster
     iv. Laminated instructions in HCC
   - Testing: annually

9. Satellite Phone: through ReddiNet satellite
   - Location: HCC
   - Function: standard phone capability
     i. Satellite Radio: Interoperable communication between county DRCs and the EMSA.
     ii. Satellite Phone: Usual phone communication
   - Operation
     i. Phone #: 323-250-9201
     ii. Note: direct dial
   - Testing: Quarterly via EMS Agency

10. Motorola Talk-About
    - Location: HCC (6), Disaster Storage (6).
    - Function: Handheld non-FCC walkie-talkies.

11. Other
    - Private mobile phones, Runners

SYSTEM

1. **Incident Command Staff Communication Algorithm**
    a. Incident Commander
        i. CEO > DHS, Regulatory Agencies
    b. Public Information Officer
        i. Staff
        ii. Visitors and Family
        iii. Local Joint Information Center (collaborate on risk communication messages and consistent content)
        iv. Other Hospital PIOs
        v. Media
    c. Liaison Officer
        i. Supporting agencies: MAC, MCC
        ii. Counterparts in cooperating agencies and regional hospitals
        iii. Facility needs and requests for assistance
    d. Safety Officer
        i. Law enforcement, local community public safety agencies
    e. Med / Tech Specialists
        i. Local EOC Health and Medical Services Branch
        ii. Public Health
        iii. Community Resources

2. **Public Information Officer**
    a. The *Public Information Officer (PIO)* is responsible for coordinating information sharing inside and outside the facility.
    b. The PIO is appointed by the Incident Commander (IC).
    c. The PIO serves as the conduit for information to internal / external stakeholders, including staff, visitors and families, and the news media, as approved by the Incident Commander
    d. Duties:
        i. Determine parameters and any restrictions in content (sensitive material) of information released. Any information released must be approved by the IC.
        ii. Collaborate with local community officials (Joint Incident Command, i.e., County EOC) on risk communication messages for consistent content.
        iii. Maintain contact with Situation Unit Leader for current information and facility status.
        iv. Schedule regular media briefings and press releases.
        v. Note: Communications with the community and media are to be conducted only under the approval of the Incident Commander, CEO (designee) and/or Emergency Manager in collaboration with the County EOC. It is paramount that any information put forth is accurate and congruent with authorities that locally, regionally and or nationally are managing the event. Specific patients who are involved and/or victims are not to be mentioned by name nor are their families.

3. **General Staff Communications**
    a. Assumptions
        i. Communication and information gathering and dissemination
            1. Will follow proper chain of command.
            2. Modalities include standard capabilities and alternate methods listed above.
        ii. Communication delivery to staff is verified by Administrator > Area Director > Supervisor/Manager > Line staff.
    b. Communication and information dissemination to staff performed via:

i. Telephone Office, and
ii. Information Systems as previously described.

c. The PIO is the conduit for official communication and information dissemination to staff and is responsible for:
i. Staff notifications, instructions, and updates
ii. Publishing the IAP and IAP revisions

4. **External Authorities**
a. As a county healthcare facility, notification of an internal/external disaster is made to the MAC / MCC.
i. Responsibility:
1. Base Station MICN
2. House Supervisor (Administrative Nursing Office)
3. Liaison Officer (HCC)
ii. Methods:
1. ReddiNet
a. HAvBED, Facility Service Level Assessment, MCI Polls
b. Updates/Messaging
2. Standard Methods: telephone, fax, CWIRS, etc.
a. Phone
i. 866-940-4401
ii. 562-347-1789
b. FAX
i. DOC: 562-944-5248
ii. MAC: 562-906-4300
b. For medical or health related incidents in which the County EOC has been activated, the MAC activates and manages the Medical Coordination Center (MCC).
c. The MCC reports to the County EOC.
d. The County EOC reports to the Regional and State EOC.

5. **Patient, Family, and Visitor Communication**
a. Patient information sharing criteria:
i. There is specific patient approval.
ii. There is a legal guardian of a minor or mentally disabled person.
iii. There is approval from the County EOC which has operational area control of disasters within the county.
1. All patient information releases must comply with HIPPA regulations unless otherwise directed by the MCC or County EOC based on a new standard of care.
iv. Utilizing Patient Confidentiality Regulations congruent with the Health Information Patient Portability Act (HIPPA), the names of patients and deceased may be released.
b. Regarding patient inquiries:
i. Staff must verify the identity of the requesting party and the identity of the patient.
ii. Information can be shared per above criteria.
iii. If criteria not met, information that a patient is present is the only information that can be provided.
c. The *Family Assistance Center (FAC)*
i. May be established for the purpose of family reunification, support, and information dissemination. This will be the central point for visitors and family members to be updated on events and locate patients.
ii. The PIO (see above) will provide scripted messages (concerning the type of event that has occurred and actions that will be taken) to patients, family, significant others.

1. Messages from the PIO to patients will be delivered by the clinical staff caring for the patient so there is an opportunity for patients to ask questions.

iii. See ERP: Family Assistance Center.

6. **The Media**
   a. The HCC will establish a Media/Press Room separate from administration, the FAC, and patient care areas.
   b. The Security Branch Director will ensure presence of the LASD in this briefing area.
   c. The PIO will provide information to the media as described above.

7. **Suppliers of Essential Services and Supplies**
   a. All efforts will be made to contact purveyors utilizing established lines and methods of communication.
   b. The Logistics Officer and Liaison Officer may contact suppliers when normal lines of communication are ineffective or overwhelmed.
   c. Alternate methods of communication may be utilized when normal methods of communication are not functional.

8. **Regional Healthcare Organizations**
   a. The Liaison Officer is responsible for communications with regional health care organizations.
   b. Community partners and mutual aid may be required regarding staffing, patient needs, patient identification, and resources and assets.

9. **Patient Information to Third Parties**
   a. Third Parties: other health care organizations, local/state health departments, CDC, police, FBI, Homeland Security)
   b. Patient information may be shared per existing protocol.
   c. All requests beyond these require approval of the HCC, MCC, and County EOC.

10. **Alternate Care Sites**
    a. Standard and redundant systems as needed whether on- or off-site alternate care site
    b. If patients are to be transported to an off-site alternate site and the electronic medical records are not available at that site, the patient chart, if feasible, will be sent and downtime procedures implemented at that site.

ATTACHED
Emergency Communications and Succession Plan for External Partners

APPENDIX
LAC+USC Contact List

Emergency Communications and Succession Plan for External Partners

Incident Notification, Messaging, and Assessment Polls	
Type of Healthcare Facility	**System Priority**
Hospitals	1) ReddiNet 2) VMED28: 155.340.156.7mHz 3) Email: laemsadutyofficer@dhs.lacounty.gov 4) Telephone: MAC (866) 940-4401 5) Fax: DOC (562) 944-5248; MAC (562) 906-4300 6) CWIRS Radio: for County-operated hospitals 7) HAM radio (Frequency List available by request) 8) Satellite Radio: For DRCs
Clinics	1) Will be coordinated through the Community Clinic Association of LA County (213-201-6500) 2) ReddiNet – for clinics with access 3) Email: laemsadutyofficer@dhs.lacounty.gov 4) Everbridge 5) Telephone: MAC (866) 940-4401 6) Fax: DOC (562) 944-5248; MAC (562) 906-4300 7) CWIRS Radio: for County Comprehensive Centers 8) HAM radio (Frequency List available by request)
Skilled Nursing Facilities	Will be coordinated through the Department of Public Health DOC and/or Health Facilities Inspection Division (800-228-1019 or 213-989-7140)
Dialysis Centers	ESRD Network 18: (800) 637-4767
Ambulatory Surgery Centers Home Health / Hospice Agencies	1) Email: laemsadutyofficer@dhs.lacounty.gov 2) Telephone: MAC (866) 940-4401 3) Fax: DOC (562) 944-5248; MAC (562) 906-4300 4) HAM radio (Frequency List available by request)
EMS Providers	1) HEAR: 155.340mHz 2) Telephone: MAC (866) 940-4401

Resource Requests	
Type of Healthcare Facility	**System Priority**
Hospitals	1) ReddiNet (message attachment to MAC) 2) Fax: DOC (562) 944-5248; MAC (562) 906-4300 3) Email: laemsadutyofficer@dhs.lacounty.gov 4) Telephone: MAC (866) 940-4401 5) HEAR: 155.340mHz 6) HAM radio (Frequency List available by request) 7) Satellite Radio: For DRCs only 8) CWIRS Radio: for County-operated hospitals

Clinics	1) ReddiNet (message attachment to MAC) – if available 2) Fax: DOC (562) 944-5248; MAC (562) 906-4300 3) Email: laemsadutyofficer@dhs.lacounty.gov 4) Telephone: MAC (866) 940-4401 5) HAM radio (Frequency List available by request)
Skilled Nursing Facilities	Will be coordinated through the Department of Public Health DOC and/or Health Facilities Inspection Division (800-228-1019 or 213-989-7140)
Dialysis Centers Ambulatory Surgery Centers Home Health / Hospice Agencies	1) Fax: MCC (562) 944-5248; MAC (562) 906-4300 2) Email: laemsadutyofficer@dhs.lacounty.gov 3) Telephone: MAC (866) 940-4401 4) Amateur radio: See frequency list
EMS Providers	1) HEAR: 155.340mHz 2) Telephone: MAC (562) 347-1789

BACKGROUND

Staff roles are defined in advance via required training and response plans. Staff are oriented in their assigned responsibilities. Due to the dynamic nature of emergencies, staff responsibilities may adjust to changes in patient volume or acuity, work procedures or conditions, and response partners within and outside the hospital.

SYSTEM

1. **Staff Training**
    a. New Employee Training (ALL Hires)
        i. *Fires Safety Training / Emergency Preparedness* Training (EP*T)*: 4 hours
            1. LAFD Regulation: approved instructor led class, 4 hours, ever 4 years
        ii. *Disaster Service Worker (DSW) Awareness Training*
            1. Objective: for the county employee to understand their role in a disaster including all county employees are expected to report to work in the event of a disaster (DHS Policy 911).
        iii. *Workplace Violence Prevention*
            1. Includes active shooter
        iv. *LAC+USC Orientation/Reorientation Handbook*
            1. Includes: patient safety, emergency codes, security, security awareness, bomb threats, hazardous materials, emergency preparedness and management, emergency transport, life (fire) safety
        v. *Employee Safety Handbook* (signed off via In-Processing Checklist): pp39-42
        vi. *Area/Unit Orientation Checklist - Sec 4*: Area Fire; Life Safety; Emergency Preparedness; Security
    b. Recurrent Training (ALL Staff)
        i. *Fires Safety Training / EPT*: 4 hours every 4 years
        ii. *LAC+USC Orientation/Reorientation Handbook*
            1. Annually with Performance Evaluation or appointment/reappointment for attending staff privileges.
        iii. *Employee Monthly Education Program*. Includes:
            1. Hazardous Materials, Fire Safety
            2. Disaster Management
            3. Security
    c. First Receiver Decon Team
        i. Team consists of ED personnel and volunteers from other departments.
        ii. Deconners have all received First Receiver Decon Operations Level Training via the EMSA or OEM.
        iii. Team meetings/exercises monthly, drill/proficiency annually.
    d. HCC Staff
        i. HCC Staff are required to take a 3-part formal Emergency Operations training provided by the OEM. Course completion statistics are documented elsewhere. Curriculum includes:
            1. County Disaster Management
                a. NIMS and NRF
                b. Background: Fed > State > County
                c. County / Operational Area Resources
                d. Coalition Programs, Partners, and Mutual Aid
                e. Emergency Management: Healthcare Facilities

2. HICS
    a. Overview
    b. Incident Management Team
        i. HICS Tools
            1. HICS Forms
            2. Job Action Sheets
            3. Incident Response Guidelines
        ii. IMT Roles & Responsibilities
        iii. Incident Action Planning
        iv. Demobilization, Reconstitution, and Recovery
        v. After Action Reporting
3. Emergency Operations
    a. Review of the EOP
    b. Tabletop Exercise

ii. HCC Staff are required to attend an annual update.

e. NIMS [11-point] Implementation for Healthcare Organizations Guidance
    i. IS-100.C: Intro to ICS (or historical equivalent): all HCC staff.
    ii. IS-700.B: Basic ICS for Initial Response (or historical equivalent): all HCC staff.
    iii. IS-200.C: Intro to NIMS (or historical equivalent): all HCC command staff.
    iv. IS-800.D: Intro to NRF (or historical equivalent): OEM staff.
f. Drills and Exercises
    i. These are discussed in the previous section.
g. Just-in-Time Training
    i. During a disaster, staff may be called upon to perform a task not within the normal activities.
    ii. Capable personnel may receive "just-in-time" training to function in these roles. Direction will come from the HCC, department heads, and/or unit managers.

2. **Staff Roles and Responsibilities in Emergencies**
    a. HICS, the HCC, and the HIMT
        i. HICS has well defined roles, responsibilities, and clear reporting channels.
        ii. The IC appoints the Command Staff and the 4 Section Chiefs as necessary to support the event.
        iii. The Section Chiefs, likewise, appoint their Branch Directors who appoint their Unit Leaders, again, as necessary to support the event.
        iv. HICS, the HCC, and the HIMT function and responsibilities have been previously detailed in that section.
    b. Medical Center Staff
        i. During an incident, all staff are required to report to their duty station and direct line of authority. This includes:
            1. County and Contracted Employees
            2. Administrative, Medical, Nursing, and Ancillary Staff
            3. Residents and Fellows in Meetings, in Grand Rounds, on Call, or on Elective.
        ii. Staff will respond, be held-over, and/or called-in as needs dictate.
        iii. During an incident, all departments, units / services should implement their respective unit-/service-based procedures.
        iv. The unit/service managers along with the department directors evaluate their specific service area's needs and current staffing. They will be assigned to those areas most needed to support the emergency.
        v. All units/ services report their status, which includes available personnel, to their department director. This information is forwarded to the HCC via their respective Operations branch.

vi. Non-essential services or day-to-day functions not directly related to an emergency response may be suspended for the duration of the emergency if necessary.
vii. Personnel may be reassigned to different locations.
viii. Personnel may be required to perform duties not related to their normal assignment (but not above their capability).
1. Just-in-time training may be necessary.
2. The overseeing unit or service will be responsible for this function.

3. **Identification of Staff, LIPs, and Authorized Volunteers in Emergencies**
a. HCC Staff:
i. Command Staff, General Staff, and Branch Directors wear the appropriate HICS vest for rapid identification of the individual holding that position.
b. Medical Center Staff:
ii. All staff (LIPs, LDPs, staff, registry staff, and volunteers) have displayed picture identification badges issued by Human Resources
iii. Personnel not wearing the above identification badges are to be immediately reported to the LASD / Allied Universal
iv. Security and are not to be left alone with patients or in areas where they cannot be supervised.
v. Specific policies referenced below.

4. **Staff Support Needs during Emergencies**
a. Purpose:
i. As needed, accommodations to be arranged for staff including sleeping areas, rest areas, child/dependent care, pet care, incident stress debriefing, hygiene, meals and communication. Additionally, such accommodations enable the employee to be at the hospital to provide needed services.
b. Responsibility: HCC Logistics Section: Service and Support
c. Transportation:
i. Arrangements may be made to transport staff to and from work if conditions permit. The hospital has a van and a truck that could be used for this purpose.
ii. Additional arrangements with transportation companies (i.e., bus, taxi) if available.
d. Sleeping and Sleeping Accommodations:
i. A sleep schedule will be devised by the unit / service director.
ii. An area will be designated.
iii. Military cots are available. Linen and hygiene supplies are maintained for this use.
e. Meals:
i. As needed, food service for staff will be authorized by the HCC.
ii. Food and Nutrition Services has included staff meal support in their disaster food service plan.
f. Stress Debriefing:
i. *Mental Health and Well-Being Unit*.
1. HCC will initiate as needed to aid patients and staff
2. Areas will be identified and staffed by hospital staff, Social Services, Behavioral Medicine, Pastoral Services, Palliative Care, and others trained in stress debriefing.
ii. *County of Los Angeles Employee Assistance Program*
1. Additional resources for county employees including counseling for emotional stress, anxiety, marital/family discord, bereavement/loss, alcohol & drug problems, and interpersonal issues.
2. 213-738-4200
3. http://ceo.lacounty.gov/EAP/default.htm

g. Family Accommodations:
    i. May be made available in those unusual situations where families must come to enable staff to be present for emergency services coverage. These services will normally be arranged prior to families arriving at the hospital.
    ii. Staff that needs such accommodations for their dependents, such as a child or adult, will provide this information to their director who will inform logistics.

REFERENCE

County of Los Angeles DHS Employee Safety Handbook
County of Los Angeles DHS Policy #911, Attachment: Employee Responsibilities During Emergencies
County of Los Angeles DHS Policy #911: Role of DHS Employees in the Event of an Emergency
County of Los Angeles DHS Policy: Non-County Workforce Comprehensive Policy Statement (CPS)
LAC+USC Area/Unit Orientation Checklist
LAC+USC Employee Monthly Education Program
LAC+USC Fire Life Safety / Emergency Preparedness Training
LAC+USC Medical Center Attending Staff Association Policy #110: Disaster Privileges for Volunteer Licensed Independent Practitioners
LAC+USC Medical Center Policy #511: Photo Identification Badges
LAC+USC Medical Center Policy #541.1: Disaster Privileges for Volunteer Licensed Dependent Practitioners
LAC+USC Orientation Review Handbook

BACKGROUND

When the hospital activates the EOP in response to a disaster and the immediate needs of its patients cannot be met, the hospital can use volunteers and volunteer practitioners to meet these needs. Practitioners may be volunteer licensed independent practitioners (LIP) or licensed dependent practitioners (LDP) or volunteer practitioners who are not licensed independent practitioners but who are required by law and regulation to have a license, certification, or registration to meet these needs.

If the usual credentialing and privileging processes cannot be performed because of the disaster, the facility may use a modified credentialing and privileging process for eligible volunteer practitioners. While this standard allows for a method to streamline the process for determining qualifications and competence, safeguards must be in place to assure that the volunteer practitioners are competent to provide safe and adequate care, treatment, or services. Even in a disaster, the integrity of two specific parts of the usual process for determining qualifications and competence must be maintained:

1. Verification of licensure, certification, or registration required to practice a profession
2. Oversight of the care, treatment, and services provided

Federal, state, and local agencies are engaged in pre-event verification of qualifications which can facilitate the assigning of disaster privileges to volunteer licensed independent practitioners at the time of a disaster. These are:

1. *ESAR-VHP*: Emergency System for Advance Registration of Volunteer Health Professionals
    a. Federal program created by the Health Resources and Services Administration (HRSA) which allows for the advanced registration and credentialing of health care professionals needed to augment a hospital or other medical facility to meet increased patient/victim care and increased surge capacity needs.
    b. www.phe.gov/esarvhp
2. *DHV*: Disaster Health Volunteers
    a. CA State ESAR-VHP.
3. *L.A. County DHV/MRC*: Los Angeles County Disaster Health Volunteers/ Medical Reserve Corps
    a. L. A. County ESAR-VHP.
    b. MRC / Surge Units are comprised of locally based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism.
    c. www.lacountydhv.org/surgeunit

SYSTEM

Refer to the following attached Medical Center policies.

ATTACHED

LAC+USC Medical Center Attending Staff Association Policy #110: Disaster Privileges for Volunteer Licensed Independent Practitioners
LAC+USC Medical Center Attending Staff Association Policy #110-A: Roster of Practitioners Granted Disaster Privileges
LAC+USC Medical Center Policy #541.1: Disaster Privileges for Volunteer Licensed Dependent Practitioners
LAC+USC Medical Center Policy #541.1-A: Roster of Practitioners Granted Disaster Privileges

REFERENCE

LAC+USC Medical Center Bylaws of the Attending Staff Association

Note: Attending Staff Association Policy ASA110/110-A and Medical Center Policy MC541.1/541.1-A hard copies are in the EOP Binder, and electronic copies are on the intranet.

Emergency Operations Plan

Emergency Operations: Environment of Care

BACKGROUND

The LASD and Allied Universal systematically manages all security matters related to the safe operation of the all the LAC+USC Medical Center and Campus

The Los Angeles County Sheriff's Department (LASD) manages law enforcement on the health facility campus. This is accomplished utilizing their sworn deputies trained to LASD standards. A sergeant is the executive director on-site and reports to a lieutenant who is the regional director.

Allied Universal Security Services (a private security firm) provides security for the facility. Organizationally, Allied Universal is under the Facilities, and reports to DHS. They are posted at all pedestrian and vehicular entry points providing ingress/egress security. All visitors are screened. Allied Universal responds to behavioral response calls. They assist in lockdown procedures. They coordinate with the LASD.

SYSTEM

1. **Hospital Security**
    a. Authority
        i. Incident Command
        ii. LASD may initiate per department policy
        iii. DEM may initiate per ERP DEM protocol
    b. Criteria: incident-driven
    c. Command Structure
        i. During an emergency, the LASD will establish their Subcommand Post.
        ii. Security Director for Allied Universal will be appointed as the Security Branch Director under Operations in the HCC.
        iii. LASD coordinates security, safety, and law enforcement activities with outside agencies per their existing policies and procedures regarding jurisdictional authority.
            1. The event may be under Federal jurisdiction, i.e., Military, FBI, and Homeland Security. The LASD, HCC, and the EOC will coordinate with their respective liaison and through existing policies and procedures.
            2. The event may be under Fire Department jurisdiction. The LASD and HCC will coordinate with the FD liaison and through existing policies and procedures.
        iv. Recovery: The LASD manages security through to return of normal operations.
    d. Facility Lockdown
        i. This could include any and all pedestrian and/or vehicle ports of entry.
        ii. This could encompass a building, the facility, or the entire campus.
        iii. Hospital staff, wearing appropriate identification, will be permitted ingress.
        iv. Outside agency visitors may be allowed ingress per direction of the HCC.
        v. Searching all persons and vehicles for contraband.
        vi. All staff: Maintain heightened security and awareness throughout the event.
    e. Re-directing Traffic.
        i. Streets and parking may be closed, and traffic diverted per direction from Incident Command in coordination with the LASD. The LASD will implement their Traffic Control Plan.
        ii. Note: the streets surrounding the campus of LAC+USC Medical Center are the jurisdiction of the Los Angeles City Police Department. LASD will coordinate this with the LAPD.

f. Additional resources:
    i. LASD, LAPD, Allied Universal Security Services as needs dictate per LASD policy.
    ii. Additional request from EOC (MAC/DHSDOC) via RRMH.
    iii. National Guard via REOC, State EOC as incident driven.
g. Staff Responsibilities
    i. All staff must maintain heightened security and awareness of staff, patients, visitors, and environment during an event.

2. **Hazardous Materials: Management and Waste**
    a. Facilities Management, Life Safety, Environmental Services, and the Radiation Safety Office manage hazardous materials and waste. Refer to respective department policies/plans
    b. Facilities Management has a Hazardous Materials divisions and designated HAZWOPERs.
        i. HAZWOPERs respond to incidental spills only.
        ii. LAFD responds for incidents beyond their capacity and capability.
        iii. Material Safety Data Sheets are on file in areas of use and storage. They are referenced as needed.
        iv. The program is in compliance with regulatory agency standards including, but not limited to, the EPA, Cal OSHA, and the AQMD.
        v. The specific policies and plans can be accessed from these respective departments.

3. **NBC (Nuclear, Biologic, and Chemical) Isolation and Decontamination**
    a. On-site release:
        i. The center will be alerted via overhead page "Code Orange" per protocol.
        ii. Facilities Management will assess to determine if their HAZWHOPPERs can mitigate the release. Refer to the Facilities plan for response to the release of a hazardous substance.
        iii. The Radiation Safety Office will respond as necessary.
        iv. If the release is beyond their capability, the Los Angeles City Fire Department or the County Health Hazmat Department may be contacted for assistance.

    b. Off-site release:
        i. Capability:
            1. Decon Shower: located at the paramedic entrance to the DEM, this shower is capable of low volume ambulatory or non-ambulatory decon.
            2. Mass Casualty Decon Trailer: located at the entrance to the ED ramp, this trailer is capable of decon approximately 50 patients per hour.
            3. Decon Equipment Inventory: see *First Receiver Decon Operations Team Manual.*
        ii. A "Code Decon" alert notification will be sent per protocol.
        iii. For multiple casualties, a "Code Triage" alert notification will be sent per protocol.
        iv. The hospital's First Receiver Decon Team and the Emergency Department will respond and follow the procedures as indicated in the *DEM Emergency Response Plan* and the *First Receiver Decon Operations Team Manual.*
            1. Per policy as set forth by industry experts and as stated in the DEM ERP:
                a. All victims of <u>chemical</u> agents will all require decon before entering the facility.
                b. All victims of a <u>radiologic</u> incident will be scanned for contamination and spot deconned before entering the facility except if they require immediate
                c. Victims of <u>biologic</u> agents may or may not require decon. Direction taken from the County EOC, County Public Health Officer, or Epidemiology/Infection Control.

c. Infectious Disease
    i. Management of patients with infectious disease are detailed in Epidemiology / Infection Control Plans:
        1. IC-9: Pandemic Influenza Plan
        2. IC-10: Influx / Surge and Hospitalization of Large Numbers of People with Infectious Disease

REFERENCE

Emergency Response Plan: Department of Emergency Medicine
LAC+USC First Receiver Decon Team Manual
LAC+USC Medical Center Policy IC-10: Influx / Surge and Hospitalization of Large Numbers of People with Infectious Disease
LAC+USC Medical Center Policy IC-9: Pandemic Influenza Plan

BACKGROUND

The facility has multiple resource and asset capabilities, processes, and storage locations. It is the responsibility of the respective department to maintain documented inventory. Specifically:

1. Medical Center Supplies
    a. *Year End Fiscal Inventory*
    b. Locations: Mini-Warehouse, Tower Warehouse, and Hudson, Roybal, and El Monte CHCs
    c. Responsibility: Supply Chain Ops
    d. Review: Annually – June
2. Medical Equipment and Tangible Property
    a. Responsibility:
        i. Clinical Engineering (Medical Equipment)
        ii. Property Management (Tangible Property)
        iii. Respiratory Therapy (ventilators)
    b. Review: Annually
3. OEM / HPP Disaster Supply and Equipment Caches
    a. Responsibility: OEM, Supply Chain Ops
    b. Review: Annually – January

SYSTEM

I. ESSENTIAL SERVICES AND RESOURCES

1. **Blood Bank**
    a. Location: D&T 2nd Floor
    b. Contact: 97134
        i. Supervisor (Day): Cheryl Matsushita
        ii. Manager: Chris Tuma
    c. Suppliers
        i. San Diego Blood Bank
        ii. Life Stream
        iii. Red Cross
    d. PAR Level: 7 days, blood products and supplies

2. **Central Sterile**
    a. Location: D&T 2nd Floor
    b. Contact: 94620
        i. Supervisor: Sylvia Labinger
    c. Suppliers: Medline
    d. System:
        i. Just-in-time 24/7 processing
        ii. Each surgery individualized requirements
    e. PAR Level
        i. Emergency Surgery: 5 OR Cases
        ii. Surgery Packs (disposables): 2 days
        iii. Case carts (for instrument tray packs): 91 carts
        iv. H2O2 cassettes: 2 days
        v. Incidentals: 4 days
    f. Dependency: Power, Water, Steam

3. **Clinical Equipment Operations**
    a. Location D&T 2nd Floor
    b. Contact: 98570
    c. System
        i. MaxAir PAPRs, Accessories
        ii. Crash Cart Exchange
        iii. Pumps (IV, Feed, PCA, Epidural)
        iv. Wound Vacs
    d. PAR Level: indeterminate

4. **Dietary / Nutrition Services**
    a. Location: IPT
    b. Contact: 97910
        i. Supervisor: Kimberly Kilpatrick
    c. Contracted Service: Morrison
    d. Supplier: Multiple (per Food and Nutrition Services, Section H: Emergency Preparedness)
    e. PAR Level: 7 days

5. **Environmental Services (EVS)**
    a. Location: C1L213
    b. Contact: 98527
        i. Supervisor: Shelia Green
    c. Supplier: Johnson Diversei, Waxi
    d. PAR Level: 10 days. cleaning supplies

6. **Linen**
    a. Location: IPT 1L214
    b. Contact: 96632
        i. Supervisor: Josephina De Alba
    c. Supplier:
    d. PAR Level: 14 days

7. **Laboratory** (Chemistry, Blood Gas, Microbiology)
    a. Core Lab (Blood Gas, Chemistry, Flow Cytology, Urine Studies)
        i. Location: D&T 2nd Floor
        ii. Contact: 97023
            1. Supervisors (Day): Debbie Stein, Janet Jones
        iii. Suppliers: multiple (20)
        iv. System
            1. Equipment/Vendor study specific
            2. Interface: Equip > Middleware (vendor specific) > Cerner
                a. IT downtime: manual backup
            3. Credentialing: College of American Pathology (CAP)
        v. PAR Level: 45 days
        vi. Dependency
            1. Power
            2. Water
            3. Gases
                a. He: H Cylinders (responsibility FM)
                b. H2: in lab generator
                c. Purified Compressed Air: H Cylinders (responsibility FM)
                d. House Air

8. **Pharmacy**
    a. Location/Contact
        i. Outpatient Pharmacy (Clinic Tower): 96763, 96764
        ii. Inpatient Pharmacy (D&T): 97641
        iii. Respective Unit/Service Pyxis'
    b. Supplier
        i. Pharmaceuticals: Cardinal Health
        ii. IV Solutions: Baxter
            1. Pharmacy: 50/100/150cc (D5, NS), 3%, Premixed (i.e., KCl)
            2. Supply Chain: $\geq$ 25occ (D5W, NS, LR, etc.)
    c. PAR Level: 7 days

9. **Respiratory Therapy**
    a. Location: IPT 5th Floor
    b. Contact
        i. Supervisor (24/7): 97928
        ii. Manager: Stephanie Summerville
        iii. ED: 91679
    c. Inventory
        i. PB980 Ventilators: 107
            1. 28 Universal
            2. 59 Adult/Ped
            3. 20 Neonatal
        ii. Hamilton C1: 18
        iii. Hamilton T1: 15
        iv. Hamilton MRI: 2
        v. Airvo2 HFNC: 89
        vi. Respironics V60: 36
        vii. Percussionaire TXP5: 50
        viii. ResMed S9VPAP: 25
        ix. Zoll Eagle 2 MRI Vent: 2
        x. Vortran-Adult: 300
        xi. Vortran-Ped: 20
    d. Consumption:
        i. Adult: Average 35-38 / day
        ii. Neonate: Average 2-4

10. **Supplies: Medical, Surgical, Routine**
    a. Location/Contact: Supply Chain Operations
        i. Mini-warehouse: 226-2381
        ii. Tower Warehouse (IPT 1CL100): 92381
    b. PAR Levels
        i. Clinics: 3 days
        ii. ED: 3 days
        iii. IPT ACU/ICU: 3 days
        iv. ORs: 3 days
        v. Tower / Mini-warehouse: 15 days

11. **Disaster Caches (Dedicated)**
    a. Type
        i. BRC Supply, Equipment, and Pharmaceutical Cache

ii. Chempack DRC Medical Supply and Equipment Caches
iii. EMS Local Pharmaceutical Cache
iv. First Receiver Decon Cache
v. Evacusleds
    1. Evacuation's devices stored under the mattress of each Hill-Rom VC bed above the 2nd floor in IPT.
    2. Facilities Management / Equipment Repair store additional for replacement.
    3. Responsibility: Facilities Management, Life Safety, Nursing
vi. Sled2Go Evacusled
    1. Portable evacuation devices
    2. Storage: 2 wire racks in Disaster Storage
    3. Qty: 30 units
vii. Evacuchairs:
    1. Evacuation devices are strategically located in the above ground floors of the CT and OPD buildings for aid in evacuation the non-ambulatory staff and patients.
    2. Responsibility: Facilities Management, Life Safety
viii. Pre-Positioning of Prophylactic Antibiotics Cache
ix. Supply Chain Operations Warehouse Disaster Supply Cache
x. U.S.P.S. BDS Pharmaceutical Cache

b. Locations
    i. Disaster Equipment
        1. Disaster Storage GH
            a. Portable ICU MP50 Monitors (6)
            b. Zoll Transport Monitor/Defibrillators (2)
            c. Portable NanoMaxx Ultrasound (3)
            d. Portable Suction (3)
            e. Decon PPE (additional) Body Bags, etc.
            f. Wheelchairs
            g. Patient Gurneys (5)
        2. Clinical Equipment Operations
            a. MaxAir PAPRs and accessories
        3. ED Ramp
            a. Mass Casualty Decon Trailer
            b. Trailer 1: Decon PPE
            c. Trailer 2: Triage tags, tarps, tents, bullhorns, Geiger Counters, portal radiation detector, etc.
        4. GH ED Ramp
            a. Trailers A & B: DRC Field Shelter
            b. Trailer 3: Wheelchairs, Easy-Ups
        5. GH Rm 728 /
            a. PPE, med/surg supplies, Vortran ventilators, disposable sheets/blankets, Body Bags, etc.
        6. GH Facilities Management (old HIM) Storeroom
            a. Portable Cots: 500
            b. DLX Tents
    ii. Disaster Medical / Surgical Supplies
        1. GH Rm 728: HPP Cache
        2. Mini-warehouse: Supply Chain Operations Disaster Cache
    iii. Disaster Pharm
        1. Inpatient Pharmacy: BRC Cache
        2. GH Rm 728: HPP Cache

3. Ward Services: BRC Cache, Pre-Positioned Antibiotic Prophylactic Cache

II. MANAGEMENT OF RESOURCES

1. **Obtaining Resources**
   a. Each unit or service will obtain and/or replenish needed resources and assets through their normal procedures including, but not limited to,
      i. Personnel
      ii. Supplies
      iii. Equipment
      iv. Pharmaceuticals
      v. Environment Services (EVS)
      vi. Laundry Service

   b. Should standard methods be insufficient, the unit/service supervisor will place a request with the HCC / Logistics Section. The Logistics Section will then assist in obtaining the requested resource or asset. Their function will be to:
      i. Provide support to other sections.
      ii. Acquire resources from internal / external sources.
      iii. Activate existing MOUs, contracts, and vendor agreements.
      iv. Employ standard and emergency procurement and contracting procedures.
      v. Work closely with Supply Chain Operations to obtain and replenish hospital stock.
      vi. Work closely with Supply Chain Operations and the Planning Section to forecast future needs.
      vii. Communicate needs with the MAC / MCC. The Liaison Officer may assist. See below for Country resource requesting procedure.

   c. County Resource Requesting: *Resource Request Medical and Health (RRMH)*
      i. Criteria: If Logistics is unable to secure needed resources and assets through the above procedures, the MAC / MCC is the conduit for ALL support (clinical and non-clinical), i.e., staff, equipment, supplies, pharmaceuticals, water, power, etc.
      ii. Primary Process: ReddiNet
         1. Note: each item (supplies, equipment, personnel) requires its own request.
         2. Access Resource Request
            a. Go to https://reddinet.net
            b. On homepage drop down menu, select ReddiNet Application and log-in
               i. Password available in HCC
            c. On menu bar, click “Resource Request”
            d. On left bar, choose open or closed incident, then click “New Resource Request”.
         3. Complete Resource Request
            a. Incident Name: select via drop down menu
            b. Requestor Details: the individual making request
            c. Describe Mission/Task: provide brief description of reason for request
            d. Select appropriate “Order Type”: supply, personnel, equipment
            e. Priority: Emergent < 12 hours, Urgent > 12 hours, or Sustainment.
            f. Description: provide detailed description, i.e., make, model, size, concentration, etc.
            g. Quantity: be specific.
            h. Confirm requirements: check all 3 boxes
            i. Requestor: as in “c.” above.

j. Command Review: Name of Section Chief or Incident Commander approving request.
k. Click "Submit"

iii. Secondary Process: Manually
1. See Attachments at the end of this sections for:
a. Algorithm
b. Instructions
c. RRMH form
2. Contact MAC / MCC
a. Phone
i. 866-940-4401
ii. 562-347-1789
b. FAX
i. DOC: 562-944-5248
ii. MAC: 562-906-4300

d. HPP Cache
i. Approval for use of HPP disaster cache is through the OEM or the EMS Agency / MAC / MCC.

2. **Sharing of Resources**
a. During a medical or health related event, the MAC / MCC manages / brokers the sharing of resources and assets for the Operational Area.
b. During an event, the communication conduit should be the Liaison or Logistics Officer in the HCC.
c. The following caches and distribution plans are part of the L.A. County EMS Agency and HPP mutual aid MOUs:
i. DRC Equipment Cache
1. DHS Reference No. 1102, 1102.2
ii. DRC Supply Cache
1. DHS Reference No. 1107, 1107.1
iii. Local Pharmaceutical Cache
1. DHS Reference No. 1106, 1106.2, 1106.2
iv. Chempack
1. DHS Reference No. 1108, 1108.1, 1108.2, 1108.3

3. **Monitoring and Documentation**
a. Each unit/service supervisor will monitor their usage of resources and assets and report through their chain of command on needs and status.
b. Procurement
i. HICS 256 - Procurement Summary Report is used to summarize and track procurements.
ii. Completed by Hospital Incident Management Team (HIMT) personnel as directed by the Procurement Unit Leader.
iii. Distribute copies to the Finance/Administration Section Chief and the Documentation Unit Leader.
c. Resource Accounting
i. HICS 257 - Resource Accounting Record documents the request, distribution for use, return, and condition of equipment and resources used.
ii. Completed by HIMT personnel as directed by Section Chiefs.
iii. Distribute copies to Finance/Administration Section Chief, the Resources Unit Leader, the Materiel Tracking Manager, the original requester of the resource, and the Documentation Unit Leader.
d. HPP Caches

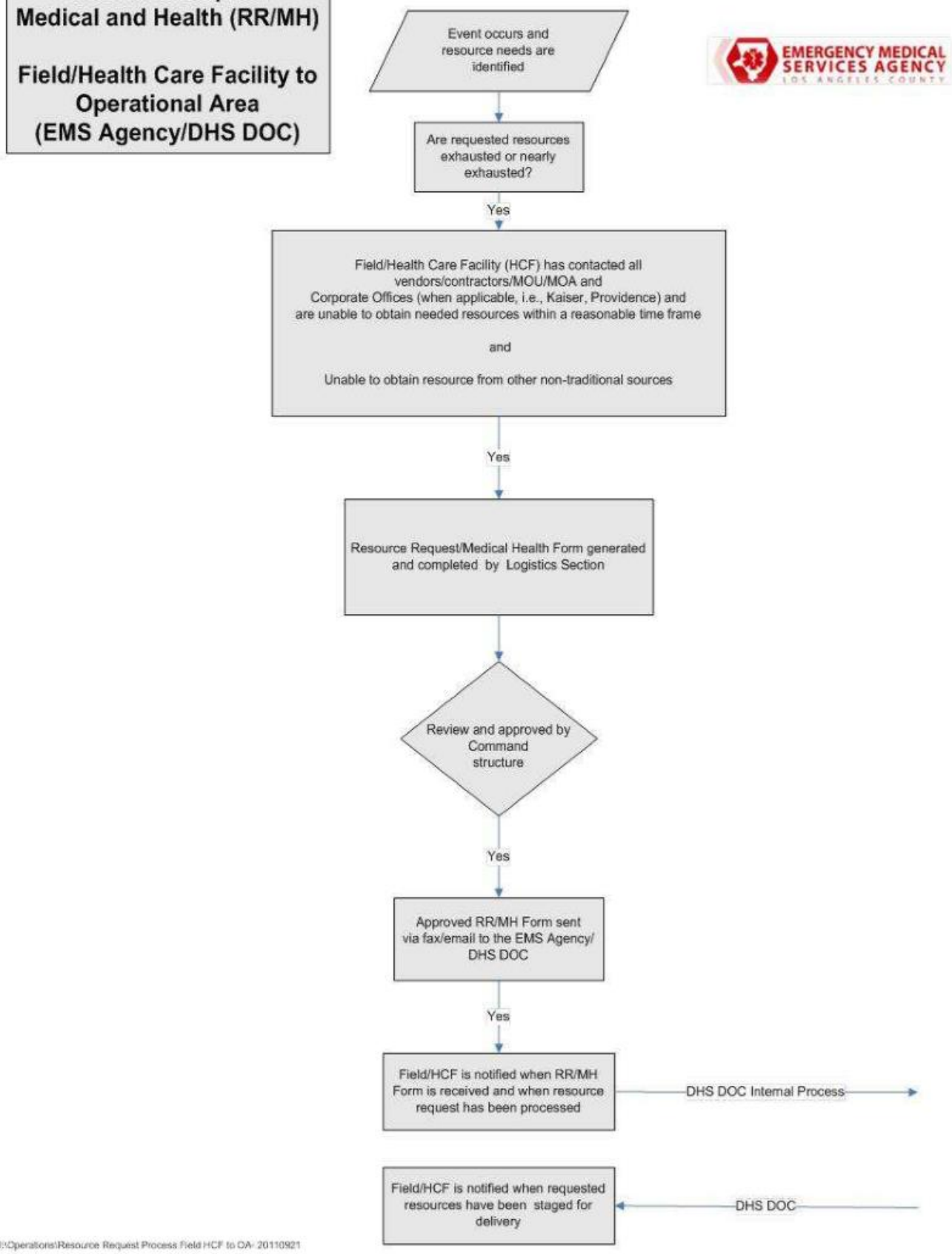
i. Each cache and its respective plan have distinct distribution checklists.
ii. Distribute copies to the Documentation Unit and the OEM.

4. **Transportation of Patients, Resources, and Assets**
   a. On Site
      i. Patients are transported per protocol. Patient equipment and records accompany the patient.
      ii. Resource and assets are transported by Facilities Management / Transportation and as directed by the Operations Branch in coordination with Logistics Branch.
      iii. The Evacuation plan is implemented for any partial or full evacuation.
   b. Off Site
      i. Patients, resources, and assets transported off-site will be arranged by the MAC / MCC.
      ii. Use of HPP and LAC+USC transportation equipment may be utilized.

ATTACHED
Resource Request Medical and Health (RRMH) HCF to OA Algorithm
RRMH Instructions
RRMH Form

Resource Request Medical and Health (RR/MH)

Field/Health Care Facility to Operational Area (EMS Agency/DHS DOC)



U:\Operations\Resource Request Process Field HCF to OA- 20110921

Resource Request Medical and Health (RRMH) Completion Instructions

1. Incident Name:	Name assigned by Incident Commander. Keep as general as possible, i.e.; March 2011 EQ or IED at Staples Center.
2 **a. Date:**	Use mm/dd/yyyy format
b. Time:	Military Time is preferred, i.e. 1900 = 7:00pm. If unable to use Military Time indicate am or pm.
c. Requestor Tracking Number:	This will be your hospitals 3 letter hospital code, a dash "-", and 3 digit number (in sequential order). Refer to Policy #'s 1102.3-1102.12 for 3 letter hospital code. Example CSM-001 is Cedars Sinai Medical Center and their first RRMH.
3. **Requestor Name:**	To be completed by whomever is filling this form.
4. **Describe Mission/Tasks:**	Give a brief description of reason for request.
5. **Order Sheets:**	Check which box applies to your order. Fill out one RRMH sheet for each type of request.
6. **Order**	
Item #:	Each new line item is numbered.
Priority:	(E)mergent <12 hours, (U)rgent >12 hours or (S)ustainment. If completing form electronically there is a drop down menu.
Detailed Description:	Specifically describe the requested item by using brand, sizes, model #, dose, form (tabs vs caps vs suspension), strength, volume. Example: 3M N-95 Mask, Model #1234 size Medium or Penicillin 500mg tablets or Normal Saline1000ml IV fluid.
Qty:	Quantity wanted based upon each, this is to simplify the ordering process. Example: Doxycycline 500mg Tabs quantity 50 = the hospital will receive 50 tablets.
Expected duration of use:	This only applies to equipment and personnel. Supplies will not be returned.
7. **Confirm Requirements:**	Facility must confirm these requirements have been met prior to submission of request.
8. **Command Review & Verification:**	Authorized management staff review and approve. Printed name and signature are required.

E-mail completed form to laemsadutyofficer@dhs.lacounty.gov[1]
or fax: number will be provided at time of event

Resource Request Medical and Health: FIELD/HCF[2] To Op Area

1. Incident Name:	2a. DATE:	2b. TIME:

3. Requestor Name, Agency, Position, Phone / Email:	2c. Requestor Tracking Number: 3 letter code-3 digit number (Assigned by requesting entity)

4. Describe Mission/Tasks:

5. ORDER SHEET(S) - ATTACH ADDITIONAL IF NEEDED	☐ SUPPLIES	☐ PERSONNEL	☐ EQUIPMENT

6. ORDER ***MEDICAL & HEALTH REQUEST DETAILS***

Item #	Priority[3]	Detailed Specific Item Description: Vital characteristics, brand, specs, diagrams, and other info. (Rx: Drug Name, Dosage Form, UNIT OF USE PACKAGE or Volume, etc.) (Attach product information pages, photos, In-House purchase order documentation)	Qty	Expected Duration of Use (does not apply to supplies)

7. Requesting facility must confirm that these 3 requirements have been met prior to submission of request

- ☐ **Is the resource(s) being requested exhausted or nearly exhausted?**
- ☐ **Facility is unable to obtain resources within a reasonable time frame (based upon priority level below) from vendors, contractors, MOU/MOA's or corporate office?**
- ☐ **Facility is unable to obtain resource from other non-traditional sources?**

8. COMMAND/MANAGEMENT REVIEW AND VERIFICATION
(NAME, POSITION , AND SIGNATURE - SIGNATURE INDICATES VERIFICATION OF NEED AND APPROVAL)

1-When EMS DOC activated MH-RR to be sent to Operations Section Coordinator
2-HCF = Health Care Facility
3-Priority: (E)mergent <12 hours, (U)rgent >12 hours or (S)ustainment

BACKGROUND

Facilities Management routinely inspects, tests and repairs utilities, which are essential to the safe functioning of the hospital. The testing of utilities is mandated by local, state and federal regulations and the records of utility testing are maintained within the department. Any deficiencies, which are identified, are corrected and maintained so that utilities are functional to the highest degree possible. Records of utility function are available for review within the department.

MOAs and vendor agreements are in place per respective contract. Facilities will activate plans to request delivery of additional supplies as needed. If resources are unavailable or insufficient, Logistics is to request by contacting the MAC / MCC via RRMH.

SYSTEM

I. UTILITIES

1. **Power / Electricity**
    a. Specs
        i. Provider: Los Angeles Department of Water and Power (DWP)
        ii. Consumption: TBD
        iii. Dependency:
            1. East Plant: CT, D&T, IPT, and East Plant
            2. Station 0: GH, OPD, IRD, General Lab, 5P21, Juvenile Hall, Coroner's Office, and West Plant
    b. System
        i. For the East Plant, DWP provides 2 Utility Power feeds (MSA and MSB) each providing power to 2 respective load banks.
        ii. The system includes a high voltage transfer switch which, when closed, allows one feed to supply Utility Power to both load banks.
            1. There is an automatic high voltage transfer switch on the DWP line side which closes when it senses a power loss in either feed.
            2. There is a manual high voltage transfer switch on the LAC+USC line side which performs the same function. Additionally, loss of Utility Power activates Emergency Power:
        iii. Utility Power loss is sensed by the Automatic Transfer Switches (ATS) which activate the Electric Diesel Generators (EDG) and switches the load to Emergency Power which then powers plant operations, critical systems, critical equipment, emergency lighting and receptacles.
    c. Emergency Procedures
        i. Electric Diesel Generators (EDG)
            1. Qty: 7
            2. Capacity: 2MW/EDG, 14MW total, Load Shedding
            3. Fuel: 50,000g, 10 days at full load
        ii. Portable Generators On Site
            1. 2kW/3kW (multiple)
            2. 60kW (1)
        iii. Portable Generators Operational Area
            1. Multiple > 25kW generators cached throughout county.
            2. Logistics to request via RRMH.
        i. Testing

3. Monthly: EDG
4. Annually: Power Shut Down Drill (Los Angeles City Fire Regulation 4)

2. **Water**
    a. Specs
        i. Provider: DWP
        ii. Use
            1. Cooling Tower (Chiller): 90% of consumption
            2. Dietary
            3. EVS
            4. Hygiene (sink/toilet/shower)
            5. Diagnostic Services
            6. Landscape
            7. Steam
            8. Sterilization (Central Sterile, Cooker/Shredder)
        iii. System – New Facility
            1. DWP Main Feed via 2 metered connections at Marengo
                a. Low $\leq$ 60 psi
                b. High $\geq$ 100 psi
            2. Main Feeds to 3 valves
                a. Main > Plant > Storage Tank > Facility
                b. Fire
                c. Auxiliary Capped
            3. Supplies CT, D&T, IPT, East Plant
            4. Tank: 390,000g
            5. Consumption: 271,000g/day
            6. Dependency
                a. Boosters
                b. Power
        iv. System – Old Facility
            1. 3 Main Feeds: Marengo (via Zonal) and Zonal (2)
            2. Mains Feed to 4 valves outside old MRI
            3. Supplies GH, IRD, OPD, West Plant
    b. Emergency Procedures
        i. See EOP: Water Emergencies

3. **Fuel**
    a. Natural Gas
        i. Provider: Southern California Gas (SCG)
        ii. Use
            1. Steam/Boilers
            2. Dietary: grills, range, ovens
        iii. System: Direct Feed
        iv. Backup: Propane
    b. Propane
        i. Supplier: Faban
        ii. Use: Backup for Natural Gas
        iii. System
            1. Tank: XXg (2)
            2. Capacity: 4 days
            3. Direct feed / mechanical. No IT dependency.
        iv. Dependency
            1. Power, Propane (vaporizer)

c. Diesel
    i. Supplier: Faban
    ii. Use: EDGs
    iii. System
        1. Tank: Day Tank (1), Storage Tank 50,000g
        2. Capacity: 10-day supply at EDG full load
d. Gasoline
    i. Supplier:
        1. Any respective County yards
        2. County Public Works: Alcazar Ave.
        3. Internal Services Department: Eastern Ave.
    ii. Use: Portable electric generators, vehicles

4. **Medical Gases**
    a. Oxygen (O2)
        i. Supplier: Praxair
        ii. Use: Medical gas
        iii. System:
            1. Tank: 100g liquid
            2. E and H Cylinders
        iv. Consumption: approx. 8g/day
        v. Capacity: 12 days
        vi. Dependency: None
        vii. Backup: External Hook-Up Valves
            1. IPT: Plant
            2. DNT/CT: Bridge
    b. Nitrogen (N2)
        i. Supplier: Praxair
        ii. Use: OR Tools
        iii. System: Tank (Liq)
        iv. Capacity: 6 days
    c. Heliox (HeO2)
        i. Supplier: Prax Air
        ii. Use: Medical Gas for RT (i.e., Status Asthmaticus)
        iii. System:
            1. H Cylinders (70/30 Mix), PAR Level: 8
            2. Heliox devices: 1
        iv. Consumption: Variable
        v. Capacity: 4 days
    d. Helium (He)
        i. Supplier: Prax Air
        ii. Use: Core Lab (Gas Chromatography)
        iii. System: H Cylinders, PAR Level: XX
        iv. Consumption: TBD
        v. Capacity: 1 month
    e. Hydrogen (H2)
        i. Supplier: Prax Air
        ii. Use: Core Lab (Gas Chromatography)
        iii. System:
            1. Primary: In-lab 2H generator
            2. Backup: H Cylinders, PAR Level: XX
        iv. Consumption: TBD
        v. Capacity: N/A

f. Nitric Oxide (NO)
    i. Supplier:
    ii. Use: Medical Gas for RT (Pulmonary Hypertension)
    iii. System:
        1. D Cylinders, PAR Level: XX
        2. NO devices: 3
    iv. Consumption: Variable
    v. Capacity: 7 days
g. Nitrous Oxide (N2O)
    i. Supplier: Prax Air
    ii. Use: Medical Gas for Anesthesia
    iii. System: E Cylinders
    iv. Consumption: TBD
    v. Capacity: 14 days
h. Air
    i. Lab Air (Utility Air)
        1. Use: Air Handlers, Pneumatic Doors
        2. System: Generator (Plant)
        3. Dependency: Power, Water (Cooling)
    ii. Medical Air
        1. Use: Medical Gas
        2. System: Generator (Plant)
        3. Dependency: Power, Water (Cooling)
    iii. Purified Compressed Air
        1. Supplier: Praxair
        2. Use: Core Lab (XX)
        3. System: H Cylinders
        4. Capacity: TBD

5. **Waste**
    a. Bio-waste
        i. Non-Sterile
            1. Provider: Stericycle
            2. System: AGVS > Shredder > Compacter > Vendor
            3. Dependency: Power
        ii. Sterilized
            1. Provider: Southland
            2. System: AGVS > Cooker > Shredder > Compacter > Vendor
            3. Dependency: Power, Steam
        iii. Backup:
            1. Bag waste
            2. Transport and Store at Facilities Yard
    b. Radioactive Waste
        i. Provider: TBD
        ii. System: TBD
        iii. Dependency: TBD
        iv. Backup:
            1. Bag waste
            2. Transport and Store at Facilities Yard
    c. Sewage
        i. Provider: DWP
        ii. System
            1. Above Grade: Gravity > Sewer

2. Below Grade: Pump > Sewer
3. Waste Holding Tank
    a. Purpose: sewage overflow if street backup
    b. Quantity: 3
    c. Capacity: 130,000g
    d. Diverter Valve/Backup Time: TBD

iii. Consumption: TBD
iv. Dependency: Power

d. Trash
i. Provider: Southland
ii. System: AGVS > Shredder > Compacter
iii. Consumption: TBD
iv. Dependency: Power

e. Water: Grey Water
i. System: Pumps

f. Water: Run Off
i. System:
1. Above Grade: Drains > Gravity > Storm Drains
2. Below Grade: Drains > Pumps > Storm Drains
ii. Dependency: Power for below grade

II. ESSENTIAL SYSTEMS

1. **Plant**
    a. East Plant
        i. Function: Plant operations for CT, D&T, IPT, East Plant
        ii. Systems
            1. Power Control System: Metasys
            2. Boosters (Water)
            3. Chillers (Cooling Tower)
            4. Emergency Diesel Generators (EDGs)
            5. Plumbers Room
            6. Steam/Boilers
            7. Water Tank
        iii. Contact: 9-6041
        iv. Dependency:
            1. Power, Steam, and Chiller: CT, D&T, IPT, East Plant
    b. West Central Plant
        i. Function: Plant operations for GH, IRD, OPD, JH, Morgue
        ii. Systems:
            1. Steam/Boiler
            2. Chiller
        iii. Contact: 9-6030
        iv. Dependency
            1. Steam: GH, OPD, IRD, General Lab, 5P21, Juvenile Hall, and Coroner's Office
            2. Chiller: GH, OPD, IRD, General Lab

2. **Air Handlers**
    a. Function: Control Air Flow, Humidity, Temperature
    b. System:
        i. Metasys Controller
        ii. Hot / Cold Coils
        iii. Humidifier
    c. Dependency:

i. Power
ii. Chiller
iii. Steam

d. Backup: Manual

3. **AGVS**
   a. Function: Trash Mover
   b. System:
      i. Robotics
      ii. Swiss Logic Controller
      iii. Dependency: Power

4. **Card Readers**
   a. Function: Card Controlled Security Door Access
   b. System: Johnson Controls
   c. Dependency: Power, Controller
   d. Backup: Manual

5. **Chillers**
   a. Function: Chill Water
   b. Use
      i. Dietary – ice batch for rapid cooling post cooking
      ii. Cooling - compressors, pumps, generators (not EDG)
      iii. HVAC – cooling coils
      iv. Linear Accelerator
      v. MRI
   c. System
      i. Types
         1. Open (Cooling Tower: condensers > evaporative cooling)
            a. HVAC / Air Handlers: cooling coils
            b. Cooling machinery
            c. Linear Accelerator
            d. MRI: Primary
         2. Closed
            a. HVAC / Air Handlers: cooling coils
               i. Standalone rooftop > ORs
            b. Dietary: Standalone
            c. MRI: Standalone Backup
      ii. Condensers
         1. Boilers > Steam > Turbines > Condenser: 2 units
         2. Power > Condensers: 3 units
   d. Dependency
      i. Water: Cooling Tower: 90% total facility consumption
      ii. Power
      iii. Steam
   e. Emergency Procedures
      i. Load Shed
      ii. Sequential closure of non-essential buildings and functions

6. **Elevators**
   a. System
      i. IPT, D&T, and CT are interconnected. Each has elevator systems.
      ii. Elevator shafts are structurally self-contained.

iii. Minimum of (1) elevator / bay on emergency power.

b. Emergency Procedure
   i. Elevator bay non-operational > proceed horizontally to functional bay.
   ii. Al elevator systems non-operational > vertical transport via stairwells.
      1. See EOP: Evacuation.

7. **HVAC**
   a. System
      i. Controllers
      ii. Mechanical intake/exhaust units
      iii. Hot/Cold Exchange units
   b. Dependency
      i. Power
      ii. Steam
      iii. Air Handlers
      iv. Chiller/Condensers

8. **Shredder/Compacter**
   a. Function: Shred > Compact trash and bio-waste
   b. System: Controller
   c. Dependency: Power

9. **Steam/Boilers**
   a. Use:
      i. Dietary
      ii. Hot Water
      iii. HVAC - heating coils
      iv. Steam > Turbines > Chiller
      v. Sterilizers (Central Sterile, Cookers)
   b. System:
      i. Water: Closed system
      ii. Power
      iii. Fuel
         1. Primary: Natural Gas
         2. Backup: Propane

10. **Sterilizers**
    a. Use
       i. Central Sterile: tool and equipment sterilization
       ii. Cookers: bio-waste sterilization
    b. Dependency
       i. Steam
       ii. Power
       iii. Water

11. **Vacuum**
    a. Use: Medical Suction
    b. System: Generator (Plant)
    c. Dependency: Power
    d. Backup: Portable Suction
       i. Clinical Engineering
       ii. Clinical Equipment Operations
       iii. Crash Carts

REFERENCE

LAC+USC Medical Center Facilities Management Procedure Manual # 401-408 (Utilities Policy & Procedures)

BACKGROUND

Disasters have the ability to impact all areas of healthcare delivery, and there is no way to predict the type or severity. Essential capabilities including resources, utilities, and system infrastructure necessary to maintain healthcare delivery and the environment of care may be disrupted. The disruption of the capability could be the cause of the event or the consequence of the event. Aid from service providers, vendors, or the local/operational/regional areas may be delayed from hours to days. Therefore, during an event, the hospital will determine 1.) Can the facility sustain capabilities (independent or by the local community) for up to 96 hours, and 2.) When the need to evacuate, i.e., when, despite all efforts, the environment of care cannot support healthcare delivery.

Note: This does not infer that hospitals are required to stand on their own for 96 hours. Rather, the hospital should plan for alternatives and determine whether they can survive for that period. For example, most organizations do not have the fuel capacity, water for drinking and patient care, or water for equipment and sanitation to sustain themselves for 96 hours. If it is determined, after all measures of conservation, curtailment, and support from outside of the community are exhausted, that the capability is only 80 hours, then evacuation would be an appropriate response.

SYSTEM

1. Responsibility
    a. Incident Management Team: IC, Planning Section, and Section Chiefs.
2. Timeframe
    a. Initiate during the first Operational Period.
3. Procedure
    a. Determine the severity and potential impact of the event.
    b. Forecast the duration of the event.
    c. Does the event have the potential to affect healthcare delivery and the environment of care?
        i. If yes, proceed to “d.”
        ii. If no, re-evaluate in 4 hours.
    d. Determine the sustainability of essential resources and capabilities with respect to forecasted duration and impact of event.
        i. Refer to the following *96 Hour Sustainability* chart.
        ii. Consider variables:
            1. Patient surge
            2. Availability of resources from inside/outside the local community.
            3. System co-dependencies
    e. Does the event disrupt or exceed capabilities?
        i. If yes, proceed to “f.”
        ii. If no, re-evaluate in 4 hours.
    f. Implement plans as needed to sustain capability.
        i. Consider additional options:
            1. Conservation of resources
            2. Curtailment of services
            3. Staged evacuation

g. Evaluate effectiveness.
h. Determine need to Evacuate > Forecast when, if after all measures of conservation and support are exhausted, essential services and the environment of care are no longer able to support healthcare delivery.
i. Re-evaluate every 4 hours

ATTACHED
LAC+USC 96 Hour Sustainability Chart

HOURS OF EMG OPS	4	8	12	16	20	24	28	32	36	40	44	48	52	56	60	64	68	72	76	78	82	86	90	92	96
Utilities																									
Power																									
Power Utility Outage																									
Power Outage + EDG Failure																									
Water																									
Water Distribution Failure																									
Water Quality Emergency																									
Fuel																									
Natural Gas Outage																									
Natural Gas + Propane Outage																									
Diesel Outage																									
Unleaded Outage																									
Medical Gas																									
Oxygen																									
Nitrogen																									
Helium																									
Nitrous Oxide																									
Air																									
Vacuum																									
Waste																									
Bio-waste Processing Failure																									
Bio-waste Vendor Failure																									
Radioactive Waste Vendor Failure																									
Sewage Utility Outage																									
Trash Processing Failure																									
Trash Vendor Failure																									
Systems																									
Air Handlers																									
Air Handlers Failure																									
AGVS																									
AGVS Failure																									
Chiller																									
Chiller Failure																									
Elevators																									
HVAC																									

HOURS OF EMG OPS	4	8	12	16	20	24	28	32	36	40	44	48	52	56	60	64	68	72	76	78	82	86	90	92	96
HVAC System Failure																									
IS (Intranet, Orchid, VoIP)																									
IS System Failure																									
Shredder/Compacter																									
Shredder/Compacter Failure																									
Steam																									
Steam Failure																									
Sterilizers																									
Sterilizer (Central Sterile) Failure																									
Vacuum																									
Vacuum Failure																									
Services and Resources																									
Blood Bank																									
Central Sterile																									
Clinical Equipment Operations																									
Dietary																									
EVS																									
Linen																									
Laboratory (Core Lab)																									
Pharmacy																									
Respiratory Therapy																									
Supplies (Medical/Non-Med)																									

Legend

1. **Green:** Services can continue without discernable impact or change.
2. **Yellow:**
    a. Selected patient, staff, and visitor services may be revised or terminated.
    b. Elected surgeries may be affected, and outpatient services may be temporarily terminated.
    c. Conservation plans may be in place.
    d. Visitors/visitation may be limited.
3. **Red:**
    a. Incoming patients and visitors may be denied.
    b. All activity centered on maintaining quality of life.
    c. Evacuation likely or imminent.

Emergency Operations Plan

Emergency Operations: Patient Clinical and Support Activities

BACKGROUND

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary may, under section 1135 of the Social Security Act, temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). Examples of these 1135 waivers or modifications include:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)
- Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive a medical screening examination in an alternative location pursuant to a state emergency preparedness plan (or in the case of a public health emergency involving pandemic infectious disease, a state pandemic preparedness plan) or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. A waiver of EMTALA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient's source of payment or ability to pay.
- Stark self-referral sanctions
- HIPAA, e.g., waiving certain HIPPA privacy requirements so that healthcare providers can talk to family members (other provisions of HIPAA remain in full effect)
- Performance deadlines and timetables may be adjusted (but not waived)
- Limitations on payment to permit Medicare enrollees to use out of network providers in an emergency situation

Other Flexibilities

In addition to the 1135 Waiver Authority, Section 1812(f) of the Social Security Act (the Act) authorizes the Secretary to provide for SNF coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the SNF benefit's "acute care nature" (that is, its orientation toward relatively short-term and intensive care). Under this authority, CMS can issue a temporary waiver of the SNF benefit's qualifying hospital stay requirement for those beneficiaries who are evacuated or transferred as a result of the emergency situation. In this way, beneficiaries who may have been discharged from a hospital early to make room for more seriously ill patients will be eligible for Medicare Part A SNF benefits. In addition, beneficiaries who had not been in a hospital or SNF prior to being evacuated, but who need skilled nursing care as a result of the emergency, will be eligible for Medicare Part A SNF coverage without having to meet the 3-day qualifying hospital stay requirement.

DHHS Threshold to Invoke 1135 Waiver

In determining whether to invoke an 1135 Waiver (once the conditions precedent to the authority's exercise have been met), ASPR convenes a meeting of relevant OPDIVS to determine the need and scope for such modifications.

Information considered includes requests from Governor's offices, feedback from individual healthcare providers and associations, requests to regional or field offices for assistance, and information obtained from the Secretary's Operation Center. The intent is to determine whether the waivers or modifications allowed under the 1135 Waiver Authority will assist healthcare providers in dealing with the response to a disaster.

Duration of 1135 Waiver
These waivers typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period. Waivers for EMTALA (for public health emergencies that do not involve a pandemic disease) and HIPAA requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the termination of the pandemic-related public health emergency. The 1135 waiver authority applies only to Federal requirements and does not apply to State requirements for licensure

PROCEDURE

Requesting to Operate Under 1135 Waiver
Once an 1135 Waiver is invoked, health care providers can submit requests to operate under that authority or for other relief that may be possible outside that authority to the CMS Regional Office with a copy to the State Survey Agency (CDPH L&C).

CMS does not provide a template but has recommended the draft letter/email to include the following:

1. Facility Name
2. Facility Full Mailing Address
3. CMS Certification Number (CCN)
4. Explanation of why the waiver is needed (including scope of the issue and the impact on the facility) and type of relief / regulatory requirement, or regulatory reference that the requestor is seeking to be waived. Be specific.
    a. Example: This facility is the sole care provider without transfer options during the specified emergent event (flooding, pandemic flu outbreak, etc.). The facility needs a waiver to exceed its bed limit by X-number of beds for Y-number of days or weeks.

Refer to our facility's 1135 Waiver Request Template: copy below, word document in MS Teams: Hospital Command Center.

Request Approval
CMS will review and validate the 1135 waiver requests utilizing a cross-regional Waiver Validation Team. The cross-regional Waiver Validation Team will review waiver requests to ensure they are justified and supportable.

Blanket Waiver Modifications
CMS can implement specific waivers or modifications under the 1135 authority on a "blanket" basis, when a determination has been made that all similarly situated providers in the emergency area needed such a waiver or modification. Examples include hospitals that have initiated their disaster plans and are operating under the Emergency Medical Treatment and Labor Act (EMTALA) waiver, the 25-bed limit and 96-hour annual average per patient length of stay requirement for Critical Access Hospitals, and requests for increases in the number of certified beds for providers.

While blanket authority for these modifications may be allowed, the provider should still notify the State Survey Agency and CMS Regional Office if operating under these modifications to ensure proper payment. Similarly, most reporting requirements (such as nursing homes providing Minimum Data Set updates on residents) are suspended for all providers in the impacted areas in accordance with the Waiver authority.

Implementation of 1135 Waiver Authority
Federally certified/approved providers must operate under normal rules and regulations, unless they have sought and have been granted modifications under the waiver authority from specific requirements.

Providers must resume compliance with normal rules and regulations as soon as they are able to do so. In any event the waivers or modifications a provider was operating under are no longer available after the termination of the emergency period.

REFERENCE
https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertemergprep/1135-waivers.html

LAC+USC MEDICAL CENTER

1200 N. State Street
Inpatient Tower (IPT)
2nd Floor, Room C2K100
Los Angeles, CA 90033

Tel: (323) 409-2800
Fax: (323) 441-8030

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

To: CMS Region 9: Office of the Regional Administrator
Division of Survey and Certification
90 – 7th Street
Suite 5-300
San Francisco, CA 94103-6706
ROSFOSO@cms.hhs.gov

From: LAC+USC Medical Center
1200 N. State Street
IPT C2K100
Los Angeles, CA 90033

CMS Certification Number (CCN): 05-0373

Contact Person: <Insert Name, Title>
<Insert Contact Information>

Date: <Insert Date>

Re: Request to Operate Under 1135 Waiver Authority

<Insert explanation of why the waiver is needed (including scope of the issue and the impact on the facility) and type of relief / regulatory requirement, or regulatory reference that the requestor is seeking to be waived. Be specific>.

c: CDPH L&C Orange County District Office

Emergency Operations Plan

Requesting Increased Patient Accommodations: CDPH L&C AFL 18-09

BACKGROUND

Title 22, CCR, section 70809 (Patient Accommodation Standards) states:

a) "No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of a justified emergency when temporary permission may be granted by the Director or his designee.
b) Five percent of a facility's total licensed bed capacity may be used for a classification other than that designated on the license. Upon application to the Director and a showing that seasonal fluctuations justify, the Director may grant the use of an additional five percent of the beds for other than the classified use.
c) Patients shall not be housed in areas which have not been approved by the Department for patient housing and which have not been granted a fire clearance by the State Fire Marshal, except as provided in paragraph (a) above."

Title 22, CCR, section 70805 (Space Conversions) states: "Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department."

Facilities may request temporary approval with a program flex for an increase in patient accommodations, flex beds, space conversions, or surge tent use due to healthcare emergencies, unexpected events, or unforeseen events, e.g., infectious disease outbreak, a disaster, or mass casualty incident.

PROCEDURE

I. Authority

1. The CEO or designee will direct the Office of Regulatory Affairs to contact the local CDPH L&C District Office (DO) Health Facilities Inspection Division (HFID) to request temporary program flex.
2. The Incident Commander will direct the Liaison Officer in coordination with the Office of Regulatory Affairs to contact the local DO HFID to request program flex.

II. Request Process for Temporary Program Flex

1. Prepare the approval request "Temporary Permission for Program Flexibility for Increased Patient Accommodations," form CDPH 5000A: copy below, fillable .pdf on MS Teams: Hospital Command Center.

2. Submission
    a. Routine: To obtain approval for increased patient accommodations that requires the use of flex beds, space conversion, or surge tent use, contact the DO with a request for advance approval to implement the proposed program flex.
    b. Emergency: The hospital should implement surge strategies and submit the request for Program Flex and other waivers as soon as possible by email and fax to the health facilities supervisor. Note: both LA and Orange County DO HFIDs are in concurrence to this caveat.

3. Contact Information
    a. CDPH L&C Orange County District Office
    681 S. Parker Street, Suite 200
    Orange, CA 92868

Phone: (714) 567-2906
Toll Free: (800) 228-5234
Fax: (714) 567-2815

Tonnu Tu, Health Facilities Evaluation Supervisor (tu.tonnu@cdph.ca.gov)
Hang Nguyen, District Office Manager

b. If the local L&C DO is non-operational due to an emergency/disaster or after hours:
    i. Call the State Office of Emergency Services Warning Center: 916-845-8911
    ii. Ask for the CDPH Duty Officer.

The facility should not assume that the request will be approved until, at a minimum, it is verbally authorized by an L&C representative. L&C will confirm approval in writing through a fax or email.

In a declared emergency, CDPH will issue guidance to inform facilities about any temporary changes authorized during the emergency.

III. Approved Tent Uses
CDPH will authorize surge tents for use as waiting rooms, to conduct triage, to conduct medical screening exams, provide basic first-aid, and/or provide outpatient treatment that meets applicable rules and regulations. Any other use will require additional CDPH approval.

If proposed tents require local fire marshal permit, CDPH will authorize the use of tents if the facility has obtained approval from the local fire authority as applicable.
1. Utilize Facilities Management: Special Event Coordinator
2. Reference: LAFD Special Events Application Packet.

If proposed tents will use utility hook up that from any hospital building, the facility must obtain Office of Statewide Health Planning and Development (OSHPD) approval.
1. Utilize Facilities Management: OSHPD Liaison and Special Event Coordinator

REFERENCE
CDPH L&C AFL 18-09: Requesting Increased Patient Accommodations
LAFD Special Events Application

ATTACHED
CDPH 5000A Form

Temporary Permission for Program Flexibility for Increased Patient Accommodations

This form is to be used ONLY for program flexibility requests when hospitals temporarily need to comply with licensing requirements by using alternative concepts, methods, procedures, techniques, equipment, or personnel.

Hospitals are required to submit a program flexibility request to the California Department of Public Health (CDPH), Licensing & Certification (L&C) Program through their local district office (DO) for written approval. This form is a mechanism to expedite the request and approval process in emergency situations.

https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx

Facility Name LAC+USC Medical Center	Date of Request
License Number 060000130	Facility Phone / Facility Fax Number
Facility Address 1200 N. State Street, IPT C2K100	E-mail Address
City / State / Zip Code Los Angeles / CA / 90033	Contact Person Name

Approval Request
Complete one form for each request

Duration of Request

☐ Tent use (High patient volume)
☐ Space conversion (other than tent use)
☐ Bed use
☐ Over bedding

Start Date:
End Date:

Program Flex Request

What regulation are you requesting program flexibility for? CCR Title 22, Section 70809

Justification for the Request

☐ A disease outbreak (verifiable through sources such as the local emergency medical service agency (LEMSA), local Public Health Officer, CDPH Division of Communicable Disease Control, the Centers for Disease Control and Prevention) is present in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: Increased cases of seasonal influenza, onset of a severe acute respiratory syndrome-type or other highly contagious virus requiring acute care, an epidemic/pandemic, a bioterrorism agent, or a declared public health emergency.

☐ An emergency resulting in the need for increased patient accommodations has occurred in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: A natural or human-caused disaster, a crime incident or transportation accident resulting in numerous mass casualties, an emergency causing the evacuation of patients or diversions from another hospital (LEMSA diversion has been implemented).

Justification for the Request

☐ Other:

Exhausting Available Alternatives

The hospital must exhaust available alternatives before requesting increased patient accommodations. Check all that apply:

- ☐ Rescheduling non-emergent surgeries and diagnostic procedures.
- ☐ Transferring patients to other beds or discharge as appropriate.
- ☐ Setting clinics for non-emergency cases (if possible).
- ☐ Requesting ambulance diversion from LEMSA, if appropriate.
- ☐ Other:

Facility Name	License Number	Request Date
LAC+USC Medical Center	060000130	

Adequate Staff, Equipment and Space

The hospital must make arrangements for adequate staffing, equipment and space for increased patient accommodations. Check all that apply:

- ☐ A plan is in place for staff if the request is for use of alternate space.
- ☐ A plan is in place for equipment if the request is for use of alternate space.
- ☐ The proposed space for care of patients provides sufficient square footage to ensure access for safe care.
- ☐ Other:

Additional Information

Provide a brief description of your conditions and explain the need for program flexibility. Provide a brief description of the alternative concepts, methods, procedures, techniques, equipment or personnel to be used, and the conditions under which this program flexibility will be utilized. Attach additional supporting documentation as needed.

Signature of person requesting program flexibility

Title

Printed name

Note: Approval for tent use, space conversion, bed use and over-bedding will be time limited and dependent on the facts presented that substantiate the emergency. Initial approval may be given verbally by the local L&C DO; however, a signed written approval must be distributed (faxed) to the hospital and filed in the hospital's facility folder.

For CDPH Use Only:

CDPH Licensing and Certification Approval:

☐ Permission Granted from: _____ to _____

☐ Permission Denied: Briefly describe why request was denied in comments / conditions below:

Comments / conditions:_____

PURPOSE
To establish operational guidelines to increase surge response capability for managing healthcare emergencies involving a surge of patients.

POLICY
This is an emergency response plan to be used as an all-hazards approach for patient surge and works within the framework of this Emergency Operations Plan (EOP) and the DEM Emergency Response Plan (ERP). The plan is to be implemented during a Multi-Casualty Incident, a Mass Casualty Incident (medical, trauma, or CBRNE), an internal/external disaster, or a healthcare emergency resulting in patient surge. Additionally, plan activation should be considered if the NEDOCS level is BLACK due to ED Crowding. The plan will remain in effect until that time that the event has resolved, and the department can be returned to normal operations.

DEFINITIONS
Surge: a sizeable increase in demand for resources compared with a baseline demand. Components include Influx (volume, rate), Event (type, scale, duration), and Resource Demand (consumption, degradation).

Surge Capacity: the maximum potential delivery of required resources either through augmentation or modification of resource management and allocation. Components include System (integrity), Space (size, quality), Staff (numbers, skill), and Supplies (volume, quality).

Surge Response Capability: the ability of Surge Capacity (the resources that can be made available) to accommodate the Surge (demand for resources).

SYSTEM

1. **Activation**
    a. Authority/ Criteria per EOP policy.

2. **Notification**
    a. Additional to EOP policy, Surge implementation notified by the HCC, AOD, or House Supervisor to the ANO, units, and services via:
        i. Everbridge
        ii. Broadcast notification
        iii. Telephone

3. **Administrative**:
    a. Cancel (or hold) and reschedule elective and non-emergent surgery, procedures, and clinic appointments. Space and staff will be flexed and / or re-purposed as below.
    b. Discharge Waiting Unit (DWU):
        i. Hours: 0600-2300
        ii. Utilize for ALL appropriate discharges, i.e., self-sufficient and stable patients without the need for contact isolation.
    c. Radiology:
        i. Open and staff ALL CT scanners.
        ii. Emergent studies have priority.

4. **Staff**
    a. Note:

i. Staff held over, called-in, re-assigned, and re-purposed as described previously. See *Staff Responsibilities*.
ii. Staff to Patient ratios (per nurse, provider, or team) may be suspended during healthcare emergencies, e.g., Title 22 CCR 70217. In such circumstances when needs are greater than resources, a new standard of care is in place.

b. Nurse Staff
   i. ANO to evaluate staffing (i.e., inpatient beds) and take appropriate measures to assure that all units are maximally staffed.
      1. Nursing to establish a notification, polling, and call back system to ensure that they meet staffing needs.
      2. Example: Everbridge
   ii. Nurse Management will assist with direct patient care.

c. Medical Staff
   i. All efforts will be dedicated to patient care activities including, but not limited to:
      1. New and existing patient evaluation and treatment.
      2. Coordinate and assist in the patient care activities of nursing and support staff as required.
      3. Coordinate and assist in obtaining necessary ancillary / diagnostic studies, consults, procedures, etc.
      4. Coordinate and assist in patient discharge and discharge planning (i.e., social work, placement, transportation, continuity follow-up, patient education, prescriptions, etc.).

d. Navy Trauma Training Center (NTTC) Personnel:
   i. The NTTC Personnel not currently on shift will report to the ED Subcommand Post for assignments. These personnel are available 3 of 4 weeks per month.
   ii. During a Trauma Surge, the NTTC Operating Room Team is capable of staffing an additional OR and assist in SICU patient care.

5. **Bed Reconciliation**
   a. ANO reports to the HCC with bed status from most recent daily Bed Huddle.

   b. The Bed Control Supervisor will verify the current status of all beds.

   c. The House Sup, PFM, ANDAs, NMs, and EVS Supervisor:
      i. Verify status of all unit beds and their occupancy.
      ii. Assure that open beds are cleaned and ready for occupancy.
      iii. Evaluate the status of beds closed due to administrative hold and re-open these beds. See “5.c.” below.

   d. Discharge and Transfer Rounds
      i. Inpatient teams and specialty services (Attendings, Fellows, Residents, and respective ANM, Charge Nurse) to review all patients and conduct discharge rounds.
         1. Identify bed status, staffing, patient status, and patient needs.
         2. Emphasis is on early, appropriate, and expeditious work-up and discharge of patients.
         3. Assure that inpatient teams have ordered and processed daily discharges.
         4. Identify and assist with barriers to potential discharges including consults, social work, transportation, etc.
      ii. The NMs will report or fax Bed Huddle results to the ANO within 1 hour of Surge implementation.

iii. This process will be repeated every 8 hours until system returns to normal.

e. ANO Bed Huddle Activation
   i. To commence immediately.
   ii. Location: Admin Conference Room per usual or the HCC. To be determined.
   iii. Unit NMs to report patient and bed status obtained during Discharge Rounds above.
   iv. ED EFC reconciles ACU/ICU admits then reports to ANO.
   v. EVS and Bed Control Shift Supervisor report to the ANO.
   vi. ANO report status to HCC Medical Care Branch.
   vii. Process to repeat every 4 hours.

6. **Licensed Bed Space**
   a. Note: During catastrophic surge, staff may be limited. Establishing alternate care sites may deplete already limited staff. Thus, increasing capacity in existing patient care areas may be more appropriate for staff and patient safety.

   b. Note: Use of flex beds (>5% of licensed beds) or repurposed/converted space will require CDPH L&C approval. Refer to section: Requesting Increased Patient Accommodations: CDPH L&C AFL 18-09.

   c. Specialty beds are NOT restricted for use.
      i. Utilize ALL staffed inpatient beds (ACU and ICU) for patients awaiting admission.
      ii. HCC Medical Care Branch in coordination with Bed Control, House Sup, and PFM determine appropriate placement.
      iii. The Primary Team assigned to the patients will be the appropriate service for the patient regardless of location.

   d. Re-open Closed Beds
      i. Closed Beds: Due to "Dirty" status
         1. Bed will be assigned.
         2. Patient will wait on gurney outside of assigned room.
         3. Assigned team and nursing unit will immediately assume care.
         4. Gurney will be returned to ED immediately upon EVS cleaning room and patient transferring to hospital bed.
      ii. Closed Beds: Due to Staffing
         1. Bed will be opened.
         2. Unit Charge RN or NM to staff
      iii. Closed Beds: Due to mechanical failure
         1. Neg/Pos pressure room malfunction: convert to non-isolation.
         2. Bed malfunction: Facilities Management (EVS, Equipment Repair) to immediately change out.
         3. Other malfunction: FM to repair immediately.
         4. Note: Only a malfunction that is a threat to patient safety will prevent room from occupancy.

   e. Reassign ACU space
      i. IPT 2E
         1. Use for non-Behavior Medicine patients.
      ii. IPT 3C
         1. Cohort all "appropriate" female pts
         2. Criteria to be established
      iii. D&T B5E (SOU)
         1. Board: All pending surgical and surgical subspecialty admits

7. **Flex Beds and Repurpose Convert Space**
    a. Note: Use of flex beds (>5% of licensed beds) or repurposed/converted space will require CDPH L&C approval. Refer to section: Requesting Increased Patient Accommodations: CDPH L&C AFL 18-09.

    a. Increase ACU / ICU room occupancy
        i. Single occupancy to Double; Double occupancy to Triple
        ii. Locations:
            1. ACUs: 2E (Behavioral Med), 3C (OB-Gyn), 5D (Burns), 6A-D, 7A-D
            2. Telemetry: 8A
            3. PCU: 4M, 8B
            4. ICUs: 4A/B (MICU), 4C(NeuroICU), 4D (CCU), 5A/B (SICU), 5C (CTSICU), 5M (BICU)

    b. Hall Beds
        i. Utilize non-licensed ACU space.
        ii. Hall Bed Criteria preferred.
        iii. HCC and Bed Control to assign Hall Beds in “round robin” fashion.
        iv. Units: 2E, 3C, 6A-D, 7A-D.

    c. Inpatient/Outpatient Surgery (IPT 3B, D&T 5A-C)
        i. Cancel (or hold) and reschedule non-emergent cases.
        ii. Utilize space and staff for inpatient care and admissions.
        iii. Convert to ACU, Telemetry, PCU, or ICU beds.
        iv. Capacity:
            1. Inpatient
                a. Pre-op area
                    i. D&T 5C: 14 monitored
                b. Post-op area
                    i. IPT 3B: 4 monitored
                    ii. D&T 5A (B5A): 17 monitored, includes 3 isolation
                    iii. D&T 5B (B5B): 14 monitored
            2. Outpatient
                a. Pre-/Post-op
                    i. CT 5C (A5C): 30 monitored, includes 2 isolation
            2. ORs
                b. IPT 3B: 2 monitored
                c. D&T 5D/E: 25 monitored
                d. Note: ORs are less useful due to larger physical area for staff to cover.

    e. Special Procedures - Cath, GI, GU, Pulm (D&T 4C) and IR (D&T 3)
        i. Cancel (or hold) and reschedule non-emergent cases.
        ii. Utilize space and staff for inpatient care and admissions.
        iii. Convert to ACU, Telemetry, PCU, or ICU beds.
        iv. Capacity:
            1. Special Procedures Intake Prep & Recovery (D&T 4B): 25 monitored
            2. IR Intake Prep & Recovery (D&T 3): 6 monitored

    f. Outpatient Clinics
        i. Cancel (or hold) and rescheduling of all non-emergent appointments.
        ii. Repurpose space and staff.
        iii. Use for low acuity and outpatient care of disaster victims triaged from ED.

8. **Alternate Care Sites (ACS**)
    a. Note: Use of surge tents or ACSs will require CDPH L&C approval. Refer to section: Requesting Increased Patient Accommodations: CDPH L&C AFL 18-09.

    a. Auditorium Conversion
        i. IPT Conference Room A/B, GH Main Auditorium
        ii. Potential use:
            1. Discharge Waiting Unit
            2. Staging and treatment area for overflow of Minor patients (walking wounded)
            3. Admit Holding Area
            4. Inpatient Ward

    b. DRC Field Hospital:
        iii. Capacity 40 beds.
        iv. Note: less useful given increased staffing requirements and austere environment.

    c. Open Shuttered Hospital (General Hospital: Unit 1).
        v. Reference “Surge Hospitals: Providing Safe Care in Emergencies” (TJC).

    d. EMS Agency Mobile Medical System (MoMS)
        vi. Deployed via MAC/MCC as indicated to support event.
        vii. Capability
            1. 12 Bed ED or monitored area
            2. 2 Bed OR monitored area
            3. 100 Bed Hospital
        viii. Staff support for MoMS EOC only.

REFERENCE
AFL 18-09: Requesting Increased Patient Accommodations
CDPH Title 22 CCR 70217

ATTACHED
CDPH 5000A Form

PURPOSE
To establish operational guidelines for managing healthcare emergencies involving a surge of pediatric patients.

BACKGROUND
The pediatric population has unique vulnerabilities and needs requiring specialized care, equipment, and safety and supervision considerations. Additionally, as a Tier 1 hospital within the Los Angeles County Pediatric Surge Plan, our commitment is to increase our surge response capability by 15 PICU and 15 PACU beds.

POLICY
This is an emergency response plan to be used as an all-hazards approach for pediatric patient surge and works within the framework of the Emergency Operations Plan and the DEM Emergency Response Plan (ERP). The plan is to be implemented for an internal or external event resulting in a surge of pediatric victims. The plan will remain in effect until it is determined that the event has resolved, and the facility can be returned to normal operations.

SYSTEM

1. **Activation**
    a. Authority
        i. Per EOP policy.
    b. Criteria
        i. If > 10 pediatric patients are expected to arrive, or
        ii. At any time if the number of pediatric patients overwhelms the capabilities of the ED as determined by the Pediatric ED Attending

2. **Notification**
    a. Per EOP policy.
    b. Surge implementation notified by the HCC, AOD, or House Supervisor to the ANO, units, and services via:
        i. Everbridge
        ii. Broadcast notification
        iii. Telephone

1. **Pediatric Disaster Response Team (PDRT)**
    a. Activation Criteria
        i. If > 10 pediatric patients are expected to arrive, or
        ii. At any time if the number of pediatric patients overwhelms the capabilities of the ED as determined by the Pediatric ED Attending
    b. Activation Process
        i. Primary: via Everbridge (see DEM ERP)
        ii. Backup: House Supervisor to initiate call tree. See attached, p.9
    c. Team Composition
        i. Child Life: Director
        ii. General Pediatrics and Pediatric Subspecialty Attending Staff: On-call Inpatient Hospitalist, Peds Charge Nurse
        iii. NICU: On-call Attending, Fellow, Charge Nurse
        iv. Pediatric Administrator
        v. Pediatric Chief Resident and General Pediatric House staff: On-call Pediatric Chief Resident

vi. Pediatric ED: Attending, Charge Nurse
vii. Pediatric RT Supervisor
viii. PICU: Attending, Charge Nurse
ix. Social Work: Pediatric Supervisor

d. Function
   i. Upon activation, report to the Casualty Care Unit: Pediatric Unit Leader.
      1. Note: This would normally be the Pediatric ED Attending.
   ii. Designate PDRT Liaison for HCC
      1. Consider Pediatric Administrator, Pediatric Nursing Director
   iii. Determine immediate, delayed, and long-term needs of the pediatric patients and allocate resources as appropriate.
      1. ED and inpatient needs vs resources
      2. Patient acuity and priority
      3. Patient and family psycho-social welfare
      4. Unit status: Patient Acuity, Disposition, Staffing, Level of Service
e. Reporting chain
   i. For purposes of notification, status, supply/staff needs, directives, etc.
   ii. Peds ED: Ped Unit Leader > DEM Unit Leader > HCC Casualty Care Unit Leader > HCC Medical Care Branch Director
   iii. Inpatient: HCC PDRT Liaison > HCC Inpatient Unit Leader > HCC Medical Care Branch Director

2. **Acute / Emergent Care**
   a. ED decompressed per DEM ERP
   b. Triage and treatment per DEM ERP and ED Protocol
      i. Peds ED, Resus, North, West, East
   c. Low Acuity or Needing Outpatient Care
      ii. Consider transfer to Clinic Areas after triage / MSE (see table below).
      iii. Requires approval from the HCC

3. **Inpatient Care**
   a. Note: Use of flex beds (>5% of licensed beds) or repurposed/converted space will require CDPH L&C approval. Refer to section: Requesting Increased Patient Accommodations: CDPH L&C AFL 18-09.

   b. **Acute Care Units**
      i. 8C (Pediatrics)
         1. Capacity
            a. Ward: 21 (13 single-, 4 double-occupancy rooms)
            b. Obs: 4 (2 double occupancy rooms)
         2. Surge Capability
            a. Increase +1 occupancy forward/obs rooms: up to +18
            b. 15 sleeper cots available on ward
      ii. 6A-D/ 7A-D/8A (Adult), 3C (OB/Gyn), 5D (Burns)
         1. Surge Capability
            a. Flex and cohort designated wards to Peds/Adolescent only
            b. Capacity: Variable. Dependent on incident type, ability to decompress, staffing, and hospital census
      iii. Flex Beds / Re-purpose Hospital Space
         1. Surge Capability
            a. Pre/Post-Op Inpatient/Outpatient Surgery, Conference Rooms, etc. per Surge Plan

b. Additional ICU Monitors available
    i. DRC Equipment cache
    ii. Clinical Engineering
    iii. Clinical Equipment Operations
c. Capacity: Variable. Dependent on incident type, ability to decompress, staffing, and hospital census

c. **Intensive Care Units**
    i. 8D (PICU)
        1. Capacity: 10 Monitored (single occupancy)
        2. Surge Capability
            a. Flex and cohort, increase occupancy
            b. 10 sleeper couches available in PICU
            c. Capacity: Variable. Dependent on incident type, ability to decompress, staffing, and hospital census
    ii. 4A/B (MICU), 4C(NeuroICU), 4D (CCU), 4M (PCU/Step-Down), 5A/B (SICU), 5C (CTSICU), 5M (BICU), 8A (Telemetry), 8B (PCU/Step-Down)
        1. Surge Capability
            a. Flex and cohort
            b. Capacity: Variable. Dependent on incident type, ability to decompress, staffing, and hospital census
    iii. Flex Beds / Re-purpose Hospital Space
        1. Surge Capability
            a. Pre/Post-Op Inpatient/Outpatient Surgery, Conference Rooms, etc. per Surge Plan
            b. Additional ICU Monitors available
                i. DRC Equipment cache
                ii. Clinical Engineering
                iii. Clinical Equipment Operations
            c. Capacity: Variable. Dependent on incident type, ability to decompress, staffing, and hospital census

4. **Outpatient Care**
    a. Consider cancellation and rescheduling of all non-emergent appointments.
    b. Repurpose space and staff.
        i. Use of outpatient clinics for further management of stable, low acuity disaster victims after triage and MSE.
        ii. Housing of the well child and those awaiting discharge or pickup.
        iii. See attached.

5. **Patient Disposition / Family Reunification**
    a. Note:
        i. Security, supervision, and capabilities are primary concerns for designating areas for pediatric housing and discharge waiting areas.
        ii. In the event of a significant pediatric surge, the Family Assistance Center (FAC) would likely have been established. See FAC Plan for more details on Family Reunification discussed below.
    b. Discharge
        i. Follow standard hospital procedures for discharging pediatric patients when discharging home with parent/guardian.
        ii. If a presenting adult is unable to provide proper identification, contact Social Work
            1. DEM: 96883

2. Ped Sup: 97629

c. Family Reunification
   i. If a patient is unaccompanied by parent/guardian
      1. Contact Social Work to locate family
      2. If the child was brought in from a daycare/school, they may be able to provide emergency contact information
      3. If the City opens a Family Information Center (FIC), they may be able to provide information and coordination
   ii. If SW unable to locate family through normal processes:
      1. SW to complete an "Unaccompanied Minor Sign-in/Tracking Form"
      2. SW to place the appropriate colored ID band on the child, and follow procedures in FAC Plan to track minors
   iii. If SW unable to locate family with the designated 24 hours, SW to utilize outside agency resources
      1. DCFS Emergency Management
         a. Phone: 213-351-5504
      2. National Center for Missing and Exploited Children (NCMEC)
         a. Phone: 800-THE-LOST
         b. Website: www.missingkids.com/DisasterResponse
      3. National Emergency Child Locator Center
         a. Established by the NCMEC for large scale incidents

6. **Staffing**
   a. The PDRT to determine staffing needs of the Peds ED, Inpatient Areas, Outpatient Areas
      i. Reassign and repurpose staff as appropriate
      ii. For the flex/cohort of ACU and ICU for pediatric care
         1. Reassign pediatric nurses to the flexed ACU/ICU areas to assist in the management of the pediatric population and just-in-time training
      iii. For additional staffing needs, request through proper chain of command as stated above
   b. Volunteer Office
      i. Business Hours: M-F 0700-1700
         1. Director: Socorro Ceja (96955)
         2. LAC+USC Volunteers
            a. All screened by the County
            b. Can assist with patient movement and housing
            c. Approximately 80-120 on-site per day

7. **Supplies**
   a. General supplies and equipment should be obtained through your normal processes. If unable to obtain via normal daily processes:
      i. DEM: DEM Logistics Officer > DEM Unit Leader > HCC Casualty Care Unit > HCC Logistics Section.
      ii. Inpatient Areas: HCC PDRT Liaison > HCC Logistics Section
   b. Beds/cribs
      i. PICU (Overflow Area): 10 high top cribs, 5 pediatric beds
      ii. NICU: 47 incubators, 4 transport incubators w/ monitor, 20 bassinettes (shared w/ 3G), 6 regular cribs
      iii. GH: 6350 has 3 cribs. Access code #41026
      iv. CWC: Rollaway beds and cots that can be reallocated to the areas in OPD
   c. Ventilators
      i. Adult/Peds capable
      ii. 134 ventilators

iii. 21/134 modified to manage neonates only

d. Non-perishable supplies
   i. Diapers, bottles, pacifiers, etc.
   ii. 7-day supply
   iii. Mini-warehouse: 323-226-2381

e. Perishable Supplies
   i. Food
      1. Refer to Food & Nutrition Services Plan: Section H - Emergency Preparedness
   ii. Baby Formula:
      1. NICU, Nursery: 3-day supply
      2. Tower Warehouse (1CL100, 92381): See attached, p.12

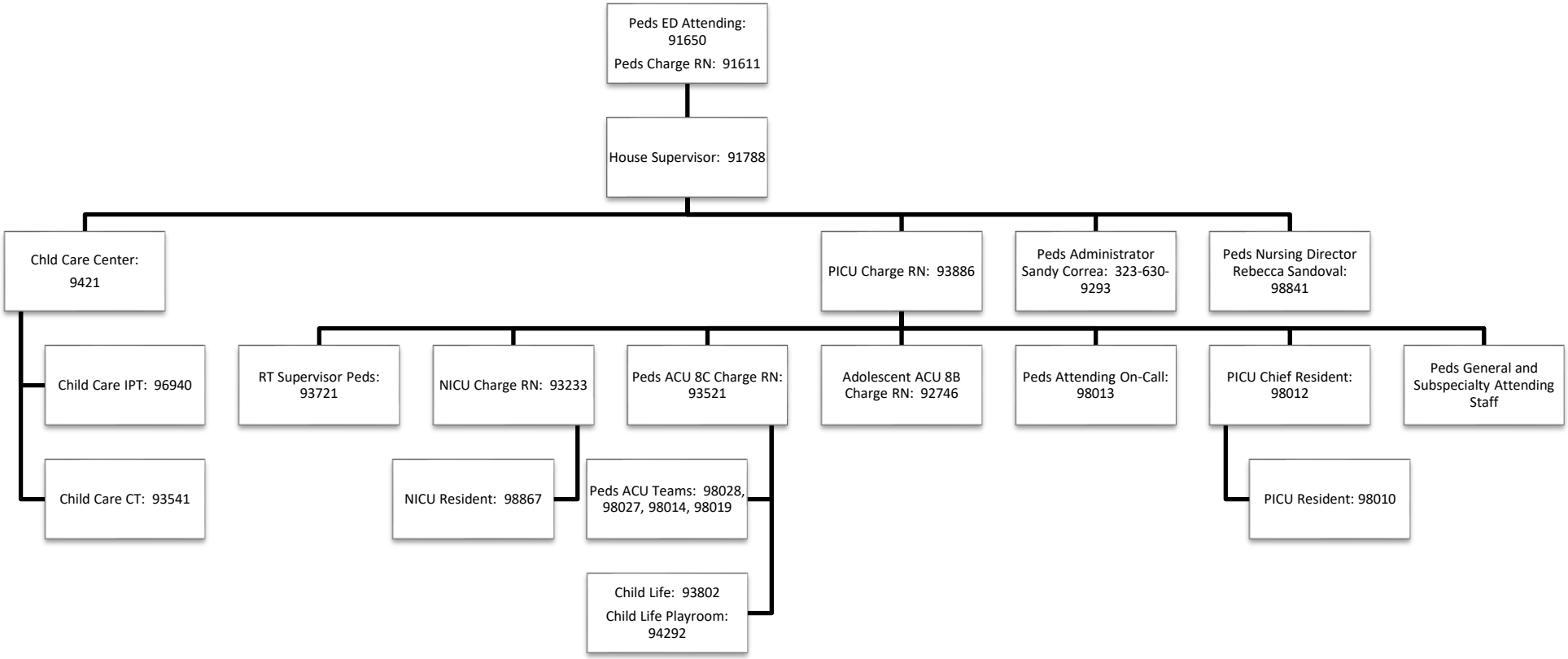
f. Breastfeeding
   i. Breastfeeding encouraged for neonates with available mother
   ii. Relactation Support
      1. Consider for mothers with infants less than 2 months in extended disaster situations
      2. Refer those mothers to the NICU.
   iii. Lactation Rooms
      1. Patients – NICU
         a. NICU Lactation Room
         b. 2 chairs available, and 5 "plug in" breast pumps
      2. Employee Lactation Room
         a. IPT 1st Floor, Rm C1C102 / 1K417
         b. 12 chairs, 6 breast pumps, one sink, and one refrigerator
         c. Access: keypad. Contact ED Nurse Manager
      3. Non-employee Lactation Room
         a. Repurposed Conference Room
         b. IPT 1st Floor, Rm. C1D101 / 1K415
         c. Off hours access: master key, key #700
   iv. Supplies
      1. Single hand breast pumps
         a. ER, NICU, or request via Clinical Equipment Operations
      2. Breast pumps (3)
         a. Lactation Nurse Office

g. Diversions/Child Entertainment
   i. CARES Childcare Services: DVD players, paints, toys, etc.
   ii. Gift Shop: toys, books, puzzles, etc.
   iii. Pediatric ED: 2 DVD players
   iv. Child Life: toys, board games, videos, and computers
   v. CWC: TV and DVDs available for use in OPD

ATTACHED
Pediatric Surge Call Tree
Contact List
Unit and Service Capabilities
Stock – Formula
Pediatric Surge Reference Guide

REFERENCE
AFL 18-09: Requesting Increased Patient Accommodations
CDPH 5000A Form
DEM Emergency Response Plan

Pediatric Surge Call Tree 2016-01-31



Contact	Phone
ACU 8B: Adolescent/Adult	92746
ACU 8C: Pediatrics	93521
CARES Office	96941
CARES CT	93541
CARES IPT	96940
CARES Director: Margie Dolinski	96952
CARES County Liaison: Vivian Saldivar	96951
CARES Child Care Sup: Maritza Morales	95173
Child Life Director: Maria Tome	93802
Child Life Playroom	94292
Dr. Astrid Heger	O: 93961
Emergency Management	96012
Emergency Manager: Dr. Celentano	P: 213-717-6777
Hospital Command Center	91443
House Supervisor	O: 94445, 9446 V: 91788
Lactation Nurse: Kittie Frantz	O: 92236
NICU	93233
NICU Attending	Amion (lacusc): Pediatrics > Neonatology NICU
NICU Fellow	Amion (lacusc): Pediatrics > NICU
NICU Resident	98867
Patient Flow Manager	O: 97572 V: 91605
Peds ACU Attending	98013
Peds ACU Admitting / Clerk	98011
Peds ACU Team – Blue	98028
Peds ACU Team – Green	98027
Peds ACU Team – Red	98014
Peds ACU Team – Yellow	98019
Peds Administrator: Sandy Correa	C: 323-630-9293
Peds ED	93601
Peds ED Attending	91650
Peds ED Charge Nurse	91651
Peds Nursing Director: Rebecca Sandoval	O/V: 98841
Peds Service Chief: Dr. Opas	C: 818-269-7839
Peds Service Chief Backup: Dr. Johnson	C: 323-691-0533
Peds Service Chief Backup: Dr. Stotts	C: 310-709-9852 P: 213-704-3672
PICU	93886
PICU Attending: Nite (Cross Cover)	98013
PICU Attending: Day	Amion (lacusc): Pediatrics > On-Call Attending
PICU Chief Resident: Day	98013
PICU Chief Resident: Nite	98010
PICU Resident	98010
Psych Child / Adolescent: Day	91818
Psych ED	97085
Psych ED Consult Room	94088
Psych Inpatient Consult	O: 97975

	P: 213-919-0137
Security	93333
Social Work DEM	96833
Social Work Peds Supervisor	97629
Respiratory Therapy Supervisor – Peds	93721
Volunteer Office	96955

Unit and Service Capabilities

Inpatient Care Areas			
Department	Location	Phone#	Capability
Normal Nursery	IPT 3G	409-3356	Licensed Beds: 20
NICU	IPT 3A	409-3260	Licensed Beds: 40 Other: 47 incubators, 4 transport incubators w/ monitor, 20 bassinettes (shared w/ 3G), 6 regular cribs
Adolescent ward	8B	409-2746	Licensed Beds: 20 (flex, shared with Adult)
Pediatric ward	8C	409-3521	Licensed Beds: 21 ACU, 4 Obs Other: 15 sleeper cots
PICU	8D	409-3886	Licensed Beds: 10 Other: 10 couches
Burn ICU Burn Ward	5M 5D	409-7996 409-7991	Licensed Beds: ACU 10, ICU 10

Clinic Areas: Patients who have been triaged and received an MSE and determined to be stable, low acuity with minor injuries or needs may be transferred to the clinic areas for minor procedures or outpatient care.			
Department	Location	Phone	Capability
Clinic Tower			
Peds Ortho	A3D	409-5121	Orthopedic Services only: 4 exam rooms, 1 treatment room, 1 cast room
OPD 3rd Floor			
Adolescent Care & Transition (ACT), Allergy (adult/peds) Hi Risk Newborn	3P40,-41 3P42	409-2559 409-3237	20 exam rooms; 1 treatment room per clinic (suction and oxygen capability)
Violence Intervention Program (VIP), Community Assessment Treatment Center (CATC)	3P61	409-3961 409-5086	13 exam rooms
OPD 5th Floor			
Peds Clinics Mother, Child, and Adolescent Clinic	5 East (5P61, -81) 5 West (5P51)	409-3683 409-2200	32 exam rooms; 1 treatment room per clinic (suction and oxygen capability)

Housing / Awaiting Dispo Areas: Patients placed in these housing areas should not require any medical assistance.			
Department	Location	Phone	Capability
Peds Waiting Rooms	OPD 3P40A OPD 5East	409-5086 409-3683	

Unit and Service Capabilities

Child Care Centers (Day Care)	Clinic Tower A2A115 Inpatient Tower 2L216	409-3541 409-6940	CARES staffs 16 employees at each of the 2 centers. Capacity: 44 children: - Infants (birth-17 months): 8 - Toddlers (18-35 months): 12 - Preschoolers (3-5 years): 12 - School-age (6-11 years): 12 CARES will accept the following categories of children: - healthy siblings of injured pediatric patients - healthy children of adult patients - employees' children
Child Life (Play Room)	IPT 8C	Playroom 409-4292 Maria Tome 409-3802	20 children and 20 adults One CLS and one community worker is available M-F. Can report to duty if contacted. Child Life will accept: - Pediatric inpatients and their healthy siblings - Burn ward's pediatric patients - No cribs for infants - Includes a room with a play mat designated as the "neutropenic" side.
Child Welcome Center (CWC)	OPD 3rd Floor 3P33`	409-4417 409-5251	Capability Child Welcome Center: 11 and under Youth Welcome Center: 12-18 years Contacts Administrator: Sandy Correa DCFS CHW Director: Mary Cruz

Tower Warehouse: Baby Formula				
Item	**Part No.**	**Qty/UM**	**UM**	**Qty***
FORMULA ENFAMIL 22 LIPIL 3 OZ	FORENFA22	48	CS	5
FORMULA ENFAMIL PREMIE LIPIL 24	FORPRE24	48	CS	5
FORMULA-BABY-2 OZ-ENFAMIL PREMIUM	FOI24801	48	CS	5
FORMULA-BABY-4 OZ-ENFAMIL WITH IRON	FOI26901	48	CS	5
FORMULA-BABY-4 OZ-PRO SOBEE-20KCAL	FOI26601	48	CS	5
FORMULA-BABY-8 OZ-PEDIALYTE-ROSS	FOIRS806	48	CS	5
FORMULA-INFANT-PREGESTIMIL 20CAL	FOPG20RTF	48	CS	5
FORMULA-INFANT-PREGESTIMIL-24CAL	FOPG24RTF	48	CS	5

*Usual PAR

NORMAL PEDIATRIC VITAL SIGNS

	HR Beats/ min	RR Breaths /min	BP (sys) mm/Hg	BP (dias) mm/Hg
Newborn 0-1 month	100-180	30-60	73-92	52-65
Infant 1-12 months	80-150	30-60	90-109	53-67
Toddler 1-3 years	75-130	25-35	95-105	56-68
Pre-School 3-5 years	75-120	22-32	99-110	55-70
School Age 5-12 years	70-110	20-30	97-118	60-76
Adolescent 13-18 years	65-105	16-22	110-133	63-83

GLASGOW COMA SCALE (GCS)

Category	For Patients <2 Years Old	For Patients >2 Years Old
Eye Opening (E)	(4) Spontaneous (3) To speech (2) To pain (1) None	(4) Spontaneous (3) To speech (2) To pain (1) None
Verbal Response (V)	(5) Coos, babbles (4) Irritable, cries (3) Cries to pain (2) Moans to pain (1) None	(5) Oriented (4) Confused (3) Inappropriate words (2) Incomprehensible (1) None
Motor Response (M)	(6) Normal spontaneous movements (5) Withdraws from touch (4) Withdraws from pain (3) Abnormal flexion (2) Abnormal extension (1) None	(6) Obeys commands (5) Localizes to pain (4) Withdrawal to pain (3) Flexion to pain (2) Extension to pain (1) None

Sources for the Pediatric Surge Quick Reference Guide can be found online at:
http://ems.dhs.lacounty.gov
www.CHLA.org/DisasterCenter

Guide last updated 11.15.16

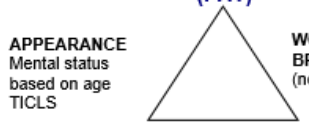
EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Pediatric Surge Quick Reference Guide

PEDIATRIC RISKS DURING DISASTERS

System / Area	Risk
Respiratory	• Higher breaths/minute increases exposure to inhaled agents • Nuclear fallout and heavier gases settle lower to the ground and may affect children more seriously
Gastrointestinal	• May be more at risk for dehydration from vomiting and diarrhea after exposure to contamination
Skin	• Higher body surface area increases risk of skin exposure • Skin is thinner and more susceptible to injury from burns, chemicals and absorbable toxins
Endocrine	• Increased risk of thyroid cancer from radiation exposure
Thermoregulation	• Less able to cope with temperature problems with higher risk of hypothermia
Development	• Less capability to escape environmental dangers or anticipate hazards
Psychological	• Prolonged stress from critical incidents • Susceptible to separation anxiety

PEDIATRIC ASSESSMENT TRIANGLE (PAT)



AVPU: Alert, Voice, Pain, Unresponsive - Used to assess level of consciousness or appearance in PAT tone or rigid or not moving

Component	Abnormal Signs
Appearance	T—tone abnormal floppy or rigid muscle tone or not moving; I –interactiveness, C - consolability; L - look/gaze decreased responsiveness to parents or environmental stimuli; S - speech/cry abnormal or absent.
Work of Breathing	Increased/excessive (nasal flaring, retractions or accessory muscle use) or decreased/absent respiratory effort or noisy breathing
Circulation to the Skin	Cyanosis, mottling, paleness/pallor or obvious significant bleeding

PEDIATRIC SIGNS OF RESPIRATORY DISTRESS AND RESPIRATORY FAILURE

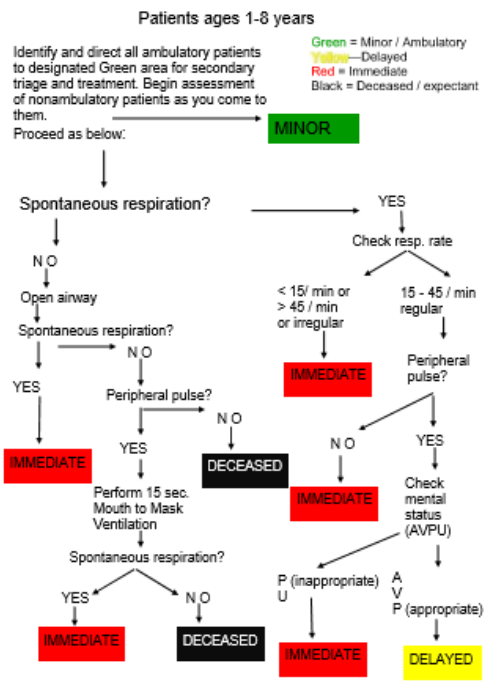
Respiratory distress is apparent when a child fails to maintain adequate gas exchange. As the child tires, effort and / or function deteriorate and gas exchange cannot be maintained.

Respiratory failure *requires* intervention to prevent deterioration to cardiac arrest.

Indicators may vary with severity.

Respiratory Distress	Respiratory Failure
Tachypnea	Marked tachypnea (early)
Increased respiratory effort (nasal flaring, retractions)	Increased, decreased or no respiratory effort
Inadequate respiratory effort (hypoventilation, bradypnea)	Bradypnea, apnea (late)
Abnormal airway sounds (stridor, wheezing, grunting)	Poor to absent distal air movement
Tachycardia	Tachycardia (early), Bradycardia (late)
Pale, cool skin	Cyanosis
Changes in level of consciousness	Stupor, coma (late)

JUMPSTART FIELD PEDIATRIC MULTICASUALTY TRIAGE SYSTEM



TREATMENT PRIORITIZATION

Triage category	Description
Green Minor	Patients with mild injuries that are self-limited and can tolerate a delay in care without increasing mortality risk
Yellow Delayed	Remaining patients who do not fit in the Red or Green categories
Red Immediate	Patients who do not obey commands Or do not have a peripheral pulse, Or are in respiratory distress, Or have uncontrolled major hemorrhage
Black Expectant or Dead	**Expectant:** Patients who have injuries incompatible with life given the current available resources **Dead:** Patients who are not breathing after life-saving interventions

USING KILOGRAMS

Weigh all children in kilograms.
1 kg = 2.2 lbs

Method to estimate weight:
Newborn (term): usually 3 kg
1-10 yrs: age multiplied by 2 + 10 (kg)
>10 yrs: age multiplied by 2 + 20 (kg)

If available, a length-based tape, (e.g., Broselow Tape) should be used for weight estimation.

DAILY MAINTENANCE FLUID AND ELECTROLYTE REQUIREMENTS

	Calculation
Fluids per hour	4mL/kg/hr for first 10kg of weight 2mL/kg/hr for next 10 kg of weight 1mL/kg/hr for each kg over 20kg
Fluids per 24 hour period	100mL/kg for the first 10kg body weight 1000mL+ 50mL/kg for the next 10kg body wt 1500mL+ 20mL for each kg of body weight over 20kg
Maintenance electrolyte calculations for IV fluid	**Sodium**: 3-4 mEq/kg/day or 30-50 mEq/m2/day **Potassium**: 2-3 mEq/kg/day or 20-40 mEq/m2/day

APPROPRIATE INFANT NUTRITION

Age	
Birth - 1 mo	2-3 ounces (60-90 mL) per feeding, breast or bottle every 2-3 hours
2-4 mos	3-4 ounces (90-120 mL) per feeding every 3-4 hours
4-6 mos	4-5 ounces (120-150 mL) per feeding, four or more time daily Begins baby food, usually rice cereal
6-8 mos	6-8 ounces (180-240 mL) per feeding, four times daily Eats baby food such as rice cereal, fruits and vegetables
8-12 mos	6 ounces (180 mL) per feeding, four times a day, Soft finger foods

Breastfeeding is best—support mothers with safe locations to breastfeed and remain hydrated

NORMAL BLOOD VOLUME

Total blood volume varies by weight. Approximate volume is 80mL/kg.
PRBC/Platelet/Albumin 5%/FFP = 10mL/kg

CLINICAL FEATURES OF DEHYDRATION

Feature	Mild (<5%)	Moderate (5% to 10%)	Severe (>10%)
Heart rate	Normal	Slightly increased	Rapid, weak
Systolic BP	Normal	Normal to orthostatic, >10 mmHg change	Hypotension
Urine output	Decreased	Moderately decreased	Markedly decreased,
Mucous membranes	Slightly dry	Very dry	Parched
Anterior fontanel	Normal	Normal to sunken	Sunken
Tears	Present	Decreased, eyes sunken	Absent, eyes sunken
Skin	Normal turgor	Decreased turgor	Tenting
Skin perfusion	Normal capillary refill (<2 seconds)	Capillary refill slowed (2-4 seconds); skin cool to touch	Capillary refill markedly delayed (>4 seconds); skin cool, mottled, gray

NORMAL DEVELOPMENT

Age (years)	Growth & Development	Common Fears	Methods to Minimize Adverse Effects
0-1	Learn through senses; Seek to build trust	Needs not being met; Stranger anxiety	Speak in quiet calm voice; Involve parents in care; Be aware of stranger anxiety
1-3	Imitates others; Understands objects exist even when not seen; Attempt to control environment	Separation; Loss of Control; Altered Rituals	Minimize separation from family; Provide continuity of familiar routines
4-6	Vivid imagination; More independent; Shares with others	Bodily injury; Loss of control; Being left alone; Dark	Be honest; Let child make choices when able; Reinforce child not responsible for injury or illness
7-12	Understands cause and effect; Greater sense of self	Loss of control; Bodily injury; Death	Allow child to make some care decisions; Prepare before major event or surgery; Emphasize things they can do
13-18	Abstract thinking; Develops own identity	Loss of control; Altered body image; Separation from peers	Explain treatment & procedures; Encourage self-participation in care

FLUID RESUSCITATION

1. Administer 20 mL/kg of isotonic or crystalloid (NS or LR)
2. Monitor: Peripheral perfusion, Urine output, Vital signs, LOC
3. Repeat bolus if no improvement
4. Reassess status

Consider blood products in traumatic injuries requiring >40-60 mL/kg of fluid

HYPOVOLEMIC SHOCK

- Hypovolemic shock is the most common type of shock in children.
- Children increase their cardiac output by tachycardia; therefore bradycardia is an ominous sign.

Look for:
Slow irregular breathing, grunting, bradycardia, cyanosis, hypotension, decreased LOC

BURN TREATMENT: FLUID RESUSCITATION

Fluid Resuscitation Formula (0 - 12 yrs):
3 mL x kg x %TBSA burn
(one half over 1st 8h, second 1/2 over next 16h)

For ages 0 - 2 years: Add maintenance fluid of D_5 Lactated Ringer's (in addition to resuscitation fluid above) - see fluids per hour calculation

Pediatric Considerations
- Increased fluid requirements relative to adults
- Increased surface area : mass ratio
- Hypoglycemia may occur in infants (<30 kg) due to limited glycogen reserves
- Hourly urine output to assess effective fluid resuscitation

EQUIPMENT ESTIMATIONS

Method to estimate Endotracheal Tube (ETT) size:
Tube diameter (mm) = [(AGE (yrs)/4)+4] uncuffed tube size up to size 5.5 mm; for cuffed tubes use 1/2 /2 size smaller (e.g., 2 year old 4.5 mm uncuffed or 4.0 cuffed)
ETT 6.0 mm or greater are all cuffed; Cuffed tubes preferred if available for all ages

ETT Depth in cm at lip = 3x ETT size

EQUIPMENT SIZES: NEWBORN - 6 YEARS

Equipment	Newborn	3-6 mos	1 year	2-3 yrs	4-6 yrs
Weight	3 kg	5 kg	10 kg	15 kg	20 kg
ETT	3-3.5	3.5-4.0	4-4.5	4.5-5.0	5.0-5.5
L Blade	Miller 0-1	Miller 0-1	Miller 0-1	Miller 1-2	Miller 2
Suction	6-8 Fr	8-10 Fr	10 Fr	10 Fr	10 Fr
NG Tube	5-8 Fr	5-8 Fr	8-10 Fr	10-12 Fr	12-14 Fr
Foley	6-8 Fr	6-8 Fr	8-10 Fr	10-12 Fr	10-12 Fr
Chest Tube	10-12 Fr	12-16 Fr	16-20 Fr	20-24 Fr	24-32 Fr
LMA (cuff)	1 (4 mL)	1.5 (7 mL)	2 (10 mL)	2 (10 mL)	2-2.5 (14 mL)

EQUIPMENT SIZES: 7 YEARS and OLDER

Equipment	7-9 yrs	10-12 yrs	13-15 yrs	>15 yrs
Weight	25 kg	30 kg	40 kg	> 50 kg
ETT	5.5-6.0 cuff	6.0-6.5 cuff	7.0-7.5 cuff	7.5-8.0 cuff
L Blade	Mil/Mac 2	Mil/Mac 2 -3	Mil/Mac 3	Mil/Mac 3
Suction	10 Fr	10 Fr	12 Fr	12-14 Fr
NG Tube	12-14 Fr	14-26 Fr	14-16 Fr	16-18 Fr
Foley	12 Fr	12 Fr	12-14 Fr	12-14 Fr
Chest Tube	28-32 Fr	28-32 Fr	32-40 Fr	32-40 Fr
LMA (cuff)	2.5	3 (20 mL)	3 (20 mL)	4-6 (30-50 mL)

Emergency Operations Plan

Family Assistance Center

PURPOSE

To provide operational guidelines for establishing and managing a Family Assistance Center (FAC) to meet patient and family psychosocial needs as the result of an internal or external event. The FAC should:

1. Assist patient location and family reunification
2. Provide crisis counseling and referral for mental health and interfaith spiritual services
3. Identify and protect displaced children and/or nonverbal victims
4. Provide an avenue for the PIO to disseminate information
5. Enable healthcare providers to concentrate on the medical treatment of casualties while providing a formal support system for patients and families.

POLICY

This is an emergency response plan to be used for an internal or external event resulting in the increased demand family support services, reunification, and psychosocial needs exceeding the capabilities and resources of standard operations. This plan works within the framework of the Emergency Management Plan and will remain in effect until it is determined that the event has resolved, and the facility can be returned to normal operations.

SYSTEM

I. Establish the FAC

1. **Activation**
    a. Criteria
        i. Should the actual or predicted demand family support services, reunification, and psychosocial needs exceeding the capabilities and resources of standard operations, the FAC should be established, and the plan activated.
    b. Authority
        i. The HCC and/or DEM Social Work
            1. DEM Social Worker: 96883 (O), 94188 (V), 213-919-7063 (P)
            2. Alicia Squalls, DEM SW Director: 97629 (V/O)
            3. Leticia Lara, Acting Director SW: 97441 (O)
    c. HICS
        i. It is assumed that the HCC has already been established.
        ii. *A Patient Family Assistance Branch Director* will be designated and report to Operations / Medical Care Branch Director. See attached FAC Organization Chart.

2. **Notification**
    a. Primary: Everbridge FAC Call Tree
    b. Backup: DEM Social Work Supervisor to initiate call tree to Social Work, Pastoral Care, Mental Health, Palliative Care, and CARES Child Care.

3. **Staffing**
    a. Social Work (Inpatient, Outpatient), Spiritual Care, Mental Health, Palliative Care, and CARES Child Care to report to the Patient Family Assistance Branch Director at the FAC and provide staffing as appropriate based on needs.
    b. Contact HCC for additional staffing, i.e., Volunteers
        i. Volunteer Office
            1. Business Hours: M-F, 0700-1700
            2. Director: Gabriela Hernandez Gonzalez (96945)

4. **Location**
    a. Consideration for appropriate locations include: facility status, ingress/egress, accessibility to utilities, access to computer/internet/phone, protected from media, patient/family privacy, i.e.:
        i. IPT Conference Room A/B
        ii. GH Auditorium
        iii. GH 1060, 1350
        iv. OPD 3P40 or 5East Waiting Rooms
        v. TBD

5. **Set-Up**
    a. FAC Toolbox (large plastic storage container).
        i. Get toolbox
            1. Location: DEM Social Work office (D&T B1J100).
            2. Keys: Obtain from DEM Nurse Manager.
        ii. Contents
            1. Brochure: Mental Health
            2. FAC Information Card
            3. FAC Plan (this document)
            4. Hygiene needs: tissue boxes, hand sanitizer
            5. ID Bands - Colored
            6. Office Supplies: notepads, clipboards, sticky notes, pens, pencils, markers, highlighters, stapler, tape, paperclips
            7. Social Work Agreement Form
            8. Social Work, Spiritual Care, Mental Health, Palliative Care, and CARES Child Care contact info and call trees
            9. Water, drinking cups
    b. Communications
        i. Phone numbers to be designated as the Call Center for Social Work:
            1. 409-5155 (M-F, 0800-1700)
            2. 409-6883 (after hours, weekends)
            3. Confirm with Telephone Office
        ii. Telephone Office to transfer inquiries re: patient whereabouts to the FAC Call Center.
    c. Computers
        i. Ready desktop and/or laptop computers for Orchid and ReddiNet access.
        ii. Computers available from:
            1. IT
            2. IPT Conference Rm C (cabinet for Survey Control)
        iii. ReddiNet and ReddiNet Family Reunification Center (FRC)
            1. Username/Password(s): located in FAC Toolbox
    d. Designate a private area within FAC for counseling

II. FAC Operations

1. **Designated Roles and Responsibilities** (see HICS Job Action Sheets)
    a. *Patient Family Assistance Branch Director*: Organize and manage the delivery of assistance to meet patient family care needs, including communication, lodging, food, health care, spiritual, and emotional needs that arise during the incident. Overall responsibility and management of the FAC.
    b. *Family Reunification Unit Leader*: Organize and manage the services and processes required to assist in family reunification
    c. *Social Services Unit Leader*: Organize and manage support to meet patient social service requirements during a disaster, coordinating with community and government resources.
    d. *Registration and Tracking Specialist*: Organize and manage FAC visitor registration, FAC ingress/egress, and completion of FAC Sign-In and Tracking Form.

2. **Communications**
    a. The Public Information Officer (PIO) is responsible for event-related communications and content (approved by the IC) to internal and external stakeholders. This includes media, visitors, and family.
    b. For security purposes, the use of social media and recording devices are not allowed in the FAC. Additionally, transmitting information regarding the FAC, visitors, patients, or other sensitive information by family, visitors, or staff is not allowed.

3. **Family/Visitor Check-In Procedures**
    a. A *FAC Visitor Check-In/-Out Log* shall be maintained at the entrance/exit to the FAC. All visitors to the FAC shall sign-in/-out each time they enter/leave the FAC. See attached.
    b. A *FAC Fact Sheet* should be provided to each family with a description of available FAC services
    c. Any child < 11 years presenting to FAC will require identification bracelets to be provided to the parent/guardian and the child.

4. **Family Reunification**
    a. Registration
        i. Family seeking reunification with a potential patient is to identify one (1) family member as the designated representative (Seeker).
        ii. FAC Registration and Tracking Specialist inputs Seeker information into the ReddiNet FRC Module. Seeker completes the *FAC Sign-In and Tracking Form* provided by the Registration & Tracking Specialist. See attached.
        iii. The Family Reunification Leader will enter information from this Family/Patient Information and Tracking Form into the *FAC Tracking Log*. See attached.
        iv. After registration, ID bands will be issued to the family. The ID band is to be worn at all times while in the FAC.
    b. Reunification Process
        i. Utilize facility resources to ascertain if family member in question is in the facility.
        ii. If unable to locate within the facility:
            1. Check ReddiNet FRC Module.
            2. Contact local facilities.
            3. If established, utilize the local city's Family Information Center and inquire about missing children/family from their database.
            4. Contact EMS Agency.

5. **Unaccompanied Minors**
    a. For unaccompanied minors, an *Unaccompanied Minor Tracking Form* will be completed. See attached.
    b. A Social Worker will be assigned to this child's case to initiate reunification strategies:
        i. Child's information to be input into ReddiNet including: physical description; information provided by the minor, if applicable; description of clothing, jewelry; distinguishing scars, birthmarks, tattoos, etc.
        ii. A 24-hour time frame is allotted for Social Work to reunite the child with their parent/guardian.
        iii. If the child was brought in from a daycare/school, they may be able to provide emergency contact information.
        iv. If the City opens a Family Information Center (FIC), they may be able to provide information and coordination
    c. If SW is unable to locate family with 24 hours, Social Work to utilize outside agency resources.
        i. DCFS Emergency Management
            1. Phone: 213-351-5504
        ii. National Center for Missing and Exploited Children (NCMEC)

1. Phone: 800-THE-LOST
2. Website: www.missingkids.com/DisasterResponse
    a. Register a child displace during a disaster
    b. Child inquiry

iii. National Emergency Child Locator Center
1. Established by the NCMEC for large scale incidents.

d. After completion of Social Work consultation and registration is complete, send child to the designate childcare area (TBD).

6. **Mental Health and Well-Being**

a. The Social Services Unit Leader or designee will coordinate Mental Health and Spiritual Care support services to assist patients, visitors, family as needed. Traumatic and disaster events have the potential to cause illness, injury, and death of co-workers, friends, and family, as well as loss of jobs, homes, and societal infrastructure. This can create loss, despair, depression, and suicidal ideations. Both Mental Health and Spiritual Care services are included in the FAC for this purpose.

b. Spiritual Care
    i. A private space for spiritual counsel will be made available in the FAC, IPT Chapel, or other appropriate space as needed.
    ii. Availability:
        1. 12 chaplains on-site: M-F, 0900-1700
        2. 1 chaplain on-call: After hours, weekends
    iii. Contacts
        1. Emergency Interfaith Chaplain: 213-919-4383 (P)
        2. Fr. Chris Ponnet, Director Spiritual Care: 94715 (O/V), 323-719-7411 (C)

III. Childcare

1. **CARES Child Care Centers**

a. Location:
    i. Clinic Tower A2A115: 93541
    ii. Inpatient Tower 2L216: 96940

b. Availability
    i. Business Hours
    ii. After Hours: Childcare Centers can be available 24/7 based on staffing availability.

c. Child Care criteria
    i. Healthy siblings of injured pediatric patients
    ii. Healthy children of adult patients
    iii. Children of employees

d. Capability
    i. CARES requires 8 employees and volunteers at each of the two centers (total of 16) for a capacity of 44 children per center.
        1. Infants (birth-17 months): 8
        2. Toddlers (18-35 months): 12
        3. Preschoolers (3-5 years): 12
        4. School-age (6-11 years): 12

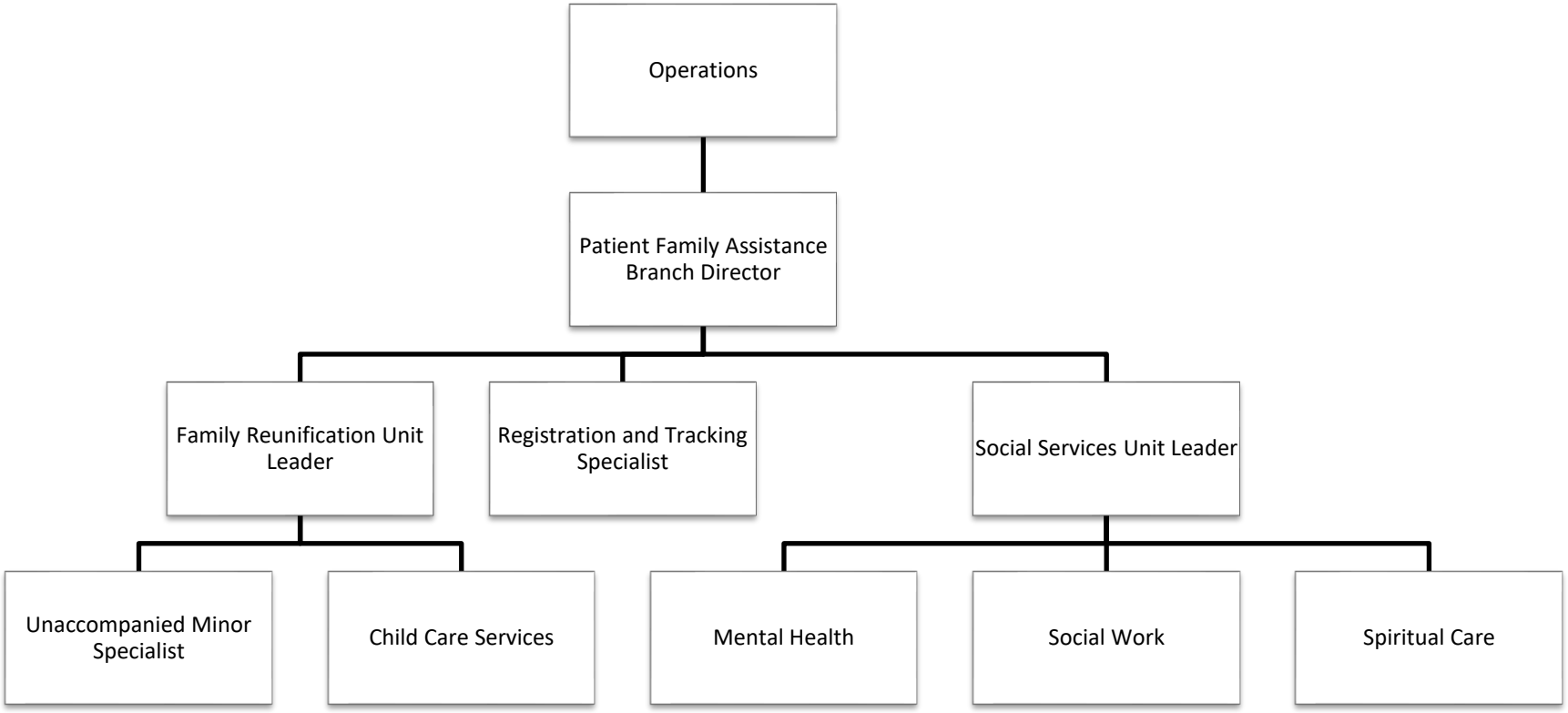
e. Procedure
    i. A *Child Identification Survey Form* must be completed for any child checking into the Childcare Center. See attached.
    ii. For children of patients, an *Unaccompanied Minor Tracking Form* must be completed, and the child registered by Social Work.

2. **Additional Childcare Areas**

a. See Emergency Response Plan: Surge – Pediatrics for an in-depth treatment of additional childcare areas.

ATTACHED
FAC Organization Chart
FAC Visitor Check-In/Check-Out Log
FAC Fact Sheet
FAC Sign-In and Tracking Form
FAC Tracking Log
FAC Unaccompanied Minor Tracking Form
Childcare Services - Child Identification Form
FAC Evaluation Tool and Checklist

Family Assistance Center Organization Chart



LAC+USC Medical Center **FAC Visitor Check-In / Check-Out Log** Date: _____

Name	Contact Number	Signature / In	Time	Signature / Out	Time

****ALL Visitors must sign in and out every time they enter or exit the FAC.**

FAMILY ASSISTANCE CENTER FACT SHEET

This fact sheet is to be given to each family in the FIC in order to provide them with an understanding of the FAC's function.

☑ ABOUT THE FAMILY ASSISTANCE CENTER

Provides a secure and controlled area for families of patients to go, removed from medical treatment areas, where information can be obtained and provided to facilitate family reunification, and to provide access to support services.

☑ INFORMATION WE HAVE ACCESS TO

Information regarding patients that are at our facility. We can also contact other healthcare facilities to determine if the patient is at another facility.

☑ INFORMATION WE CAN SHARE

Location of patients/victims.

☑ INFORMATION WE CANNOT SHARE

We do not share information to the general public or the media. We do not share sensitive information concerning a patient's medical condition such as diagnosis and specific health information.

☑ RESOURCES THAT WE HAVE ACCESS TO

Nursing services to answer questions about medical conditions. Support services such as a social work, mental health counselors, chaplains, and brochures. Referrals for support services can be made available as needed.

☑ THINGS TO REMEMBER

This is a secure area. Everyone must sign in and out. No press or media are allowed. We only share information to the intended recipient.

FAC SIGN-IN AND TRACKING FORM

The FAC Sign-In and Tracking Form is given to each family that enters the FAC in order obtain information about the patient that the family is looking for, as well as family information, to include the number of people in the FAC per family.

PATIENT INFORMATION					
LAST NAME	**FIRST NAME**		**DATE OF BIRTH**	**AGE**	**GENDER** ☐ M ☐ F
EYE COLOR	**HAIR COLOR**		**LANGUAGES SPOKEN**		
HEIGHT	**WEIGHT**	**RACE**	**DISTINGUISHING MARKS**	**LOCATION LAST SEEN**	
OTHER DESCRIPTIVE INFORMATION					

FAMILY INFORMATION		
FAMILY PRIMARY CONTACT	**PREFERRED CONTACT** **Name:** **Telephone:** ☐ **CALL** ☐ **TEXT**	**SECONDARY CONTACT** **Name:** **Telephone:** ☐ **CALL** ☐ **TEXT**
RELATIONSHIP	**THIS SECTION TO BE COMPLETED BY FAC STAFF**	

ALL ADDITIONAL FAMILY MEMBERS MUST BE LISTED
USE REVERSE SIDE OF FORM FOR ADDITIONAL NAMES IF NEEDED

NAME	RELATIONSHIP

STATUS
Date: _____
Time:_____

☐ **Waiting for patient**
☐ **Waiting for reunification**
☐ **Reunited**
☐ **Waiting for patient location**
☐ **Departed to actual location**

Wish to speak to media? ☐ YES ☐ NO

LISTED IN REDDINET?
☐ YES ☐ NO

THIS SECTION TO BE COMPLETED BY FAC STAFF			
Incident Date/Time	**Incident Name**	**Family Arrival Date/Time**	**Family Departure Date/Time**
ADDITIONAL NOTES		**DO NOT WRITE IN THIS SECTION FOR OFFICIAL USE ONLY**	

ICS Form 400 FIC Sign-In and Tracking Form

FAC TRACKING LOG

This log displays information about each non-staff person in the FAC. A staff member should use the FAC Sign-In and Tracking Forms collected upon registration to fill in this form.

FAC TRACKING LOG TO BE COMPLETED BY OFFICAL STAFF UPON RECEIPT OF FAC SIGN-IN AND TRACKING FORM					
Person Seeking Information			**Patient Name**		**Status**
Last Name	**First Name**	**Contact Number**	**Last Name**	**First Name**	**Notification made? Services provided? Other?**

ICS Form 400A FIC Tracking Form

FAC UNACCOMPANIED MINOR SIGN-IN AND TRACKING FORM

To be completed by a staff member for each unaccompanied minor present in the FAC. The staff member should speak with the minor to obtain the necessary information. This form will be used to reunify the individual with his/her guardian.

FAC ID#:_____ **MEDICAL RECORD # (IF ADMITTED TO FACILITY):** _____

HAS LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES BEEN CONTACTED?
☐ **YES** ☐ **NO** **IF YES, INDICATE DATE, TIME:** _____

Los Angeles County Department of Children and Family Services: 213-351-5507
Los Angeles County Department of Children and Family Services Custody Hotline: 800-540-4000

LAST NAME OF MINOR		**FIRST NAME OF MINOR**		
ARRIVAL DATE/TIME	**RACE**	**AGE**	**GENDER** ☐ **M** ☐ **F**	**LANGUAGE**
HAIR COLOR	**EYE COLOR**	**DOB**	**HEIGHT**	**WEIGHT**
DISTINGUISHING MARKS	**SIBLINGS**	**BROUGHT IN BY**	**LISTED IN REDDINET?** ☐ **YES** ☐ **NO**	
OTHER DESCRIPTIVE INFORMATION				
LOCATION FOUND		**HOME ADDRESS/TELEPHONE IF KNOWN**		

STATUS
☐ **Identified** **Time:**_____
☐ **Reunited** **Time:**_____
☐ **Waiting for guardian/family to be identified** **Time:**_____
☐ **Guardian/family is on his/her way** **Time:**_____
☐ **Waiting for guardian/family to be contacted** **Time:**_____
Guardian's Telephone:_____ **Estimated Arrival Time:**_____

COMPLETE THE FOLLOWING WHEN THE MINOR LEAVES THE SAFE AREA:

TIME OUT	**TO**	**ESCORT BY**	**TIME RETURNED**

DEPARTURE DATE/TIME	**GUARDIAN ID CHECKED** ☐ **YES** ☐ **NO**	**GUARDIAN ID#**	**GUARDIAN TELEPHONE NUMBER**
NAME OF GUARDIAN	**SIGNATURE OF GUARDIAN**	**STAFF NAME**	**STAFF SIGNATURE**
INCIDENT NAME		**INCIDENT DATE/TIME**	

Child Care Services - Child Identification Form

Please complete this form for ALL children who will be registered with Childcare Services.

ID band # _____

Last Name: _____ First Name: _____

Age: _____years/months old DOB: _____ Gender: M/F

Child's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Alternate Emergency Contact #: _____

Was child brought in by a supervising adult? Yes/No (If NO, complete an Unaccompanied Minor Form)

Name of supervising adult: _____ Age: _____

Relationship to child: Parent/Grandparent/Other (please specify) _____

Is supervising adult the guardian? Yes/No

Did the child live with this person before the disaster? Yes/No

Does the supervising adult have proof of legal guardianship or relationship to the child? Yes/No

If yes, please attach a copy.

Is the supervising adult a:

- ☐ PATIENT MRUN # _____

Location in the facility: _____

Phone # _____

- ☐ EMPLOYEE Employee # _____

Location of work area: _____

Phone # of work area: _____ Alternate Phone #: _____

Was the child treated for illness or injury? Yes/No

If yes, please describe: _____

_____

Does the child have any allergies? Yes/No

If yes, please list: _____

Does the child have any history of medical problems/ special needs? Yes/No

If yes, please list: _____

_____

FAC Evaluation Tool and Checklist

Task to Accomplish	Time Completed	Comments
HCC is notified of request for initiation of FAC		
FAC Toolbox is opened, and the conference room is set up for registration, reunification, childcare, bereavement/chaplain services		
Orchid and ReddiNet programs are set up and available for use.		
Call trees are initiated by respective departments: SW, Spiritual Care, and Child Care departments		
One representative of the family is registered and issued an ID band.		
The Registration & Tracking Specialist will provide a Sign-In/Tracking Form for the family member to complete.		
Reunification leader will enter basic information into the FIC Tracking Log.		
A Family Information Fact Sheet should be distributed to each family with a description of services available in the FIC.		
A Check-in/Check-out sheet is maintained at the entrance/exit to the FAC . All family members with an ID band must sign in/out each time they enter/leave the FIC.		
Reunification process for families: Utilize ReddiNet or Patient Tracking programs or call the ED to locate the family member in question.		
Unaccompanied Minors: Complete an Unaccompanied Minor Form Social Worker is assigned to this child		

FAC Evaluation Tool and Checklist

Input the child's information into the ReddiNet including physical description; info provided by the minor if applicable, description of clothing and jewelry; distinguishing scares, birthmarks, and tattoos. Call the Childcare Center to inquire availability of services.		
Accompanied Minors: Child Identification Survey Form is completed for all children under age 11 A matching ID band must be placed on the child and parent/guardian. Call the Childcare Center to inquire availability of services.		
Mental Health Support Services: A Family Services Specialist is designated to coordinate provision of support services.		
Spiritual Care: Provide a chaplain to address specific spiritual needs in a timely fashion Locate a private room for families requesting for privacy		

Evaluator: _____

Title: _____

Date: _____

PURPOSE
This plan establishes operational guidelines for managing decedents as the result of a mass fatality event.

POLICY
This is an emergency response plan to be used in the event of a mass fatality incident and works within the framework of the Emergency Management Plan. The plan is to be implemented for an internal or external event resulting in mass fatalities and will remain in effect until it is determined that the event has resolved, and the facility can be returned to normal operations.

DEFINITIONS
Mass Fatality Incident (MFI): an occurrence of multiple deaths that overwhelms the usual routine capabilities of the hospital.

SYSTEM
I. Incident Management: HICS/HCC

1. For an event of such magnitude as to result in an MFI, the HCC will already have been established and HICS activated.
2. In the event of an MFI, the Operations Section will establish an ad hoc branch under the Medical Care Branch Director for the Mass Fatality Incident Leader (MFIL). See attached MFIL Job Action Sheet.
3. At which time that mass fatalities have been predicted or are occurring, the IAP must be updated. Of note, the IAP should include the following for an MFI:
    a. Managing the incident and developing the incident plan, objectives, and administrative oversight.
    b. Tracking and documenting the event.
    c. Directing Decedent Affairs.
    d. Directing Pastoral and Social Service activities.
    e. Coordinating Law Enforcement activities.
    f. Directing Health Information (HIM) Services.
    g. Coordinating additional labor resources as required.
    h. Coordinating the hospital response with local and operational area agencies.
    i. Allocating and providing resources as required.
    j. Updating the IAP and MFI plan as necessary.
    k. Maintaining hospital operations.
    l. Documenting the incident.
4. External Communications
    a. The HCC will be in constant communication with the DHS Department Operations Center (MCC) who then communicates with the County Emergency Operations Center (EOC).
    b. If capacity has been superseded, the HCC will request guidance, assistance, and resources from the MCC.
    c. In the event of pandemic, criminal/terrorist event, or war, the HCC will take direction from the MCC / County EOC regarding decedents and personal property disposition.

II. Decedent Affairs/Morgue/Crematory Services

1. **Capability:**
    a. Morgue Capacity:

i. Refrigerated post-mortem capacity at LAC+USC MC: 254. Average occupancy 65% (165).
ii. Additional surge capacity: 74.
iii. Total surge capacity: 239.
iv. See attached LAC+USC DRC Morgue Capacity Survey.

b. Morgue Infrastructure:
i. The hospital morgue is powered by DWP (utility provider).
ii. The on-site post-mortem containers have back-up generators.
iii. The facility has Electric Diesel Generators (7) with a combined capacity of 14 MW and fuel capacity for > 1 week at full load.
iv. The facility has numerous, on-site portable generators for additional redundancy.

c. Crematory Services:
i. The LAC+USC crematorium has one units remaining with a total capacity of up to 14 decedents / week.
ii. Additionally, private crematoriums can be accessed (see attached Crematorium List).

2. **Procedure:**
a. The Decedent Affairs/Morgue/Crematory Services (see attached org chart) will implement their service-based plans in coordination with the MFIL and the HCC. This includes identifying its current capacity, staffing, and ability to increase its crematory and burial services to provide for an increase in demand.
b. The MFIL and Decedent Affairs are responsible for:
i. Maintaining the Mass Fatality Tracking Form and the Decedent Information and Tracking Card (see attached) in conjunction with the Situation Unit Leader.
ii. Maintaining decedents until relieved of duties which include on-going tracking of where decedents are housed and disposition of decedents including burial and cremation as appropriate.
iii. Take direction from the MCC / County EOC (FBI, CDC, etc.) via IC regarding maintenance and disposition of decedents and valuable in case of pandemic, criminal/terrorist event, etc.
iv. Processing death records and securing the licensed physician's signature for the Certificated of Death per Network Policies 227 and 228 (Patient Death Certification Policy and Patient Death Policy, respectively).
v. Securing the decedents valuables in conjunction with the Department of Nursing, Cashiers Office, and Sheriff's Department as applicable.
vi. Notifying the County Coroner (the Public Administrator) of cases under their jurisdiction.
vii. Coordinating post mortem care including transfer to private mortuaries as applicable.
viii. Coordinating and tracking the utilization of post mortem refrigeration space within the hospital as above.
ix. Advising IC via Operations if and when post mortem refrigeration space is being negatively impacted.
x. Assisting other facilities in providing post mortem care only upon direction of the HCC (in conjunction with the MCC).
xi. Reporting and tracking of resources and supplies required to manage the event through the appropriate chain of command to Logistics and Finance/Admin.

III. Infrastructure and Facilities Management

1. The Infrastructure Branch Director will coordinate with Facilities Management and are responsible for:
a. Maintaining morgue refrigeration and functionality.
b. Maintaining power for refrigeration.
c. Assisting Decedent Affairs with morgue surge capacity.
d. Assisting in obtaining additional refrigeration capacity if surge capacity has been maximized.

   e. Reporting and tracking of resources and supplies required to manage the event through the appropriate chain of command to Logistics and Finance/Admin.
2. In the event that surge capacity has been maximized:
   a. Infrastructure Branch in coordination with the Logistics Branch to contact their vendors to procure refrigerated trailers through existing contracts. Tentatively, these are to be staged alongside the existing trailers.
   b. Infrastructure Branch will consider establishing alternative morgue capability with the use of tents and dry ice. Tentatively, these are to be staged alongside the existing trailers.

IV. Sheriff's Department (LASD)

1. The Security Branch Director will coordinate with the LASD (the Medical Center's security and law enforcement agency).
2. The LASD has the authority and responsibility for the security and safety of the medical center campus and coordination with outside law enforcement agencies.
3. During an MFI, i.e., if due to a criminal/terrorist event, LASD is responsible for:
   a. The security of decedents and decedent personal property in coordination with Decedent Affairs and any outside jurisdictional law enforcement agencies as directed by the MCC / County EOC.
   b. Releasing decedents only with the approval of the HCC and the Law Enforcement Agency responsible for coordinating the incident regionally which may include the Sheriff, State Police, FBI, and/or Homeland Security.
   c. Relinquishing police oversight of decedents only when medically directed as safe to do so.
   d. Providing security to the morgue as needed.
   e. Maintaining tracking documents of victims and activities for law enforcement purposes.

V. Family Assistance

The Family Assistance Center will coordinate with Pastoral Care / Social Services and are responsible to coordinate the spiritual and psychosocial needs of victims, families and significant others. Their responsibilities include:

1. Assisting in coordinating services for victims and significant others.
2. Assisting the Department of Decedent Affairs in managing decedent care so that care is congruent with victims, families and significant others wishes.
3. Providing spiritual and psychosocial interventions to families and significant others as needed.
4. Providing emotional support to healthcare providers as needed.
5. Documenting efforts.
6. Reporting and tracking of resources and supplies required to manage the event through the appropriate chain of command to Logistics and Finance/Admin.

See previous section on the FAC.

VI. Health Information Management (HIM)

Health Information Management (HIM) establishes and secures the medical record. Their responsibilities include:

1. Assisting departments in managing the medical record during emergency or disaster events.
2. Securing the medical record when final care has been undertaken.
3. Maintaining the medical record for review of governing agencies as indicated.
4. Transporting medical records of victims as needed.
5. Maintaining the medical record according to hospital policy.
6. Documenting efforts.
7. Reporting and tracking of resources and supplies required to manage the event through the appropriate chain of command to Logistics and Finance/Admin.

ATTACHED

Mass Fatality Incident Leader Job Action Sheet
Mass Fatality Tracking Form (HICS 254A)
Decedent Information and Tracking Card
Decedent Affairs/Morgue/Crematory Services Organization Chart

DRC Region 6 Morgue Capacity Survey
Crematoriums List

REFERENCE
MC227: Patient Death Certificate
MC228: Patient Deaths

MFI UNIT LEADER
JOB ACTION SHEET

Mission: Collect, protect, identify and track decedents.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Medical Care Branch Director Signature:

Hospital Command Center (HCC) Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment and briefing from the Medical Care Branch Director. Obtain MFI Unit activation packet.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Determine need for and appropriately appoint MFI Unit staff, distribute corresponding Job Action Sheets and position identification. Complete a unit assignment list.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief MFI Unit staff on current situation; outline unit action plan and designate time for next briefing.		
Confirm the designated MFI Unit area is available, and begin distribution of personnel and equipment resources. Coordinate with the Medical Care Branch Director.		
Regularly report MFI Unit status to Casualty Care Unit Leader.		
Assess problems and needs; coordinate resource management.		
Use your Death Certificated Coordinator physician or request an on-call physician from the Casualty Care Unit Leader to confirm any resuscitatable casualties in Morgue Area.		
Obtain assistance from the Medical Devices Unit Leader for transporting decedents. Assure all transporting devices are removed from under decedents and returned to the Triage Area.		
Instruct all MFI Unit Task Force members to periodically evaluate equipment, supply, and staff needs and report status to you; collaborate with Logistics Section Supply Unit Leader to address those needs; report status to Medical Care Branch Director.		
Coordinate contact with external agencies with the Liaison Officer, if necessary.		
Monitor decedent identification process.		
Enter decedent information in ReddiNet, if appropriate.		
Assess need for establishing surge morgue facilities.		

Immediate (Operational Period 0-2 Hours)	Time	Initial
Coordinate with the Patient Registration Unit Leader and Family Information Center (Operations Section) and the Patient Tracking Manager (Planning Section).		
Contact the Medical Care Branch Director and Security Branch Director for any morgue security needs.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Maintain master list of decedents with time of arrival for Patient Tracking Manager.		
Assure all personal belongings are kept with decedents and/or are secured.		
Assure all decedents in MFI Areas are covered, tagged and identified where possible.		
Monitor death certificate process.		
Meet regularly with the Casualty Care Unit Leader for update on the number of deceased; status reports, and relay important information to Morgue Unit staff.		
Implement surge morgue facilities as needed.		
Continue coordinating activities in the Morgue Unit.		
Ensure prioritization of problems when multiple issues are presented.		
Coordinate use of external resources; coordinate with Liaison Officer if appropriate.		
Contact the Medical Care Branch Director and Security Branch Director for any morgue security needs.		
Develop and submit a MFI Unit action plan to the Medical Care Branch Director when requested.		
Ensure documentation is completed correctly and collected.		
Advise the Medical Care Branch Director immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor the MFI Unit's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Coordinate assignment and orientation of external personnel sent to assist.		
Work with the Medical Care Branch Director and Liaison Officer, as appropriate on the assignment of external resources.		
Rotate staff on a regular basis.		
Document actions and decisions on a continual basis.		
Continue to provide the Medical Care Branch Director with periodic situation updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well-Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the MFI Unit decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader.		
Ensure the return/retrieval of equipment/supplies/personnel.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Medical Care Branch Director on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and MFI Unit Operational Logs (HICS Form 214) are submitted to the Medical Care Branch Director.		
Submit comments to the Medical Care Branch Director for discussion and possible inclusion in the after-action report; topics include: • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- Incident Action Plan
- HICS Form 207 – Incident Management Team Chart
- HICS Form 213 – Incident Message Form
- HICS Form 214 – Operational Log
- Mass Fatality Incident Activation/Operational Plan
- Mass Fatality Incident / Morgue Unit Assignment List
- Fatality Tracking Form
- Decedent Information and Tracking Card
- Hospital emergency operations plan
- Hospital organization chart
- Hospital telephone directory
- Key contacts list (including Coroner, DPH, ReddiNet, LAC DMH, ARC, etc.)
- Radio/satellite phone

FATALITY TRACKING FORM

Adapted from HICS Form 254

INCIDENT NAME				DATE / TIME PREPARED				OPERATIONAL PERIOD DATE/TIME		
MRN OR TRIAGE NUMBER	NAME	SEX	DOB / AGE	NEXT OF KIN NOTIFIED YES / NO	ENTERED: YES / NO		HOSPITAL MORGUE		FINAL DISPOSITION, RELEASED TO:	
					REDDINET	EDRS	IN DATE/TIME	OUT DATE/TIME	CORONER, MORTUARY, COUNTY MORGUE, OR OTHER (LIST)	DATE/TIME
COMPLETED BY HOSPITAL MFI UNIT		NAME								

Purpose: Account for decedents in a mass fatality disaster **Origination:** Hospital Mass Fatality Unit **Copies to:** Patient Registration Unit Leader and Medical Care Branch Director

First Letter of Decedent Last Name: _____

DECEDENT INFORMATION AND TRACKING CARD

INCIDENT NAME		**OPERATIONAL PERIOD**		
MEDICAL RECORD / TRIAGE #	**DATE**	**TIME**	**HOSPITAL LOCATION PRIOR TO MORGUE**	
FIRST	**MIDDLE**	**LAST**	**AGE**	**GENDER**

IDENTIFICATION VERIFIED BY
□ DRIVERS LICENSE □ STATE ID □ PASSPORT □ BIRTH CERTIFICATE □
OTHER:_____

IDENTIFICATION #:
_____

ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)

LISTED IN REDDINET □ YES □ NO	**RECORD CREATED IN EDRS** □ YES □ NO	**DEATH CERTIFICATE SIGNED** □ YES □ NO

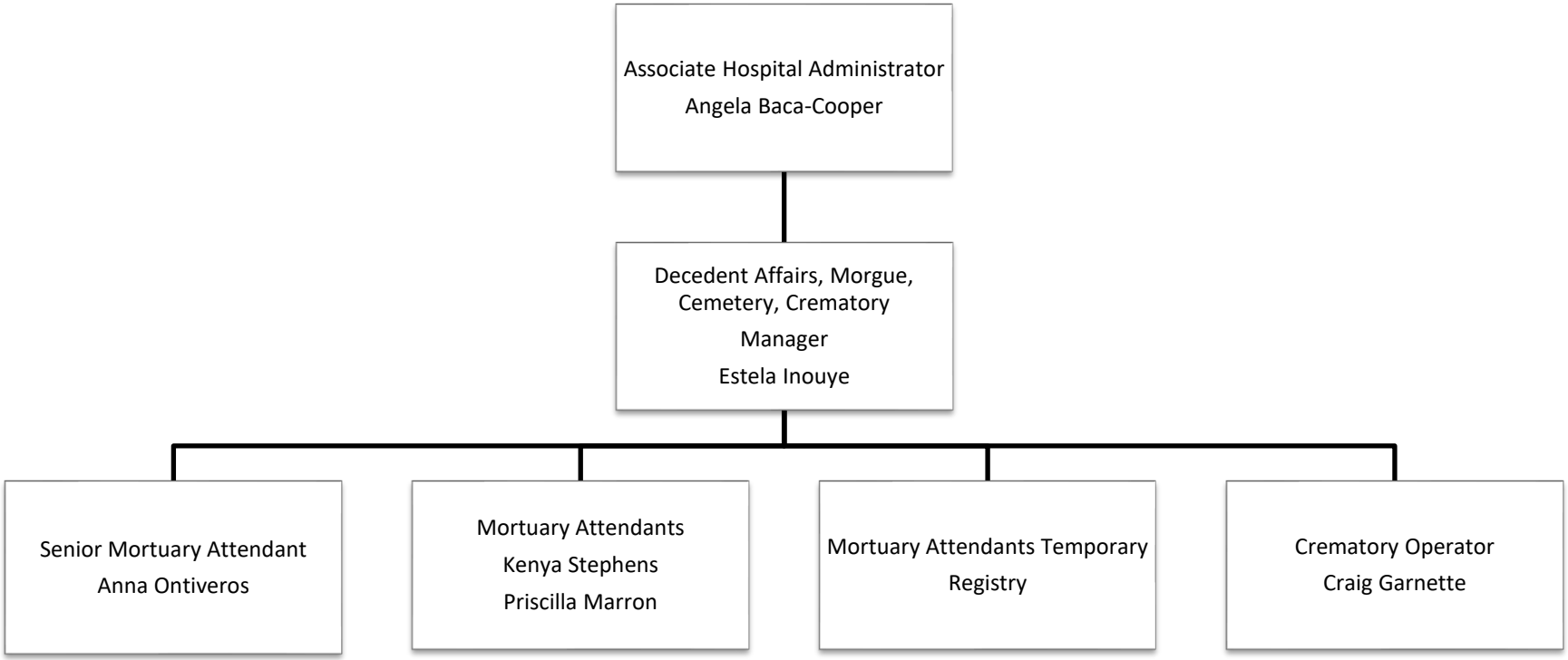
PHOTO ATTACHED TO THIS CARD □ YES □ NO	**FINGERPRINTS ATTACHED TO THIS CARD** □ YES □ NO

NEXT OF KIN NOTIFIED? □ YES □ NO	**NAME**	**RELATION**	**CONTACT TEL**
STATUS	LOCATION	DATE / TIME IN	DATE / TIME OUT
HOSPITAL MORGUE			
HOSPITAL MORGUE			
HOSPITAL MORGUE			
HOSPITAL MORGUE			
FINAL DISPOSITION	DATE / TIME	NAME OF RECIPIENT	SIGNATURE OF RECIPIENT
RELEASED TO: □ CORONER □ COUNTY MORGUE □ MORTUARY □ OTHER: _____	**DATE** **TIME**		

LIST PERSONAL BELONGINGS	**STORAGE LOCATION**

ORIGINAL ON FILE IN MFI UNIT
COPY WITH DECEDENT
COPY TO MEDICAL CARE BRANCH DIRECTOR

Form Revised: May 2008


Associate Hospital Administrator
Angela Baca-Cooper
Decedent Affairs, Morgue, Cemetery, Crematory
Manager
Estela Inouye
Senior Mortuary Attendant
Anna Ontiveros
Mortuary Attendants
Kenya Stephens
Priscilla Marron
Mortuary Attendants Temporary
Registry
Crematory Operator
Craig Garnette

Facility	Normal Capacity	Comments	Surge Spaces	Method	Total Capacity	MFI Plan
Alhambra Hospital	6		0		6	
East LA Doctors Hospital	2		10	Basement office area for surge capacity storage	12	
Garfield Medical Center	2		100		102	Yes
Huntington Memorial Hospital	28		8		36	Yes
Keck Hospital of USC	7	6 regular, 1 bariatric	0		7	Yes
LAC+USC	403	Average Occupancy 65% (260)	58	*See below	461	Yes
Los Angeles Community Hospital	2		0		2	
Monterey Park Hospital	2	No morgue. Utilize empty room. 24 hour hold.	0		2	Yes
Pacific Alliance Hospital	2	2 single coolers	6	Tent.	8	Yes
San Gabriel Valley Medical Center	2		4		6	
USC Norris Comprehensive Cancer Center and Hospital	4		0		4	Yes
White Memorial Hospital	12		0		12	
Total Normal Capacity	**472**	**Total Surge Spaces**	**186**	**Total Surge Capability**	**658**	

LAC+USC	Normal	Surge	Comments
Container 1	90	10	Surge: Extra Stretchers/MFI Rack (10)
Container 4	75	0	
Container 5	190	40	Surge: Extra Trays/Tables
GH Morgue	0	18	Surge: Re-open Shuttered Morgue (18)
IPT Morgue	48	0	
Total	**403**	**58**	
LAC+USC Other			
Trailer: On loan to OVMC.	40	60	Surge: Extra Trays/Tables
Container 2: Decommissioned.	80	10	Surge: Extra Stretchers/MFI Rack (10)
Container 3: Decommissioned.	36	46	Surge: Double Up on Extra Wide Shelfs (36); Extra Stretchers/MFI Rack (10)

CREMATORY RESOURCES

Plan: Decedent Affairs staff will contact the respective resource if and when the need is required.

1. Community Crematory of Whittier – Contracted as an overflow
   13304 E. Philadelphia
   Whittier, CA 90601
   562-698-0304

2. Macera Crematory – Contracted as an overflow
   1020 Fuller St.
   Santa Ana, CA 92701
   714-647-0709

3. All Caring Cremation – Contracted as an overflow
   13800 Saticoy St.
   Van Nuys, CA 91402
   877-630-7191

4. Joshua Tree Memorial Park – Contracted as an overflow
   30121 29 Palm Hwy
   Joshua Tree, CA 92252
   877-630-7191

5. Desert Cremations – Contracted as an overflow
   73-700 Dina Shore Dr.
   Ste 304
   Palm Desert, CA 92211

   877-630-7191

   *Approximate cost to cremate: $240.00 per decedent

Emergency Operations Plan

Emergency Operations: Incident Response Plans

Note: Please refer to Medical Center Policy #665: Person With a Weapon and/or Hostage Situation Response: Code Silver hard copy in the EOP Binder or electronic copy available on the intranet.

Note: Please refer to Medical Center Policy #613, 613-A: Bomb Threat Procedure hard copy in the EOP Binder or electronic copy available on the intranet.

Earthquake

PURPOSE

Earthquakes occur without warning. Included in the following are guidelines for protecting personnel, patients, and visitors.

MITIGATION

Each unit evaluates the security of pictures and objects throughout their working area. As items are identified, they are to notify Facilities Management to help affix objects securely to the wall, etc.

PREPAREDNESS

Staff should be aware of potential hazards in their work environment and take precautions.

1. Shelves should be fastened.
2. Heavy objects should be placed on low shelves.
3. Moveable objects that may cause injury should be secured to the floor.
4. Flammable products and hazardous chemicals should be stored away from heat sources and in tightly secured containers.
5. Maintain emergency preparedness box on unit (flashlight, pliers, gloves, etc.).

RESPONSE

A. During the Shaking

1. Remain calm.
2. Assess the situation and then act. Remember, most injuries or deaths are caused by falling or flying debris.
3. Drop, Cover, and Hold until shaking stops.
    a. Take cover under desks, tables, other heavy furniture, or in interior doorways or narrow halls.
    b. Stay away from windows, bookshelves and hanging objects.
    c. Be aware of falling objects.
    d. Stay away from masonry walls.
4. Protect patients by shielding them with blankets, pillows, or protective padding.
5. If outside:
    a. Move away from buildings if possible.
    b. Avoid utility poles and overhead wires.
    c. Stay away from trees.
    d. Stay away from masonry walls.
6. Encourage others to take cover.

B. After the Shaking

1. For patient care areas: Secure the unit.
    a. The charge nurse should take lead.
    b. Check status of patients, staff, and visitors in the area.
        i. Assist those who are injured.
    c. Check for possible missing personnel, patients and visitors.
        i. Perform a head count of staff and compare with shift schedule.
        ii. Perform a head count of patients and compare to unit census sheets.
    d. Check your immediate area for structural deficiencies and possible hazards.
    e. If there is an immediate threat to life and safety, evacuate to a safer area.
    f. Report unit status to on-site Nurse Manager/House Supervisor per protocol.

2. For other departments and services: Secure the area.
    a. Shift supervisor should take lead.
    b. Check status of staff and visitors in the area.
        i. Assist those who are injured.
    c. Check for possible missing personnel and visitors.
        i. Perform a head count of staff and compare with shift schedule.
    d. Check your immediate area for structural deficiencies and possible hazards.
    e. If there is an immediate threat to life and safety, evacuate to a safer area.
    f. Report area status to department head per protocol.

3. General Instructions (ALL Staff)
    a. DO NOT evacuate patients or staff unless instructed to do so by the Hospital Command Center, LAFD, LASD, Main Administration, or there is an immediate danger to life and safety.
        i. Follow evacuation procedures as outlined in the LAC+USC Fire Life Safety Manual and this EOP Evacuation.
        ii. Do not re-enter the building until engineering has checked for possible structural damage, leaking gas lines, and other utility disruptions.
        iii. If the building is incapable of housing patients, relocation procedures will begin as per the Emergency Operations Plan.
    b. DO NOT use Elevators unless cleared by FM Engineers.
        i. See Evacuation Plan: Evacuation > Evacuation Method > Vertical Evacuation.
    c. DO NOT use any open flames (candles, matches etc.).
    d. Listen for announcements on the overhead paging system and/or turn on the radio for the latest bulletins.
    e. Conserve resources such as power and water.
    f. Limit telephone use to emergency notification only.
    g. Maintain awareness of potential Aftershocks.

4. Facilities Management
    a. Engineers
        i. Evaluate the campus and all structures for operational capability.
        ii. Evaluate all elevator systems for safety and structural integrity.
        iii. Check for sprinkler leaks at the risers, cross mains, branch lines, and sprinklers.
            1. Maintain as much fire protection in services as possible.
            2. Shut the minimum number of valves necessary to control the leaking of impaired piping.
        iv. Investigate for domestic water leaks, and shut off all domestic water valves to control the leaking from broken piping.
        v. Investigate for natural gas leaks, and isolate the supply lines as necessary.
    b. Operational Status Report
        i. HCC not established
            1. Business Hours: FM Engineers > Facilities Director, Chief Operations Officer, and House Supervisor
            2. After Hours: FM Engineers > House Supervisor and AOD
        ii. HCC established: FM Engineers > Infrastructure Branch / Operations Section

5. Hospital Command Center
    a. Notification and Activation per protocol.
    b. Review: Incident Response Guide: Earthquake
    c. Conduct Incident Management as protocol.
    d. Update facility/staff per protocol.

RECOVERY

Response activities continue until all systems return to normal or better. Life Safety issues will be addressed first and returned to normal as soon as possible. Close communication between units, departments, and services with the HCC and Facilities Management will occur to resolve issues with the Life Safety and the Environment of Care.

REFERENCE
LAC+USC Fire Life Safety Manual

PURPOSE

1. To direct the activities required to implement sheltering-in-place, internal relocation, partial evacuation, or full evacuation.
2. To outline the responsibilities of individuals and departments during shelter-in-place, partial evacuation/relocation, and full evacuation.
3. To prioritize response requirements and establish an orderly shelter, relocation, or evacuation process using the Incident Command System (ICS).

DEFINITIONS

1. **Shelter in Place (SIP):** A procedure used to take immediate shelter in a current location or refuge area when the threat does not permit safe relocation or evacuation
2. **Partial Evacuation**: Simple or partial evacuation involves moving patients, visitors, or employees from a single dangerous room, ward, or floor into an adjacent safe area or smoke compartment within the building. This can be horizontal or vertical evacuation; however, horizontal is the most simple and preferred method.
3. **Total Evacuation**: Total evacuation is moving patients, visitors, and staff to a safe area outside of the building. Evacuation locations for respective units may be pre-identified or they may be reassigned by the HCC based on the type and impact of the event.
4. **Horizontal Evacuation**: Evacuation to a safe and unaffected adjacent area on same floor or connecting building, often to the other side of a set of fire barrier doors. Horizontal is the most simple and preferred method.
5. **Vertical Evacuation**: Evacuation to a safe and unaffected adjacent floor or exterior safe refuge area that is deemed at no future threat by the incident.

SYSTEM

I. General Considerations

1. Sheltering-in-place, relocation, and evacuation activities:
    a. May occur as standalone response or may be implemented in a progression, if necessary, as the incident evolves
    b. May be implemented in a proactive response to impending hazards
    c. May be implemented in response to an acute incident
2. The following are examples of factors that could lead to activation of the shelter-in-place / relocation / evacuation plan.
    a. Loss of environmental support services including heating, water, air conditioning, sterilization, electrical power, and medical gases.
    b. Internal emergencies such as fire, smoke, hazardous materials release, or active shooter or threat.
    c. External emergencies including natural and man-made disasters such as earthquake, urban and wildfires, flood, power outage, civil disturbance, terrorism, hazardous materials spills, contaminated victims/toxic agents, radiation exposure, explosions and police actions.
3. Horizontal evacuation preferred over vertical evacuation.
4. Internal evacuation preferred over external (last resort).

II. Authority

1. The following staff has the authority to order SIP or Evacuation:
    a. Incident Commander

b. CEO
c. AOD
d. Safety Officer
e. LASD
f. LAFD

2. All personnel are authorized to take immediate patient/resident relocation actions in response to an immediate life safety emergency.
3. Initiation of a vertical or complete evacuation, with the exception of persons in immediate danger, will be coordinated by the Incident Commander/Command Center if the HCC has been established.

III. Incident Management

1. **Command and Control**
    a. The overall management is the responsibility of the IC as designated in the EOP.
    b. Every department is responsible for implementing their activities within the evacuation plan.
    c. ICS and HCC operations shall be guided by:
        i. This plan and other plans activated in support of this incident, i.e.
            1. Active Shooter
            2. Bomb Threat
            3. LAC+USC Fire / Life Safety Plan
        ii. HICS Incident Response Guidelines
        iii. ICS Job Action Sheets
        iv. HICS Forms, including the following evacuation related forms:
            1. HICS 254: Disaster Victim/Patient Tracking Form
            2. HICS 255: Master Patient Evacuation Tracking Form
            3. HICS 259: Hospital Casualty/Fatality Report
            4. HICS 260: Patient Evacuation Tracking Form
    d. All information related to the incident shall be coordinated and released through the HCC.
    e. HCC will coordinate with outside agencies, other healthcare facilities and facility administration regarding facility status, evolving situational needs, and overall status of the evacuation/shelter in place process.

2. **Roles and Responsibilities**
    The following are incident specific additions to the IC roles:
    a. *Incident Commander*
        i. Has the full authority and responsibility for the decision-making processes for this response.
    b. Public Information Officer
        i. Coordinate media communications regarding the status of the facility, including the need to evacuate.
        ii. Via the Family Assistance Center, notify and respond to queries from visitors and family members regarding the status and location of patients who have been evacuated. Utilize the tracking information provided to the HCC the Planning Section Chief.
        iii. Assign staff to notify the patients/residents emergency contact person.
    c. Liaison Officer
        i. Notify local agencies to notify that you are experiencing an adverse incident that requires sheltering or evacuation and update your operational status (capabilities, resources needs, etc.).
        ii. Hospitals:
            1. Los Angeles County Department of Health Services Emergency Medical Services (EMS) Agency:
                a. ReddiNet
                b. Call the Medical Alert Center (MAC): 866-940-4401
                c. or use the VMED28 radio

2. Ensure the facility is placed on ambulance diversion via ReddiNet

iii. All Facilities: Notify Licensing and Certification: 714-567-2906

iv. Notify community response partners, including:

1. Local fire department (may be able to assist with evacuation; provide information on the incident, etc.)
2. Local police department (may be able to assist with securing the facility / area; provide information on the incident, etc.)
3. If you rent space, notify your landlord

d. Safety Officer

i. Oversee the immediate stabilization of the facility.

ii. Recommend areas for immediate evacuation to protect life.

iii. Ensure the safe evacuation of patients, staff and visitors.

iv. Conduct initial and ongoing analysis of existing evacuation practices for health and safety issues related to personnel, patients, and facility, and implement corrective actions to address.

e. Operations Section Chief

i. Coordinate the processes necessary to safely evacuate a portion or all of the facility.

ii. Identify appropriate staging areas for the receipt and movement of patients/residents, personnel and visitors.

iii. Work with the Medical Care Branch Director to identify (number and acuity levels), prioritize, and evacuate patients in a systematic and orderly manner.

1. See attached worksheet.

iv. Communicate with the Infrastructure Branch Director to determine the need for — and orderly implementation of — the operational reliability and/or shut down of utilities and structural support systems.

v. Coordinate with the Infrastructure Branch Director to determine and supply necessary utilities and medical gases to the sheltering or evacuation assembly points.

vi. Coordinate with the Liaison Officer to determine the number and type of transportation vehicles that will be necessary to evacuate patients to alternate care sites.

vii. Work with the Security Branch Director to establish access and control of key areas of the facility and campus during the evacuation.

viii. Interface with the Business Continuity Branch Director to assure that the security and availability of vital patient/resident health record, and other key information is maintained.

f. Planning Section Chief

i. Establish and implement processes to track the location of patients/residents, personnel and resources who have been moved from one location to another — including evacuation to alternate sites of care.

g. Logistics Section Chief

i. Work with the Operations Section Chief to provide the necessary medical equipment, beds, medications, and supplies to safely relocate patients to alternate locations. Caches of equipment, supplies, and medications pre- positioned to manage an influx of casualties can be used if they are not required for their intended purpose.

ii. Assure an adequate supply of personnel and other human resources to safely evacuate patients/residents and visitors to alternate locations.

iii. Ensure that potable water and basic food supplies are brought to the sheltering area or assembly points.

iv. Collaborate with the Operations and Planning Section Chiefs to identify and address both internal and external transportation needs.

v. Establishing a family information center to notify and respond to queries from family members of personnel regarding the status and location of personnel who have been evacuated.

3. **Communications**
   Internal notification and external communications should be conducted according to the Emergency Operations Plan. Key communications for facility evacuations include, but are not limited to:
   a. **Personnel, on duty**: Notification of potentially unsafe situation(s) at the facility. If evacuation activities are possible, an 'evacuation standby' notification should be made as soon as possible so that units may begin accessing appropriate supplies and collecting belongings and records.
   b. **Personnel, off duty**: Notification of potentially unsafe situation(s) at the facility. Provide guidance on whether personnel should report to duty as usual or not.
   c. **Medical providers**: Notification of evacuation destinations.
   d. **Patient families**: Notification of patient/resident families of evacuation destinations
   e. **Personnel families**: Notification of incident status and evacuation destinations

4. **Public safety**: Communication links to facilitate coordination with public safety agencies (security and traffic control), EMS and other transport providers (buses, etc.), and fire agencies (lifting assistance)

5. **Media**: Public information reflecting the capabilities of the facility.

PROCEDURE

I. SHELTER IN PLACE (SIP)

When the threat does not permit safe relocation or evacuation, the following actions may be taken to Shelter-In-Place. Note: clinical and non-clinical departments are authorized to initiate these actions upon recognition/notification of threat (in conjunction with notification of supervisors or other actions under the Emergency Operations Plan).

1. *Weather* – wind, hail, or other weather threat
   a. Remain calm.
   b. Move patients/residents and personnel away from windows as possible.
   c. Close drapes/blinds and exterior doors/windows.
   d. Ensure personnel and visitors also advised of weather situation.
   e. Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
   f. Personnel will remain with patients/residents.

2. *Security emergency* – bomb threat, individual posing security threat, external civil unrest
   a. Remain calm.
   b. Refer to Active Shooter, Bomb Threat policy.
   c. Implement department-specific access controls.
   d. Close smoke compartment doors, patient/resident room and office doors, and perform other take cover measures as needed.
   e. Ensure personnel and visitors are aware of the situation.
   f. Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
   g. Personnel will remain with patients/residents.

3. *Hazardous materials (HAZMAT) incident*
   a. Remain calm.
   b. If there is an airborne hazardous materials plume, facilities will shut down air intake into ventilation system; security will implement access controls as needed.
   c. Ensure visitors and personnel aware of threat – location and actions to take.
   d. Update incident command on your operational status and impact on patients/ residents, personnel, and visitors.
   e. Personnel will remain with patients/residents.

II. EVACUATION

1. **Staff Responsibilities**
    a. All staff to assist patients, visitors, and staff with evacuation or sheltering as indicated.
    b. Affected Area
        i. Assist with evacuation preparation
        ii. Assist with patient care
        iii. Assist with evacuation of current patients from their area.
        iv. Assist with evacuation of visitors and staff from their area.
    c. Unaffected Area
        i. Clinical
            1. A minimum number of clinicians will remain with current patients.
            2. Additional staff will report to unit being evacuated to assist. Utilize internal stairwells if possible.
        ii. Non-clinical personnel
            1. All non-critical functions will cease and staff will report to unit being evacuated to assist. Utilize internal stairwells if possible.

2. **Supervisor Responsibilities**
    a. Affected Area:
        i. Assign staff to clear obstructions for corridors and control fire/smoke doors and other exits.
        ii. Assign (1) individual staff to "sweep" area to ensure completeness of evacuation. See "3. Evacuation Procedure".
        iii. Assign staff to maintain a record of patients, visitors, staff to be evacuated and their relocation site.
            1. HICS Form 255 may be used.
    b. Affected Clinical Area to also:
        i. Recruit additional staff (i.e. RN, LVN, NA) to assist.
        ii. Prepare patients:
            1. Inform patients of plan to evacuate, i.e. why, when, how.
                a. Avoid statements prone to panic.
                b. Reassure patients of their safety and the importance to remain calm.
            2. All patients to have their ID bands.
            3. Identify patient's ability to move using the code below and document on the patient evacuation record.
                a. A: ambulatory
                b. W: wheelchair
                c. S: stretcher/gurney/bed.
            4. Time permitting, with the patient should be:
                a. Medical record: this should remain in their possession during the entire evacuation process.
                b. Addressograph, ID card, patient labels.
                c. Necessary medications along with their MAR.
                d. Personal belongings.
                e. Necessary equipment and supplies.
                f. Ideally, place these items in a large plastic bag marked with the patient's name and MRN.
        iii. Assign personnel to remain with patients at the relocation site.

3. **Evacuation Priorities**
    a. By Location
        i. Patients, visitors, and staff in immediate threat.
        ii. Patients, visitors, and staff next closest to the hazard.

iii. Then, Patients, visitors, and staff farthest from the evacuation route to closest.

b. By Status
   i. Ambulatory
   ii. Wheelchair
   iii. Gurney / Bed
   iv. Critical patients (moved last when the maximum number of personnel and equipment is available)

4. **Evacuation Method**
   a. Horizontal Evacuation
      i. Ambulatory
         1. "Human Chain": Lead patients and visitors with hands joined. 2 staff (1 at the beginning and 1 at the end).
      ii. Non-ambulatory: Wheelchair, Gurney, Bed
         1. Wheelchair: May lead several at once if independent functioning; 2 staff (1 at the beginning and 1 at the end). Otherwise, minimum 1 staff per wheelchair.
         2. Gurney: Minimum 1 staff per gurney.
         3. Hospital Bed: Minimum 2 staff per bed.
   b. Vertical Evacuation
      i. Ambulatory
         1. Use stairwells.
         2. Lead patients and visitors with 1 staff at beginning and 1 staff at end.
      ii. Non-Ambulatory
         1. Elevators Operational
            a. Wheelchair: May lead several at once if independent functioning. Otherwise, minimum 1 staff per wheelchair.
            b. Gurney: Minimum 1 staff per gurney.
            c. Hospital Bed: Minimum 2 staff per bed.
         2. Elevators Non-Operational
            a. Wheelchair: Patients are moved to nearest stairwell. Utilize vertical transport chair or carry methods per Fire / Life Safety Manual.
            b. Bed Bound: Patients are moved to nearest stairwell. Vertical carry/transport methods per Fire / Life Safety Manual.
      iii. Note: Elevators
         1. Fire
            a. If smoke is sensed in elevator bay or shaft, elevator moves to primary egress floor then stops. If fire on primary egress floor, elevator moves to 1 floor above then stops.
            b. Elevators will now only operate by key in Phase 2 (LAFD or FM).
            c. System reset required.
         2. Earthquake
            a. Elevators have seismic sensors / earthquake circuit.
            b. If sensor is triggered, elevator moves to next floor away from counter-weight then stops.
            c. System reset required.
         3. General Rule:
            a. DO NOT use elevators if there is a possibility of fire or structural damage (e.g. earthquake).
            b. Elevators will be systematically cleared for use by FM Engineers (and in coordination with LAFD as indicated).
            c. Reporting Operational Status:
               i. HCC established: Engineers > Infrastructure / Operations Section > Liaison > Help Desk for broadcast email.

ii. HCC not established: Engineers > House Supervisor > Help Desk for broadcast email.

5. **Evacuation Procedure**
    a. Remain calm.
    b. Follow instructions of the HCC, Area Supervisor, LAFD, or LASD.
    c. Identify evacuation route and relocation area.
        i. Departments have pre-identified evacuation routes and safe refuge areas. See LAC+USC Fire / Life Safety Plan.
        ii. Incident-specific evacuation routes and safe refuge areas may be necessary and must be communicated by the HCC quickly to affected areas.
    d. Evacuate by priority and method as described above.
    e. If an individual requires more evacuation support than is immediately available, mark room by a closed door with a white sheet outside so that returning responders know which room to evacuate.
    f. As each room is cleared:
        i. Turn off lights.
        ii. Close Windows.
        iii. Turn off and unplug nonessential equipment.
        iv. Close door and mark as clear/evacuated > Closed door with an "X" marked prominently on the door with tape.
    g. Assigned individual to "sweep" the area:
        i. Check for remaining persons.
        ii. Check all patient rooms, offices, storage areas, restrooms, etc.
        iii. Check that the room is marked as clear/evacuated > Closed door with an "X" marked prominently on the door with tape.
    h. Continue to care for all patients during transport and relocation.
    i. Account for all patients and staff.
        i. Check off the names of patients and staff as they are evacuated and as they arrive in the new location.
            1. Check ID bands.
            2. Match to evacuation record.
        ii. HICS Form 255 may be used.
    j. Maintain communications with the HCC:
        i. Operational status
        ii. Evac impact on patients, personnel, and visitors
        iii. Evac status: persons still needing evac or if the area is "cleared"
        iv. Receive and implement instructions from the HCC.
    k. Staff will remain with patients.

6. **Return to Facility**
    Do not re-enter the facility for any reason unless:
    a. Assisting with evacuation of patients, visitors, staff, or equipment
    b. Authorized by the Hospital Command Center
    c. An order to repopulate / reopen the facility has been approved by CDPH Licensing and Certification

VI. Security

1. Security at the evacuation locations will be provided by LASD, Allied Universal, and staff.
2. Direction will come from the HCC (if established), LASD, or Department Supervisor.
3. Special populations at risk include:
    a. Jail
    b. Psych/Behavioral

c. Pediatrics

VII. Alternate Care Sites (ACS)

1. ACS's are identified in EOP: Surge.
2. The EMS Agency can provide locations for and support services rendered in alternative care sites including transportation of patients, staff, equipment, supplies and pharmaceuticals as needed.
3. LAC+USC HCC will contact the MAC / MCC.

VIII. Transfer Relocation

1. LAC+USC will contact the MAC / MCC.
2. In the event that patients (evacuated or otherwise) are required to be transported / transferred off-site, the EMS Agency (via the MAC) is the department responsible and charged with this task.
3. In addition to having the responsibility for all transfers of county patients to and from county facilities, the MAC has pre-existing MOUs with the respective private, county, and state hospitals to affect these transfers.

ATTACHED

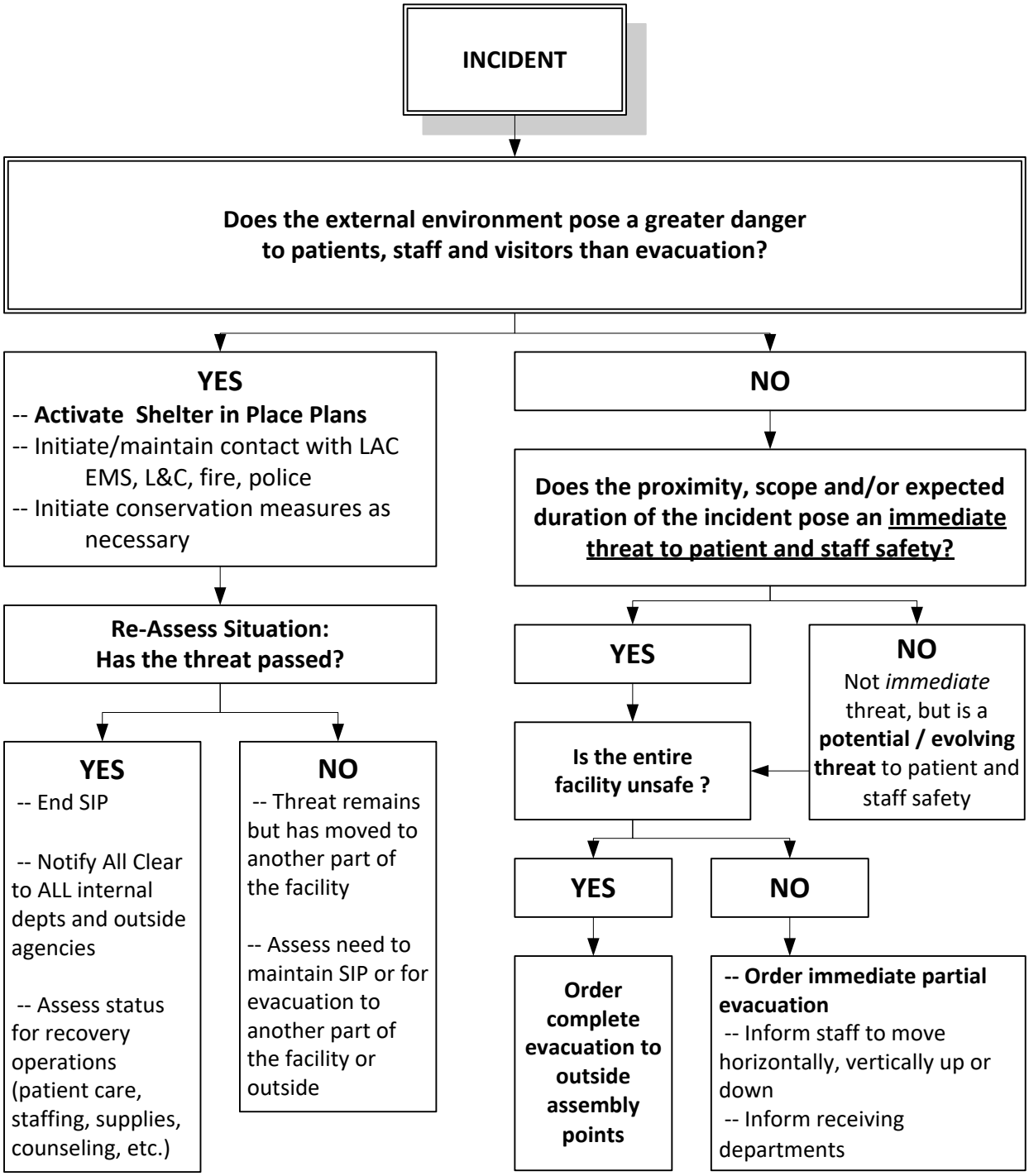
Decision Matrix
Estimate of Persons Needing SIP/Evacuation

REFERENCE

HICS 255
LAC+USC Fire / Life Safety Manual
LAC+USC Medical Center Policy SP 112: Evacuation Procedures

Decision Matrix

When the decision is made to activate, the magnitude of the emergency response must be determined. The Incident Commander will utilize the Decision Tree and Matrix to determine what type and level of response is needed.



Estimate of Persons Needing Evacuation or SIP

Directions: Use this table to estimate the number of people that will need to be evacuated or relocated, or will require resources if they are sheltering in place.

Personnel, Patient/Resident and Visitor Census					
Day of the Week:		**Time of Day:**			
Department or Area	**Location (Floor, etc.)**	**# of All Personnel***	**# of Ambulatory Pts/Residents**	**# of Non-ambulatory Pts/Residents**	**# of Visitors**

* Includes clinical and non-clinical personnel. This may further be broken down by ambulatory and non-ambulatory.

Emergency Operations Plan

Information Systems Failure

PURPOSE

Information Systems (IS) Failure can occur due to human, nature, and technological events. With the ever-increasing reliance of hospital systems and patient care services on IT, any disruption can threaten the ability to care for patients. Healthcare personnel should follow these guidelines to best maintain business continuity in the event of systems failure.

BACKGROUND

Systems failure can include any and all systems including internet, intranet, VoIP, Cerner/Orchid (health and information management), pharmacy, diagnostic imaging, laboratory, bed control, and infrastructure. Failure can be single point (total power outage), isolated server / function, or Cerner/Orchid downtime. Although catastrophic events may lead to complete IS Failure, Cerner/Orchid downtime would be the most immediate and is the most recurrent event for which paper backup will be employed and is used as the Orchid Downtime Procedures.

MITIGATION

Units contact IS Support in real time to ensure all workstations and data networking devices are operational and in a state of readiness. Devices that are critical to patient safety are attached to ups (uninterruptible power supply) or emergency powered outlets (red plugs). The LAC+USC IS department has developed and maintains their contingency plan.

PREPAREDNESS

Units, departments, and services store all forms necessary policies, procedures, and forms to implement a paper back-up system in the event of computer failure.

RESPONSE

I. Notification and Activation

1. Remain calm.
2. Report any IS failure to the Nurse Manager / House Supervisor.
3. The Nurse Manager / House Supervisor should contact Information Systems 409-8000.
4. Leadership, AOD, House Supervisor, and IT to determine extent and impact of failure then:
    a. Activate the EOP and HCC as indicated
    b. Activate Orchid Downtime Procedure as indicated
        i. ED
            1. ANM will notify staff by overhead page “Orchid [or IS] Downtime Procedure Initiated”
            2. ANM will notify DEM Nursing and Physician administrators.
        ii. Hospital
            1. Telephone Office to overhead page facility “Orchid [or IS] Downtime Procedure Initiated”
            2. IT to notify via DHS email blast and Everbridge
        iii. All Staff will promptly switch to paper charting
        iv. IS will disseminate the 7/24 workstation log-in and password by overhead announcement and DHS email blast.
            1. Note: 7/24 use assumes intranet and respective server capability intact.
5. Note: Initiate paper charting immediately if disruption interferes at all with patient care.

II. Command and Control

1. Proceed per previously stated guidelines.

III. Systems and Services

1. Bed Control / Patient Tracking
    a. Utilize Unit Census Sheet.
    b. Maintain communication with Bed Control.
    c. Communications
        i. Digital and Analogue telephone lines should not be affected by computer failure.
        ii. The VoIP telephone systems may be affected as this is computer based.
        iii. Consider personal mobile phones, FAX, Tube System, or runners to relay information.

2. Electronic Health Records
    a. Re-implement paper based Patient Charting and Physician Orders (see below)

3. Security
    a. Doors
        i. Electronic, Pneumatic
        ii. Controller not part of IS
    b. Security Cameras
        i. TBD.

4. Pharmacy / Pyxis
    a. Nurses can override Pyxis to gain access for medications.
    b. These medications removed and dispensed should be documented.

5. Implement backup paper system for the following:
    a. Bed Control
    b. Dietary
    c. Laboratory
    d. HIM
    e. PFS
    f. Radiology
    g. Supply Chain Operations

IV. Orchid Downtime Procedures

1. Procedures and policies for Orchid Downtime are on-line via Intranet > Orchid > Orchid Downtime.
2. Units, Services, and Departments to follow their respective downtime policies.
3. Regarding Patient Charts and Forms: "Downtime Procedure Paperwork" Carts contain paper charts and forms necessary for immediate and extended patient care. These are pre-staged in the clinical areas.
    a. Emergency Department
        i. Cabinets: Hallway across from Adult Waiting, Resus B nursing station overhead
        ii. Carts labeled "ORCHID Downtime Forms": Resus, North
        iii. Fish Bowl ED Lobby: Consent Forms
    b. Inpatient Units and Clinics: Nurse Managers Office
    c. **See attached** for list of basic charts and forms.

V. Recovery Phase

Activities continue until all systems return to normal or better. Paper back-up systems will remain in effect until computer systems are reliably on-line. Close communication between the HCC and IS will be maintained to resolve issues with the physical plant, supplies, communications, diagnostic services, and patient safety.

ATTACHED

Basic Patient Chart and Forms

REFERENCE

LAC+USC Medical Center Policy #467: Information Technology (IT) Contingency Plan
LAC+USC Medical Center Policy #467-A: Information Technology (IT) Contingency Plan Guideline
LAC+USC Medical Center Nursing Services Policy #403: Computer Downtime Procedures

ED Chart (Basic Adult)

1. Emergency Department Record [ED H&P] (381)
    a. Use for the Physician encounter including H&P and Orders
2. Emergency Department Continuation Sheet (1098)
    a. Continue ED Physician Notes and Orders
    b. ED Physician Pass-On Notes
    c. Consult Note
3. ED / Urgent Care Nursing Data Base and Flow Record – Long Form (345B)
4. ED / Urgent Care Nursing Data Base and Flow Record – Continuation (345C)
5. Emergency Department Trauma / Resuscitation Flow Sheet (LAC101270)
6. Application for 72-Hour Detention for Evaluation and Treatment (SF-302)
7. Emergency Department Discharge Instructions (1082A)

Inpatient Chart (Basic Adult)

1. Inpatient Record Cover (Form 439A)
2. Emergency Medical Treatment Consent Form (HS62)
3. Physician's Orders (27M)
4. Problem List (H1201)
5. Inpatient Progress Notes (206)
6. Patient's Admission History and Physical (H-116)
7. Abstracted – Laboratory Record Clinical (548)
8. Medicine Admission Orders (LAC101327)
9. Admission Order and Medication Reconciliation (T-1063)
10. Adult Venous Thromboembolism Risk Assessment and Prophylaxis Orders (LAC101295)
11. Adult Subcutaneous Insulin Orders (1063)
12. Physician Order for Radiological Imaging Procedures (1134)
13. Record of Radiological Examination (702)
14. Pre-Operative Checklist (H49)
15. Restraint Orders (788)
16. Restraint / Seclusion Patient Observation Record (910)
17. Medication Administration Record (1013N)
18. Nursing Record Adult Med /Surg / Gyn (356)
19. Nursing Progress Record (359)
20. Patient Transfer Record – Nursing (347)
21. Interdisciplinary Assessment & Discharge Planning (IADP) Adult (346)
22. Interdisciplinary Patient Care Plan (PCP) (1059)
23. Teaching Protocol: Generic Inpatient Teaching Protocol (PTP1521)
24. Discharge Record

Order Forms

1. Computer Downtime Stat Request Form (Form CL 5.000): Standard Blood, Urine, Body Fluid tests
2. Blood Gases, Co-oximetry and Electrolytes Form
3. Blood Bank Transfusion Medicine / Blood Component Request Form (Form 485)
4. Blood Call Slip (Form 419A)
5. Microbiology Laboratory Test Request Form: Gram stain, Culture
6. Physician Order for Radiological Imaging Procedures (1134)

Note: Please refer to Medical Center Policy IC-09: Pandemic Influenza Plan, LAC+USC Medical Center Policy IC-10: Influx / Surge and Hospitalization of Large Numbers of People with Infectious Disease hard copies in the EOP Binder or electronic copies available on the intranet.

Emergency Operations Plan

Power Failure

PURPOSE
Power Outages occur due to human, nature, and technological events. Although back-up systems are in place to maintain electrical supply, these systems may fail. Power Failure may be localized to an area of the facility, involve the entire facility, or involve the local community. These guidelines are to assist the healthcare personnel best maintain business continuity in the event of power failure.

MITIGATION
Units are responsible to ensure that devices critical to patient safety are attached to ups (uninterruptible power supply) or emergency powered outlets (red plugs). The unit assists in maintaining the equipment in a state of readiness by contacting Facilities Management or Information Systems for any equipment needing service.

Facilities Management performs preventive maintenance on their emergency generators and performs power failure testing as delineated in their policies and procedures.

PREPAREDNESS
Units maintain a list of electrical equipment and utilities used for patient care. Emergency backup lights (battery operated lanterns and flashlights) are located at the Nurse Stations. Unit staff are in-serviced and updated on this plan.

RESPONSE

1. **General**
    a. Remain Calm.
    b. Assess the situation and then act.
    c. Staff to report any power failure to the Nurse Manager / House Supervisor.
    d. The Nurse Manager / House Supervisor should contact Facilities Management.

2. **Notification/Activation and Command/Control**
    a. Proceed per previously stated guidelines.

3. **Staff**
    a. The on-site Nurse Manager / House Supervisor will
        i. Notify unit personnel of the incident.
        ii. Task unit personnel to:
            1. Identify runners to communicate information from the unit, subcommand post, intra-facility services in the event of communication failure
            2. Utilize backup lights located at the nursing station for day room and nursing station use.
            3. Establish a team of nursing staff to escort patients to Day Room for safety and security.
        iii. The unit Charge Nurse will:
            1. Ensure the unit is secured.
            2. Obtain a head count of staff and match to the shift schedule.
            3. Obtain a head count of patients and match to unit census sheets.
            4. Work with the unit nurses to inform patients of the incident

4. **Systems**
    a. Bed Control / Patient Tracking

i. Utilize unit census sheet.
ii. Maintain communication with LAC+USC Bed Control.

b. Communications
i. Digital and Analogue telephone lines may be affected.
ii. The VoIP telephone systems may be affected may be affected by power or IT failure.
iii. Consider personal mobile phones, FAX, or runners to relay information.
iv. Contact MLK MACC Facilities Management to obtain radio handset.

c. Electronic Health Records
i. Re-implement paper based Patient Charting and Physician Orders

d. Security
i. Security cameras will likely be affected.
ii. Security doors are mechanical and should not affect ingress or egress.

e. Pharmacy / Pyxis
i. Contact the pharmacy supervisor to manually unlock Pyxis.
ii. The medications removed and dispensed should be documented.

5. Services

a. See Information Systems Failure. Implement backup paper system for the following services:
i. Bed Control
ii. Dietary
iii. Laboratory
iv. HIM
v. PFS
vi. Radiology
vii. Supply Chain Operations

6. Power Restoration

a. Primary responsibility is Facilities Management.
b. EDGs automatically restore power.
c. EDG failure
i. Unlikely due to 7 generator redundancy
ii. Can rig portable generators to grid
1. Multiple > 25kW available via EMS
iii. Consider Evacuation for total power loss.

d. After power is restored
i. Nurse Manager to ensure that all patient care equipment and utilities are returned to normal operations
ii. Use attached Power Outage Equipment Checklist

RECOVERY

Activities continue until all systems return to normal or better. Life Safety issues will be addressed first and returned to normal as soon as possible. Close communication between Facilities Management, the HCC, EMS, and DHS will occur to resolve issues with the physical plant, supplies, communications, diagnostic services, and patient safety.

REFERENCE

LAC+USC Medical Center Facilities Management Procedure Manual # 401-408 (Utilities Policy & Procedures)

Emergency Operations Plan

Prepositioned Prophylactic Antibiotics Storage and Distribution

PURPOSE
To plan for storing and distributing pre-positioned antibiotic caches within the LAC+USC Medical Center hereafter referred to as "LAC+USC".

The goal is to provide ready access to antibiotics for first responders and other key personnel when the Los Angeles County Health Officer announces activation of the Employee Prophylaxis Plan. Notification to cities will be via activation of the County's Emergency Public Information Plan (EPI), the media, and the Emergency Management Information System (EMIS). Of note, these personnel would, otherwise, need to go to an LADPH Point of Distribution (POD) to receive prophylaxis.

BACKGROUND
In 2004, the United States Department of Homeland Security and the Centers for Disease Control and Prevention announced the Cities Readiness Initiative. This program is a first step by the federal government to increase and enhance readiness of selected cities to make full and effective use of the Strategic National Stockpile in the event of several possible types of catastrophic terrorist attacks. Of foremost concern is the ability to respond in a timely manner to a bioterrorism attack, specifically, *Bacillus anthracis* the organism that causes anthrax. In this case, antibiotics must reach the population within 48 hours to have the greatest life-saving effect.

INTRODUCTION
The pre-positioned antibiotics for prophylaxis will strengthen the ability of all response agencies to provide protection for their work force during an anthrax incident quickly and safely. If additional antibiotics are needed, requests will be made through the Health Services Department Operations Center. The additional resources will come from other local, regional, and/or State caches or the Strategic National Stockpile (SNS).

This planning and preparation will speed subsequent distribution to the general public and reduce morbidity and mortality while assuring continuity of day-to -day operations. It will be the responsibility of each agency to store and secure the pre-positioned antibiotics in **BULK**. Distribution of the antibiotics to individuals will occur only upon the direct order of the County Health Officer.

AUTHORITIES
Cities Readiness Initiative: See web site: http://www.bt.cdc.gov/cri

ADDITIONAL INFORMATION
See web site: http://www.cdc.gov/anthrax

RESPONSIBILITIES
The County of Los Angeles Department of Health Services (LACDHS) will coordinate the Employee Prophylaxis Plan with the eighty-eight (88) cities, County Departments, hospitals and clinics which compose the Los Angeles County Operational Area and have emergency management responsibilities. DHS will work with the appropriate pre-designated representatives to ensure compliance is met.

SYSTEM
The medications, consisting of bottles of antibiotics, provided by LACDHS ARE to be stored in BULK by LAC+USC. Each case contains 100 bottles. Each bottle contains fourteen (14) pills, which represents seven (7) days' worth of medications in each bottle, at two (2) pills per day per person. Three (3) bottles of medications are allocated for each person identified as essential personnel: one (1) bottle for the employee/official and two (2) bottles for immediate family members.

The amount provided is for immediate needs until such time as POD sites are established and/or persons are identified as having/not having been exposed. The amount provided should not be considered as a complete course of treatment if exposure to Anthrax has occurred.

At the time of distribution to the employees, an instruction sheet will be provided to each person (Attachment A). While Ciprofloxacin is not routinely used for children, it is appropriate when following the guidelines on the instruction sheet. (Note: Respiratory Anthrax is highly lethal and this should be considered before withholding to children)

The LAC+USC Office of Emergency Management, Pharmacy Services, and Employee Health will be responsible for the maintenance of the distribution plan. LAC+USC Pharmacy Services IS responsible to receive, store, and monitor this cache.

I. Identification of Essential Personnel
LAC+USC has identified the following number of personnel as critical to the Continuity of Government and providing essential services within the jurisdiction.

Department/Agency/Hospital/Clinic Personnel	Total
ALL	8,500

LAC+USC personnel and officials identified to receive medications are detailed in Attachment B.

II. **Authority to Activate Plan**
The Employee Prophylaxis Plan in the Los Angeles County Operational Area is activated upon order by the Public Health Officer for Los Angeles County. Upon the order of the Public Health Officer, the LAC+USC Point of Contact (POC) will initiate the LAC+USC distribution plan.

LAC+USC will be notified to activate the distribution plan by multiple methods including: EMIS, Disaster Management Area Coordinators (DMACs), local media, and Los Angeles County's EPI system.

III. **Storage Location**
Antibiotics are to be stored in **BULK** in a secured, climate controlled environment in a temperature range of 68°F to 77°F. Medications are NOT to be distributed to individuals prior to the activation of the county's mass prophylaxis plan.

The prophylaxis medications will be stored at:

Name of Facility:	LAC+USC Pharmacy Services Building
Address:	1100 N. Mission Road, Los Angeles, CA 90033
Location within Facility:	Room 138

IV. **Access to Storage Location**
The following personnel have access to the storage location on a 24/7 basis:

Primary (Title):	Ghassan Moubarak, Pharmacy Supervisor I
Office Telephone:	323-409-1891
Cell Phone:	702-406-8313
1st Alternate (Title):	Steven Dong, Pharmacy Supervisor I
Office Telephone:	323-226-6021
Cell Phone:	626-319-0802

2nd Alternate (Title):	Kevin Weismann, Pharmacy Supervisor I
Office Telephone:	323-409-7552
Cell Phone:	949-246-3717

NOTE: If multiple storage locations are used please attach a listing for each site.

V. **Monitoring**

LAC+USC will submit a quarterly report to DHS as to the status of the pre-positioned medications (Attachment C). The Pharmacy POC for LAC+USC will submit this report on behalf of LAC+USC. This report will be submitted during the week of the 15th in the following months: March, June, September and December.

The pre-positioned antibiotics provided have a shelf life of approximately four (4) years. LACDHS will provide instructions for disposal of medications that have reached their expiration date. Medications should not be disposed of until DHS has approved of their disposal.

VI. Point of Contact (POC)

Primary Point of Contact:

Name: Ghassan Moubarak	Title: Inpatient Pharmacy Supervisor
Telephone: 323-409-1891	Cell/Mobile Phone: 702-406-8313
FAX: 323-441-8268	Email: gmoubarak@dhs.lacounty.gov

1st alternate Point of Contact:

Name: Steven Dong	Title: Inpatient Pharmacy Supervisor
Telephone: 323-226-6021	Cell/Mobile Phone: 626-319-0802
FAX: 323-441-8268	Email: sdong@dhs.lacounty.gov

2nd alternate Point of Contact:

Name: Kevin Weissman	Title: Interim Inpatient Pharmacy Manager
Telephone: 323-409-7552	Cell/Mobile Phone:
FAX: 323-441-8268	Email: kweissman@dhs.lacounty.gov

VII. Site Distribution Process

Upon activation of the county's Prophylaxis Plan, LAC+USC will initiate the distribution process in the following manner:

1. The Hospital Command Center, CEO, CMO, AOD, or House Supervisor will contact Executive Leadership, Employee Health, and Pharmacy Services of the activation of the Prophylaxis Plan.

2. An on-site distribution POD will be established. Location and set-up to be determined by the HCC at the time of incident. Consideration should be given to access, weather, space, security, and crowds. Suggested locations include:
    a. IPT Conference Rooms A-D
    b. GH Main Auditorium
    c. GH 1350
    d. The Quad

3. Pharmacy Services will release cache contents as needed to the designated agent/department, i.e. Employee Health, for distribution at the POD(s). Any unused portion of the SNS may be sequestered by LACDHS or LADPH.
    a. Note: Transportation of cache may require assistance of Facilities Management, Transportation, or Supply Chain Operations.

4. Upon direction of the HCC/Incident Commander, CEO, CMO, or AOD, notification to employees will take place through the emergency notification system, DHS-LACUSC Broadcast, and/or department manager(s)/supervisor(s). Included in the notification process will be the location for pick-up, hours of operation and a telephone number for additional information.

5. At the time of distribution:
    a. Three (3) bottles of medications (14 pills per bottle) are allocated for each person identified as essential personnel: one (1) bottle for the employee and two (2) bottles for immediate family members.
        i. Note: The amount provided is for immediate needs until such time as POD sites are established and/or persons are identified as having/not having been exposed per CDC / LADPH. The amount provided should not be considered as a complete course of treatment if exposure to Anthrax has occurred.
    b. An instruction sheet will be provided to each person (Attachment A).
    c. All persons will sign for medications (Attachment D) acknowledging their receipt and receipt of instructions.

6. Employee Health will be responsible for overseeing the distribution of the medications and will retain all records regarding the process. The person(s) responsible are:

Primary (Title):	Shawn McGowan, Nursing Director – Employee Health Services
Telephone:	323-409-5109
1st Alternate:	Leslie Astorga-Cook, Nurse Manager – Employee Health Services
Telephone:	323-409-5979
2nd Alternatve:	Wellington Da Silva, Nursing Supervisor – Employee Health Services
Telephone:	323-409-2292

ATTACHED
LADPH Instruction Sheet: Use of Doxycycline in a Bioterrorism Event
List of Essential Personnel
Pre-positioned Antibiotics Semi-Annual Report
Antibiotic Prophylaxis Distribution List

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

DO NOT USE UNLESS DIRECTED BY THE HEALTH OFFICER

Use of Doxycycline in a Bioterrorism Event

You are being given a limited supply of medicine. This supply is for you and your immediate family members.

If you have been instructed to take this medication, it has been determined that Anthrax, Plague or Tularemia may be present in the environment. Please note that these are preliminary doses only. You will be notified if you need additional supplies by the Health Authorities.

DO NOT TAKE IF YOU ARE ALLERGIC TO TETRACYCLINE, IF YOU ARE PREGNANT OR BREAST-FEEDING:

Adult Dose: Doxycycline 100 milligram (mg), take one (1) tablet by mouth, every 12 hours.

Pediatric Dose: See reverse side

Drink at least one full glass of water when taking Doxycycline. You may take this medicine with or without food or milk, but food or milk may help you avoid upset stomach.

If you miss a dose, take the missed dose as soon as possible. However, **do not take 2 pills to make up for the missed dose**.

Finish all your pills, even if you feel okay, unless your doctor tells you to stop. Public Health will be investigating this event and will determine if you and your family were at risk for exposure and will need additional treatment.

Side effects

Infrequent side effects of doxycycline include an upset stomach, vomiting, or diarrhea. If you have problems with any of these symptoms, tell your doctor. Less common side effects include dark urine, yellowing of the eyes or skin, sore throat, fever, unusual bleeding or bruising, fatigue, white patches in the mouth. In women, doxycycline can cause vaginal itching and discharge commonly known as a yeast infection. If any of these symptoms occur, call your doctor right away.

Allergic reactions are rare. Signs of an allergic reaction are rash, itching, swelling of the tongue, hands or feet, fever, and trouble breathing. If any of these symptoms occur, call you doctor right away.

SPECIAL NOTE FOR CHILDREN:

- This medicine may cause staining of the teeth in children younger than 8 years old. This means that their teeth can become grayish in color and this color does not go away. Given the seriousness of the risk, the benefit of the doxycycline treatment may be acceptable.
- This medicine can also cause bone growth delay in premature infants but this side effect goes away after the medicine is finished.

SPECIAL NOTE FOR PREGNANT, BREAST-FEEDING OR WOMEN TAKING BIRTH CONTROL PILLS:

- If you are pregnant or breast-feeding **DO NOT TAKE** this medication. You will need to obtain an alternate medication at a dispensing site.
- Birth control pills may not work as well when taking this medication. Be sure to use another form of birth control until you have finished the entire course of treatment.

PRECAUTIONS:

- Do not take if you are allergic to Tetracycline based medications: Achromycin V, Adoxa, Arestin, Bio-Tab, Declomycin, Demeclocycline, Doryx, Doxycycline, Dynacin, Helidac, Minocin, Minocycline, Monodox, Periostat, Sumycin, Terramycin, Topicycline, Vectrin, Vibra-Tabs, Vibramycin.
- Do not take antacids (Maalox, Mylanta, Tums), Bismuth Salts (Pepto-Bismol), or vitamin supplements with aluminum, magnesium, iron, calcium or zinc while taking this medication.
- Doxycycline can make skin very sensitive to the sun which increases the chance of getting severe sunburn. Avoid the sun as much as possible. When outside, wear a long sleeve shirt and hat and always apply sunscreen (30 SPF).

U.S. Department of Health and Human Services
Food and Drug Administration
FDA

This card explains how to prepare emergency dosages of

Doxycycline

for infants and children exposed to anthrax

*Once you have been notified by your federal, state, or local authorities that you have been exposed to anthrax, it may be necessary to prepare **emergency** doses of doxycycline for infants and children using doxycycline tablets.*

You will need:

- One (1) 100 millgram (mg) doxycycline tablet or capsule
- Metal teaspoon
- Measuring spoons [1 teaspoon; and 1/2 teaspoon]

  NOTE: measuring spoons are preferred, however if not available, use the metal teaspoon to grind, measure and give the medicine.
- 1 or 2 small bowls
- One of these foods or drinks

  __lowfat milk
  __lowfat chocolate milk
  __regular (whole) chocolate milk
  __chocolate pudding
  __apple juice mixed with table sugar*

* *For apple juice mixture only*

- Add four (4) level ***teaspoons*** of sugar and four (4) ***teaspoons*** of apple juice in a second small bowl.
- Stir the mixture until all the sugar is dissolved.
- Then follow directions 1 and 2 below.

Directions:

1. Put **one** (1) 100-mg doxycycline tablet into a small bowl. Grind into a fine powder using the back of the metal teaspoon. The powder should not have any large pieces. If you use Doxycycline capsules open the capsule and pour the powder from the capsule into a small bowl.

2. Add four (4) level ***teaspoons*** of a food or drink to the doxycycline powder. Mix them together until the powder dissolves

How Much of the Doxycycline Mixture To Give A Child

The number of teaspoons of the doxycycline mixture to give a child depends on the child's weight. The chart below tells you how much to give a child for **one dose.** You should give a child **two doses** (one in the morning and one in the evening) each day.

If the child weighs	**Give the child**
0-12.5 lbs.	**One half (1/2) teaspoon** of the doxycycline mixture
12.5 - 25 lbs.	**One (1) teaspoon** of the doxycycline mixture
25 - 37.5 lbs.	**One and one half (1 1/2) teaspoons** of the doxycycline mixture
37.5 - 50 lbs.	**Two (2) teaspoons** of the doxycycline mixture
50 - 62.5 lbs.	**Two and one half (2 1/2) teaspoons** of the doxycycline mixture
62.5 - 75 lbs.	**Three (3) teaspoons** of the doxycycline mixture
75 - 87.5 lbs.	**Three and one half (3 1/2) teaspoons** of the doxycycline mixture
87.5 - 100 lbs	**Four (4) teaspoons** of the doxycycline mixture

Children heavier than 100 pounds who are exposed to anthrax should take one (1) 100-mg tablet of doxycycline twice a day (one in the morning and one in the evening) for 60 days.

How already prepared Doxycycline mixture should be stored

- Doxycycline mixed with any of the recommended foods and drinks will keep for at least 24 hours.
- Store the mixture in a covered container and **always refrigerate** mixtures made with milk or pudding.
- Mixtures made with juice can be stored at room temperature.

FDA recommends that doxycycline mixtures be prepared daily; unused portions should be thrown away.

For more information about doxycycline, go to:
www.fda.gov/cder/drug/infopage/penG_doxy

Children's Hospital LOS ANGELES
We Treat Kids Better

Liquid Ciprofloxacin –
for infants and children exposed to a disease

How to Make Liquid Ciprofloxacin:

125 mg per 5 ml

You will need:
- One (1) 500-mg ciprofloxacin tablet
- Measuring device: 20-mL oral syringe and cup

Step 1

Measure 20 mL of room temperature water in an oral syringe and place into a small cup.

Put one (1) 500 mg ciprofloxacin tablet into the water and let it sit for five (5) minutes until the tablet breaks apart. Mix well until the powder dissolves and there is no more powder left at the bottom.

Step 2

Weigh your child. Use your child's weight to find the correct dosage on the chart below.

Weight: _____ lbs

Dosage Chart
How much medicine to give your child is based on your child's weight.

Use this chart to find the amount for one (1) dose.

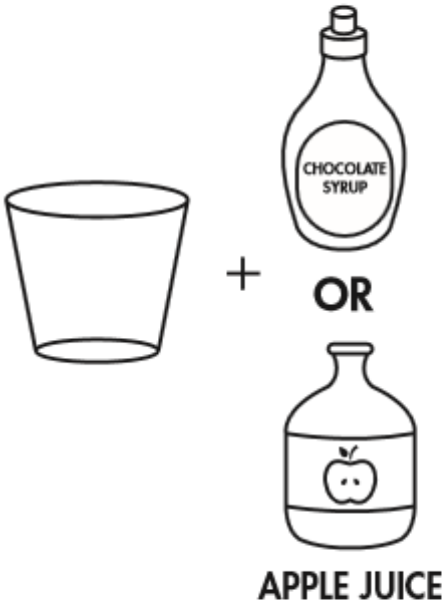
Give this dose two (2) times a day – once in the morning and once in the evening. Please mix this medicine every 24 hours. Continue for as many days as you were told to give this medicine.

Ciprofloxacin Oral Liquid	
Weight (lbs)	**Dose (mL)**
4 - 7 lbs	1.2 mL
Over 7 to 9 lbs	2.5 mL
Over 9 to 13 lbs	3.8 mL
Over 13 to 18 lbs	5 mL
Over 18 to 26 lbs	7.5 mL
Over 26 to 36 lbs	10 mL
Over 36 to 42 lbs	12.5 mL
Over 42 to 48 lbs	15 mL
Over 48 to 55 lbs	17.5 mL
More than 55 lbs	20 mL (1 whole tablet - dissolved)

My child's name is: _____

My child's dose is: _____

Mix this amount with food or liquid. See back.



Step 3

This medicine is very bitter. Mix one (1) dose of ciprofloxacin liquid with food or drink before giving it to older infants and children. Administer the entire dose.

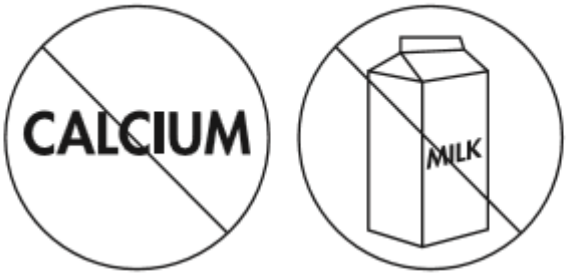
Mix with:

- Chocolate syrup
- Table sugar
- Apple juice or apple sauce sweetened with extra table sugar

For formula-fed or breastfed infants, mix medicine only with water.

Mix well before using. Consume the entire dose.

You may use this medicine for up to 24 hours if it is kept covered and stored at room temperature or in the refrigerator. Throw away any unused liquid after 24 hours and mix fresh every day.



DO NOT mix with:

- Calcium-fortified juice
- Infant formula
- Breast milk
- Milk or any milk products, such as yogurt or ice cream

Initially funded by a federal grant from the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services. Content developed by the Illinois Terrorism Task Force's Pediatric Bioterrorism Workgroup.

Attachment B
List of Essential Personnel

Department	Title/Position	# of Personnel	Total
ALL	ALL	ALL	8,500

Essential personnel are those considered necessary for provision of critical services or Continuity of Government.

Attachment C: Bi-Annual Antibiotics Report

Organization's name: _____

Number of boxes originally issued: _____

Please complete this bi-annual report and send to antibiotics@dhs.lacounty.gov or fax to (562) 944-6931. This is report is due by September 15th and March 15th of each year.

March 15th Report		**September 15th Report**	
Box Lot Number(s)		Box Lot Number(s)	
Number of boxes on hand		Number of boxes on hand	

If the information for the primary or secondary point of contact has changed, please fill out the information below.

Primary Contact		**Secondary Contact**	
Name		Name	
Title		Title	
DEA License (if applicable)		DEA License (if applicable)	
Email		Email	
Phone number		Phone number	
Cell number		Cell number	
Address		Address	

I certify that the information in this report is true and correct. Please initial the following statements, and sign the bottom of the form.

_____ Medication boxes and bottles are sealed and unopened.

_____ Antibiotics are stored in a secured, climate controlled environment.

_____	_____	_____
Signature	Print Name	Date

Attachment D
Antibiotics Prophylaxis Distribution List

By signing this document, I acknowledge receipt of medications and receipt of the *Use of Ciprofloxacin in a Bioterrorism Event* instruction sheet.				
Employee Number	Name (Please Print)	Signature	LAC+USC Department	Date Received

PURPOSE
To establish criteria and guidelines for water management during a water emergency.

BACKGROUND
A water emergency can occur due to human, nature, and technological events. Although back-up systems are in place to maintain supply, these systems may become exhausted or fail. The emergency may be localized to the facility, the local area, or the region.

Water Emergencies are classified into 2 types:

1. Distribution Failure
    a. Drought
    b. Regional power outage
    c. Supply line failure

2. Water Quality Emergencies
    a. Authority
        i. Issued by the Department of Water and Power (DWP) or the California Department of Public Health (CDPH).
        ii. Only the CDPH (and LADPH by proxy) can rescind "Do not use" order.
        iii. LADPH Contact: 626- 430-5420

    b. LADPH Classifications for Water Quality (LADPH website: http://www.publichealth.lacounty.gov/eh/EP/dw/dw_watersafe.htm)
        i. **BLUE**
            1. No restrictions on water usage.
        ii. **YELLOW**
            1. Water is safe for consumption if boiled for ≥ 1 minute
            2. May use for drinking, cooking, dish-washing, or brushing teeth AFTER boiling.
            3. Do not need to boil for hand-washing, bathing, doing laundry, watering lawn/plants, or flushing toilet.
        iii. **ORANGE**
            1. Do not consume under any circumstance. Boiling is ineffective
            2. Do NOT use for drinking, cooking, dishwashing, or brushing teeth.
            3. May use for hand-washing, bathing, doing laundry, watering lawn/ plants, or flushing toilet.
        iv. **RED**
            1. Do not consume or have bodily contact with water.
            2. Do NOT use for drinking, cooking, dishwashing, bathing, hand-washing, or brushing teeth.
            3. May use for watering lawn/plants, doing laundry, or flushing toilet

SYSTEM

1. Activation and Notification
    a. Per protocol.
    b. Assure communication with EMS / MCC.

2. Command and Control
    a. Overall responsibility for the incident lies with and directives come from the IC/HCC per protocol.

3. **Distribution Failure**
    a. Impact
        i. Dependent on type and duration of incident
        ii. More significant due to chiller demands
        iii. Reliance on water storage tank, stored water, vendors, community partners
    b. Response
        i. Water Consumption Reduction Strategies
            1. Facilities Management
                a. Shut off all non-essential water functions
                b. Evaluate use of Chiller and Steam
                    i. Prioritize units, services needs
                    ii. Shut off non-essential areas and services
                    iii. Activate backup closed systems where available
            2. Staff/Patients
                a. Personal Hygiene
                    i. Sink/Showers closed off
                    ii. Utilize personal wipes and alcohol-based rubs.
                b. Sanitation / Refuse
                    i. Toilets closed off
                    ii. Utilize: kitty litter, bags in toilet, bucket brigade
            3. Dietary
                a. Utilize disposable utensils, serving trays, bags
                b. Implement No Water Prep meals
            4. Phase closure of buildings and services
                a. HCC to analyze impact and potential duration.
                b. Consider sequential closure of non-emergent services, departments, buildings.
        ii. Supply Chain Ops to provide stocked water.
            1. Develop rationing strategy based on type and expected duration of event.
        iii. Vendors
            1. Contacts
                a. Arrowhead: 800-950-9393
                b. Sparkletts: 800-453-0294
            2. Request
                a. Bottled water
                b. Water Tankers to fill storage tank
        iv. Contact EMS / MCC
            1. Community and brokered resources

4. **Water Quality Emergency**
    a. Impact
        i. Dependent on classification and duration of incident
        ii. Less significant
            1. Per LADPH usage criteria, usage restrictions still allow majority of the facility's water use functions

iii. Reliance on water storage tank, stored water, vendors, community partners

b. Response
    i. Follow LADPH recommendations on water quality emergency classification and usage.
    ii. Isolate the water storage tank.
        1. Test if indicated.
        2. Follow FM procedures for purification if indicated.
    iii. Implement Water Consumption Reduction Strategies. See above.

5. **Re-Assess**
    a. Continual assessment and evaluation of strategies and actions.
    b. Determine need to alter plan.
    c. Determine when the facility and community can no longer support the water needs of the facility and Evacuation is likely or imminent.

Emergency Operations Plan

Addendum

Version	Update / Revision
2022-10-05	Notification update, Staff Training update, MFI update.
2020-01-07	Activation authority and notification update.
2019-11-08	Updated policy locations and TOC. Satellite Phone change. FAC update.
2019-08-26	Added Sections: Increased Patient Accommodations; CMS 1135 Waiver. Respective corrections to additions. Updated Evacuation, Earthquake. General proofreading.
2018-04-17	Updated EMS Policies and TOC.
2018-04-14	Name change: Allied Barton to Allied Universal
2018-01-25	Added Section "Background: NIMS Implementation for Healthcare Organizations" Updated Planning and Preparedness: Drills and Evaluation: Drills and Exercises, Emergency Operations: Staff: Staff Training, Updated Emergency Operations: Communication: Background
2016-09-01	Phone number update: East, West Central Plant.
2016-04-25	Update to formatting, table of contents, typographical errors.

Emergency Operations Plan

Appendix I: Mutual Aid, Community Partners and Coalition

Note: Regional Response Plan – DRC Region 6 hard copy is in the EOP binder, and the electronic copy is on MS Teams: Hospital Command Center.

Note: the related County EMS Disaster Policies are in the EOP binder, and the electronic copies are on MS Teams: Hospital Command Center and internet via EMS Agency website (http://dhs.lacounty.gov/wps/portal/dhs/ems/prehospitalcaremanual)

1. Regional Response Plan – DRC Region 6
2. EMS Disaster Related Policies
    a. EMS Policy No. 519: Management of Multiple Casualty Incidents
    b. EMS Policy No. 538: Burn Resource Center Designation and Activation
    c. EMS Policy No. 1102.: Disaster Resource Center (DRC) Designation and Mobilization
    d. EMS Policy No. 1102.2: DRC Equipment Checklist for Items Deployed to Other Facilities
    e. EMS Policy No. 1106.: Mobilization of Local Pharmaceutical Caches (LPCs)
    f. EMS Policy No. 1106.1: LPC Inventory and Checklist for Items Deployed
    g. EMS Policy No. 1107.: Mobilization of Medical/Surgical Supply (M/SS) Caches
    h. EMS Policy No. 1107.1: M/SS Cache Inventory and Checklist for Items Deployed
    i. EMS Policy No. 1108.: Chempack Deployment for Nerve Agent Release
    j. EMS Policy No. 1108.1: Chempack Inventory List
    k. EMS Policy No. 1108.3: Chempack Checklist for Items Deployed
    l. EMS Policy No. 1112: Hospital Evacuation
    m. EMS Policy No. 1122.: Bed Availability Reporting
    n. EMS Policy No. 1122.1: Bed Availability Report
    o. EMS Policy No. 1124: Disaster Preparedness Exercise/Drills
    p. EMS Policy No. 1128: Decontamination Trailer Deployment for Mass Casualty Event
    q. EMS Policy No. 1130: Trauma Center Emergency Preparedness
    r. EMS Policy No. 1132: Amateur Radio Communications
    s. EMS Policy No. 1138.: Burn Resource Center (BRC) Designation and Activation
    t. EMS Policy No. 1138.1: Burn Resource Center Equipment/Supplies/Pharmaceutical Cache
    u. EMS Policy No. 1140.: Mobile Medical System Deployment
    v. EMS Policy No. 1140.1: Mobile Medical System Deployment Summary
    w. Los Angeles County Pediatric Surge Plan