HOSPITAL INCIDENT COMMAND SYSTEM

Guidebook

Fifth Edition 2014

Project Sponsored by

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May 2014

Project Sponsor: CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY

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About This Guidebook

Since the 2006 publication of the revised Hospital Incident Command System (HICS), countless numbers of hospitals have benefited from the Guidebook and accompanying tools for use during training activities and in response to real world emergencies.

This latest revision has been expanded to meet the needs of all hospitals, regardless of their size, location or patient care capabilities. Significant effort has also been made to support other types of healthcare providers such as rehabilitation centers and urgent care centers. By incorporating and adopting these concepts and tools, hospitals will be closely aligned with the National Incident Management System (NIMS) including the Incident Command System (ICS) and subsequent common terminology, response concepts, and procedures.

As with the 2006 guidebook, the principal beneficiaries of HICS will continue to be anyone with a response role during a crisis including hospital physicians, nurses, and administrators. Community partners with whom hospitals collaborate (e.g., public safety, local health department, emergency management, etc.) as well as students of emergency management will find the information in this guidebook useful in understanding healthcare response issues and incident command practices and tools used during various health-impacted events.

Unlike the changes made in the 2006 version of HICS, this update does not involve wholesale changes in design and content. However, lessons learned from real-world emergencies have been incorporated from the 2009–10 National HICS Survey, the 2011 HICS National Stakeholders' Summit, and from examples provided by the HICS Secondary Review Group members who once again evaluated the draft materials and provided their comments and suggestions to all proposed changes.

This revision includes the following updates:

- The term, "Incident Management Team" has been changed to "Hospital Incident Management Team" to eliminate any potential confusion with other response teams such as deployed state or federal resources sent to help manage an incident.

- A Patient Family Assistance Branch has been added under the Operations Section to address patient family needs during a response.
- An Employee Family Care Unit Leader has been included in the Support Branch within the Logistics Section to assist healthcare staff and clinicians by providing support for their families.
- Greater emphasis has been placed on incident action planning including the introduction of new, more practical tools.
- The Incident Planning Guides (IPGs) and Incident Response Guides (IRGs) have been reformatted and consolidated or expanded for improved application among hospitals.
- The HICS Forms have been revised to be more consistent with those used by the Federal Emergency Management Agency (FEMA). Additionally, there are 3 new HICS Forms available for hospital use: Incident Action Plan (IAP) Quick Start; the HICS 200: IAP Cover Sheet; and the HICS 221: Demobilization Check-Out.
- A new chapter addressing the implementation of HICS during off hours and for small and rural hospitals has been added.

As with prior guidebooks, this edition has NOT been written to be a definitive text on hospital preparedness and response, nor should it be considered an Emergency Operations Plan (EOP). It is hoped that the reader will benefit from its concise, clear content in a format that is easier to read and find this revision more appropriate for a broader scope of hospitals and healthcare organizations. The HICS Tools have been made available in Microsoft Word and Adobe, to support use during general training and exercises while still encouraging customization among individual organizations or coalitions.

This guidebook and the accompanying HICS tools should be considered, "living documents." That is, as hospitals adopt these new materials, no doubt additional best practices and lessons learned will be considered. Consequently, recommendations will evolve and lead to the next HICS update. [1]

[1] The California Emergency Medical Services Authority would like to receive copies of After Action Reports (AAR) and presentations on the use of HICS. This information will aid future revisions. Address these informative documents to the HICS Coordinator via email HICS@EMSA.CA.GOV

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CHAPTER 1

Introduction to the Hospital Incident Command System

OBJECTIVES

- Define Hospital Incident Command System (HICS).
- Identify the relationship of HICS to the Incident Command System (ICS) component of the National Incident Management System (NIMS).
- Provide a brief history of HICS.
- Detail 7 fundamental elements of HICS.
- List five benefits of using HICS.

1.1 What is HICS?

The Hospital Incident Command System (HICS) is an incident management system that can be used by any hospital to manage threats, planned events, or emergency incidents.

As a system, HICS is extremely useful; not only does it provide an organizational structure for incident management but it also guides the process for planning, building, and adapting that structure. Using HICS for every incident or planned event helps hone and maintain skills needed for the large scale incidents.

1.2 Relationship to the Incident Command System (ICS)

HICS is based on the same principles as the Incident Command System (ICS) component of the National Incident Management System (NIMS), adapted for the healthcare environment. The principles presented in the HICS material apply to all mission areas (Prevention, Protection, Mitigation, Response, and Recovery) and all hazards.

Like ICS, HICS is a flexible, scalable, and adaptable system that can be used by all hospitals regardless of size, location, patient acuity, patient volume, or hazard type. HICS expands or contracts relative to the needs of the situation. By using HICS, hospitals adopt a nationally recognized system that promotes successful incident management within

the hospital and strengthens integration with community response partners. Federal funds were used in the development of the HICS material.

1.3 History of HICS

In the late 1980's, it was recognized that hospitals would benefit from adopting an incident management system based on the principles of Incident Command System (ICS). HICS has undergone three revisions since its introduction, the most recent in 2006 (HICS IV). An important evolutionary change is the recognition that HICS is not only highly applicable to hospitals but also to other healthcare facilities. With nearly 25 years of use at hospitals throughout the United States and abroad, the HICS revision process has captured and incorporated the lessons learned from exercises and real-world use. HICS 2014 represents the culmination of these lessons learned and the direct experiences of HICS users.

1.4 Components of HICS

HICS provides an adaptable system for incident management. Its success is based on essential components whose value has been proven repeatedly through application by public and private sector organizations, large and small.

HICS establishes a standard format for response that is not only effective but immediately recognizable to others from responding agencies. This has tremendous value when disasters require coordination among multiple community response partners during an incident when there is no time to learn the nuances of disparate systems.

1.5 Characteristics of HICS

HICS is a *comprehensive* all-hazards incident management strategy that:

- Is a model for hospital emergency management systems and is used both nationally and internationally.
- Can be used in both emergent and non-emergent incidents and events. Some hospitals only see HICS as a system to manage emergency incidents. However, the modular design and flexibility of HICS lends itself to managing non-emergency incidents or events, such as moving patients within the facility, dispensing medication to hospital staff, annual influenza vaccination programs, or hosting a large hospital or community event.

- Assigns positions only as determined by the scope and magnitude of the incident in keeping with the principle of scalability, which is important during an emergency. Staff assigned positions are returned to their normal work functions once their position is no longer needed for the incident response.
- Is based on fundamental elements:
    1) Predictable chain of command with a suggested span of control
    2) Accountability of position and team function, including prioritized action checklists
    3) Common language for promoting interagency communication
    4) A flexible and scalable incident management system addressing planning and response needs of any size hospital with universal applicability
    5) Modular design and adaptability allowing planning and management of non-emergent incidents or events
    6) Guidance requirements from the National Incident Management System (NIMS) and accreditation agencies regarding hospital use of incident command system principles in unity of effort with community response partners
    7) Management by Objectives (MBO) in which the problem encountered is evaluated, a plan to remedy the problem identified and implemented, and the necessary resources assigned

HICS is not meant to replace the everyday organization design. The HICS organization structure frequently does not correlate to the daily administrative structure of the hospital. This practice is purposeful and done to reduce role and title confusion.

The HICS Guidebook does not serve as the hospital's Emergency Operations Plan (EOP). Each hospital is unique and requires a detailed, all-hazards EOP with specific functional annexes to address special situations and threat scenarios. Information provided in this guidebook may be used in the development of the EOP (see Chapter 2.4.1 All-Hazards Emergency Operations Plan).

The application and adaptation of HICS to the individual hospital requires education and training to produce proficiency and competency. Once mastered, it provides an easy-to use framework to manage any incident.

1.6 Benefits of Using HICS

Benefits of using HICS include:

1) Efficient and coordinated response to emergencies;
2) Seamless integration in the Multi-Agency Coordination System (MACS) with community response partners;
3) National Incident Management System (NIMS) consistence;
4) Federal preparedness and response grant consistence; and
5) Accreditation consistence

1.6.1 Efficient and Coordinated Response to Emergencies

Hospitals conduct vital business on a day-to-day basis and often function as first receivers when disasters strike. Whether an internal or external incident impacts a hospital, its ability to effectively respond is paramount to the safety of patients, visitors and staff and the continuation and/or resumption of healthcare services.

The ability and capacity of hospitals to optimally function during an incident is dependent on a number of factors, including effective coordination with other responding agencies (e.g., emergency medical services [EMS], fire, law, local health department, and emergency management). By implementing HICS, hospitals are able to "speak the same language" as these responses partners and communicate and coordinate more effectively.

Disasters often do not fit a "business as usual" management model for hospitals. Beyond the additional patient care demands that may arise due to the incident, multiple internal operations and business processes may also be affected. Since disasters can impact several areas simultaneously and different activities are necessary to manage each affected area, routine business management processes may be inadequate. Again, HICS brings order to the additional demands created by these complex situations.

By implementing and using HICS, hospitals will more efficiently respond to emergencies and successfully coordinate with other responding agencies. The hospital's role in the community response effort with be strengthened and patients will directly benefit from efficient, coordinated actions within the hospital and between community response partners.

1.6.2 Multi-Agency Coordination System (MACS)

A Multi-Agency Coordination System (MACS) is a combination of facilities, equipment, personnel, procedures, and communications integrated into a common system with responsibility for coordinating agency resources and supporting agency emergency operations. MACS provide the architecture to support incident prioritization, critical resource allocation, communications systems integration, and information coordination. The MACS establishes relationships between all elements of the system and assists agencies and organizations responding to an incident.

1.6.3 National Incident Management System (NIMS) Consistence

The National Incident Management System (NIMS) is a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all hazards - regardless of cause, size, location, or complexity - in order to reduce loss of life, property and harm to the environment. The NIMS is the essential foundation to the National Preparedness System (NPS) and provides a common approach for the management of incidents and operations in support of all five national planning frameworks. In 2006, the Federal Emergency Management Agency (FEMA) National Integration Center, working in conjunction with the U.S. Department of Health and Human Services (HHS) and the HICS Working Group, identified 14 NIMS requirements for hospitals and healthcare systems. One of the requirements stated:

> *"Manage all emergency incidents, preplanned exercises and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS. ICS implementation must include consistent application of Incident Action Planning and Common Communication Plans."*

HICS addresses the importance of information sharing and intelligence under the Planning Section to best maintain situational awareness and response accordingly to emerging events, both within the hospital and the broader community. A helpful resource to guide planners is the NIMS Intelligence/Investigations Function Guidance and Field Operations Guide (October 2013) (see Appendix I: Resources and References: National Reference Documents).

1.6.4 Federal Preparedness and Response Grant Consistence

Hospitals that receive federal preparedness and response grants, contracts or cooperative agreements must work to be compliant with the National Incident Management System (NIMS) by implementing certain activities. In 2011, the Office of the Assistant Secretary for Preparedness and Response (ASPR) within the U.S. Department of Health and Human Services (HHS) released *NIMS Implementation for Healthcare Organizations Guidance*. The Incident Command System (ICS) elements include:

> *"Manage all emergency incidents, exercises, and preplanned (recurring/special) events with consistent application of ICS organizational structures, doctrine, processes, and procedures"* and
>
> *"Promote and integrate, as appropriate, NIMS concepts and principles (i.e., the ICS) into all healthcare organization-related training and exercises."*

1.6.5 Accreditation Consistence

Most accreditation organizations (e.g., The Joint Commission) include requirements for emergency management programs, Emergency Operations Plans (EOP), and a standardized incident response system. HICS is therefore a vital tool for meeting the accreditation requirements for providing a comprehensive hospital emergency management program and can aid in accreditation compliance.

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CHAPTER 2

The Emergency Management Program

OBJECTIVES

- Describe the hospital's Emergency Management Program.
- Describe the hospital's Emergency Operations Plan (EOP) and its relation to HICS.
- Identify the Hazard Vulnerability Analysis (HVA) and its importance to incident planning.
- Describe the importance of hospital coordination with external partners.
- Describe community strategies for expanding emergency healthcare services.

2.1 Emergency Management Program

A hospital's Emergency Management Program is composed of a number of critical elements that are relevant to the four phases of emergency management: mitigation, preparedness, response, and recovery.

To develop a comprehensive Emergency Management Program, the hospital could consult resources such as *Emergency Management Principles and Practices for Health Care Systems (2nd edition)*, National Incident Management System (NIMS), National Response Framework (NRF), National Fire Protection Association (NFPA) 1600 *Standard on Disaster/Emergency Management and Business Continuity Programs - 2013 Edition*, Homeland Security Presidential Directive (HSPD) 5, Presidential Policy Directive (PPD) 8: *National Preparedness*, and Continuity Guidance Circular 1 (CGC 1): *Continuity Guidance for Non-Federal Governments- July 2013*. In addition, appropriate state, local, and non-governmental regulatory and accreditation standards should be considered in developing the Emergency Management Program.

Appendix I: Resources and References provides a list of resources and reference materials that may be useful in the development of a comprehensive Emergency Management Program. A helpful resource to guide planners is the *Emergency Management Program Guidebook* developed by the U.S. Department of Veterans Affairs.

The guidance outlines a nine-step process for the development, maintenance, and evaluation of a hospital Emergency Management Program. The process includes:

- Designate an Emergency Program Manager;
- Establish the Emergency Management Committee;
- Develop the all-hazards Emergency Operations Plan (EOP);
- Conduct the Hazard Vulnerability Analysis (HVA);
- Develop incident-specific guidance;
- Coordinate with external entities;
- Train key staff;
- Exercise the Emergency Operations Plan (EOP); and
- Conduct program review/evaluation and plan for and execute improvement processes.

2.2 Emergency Program Manager

The appointment of a qualified and motivated individual to serve as Emergency Program Manager is vital. This individual facilitates the hospital's preparedness efforts, including the development of relevant policies and procedures, development and revision of the Emergency Operations Plan (EOP) and supporting annexes, planning and executing training and exercises, and preparing After Action Reports (AAR) and Corrective Action and Improvement Plans (IP). The Emergency Program Manager also represents the interests of the hospital at various preparedness meetings at the local, regional and state levels.

The desired background for an Emergency Program Manager includes formal and informal training, education, and experience in emergency management; working knowledge of the Incident Command System (ICS) and the National Incident Management System (NIMS) and HICS; understanding of hospital operations; and familiarity with local, regional, and state healthcare system design and emergency response procedures. Advanced degree and certification programs are now available for healthcare emergency managers. Examples include Certified Emergency Manager (CEM), Certification in Hospital Emergency Management (CHEM), and Certified Healthcare Emergency Professional (CHEP).

2.3 Emergency Management Committee

The Emergency Management Committee should include multi-disciplinary representatives, including a staff physician, clinical and nonclinical representatives from key departments and functional units, and the administration. For some hospitals, the Emergency Management Committee functions as a stand-alone governing body, and at other hospitals, it is a subcommittee of another committee (e.g., Environment of Care, Disaster Committee or Safety Committee). The Emergency Management Committee is a repository for documentation related to hospital readiness (e.g., minutes, regulatory/accreditation requirements, training records, After Action Reports [AAR], etc.).

A well-qualified and motivated committee chairperson should be selected according to hospital policies or bylaws. The Emergency Management Committee should meet on a regularly scheduled basis and establish an annual set of objectives, priorities and work plan to achieve the objectives. The minutes from each meeting should be published and widely disseminated to apprise all hospital staff of committee activities and any changes to the Emergency Management Program or Emergency Operations Plan (EOP).

Subcommittees should be appointed as necessary to accomplish specific projects identified by the Emergency Management Committee or to plan training and exercises. Members of subcommittees may include members of the Emergency Management Committee or other individuals from the hospital or community who have subject matter expertise relative to the specific project.

The highest priority of the United States Department of Health and Human Services' National Healthcare Preparedness Programs is healthcare coalition building. It is useful to involve local agencies (e.g., emergency medical services [EMS], fire, law, local health department, and emergency management) in Emergency Management Committee activities. This collaborative approach will help clarify roles and responsibilities and promote personal networking with other emergency response agencies prior to an urgent need for response coordination.

The Emergency Management Committee should focus on activities to:

- Develop and update a comprehensive all-hazards Emergency Management Program on an annual basis

- Conduct an annual Hazard Vulnerability Analysis (HVA) in coordination with community partners
- Develop and update an EOP and standard operating procedures that reflect the hazards identified in the annual HVA as well as lessons learned from training, exercises and incident response
- Provide for the continuity of business operations through the development of hospital Continuity of Operations (COOP) Plans or Business Continuity Plans
- Ensure that all employees and medical staff receive training in accordance with healthcare accreditation requirements and regulatory guidelines to understand their role(s) and responsibilities for an incident response

The Emergency Management Committee should identify education and training needs and develop an annual education and training program. This should emphasize all-hazards response as well as hazard-specific roles and responsibilities. Staff should have a clear understanding of the role of the hospital in community emergency incident response, their specific role in an event, and resources available to support patients, staff, and families during an incident response and recovery. This may be accomplished through an annual orientation, refresher training, online training programs, safety fairs, staff meetings and other methods of information dissemination.

The Emergency Management Committee chairperson should regularly inform the hospital's Chief Executive Officer (CEO) and senior administrators regarding Emergency Management Committee activities, challenges, program successes, modifications to response plans, and additional assistance or resources needed to effectively conduct the committee's business. If the hospital is part of a larger healthcare system, the appropriate corporate administrators should also be briefed regularly on the hospital's emergency preparedness activities.

2.4 Planning

Planning is a fundamental capability for emergency preparedness and serves as a systematic process for developing strategic, operational, and tactical approaches to meet defined objectives. Planning is based on threats, hazards, and risk that the hospital has identified while also recognizing current and desired incident management capability levels. Planning applies to all hazards and all five mission areas. Key considerations of planning include the following:

- **Planning should ensure engagement of senior leadership and stakeholders.** Effective planning ensures that all appropriate stakeholders, groups, and mutually supportive operations are represented and involved in the planning process. The most realistic and complete plans are prepared by a diverse planning team, including representatives from the various hospital departments and offices, supporting facilities, and other community representatives as appropriate who are able to contribute critical perspectives and/or have a role in executing the plan.
- **Planning should acknowledge the threats, hazards, and other risks during the planning process.** While the causes of emergencies can vary greatly, many of the effects do not. Planners can address common operational functions in their basic plans instead of having unique plans for every type of hazard or threat. For example, the 2006 External and Internal Scenarios, Incident Planning Guides (IPGs), and Incident Response Guides (IRGs) have been consolidated as appropriate because their operational functions are similar. (See Table 2 on page 97 and Table 3 on page 98.) Planning for all threats and hazards ensures that, when addressing emergency functions, planners identify common tasks and those responsible for accomplishing the tasks.
- **Planning should be focused on particular goals and objectives that identify the mission and desired outcomes.** Clear definition of the planning goals and objectives enables unity of effort and consistency of purpose among the multiple groups and activities involved in the planning process.
- **Planning should be flexible enough to address both traditional and catastrophic incidents.** Scalable planning solutions are the most likely to be understood and executed properly by the operational personnel who have practice in applying them. Planners can test whether critical plan elements are sufficiently flexible by exercising them against scenarios of varying type and magnitude.
- **Planning is one of the key components of enhancing preparedness. Preparedness is an ongoing cycle of activity.** Planning, in coordination with assessing risk, building capabilities, validating capabilities (through exercises, evaluation, lessons learned etc.), and reviewing and updating plans, policies, and other supporting doctrine is a key component of enhancing preparedness and building resiliency.

2.4.1 All-Hazards Emergency Operations Plan (EOP)

The Emergency Operations Plan (EOP) describes how the hospital will respond to and recover from a threat, hazard, or other incident. Critical areas that should be addressed include:

- Incident recognition
- Alerts and notifications
- Triggers for EOP activation
- Authority for EOP activation, implementation of associated policies and procedures, demobilization and system recovery
- Management and planning
- Situational awareness
- Departmental/organizational/staff roles and responsibilities before, during, and after emergencies
- Communications (internal and external)
- Staffing
- Credentialing
- Volunteer management
- Health and medical operations
- Patient management
- Fatality management
- Decontamination
- Logistics
- Finance and emergency spending authorizations
- Resource management, including mutual aid
- Donations management (solicited and unsolicited)
- Infrastructure management (building, grounds, utilities, damage assessment)
- Evacuation
- Safety and security
- Coordination with external agencies

It is important that the hospital EOP is consistent with local, tribal, regional, state and national plans, including the National Incident Management System (NIMS) and the recently revised National Response Framework (NRF) (2013).

A helpful resource to guide planners is the *Comprehensive Preparedness Guide (CPG) 101: Developing and Maintaining Emergency Operations Plans* (November 2010) developed by the Federal Emergency Management Agency (FEMA) (see Appendix I: Resources and References: National Reference Documents).

2.6 Hazard Vulnerability Analysis (HVA)

The annual Hazard Vulnerability Analysis (HVA) should identify the significant internal and external hazards faced by the hospital that are in turn reflected in hazard or incident-specific guidance documents included as annexes to the Emergency Operations Plan (EOP). The HICS Incident Planning Guides (IPGs) and Incident Response Guides (IRGs) may serve as starting points for building appropriately customized response annexes (see Appendix E: Incident Planning Guides and Appendix F: Incident Response Guides).

HVA review is typically accomplished through the Emergency Management Committee. Many tools are available to assist the hospital in performing an HVA. Choosing the HVA tool that best meets the hospital needs will require some investigation.

Two primary elements are considered in the HVA process:

- *Probability* is the likelihood of an event's occurrence. It can be calculated through a retrospective assessment of event frequency or predicted through a prospective estimation of risk factors.
- *Impact* is the severity of damage caused by a threat and should include effects on human lives, business operations/infrastructure, and environmental conditions.

Risk is the calculated score of the interactions between probability and impact that is applied to each threat type. Risk may be reduced by implementing threat-mitigation activities focused on probability (e.g., reduced likelihood of electrical failure through routine generator testing) or severity (e.g., fewer earthquake injuries by securing heavy wall cabinets).

The HVA should be reviewed at least annually or sooner if needed (e.g., after exercises) significant changes in hospital operations or services, or the recognition of new threats.

Changes in the HVA should be reflected in an updated EOP, with incident-specific response plans for high priority threats tested during annual disaster exercises.

A related process that the hospital may utilize or participate in is the Threat and Hazard Identification and Risk Assessment (THIRA) as administered at the broader community level (typically among large urban areas and at the state level). The THIRA process helps communities identify capability targets and resource requirements necessary to address anticipated and unanticipated risks. More information on THIRA can be found in the Threat and Hazard Identification and Risk Assessment Guide; Comprehensive Preparedness Guide 201, Second Edition (August 2013) (see Appendix I: Resources and References: National Reference Documents).

The inter-relatedness between the hospital's HVA and the vulnerabilities facing the community should be considered. This may be achieved by Local Emergency Planning Committees or healthcare coalitions. An integrated review of threats and planning efforts within the community promotes strategic alignment and maximizes the value and effectiveness of limited resources.

2.7 Evaluation of Incident Planning Guides (IPGs) and Incident Response Guides (IRGs)

A series of Incident Planning Guides (IPGs) and Incident Response Guides (IRGs) have been developed to assist the hospital in evaluating existing plans or writing needed plans (see Appendix E: Incident Planning Guides and Appendix F: Incident Response Guides). The IPGs involve scenarios that a typical hospital might experience. The IRGs provide suggested response actions to these scenarios.

Each IPG contains 2 elements. First, it presents a scenario that defines the impact of the threat. Second, the scenario is followed by a list of suggested questions requiring actions for mitigating, preparing for, responding to, and recovering from the incident.

Each IRG is generally organized according to four specific time periods: Immediate Response (0–2 hours); Intermediate Response (2–12 hours); Extended Response (greater than 12 hours); and Demobilization/System Recovery.

These guides should be evaluated by the Emergency Management Committee for relevance to a particular hospital's situation. The purpose of the IPGs and IRGs is to plan for common emergent situations, either by prompting the addition of new incident-

specific plans, or the evaluation and modification of existing incident-specific plans. Refer to Chapter 6.1 Use of Incident Planning Guides and Incident Response Guides for detailed explanation of IPGs and IRGs and Chapter 3.2 Review and Customize HICS Tools for more information on customizing IPGs and IRGs.

2.8 Coordination with External Partners

Hospital representatives should be actively engaged in meeting with their emergency management colleagues from local emergency medical services (EMS), fire, law enforcement, local public and behavioral health, other area hospitals, healthcare coalition coordinator, and other appropriate public and private organizations. Hospitals cannot plan, train, or respond effectively without a fundamental understanding of community medical and health response plans and the roles and activities of their response partners. Clear guidance on who and when to call for information, response guidance, and resource management assistance should be well understood prior to an emergency.

Some healthcare communities have designated Duty Officers to help facilitate information sharing and response coordination among hospitals. This effort is typically accomplished in collaboration with the local health department or emergency medical services agency. Other communities may use a Regional Hospital Coordination Center (RHCC) (see Chapter 2.7.1 Regional Hospital Coordination Centers and Other Coalitions) or an equivalent entity to play an active role in coordinating hospital response, working in collaboration with public safety officials to optimize information sharing and resource access and utilization.

While healthcare response capacity is often focused on hospitals, healthcare in a community is provided by a network of hospitals, clinics, urgent care centers, free-standing surgical centers, physician offices, ambulance providers, extended care facilities, nursing homes, home health agencies, hospices, and others. It is important to recognize that all healthcare partners should participate in joint planning, training and exercises. Such participation can help clarify perceived roles and responsibilities, available resources and resource limitations, and response capabilities including patient transfer. Effective coordination among healthcare partners can help ensure that important healthcare system components remain part of the solution rather than compounding problems during a response.

The healthcare partners in each community should meet on a regular basis to discuss planning and training issues specific to their individual and collective needs and to conduct joint drills and exercises. Discussion should include how terminology, as well as plans and procedures, can be standardized and how limited resources can be shared.

Effective planning often leads to the creation of emergency assistance agreements among hospitals within a community and between neighboring communities. A mutual aid agreement or memorandum of understanding (MOU) among hospitals should be developed and signed before disaster strikes. The agreement should address processes such as requesting assistance, sharing resources, credentialing of volunteers, initiating patient transfers, and identifying mechanisms for reimbursement. Some hospitals have also joined together to purchase standardized equipment and supplies, thus enjoying a cost savings and increased capability to share common resources. Consideration should be given to including other healthcare facilities (e.g., nursing homes and primary care centers) in emergency assistance agreements.

2.8.1 Regional Hospital Coordination Centers (RHCC) and Other Coalitions

Growing numbers of communities are developing a regional approach to coordinate hospital information sharing and medically-related resource management during a crisis. Sometimes called Regional Hospital Coordination Centers (RHCC) or other designations, they are staffed by trained personnel (often senior or mid-level hospital personnel or administrators from the local/state hospital association) and operate from a well-equipped area within a designated hospital (not typically the Hospital Command Center [HCC], separate private facility, or local emergency operations center [EOC]).

2.8.2 Fire and Emergency Medical Services (EMS)

Fire departments, ambulance providers, aeromedical services, and a governing emergency medical services (EMS) authority all have significant roles during an incident and frequently interface with hospitals.

Fire departments may provide any or all of the following services: Basic Life Support (BLS) and/or Advanced Life Support (ALS) medical care; ambulance transport; hazardous materials (HazMat) response; and search and rescue.

Private and municipal ambulance companies provide: BLS and/or ALS services or transport for 911 response; inter-facility transports; and standby service for scheduled events, HazMat events, or search and rescue events.

EMS governing entities provide medical direction to pre-hospital emergency medical technicians and paramedics and system oversight for ambulance activities, including licensure, inspection, and approval or agreement for operating areas. The EMS oversight often extends to the interface between pre-hospital and hospital emergency services, and in many communities this entity acts as the disaster coordinator/manager for planning and during a large scale emergency.

Hospitals should be familiar with available aeromedical services (rotary and fixed wing). Planning consideration should be given to the coordination of multiple requests for aeromedical personnel, patient, and equipment/supply transport. It is important for hospitals to understand landing zone requirements for various size aircraft and recognize that inclement weather (low ceiling, high winds, icing, etc.) may impact availability.

During an emergency, EMS can be expected to transport a significant number of the impacted population to the hospital for medical care. Information sharing procedures must be well known by all involved parties and be dependable, redundant, and interoperable (i.e., use common radio frequencies).

Hospitals should be familiar with their community's Mass Casualty Plan, including response codes and terminology, as well as the triage, treatment, and transportation practices to be employed. EMS personnel should have an understanding of the importance of early notification and the provision of situational information that may impact activation of the hospital's Emergency Operations Plan (EOP), where triage and decontamination will be conducted, etc. Hospitals should be familiar with the Incident Command System (ICS) used by their public safety agencies and who will be assigned responsibility to establish and maintain effective communication with them.

Effective scene management will in part depend on the information hospitals can quickly determine and report back to incident command at the scene. This information will include:

- Available emergency department beds for various severity of patients (e.g., Sort, Assess, Lifesaving Interventions, Treatment/Transport [SALT] Red - Immediate, Yellow - Delayed, Green - Minimal, Black - Deceased, Grey - Expectant; or Simple

Triage and Rapid Treatment [START] triage categories: Red - Immediate, Yellow - Delayed, Green - Minor, Black - Deceased)

- Number of patients that can be decontaminated, information on chemical toxicity, etc.

If EMS is to effectively distribute patients during an incident they must be informed of the severity and number of patients being seen at the receiving facilities. Planning should also address issues such as what personnel supplementation can be provided by either party, including trained decontamination team supplementation, and how ongoing response information will be shared between the scene(s) and hospitals receiving patients.

In addition to patient transport and possible staff and equipment augmentation, EMS and fire departments respond when the hospital itself is the scene of an incident such as during a fire or evacuation. Plans for such response should also be mutually developed and periodically exercised.

2.8.3 Law Enforcement

Hospitals typically have a successful working relationship with local law enforcement, especially at hospitals with police and security forces. This foundation can help ensure effective communication and mutual understanding of response capabilities and needs during a disaster. Planning should address what security supplementation local and state law enforcement can provide, integration of law enforcement personnel into hospital incident operations (including response decision-making), rules of engagement for crowd control, and chain-of-custody practices and professional reporting obligations to be followed (including for patients who have been decontaminated). In some communities hospitals share their facility schematic drawings with law enforcement and fire service partners so they are immediately available in case of an emergency. Another approach is to provide an “emergency go-bag” strategically located and known to local law enforcement that contains facility plans, blueprints, door and elevator keys, and swipe cards for their use. Ideally, a formal agreement should be developed and periodically exercised. Similar to fire and EMS agencies, the hospital should be familiar with the Incident Command System (ICS) used by their local law enforcement and who will be assigned responsibility to establish and maintain effective communication with them.

2.8.4 Local Health Department

Select hospital staff members such as an infectious disease physician, infection preventionist, or laboratory director have routine communication with the local and/or state health department. However, the importance of the relationship between the two organizations grows significantly during a disaster response (e.g., infectious patient case definition, boil water orders, respiratory protection guidance, laboratory testing, etc.). It is important that representatives from each party regularly meet to clarify roles and responsibilities, discuss response needs, and develop plans and procedures directed at keeping the healthcare system as responsive and operational as possible in the interests of public health and well-being.

In many communities the local health department or emergency medical services agency provides leadership for the operation of a Medical Reserve Corps (MRC). The MRC is composed of volunteer healthcare providers who can give medical assistance during a crisis. These persons attend specified training, receive an identification badge, and may be deployed to assist at shelters, alternate care facilities and alternate care sites (ACS), medication distribution sites, and in some cases, to various hospitals.

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is the federal program to establish and implement guidelines and standards for the registration, credentialing, and deployment of medical professionals in the event of a large scale emergency. The ESAR-VHP standards are mandated to all U.S. states and territories, enabling an enhanced national interstate and intrastate system for using and sharing medical professionals. Each state maintains a system to register, verify licensure, and assign an Emergency Credential Level (ECL) for these volunteer healthcare professionals.

2.8.5 Medical Examiner or Coroner's Office

When a disaster involves deaths, local and/or state Mass Fatality Plans may be activated. These plans should be developed in advance of the incident as a joint effort involving the medical examiner or coroner, public safety, local health department, local resources (e.g., funeral homes, morticians), and hospital representatives. Hospitals should be familiar with the local plan and ensure their procedures for managing the deceased (including mass fatalities, religious and cultural considerations, identification and tracking, and decedent family support) are consistent with expected practices set forth in

the plan and coordinated with the medical examiner or coroner's office and law enforcement.

2.8.6 Behavioral Health Specialists

The psychological impact of a disaster will have both immediate and long-term consequences across a wide segment of the affected community, including the hospital staff and community responders. Hospitals must have a comprehensive response plan to address these issues using qualified staff members and outside expertise when needed. This plan should be coordinated with government and local health department programs to the best extent possible. Pediatric and adult age groups may require assistance, including those with special needs. A serious injury or line-of-duty death involving a staff member will also require extensive behavioral health support for both the families of those involved and also other hospital staff.

Effective planning should address the provision of short-term and long-term behavioral health and pastoral assistance to patients and their families in addition to hospital staff and their families. The PsySTART psychological triage program is being used by some hospitals to assist with this process. Furthermore, behavioral assistance should be available as necessary to incident management personnel and the behavioral health specialists providing care to others.

2.8.7 Local Emergency Management Agency (EMA)

The local Emergency Management Agency (EMA) is another important response partner. Because the local EMA has primary responsibility for coordinating the community's all-hazards preparedness efforts, those responsible for hospital preparedness should become familiar with the personnel in the local emergency management office and how the agency operates during an emergency. The local EMA will activate and staff the jurisdictional emergency operations center (EOC) that will support the first responders/receivers providing direct operational response to the event.

The local EMA typically recommends local emergency proclamations or declarations by government officials and requests for state and federal emergency declarations, as well as requests for response assistance beyond existing resources and mutual aid agreements. These declarations help to ensure that needed assistance and coordination occurs at the local level and available funding is authorized for use. They also provide

needed response guidance, allow directed variations in daily government operations, support financial management practices, and potentially allow flexibility in patient care practices. It is important that hospitals understand the implications of local, state and national emergency declarations and the impact such declarations may have on their response and recovery activities, including applying for Federal Emergency Management Agency (FEMA) aid or reimbursement of allowed response expenses. Advance planning with the local EMA and other response agencies will help to determine the best methods for sharing information, requesting resources, and obtaining aid or reimbursement.

2.8.8 Local Emergency Operations Center (EOC)

The local emergency operations center (EOC) is typically coordinated by the local Emergency Management Agency (EMA) and serves as the hub that provides support and coordination assistance during an emergency.

The operation of the local EOC may be structured in the standard Incident Command System (ICS) format identified in the National Incident Management System (NIMS). The primary functions include Command, Operations, Planning, Logistics, and Finance/Administration. However, in some communities, the local EOC may be modeled using the Emergency Support Functions (ESF) or a combination of both. It is important that each hospital become familiar with the structure of their community's EOC along with the operational procedures and decision-making processes that will be utilized during emergency response.

Hospitals should clearly document in their Emergency Operations Plan (EOP) the mechanism for requesting assistance through the local EOC to acquire resources as needed.

When information or resource needs cannot be met through normal daily practices, hospitals should contact their designated local representative in accordance with local policies and procedures. In some states, this may be a specialized medical and health coordinator for the community, and in other states, it may be the local EMA. Once a local EOC is activated and operational, hospitals will usually make their resource requests to the Medical and Health Branch or ESF # 8 – Public Health and Medical Services Branch in the Operations Section unless the Regional Hospital Coordination Centers RHCC (or equivalent) is performing this role and coordinating with the local EOC.

In addition to submitting and receiving information and requests from the local EOC, hospitals should anticipate submitting their situation reports and Hospital Incident Action Plans (IAPs) (see Chapter 7 Incident Action Planning). A hospital's IAP is a written document that provides the hospital's incident objectives, anticipated obstacles, and needed resources during the operational period. This information improves area situational awareness and creates a better common operating picture for all response agencies, including hospitals. Note that the hospital IAP is different from the jurisdictional IAP that may be created at the field level Incident Command Post (ICP) established by the governmental agencies statutorily responsible to mitigate the impacts of emergency.

2.8.9 State Emergency Operations Center (EOC)

In addition to the local emergency operations center (EOC), regional and/or state EOCs may activate to support emergency response activities. The state EOC activates at the direction of the governor or designee to ensure that a community or communities impacted by a disaster receive needed information and assistance. When the state is unable to meet incoming requests, the requests are forwarded to other states and/or the federal government.

2.8.10 State Response Teams

Some states have developed and are prepared to deploy "strike teams" representing various clinical and non-clinical disciplines to assist local communities with disaster response. These teams typically arrive 12–48 hours after a request is received. Their assignments may include working at a hospital that requested staff supplementation or at special healthcare delivery sites established in response to the incident. Logistical support (housing, meals, etc.) for incoming response assets should be coordinated in advance by the local emergency operations center (EOC).

Hospitals should clearly document in their Emergency Operations Plan (EOP) the mechanism for requesting assistance through the local EOC to acquire these and other resources as needed.

2.8.11 Federal Response Teams

The federal government has created a number of specialty teams that are available for deployment upon request of a state's governor. These teams can assist an impacted

community when the available local and state medical resources are insufficient to meet the identified or forecasted needs. Among these teams are:

- *Disaster Medical Assistance Teams (DMAT)* – Teams of medical professionals and paraprofessionals capable of providing primary and critical care
- *Disaster Mortuary Operational Response Teams (DMORT)* – Teams of medical examiners, pathologists, and funeral directors trained and equipped to assist the medical examiner or coroner with recovery, identification, and processing of the deceased
- *National Veterinary Response Team (NVRT)* - Teams of veterinarians, animal health technicians, veterinary pharmacists, and other animal care experts trained and equipped to provide veterinary medical care and public health support

Once on site (usually within 24–48 hours), they may supplement hospital personnel or work in external facilities established to support the local healthcare system. Planning should address the need to effectively integrate these personnel once they arrive and provide appropriate orientation, credentialing and privileging, supervision, and patient assignments. The housing, transportation, and other non-work-related support these personnel require should be coordinated through the local emergency operations centers (EOC).

Again, hospitals should clearly document in their Emergency Operations Plan (EOP) the mechanism for requesting assistance through the local EOC to acquire these and other resources if needed.

2.8.12 American Red Cross (ARC)

The American Red Cross (ARC) is a non-governmental organization (NGO) chartered by Congress to create a system of national and international relief in times of peace and calamity. ARC provides a variety of disaster-related services ranging from supplying blood products, food, water, clothing, and shelter to those in need. Hospitals should be familiar with the disaster response capabilities of their local and state ARC chapters and address how these resources can be utilized and integrated if needed.

2.8.13 Print and Television Media

Establishing effective working relationships with members of the media before an incident should be a priority. The media play a vital role in reporting information about an incident and providing public education and risk communication information to the public on behalf of the response community. The information disseminated to the public must be well coordinated, timely, and accurate in order to avoid confusion, anger, or the loss of public trust.

During an incident, the hospital's Public Information Officer (PIO) or designee must work closely with other official information sources to provide "one message, many voices." To achieve this, a Joint Information System (JIS) designed to gather, prepare, and disseminate information to the public should be operated from a designated physical or virtual work location known as the Joint Information Center (JIC). A Lead PIO, operating within the parameters of the JIS, will facilitate interagency coordination for developing and delivering organized, integrated, and coordinated messages and support for stake holders and decision-makers. The JIS also includes plans, protocols, and structures used to provide information to the public. A qualified hospital representative should be designated to participate when a JIC is established. Whether physically present in the JIC or participating virtually, the hospital representative should be part of a unified process designed to address risk communication and public education efforts in a collaborative manner.

As part of the planning process, hospitals (either individually or as a collaborative group with local officials) should pre-script risk communication messages for higher probability incidents so these messages are ready for use when needed. Inviting the media to attend designated planning meetings or exercises helps promote effective communication and a common understanding of the roles and responsibilities of all parties in an emergency.

2.8.14 Social Media

Increasingly, hospitals are monitoring social media sites such as Twitter, Facebook, YouTube, Instagram and others to assess both positive and negative incident-related information. The hospital's Public Information Officer (PIO) may use social media to disseminate information to the public (in coordination with the Joint Information Center [JIC]) as well as their own staff.

2.9 Community Strategies for Expanding Emergency Healthcare Services

During disasters, patients and victims may seek assistance from their nearest medical facility. In many cases, these are not hospitals. Physician offices, freestanding emergency centers, urgent care clinics, and community clinics may also see the ill or injured and should be prepared to operate under expanded or reduced office hours. However, it is important that hospitals with the ability to treat and stabilize serious injuries see those patients through triage and transfer while patients with less acute injuries or in need of routine care may be more appropriately directed to these alternate facilities.

The public trust is supported by a clearly communicated, fair and equitable system of care. Communication among healthcare facilities will most often be coordinated by the local health department or emergency medical services (EMS) agency; in other communities it may be accomplished as part of a healthcare coalition response activity.

Depending on the type and extent of a disaster, local, state, or federal authorities may bolster the local/regional healthcare system capability by establishing specialized patient care and/or family assistance centers and/or providing staffing support to select hospitals.

This may include:

Off-Site Facility Integration

- Intended to divert patient volume away from emergency departments
- Limited to assessment and basic medical care capability
- May provide family reunification services
- May provide behavioral health services
- May be staffed by hospital or corporate partners

Alternate Care Sites (ACS)

- Secondary site for primary medical care
- Established to divert patient volume from emergency departments
- Will include triage and treatment functions and may include temporary holding capability while patients await transfer to a hospital

- Usually staffed by healthcare personnel, Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), Medical Reserve Corp (MRC) members, or regional, state, or federal response teams and federalized volunteers

Screening Facility

- Performs primary triage to determine who needs further evaluation and medical care
- Usually located away from the primary hospital, but may be on the campus
- May be staffed by hospital, local health department, EMS, ESAR-VHP, and/or MRC members

Family Assistance Center (FAC)

- Provides victim and decedent information and behavioral health support to families/friends
- May be located near the incident scene. Works closely with hospitals and medical examiner or coroner's office to obtain patient or decedent information
- May require standby medical assistance to identify persons with medical issues who will require evaluation at an alternate care site or hospital
- May be coordinated and staffed by the American Red Cross (ARC) or local health department (depending on local policies and procedures) in conjunction with other local and state authorities or non-governmental organizations (e.g., faith-based groups).

Mass Prophylaxis/Vaccination Point of Distribution (POD)

- Distributes medications and vaccinations in addition to risk communication and public information during a public health emergency
- May also be used as site for food and water distribution
- May be a Closed POD operated by a hospital to distribute medications to their patients and staff or an Open POD used to distribute medications to the general public
- Usually coordinated by the local health department with assistance from other local agencies and organizations

- Likely to be operational 24 hours a day until objectives are met
- Depending on the size of the community, multiple sites may be operational
- May need to send victims to hospitals for additional medical evaluation and care

Federal Medical Station (FMS)

- Provides primary care and "hospital-like" care for short periods
- Provides temporary assistance to community healthcare systems impacted by incident
- Staffed by federal healthcare personnel from public health commissioned service corps and federalized volunteers

National Disaster Medical System (NDMS)

- A division of the U.S. Department of Health and Human Services (HHS)
- Coordinates hospitals that volunteer to take patients requiring admission when the local/state healthcare system is overwhelmed by surge needs or functionally is compromised (e.g., internal flooding)
- Transfer coordination is accomplished in conjunction with local and state emergency operations centers (EOCs) and/or Regional Hospital Coordination Centers (RHCC) or equivalent

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CHAPTER 3

Operationalizing HICS

OBJECTIVES

- Describe the steps necessary to operationalize HICS.
- Describe the tools provided to support HICS implementation.
- Describe the recommended approach to training and exercises.
- Describe how the hospital can integrate with community response partners through Incident Command, Unified Command or the local or state emergency operations center (EOC).
- Describe how the hospital can integrate with their corporate healthcare system during emergencies.

3.1 Appoint Individual or Committee to Review HICS Tools

The successful implementation of HICS at a hospital begins with the designation of an individual or committee to review the HICS materials for applicability relative to the hospital's mission, size and risks identified in the annual Hazard Vulnerability Analysis (HVA). In most cases, the Emergency Program Manager will lead this effort with oversight by the Emergency Management Committee (see Chapters 2.2 Emergency Program Manager and 2.3 Emergency Management Committee.).

3.2 Review and Customize HICS Tools

In addition to the information contained in the HICS Guidebook, a number of tools have been created to assist the hospital in implementing HICS. The review of each HICS tool should be deliberate and thoughtful, understanding that HICS is based on an incident management system that has proven to be successful across many disciplines. Minor modifications are acceptable to fit the mission and resources of the hospital; however, significant variations should be approached with caution. Substantial deviation from accepted Incident Command System (ICS) principles may result in a system that is not

recognized by other response partners and could potentially have an adverse impact on the coordination that is necessary during large scale disasters.

Examples of customization include placement of the hospital logo on materials prior to printing; customized document placement on a designated intranet location for electronic data collection; pre-populating key forms for use during incident response; and adding hospital specific information to internal Job Action Sheets (JAS) and creating Incident Planning Guides (IPGs) and Incident Response Guides (IRGs) (see Chapter 8 Customizing HICS).

The HICS tools include:

Hospital Incident Management Team (HIMT) Chart – The HIMT chart identifies the various HIMT positions and their relationship to one another. This information is posted in the Hospital Command Center (HCC) for everyone to see, using projection or wall charts. Since HICS is a flexible and scalable system, the specific positions activated will depend on the nature and scope of the emergency. In some cases, it may only be necessary to activate the Incident Commander, while a large scale disaster may require the activation of numerous positions. (See Figure 2 on page 45 and Appendix C: Hospital Incident Management Team.)

Three versions of the HIMT Chart are provided that allow the hospital options to quickly insert the names of individuals into the activated HIMT positions. The first is the HIMT chart with the ability to enter names into each HIMT position using an Adobe Acrobat fillable PDF format; the second provides the same functionality using a Microsoft Word format; the third in Microsoft Visio Drawing.

Hospital Incident Management Team (HIMT) Depth Chart – This chart identifies possible administrative or clinical positions that may be appropriate to specific HIMT positions. (See Table 1 on page 46 and Appendix D: Potential Candidates for HICS Command and General Staff Positions.)

Incident Planning Guides (IPGs) and Incident Response Guides (IRGs) – These are guidance documents that are intended to assist the hospital in improving their own plans by providing additional considerations based on best practices and actual incidents experienced by other hospitals. The scenarios provided are not meant to be exhaustive; each hospital should build and/or modify the guides based on their Hazard Vulnerability Analysis (HVA) (see Appendix E: Incident Planning Guides and Appendix F: Incident Response Guides).

Job Action Sheets (JAS) – These provide specific position guidance for each member of the Hospital Incident Management Team (HIMT) by describing their individual responsibilities, reporting relationships, needed forms, and potential action steps based on consecutive response time periods (see Appendix G: Job Action Sheets).

HICS Forms – These are the Incident Command System (ICS) forms that have been modified for use in the hospital environment. They provide guidance for incident documentation, resource tracking, safety information, cost collection and other critical activities within the Hospital Command Center (HCC) (see Appendix H: HICS Forms).

3.3 Key Requirements

Several steps are necessary to integrate HICS into hospital operations, including:

- Assign an individual with appropriate authority and respect within the hospital to be in charge of HICS implementation according to an outlined plan
- Obtain support from the hospital's Chief Executive Officer (CEO) and other senior administrators
- Encourage the recognition that HICS implementation must be a high priority for both administrators and staff
- Provide financial resources and budgets needed to support emergency management and HICS activities
- Establish training requirements/competencies that meet established national standards
- Promote hospital integration into the community-based response
- Provide training of HICS, in addition to training of the hospital Emergency Operations Plan (EOP)

3.4 Training

Once the HICS materials have been reviewed and accepted for use by the hospital, the next phase involves training the hospital leadership and those who may potentially be assigned to the Hospital Incident Management Team (HIMT). This training can be accomplished using traditional classroom-based presentations, computer-based learning, and/or interactive tabletop sessions. It is commonly recommended to train at least 3 persons for each key HICS's HIMT position to accommodate longer duration incidents and staff turnover.

The National Incident Management System (NIMS) *Compliance Guidance for Healthcare Organizations* should be utilized to tailor training requirements for hospital staff. It is important to maintain training records and progress toward reaching training benchmarks. Hospitals should be also familiar with NIMS requirements associated with accepting federal preparedness and response grant awards. Hospitals should have a clear understanding of NIMS requirements to ensure compliance prior to accepting federal grant awards.

The NIMS courses generally recommended for hospital personnel, depending on state guidelines and HIMT assignment, include:

- IS-100.b – Introduction to Incident Command System or IS 100.HCb - Introduction to the Incident Command System (ICS 100) for Healthcare/Hospitals
- IS 200.b ICS for Single Resources and Initial Action Incidents or IS 200.HCa – Applying ICS to Healthcare Organizations
- IS 700.a - NIMS, An Introduction
- IS 800.b - National Response Framework, An Introduction

As a supplement to the online courses, Federal Emergency Management Agency's (FEMA's) Emergency Management Institute (EMI) and the Center for Domestic Preparedness (CDP) Noble Training Center provide other incident command and healthcare related emergency management courses through local jurisdiction courses or resident programs on their respective campuses.

Individual states may offer classroom or web training for healthcare personnel. Therefore, the hospital's Emergency Program Manager should check with the local or state Emergency Management Agency (EMA) to learn more about these offerings.

Beyond the federal and state educational offerings, various courses may be offered in the community. A single hospital or a consortium of hospitals may sponsor one or multiple day classes. In other cases, contractors hired to present a specified curriculum may provide instruction or local/state disaster conferences might be held. For those persons within a hospital looking for higher-level instruction on emergency preparedness, the local college or university may have on-campus or web training courses available.

The hospital's educational program on emergency management should include seminars and tabletop exercises which are coordinated with accreditation exercise requirements.

The importance of emergency preparedness should be included at employee orientation and recurring training. Adequate time must be allocated to acquaint each employee with activities the hospital is doing to be prepared, their role during an emergency, and the importance of individual and family preparedness planning.

Whenever possible, courses or classes completed by staff members should involve self-evaluation and provide Continuing Medical Education (CME) or Continuing Education Units (CEU) credit as an incentive to encourage participation. Accurate records should be maintained on the training completed by all hospital personnel, especially those expected to assume a response role during an incident. Copies of each employee's completed training and educational credits should be kept in a central location in the hospital.

Where appropriate, the education may lead to revisions in the Emergency Operations Plan (EOP), or HICS materials. Persons within the hospital who have been identified to fill roles within the HIMT chart should be involved in the educational programs. Whenever possible, a minimum of 3 persons should be identified for each of the positions and attend appropriate training programs to prepare them to serve in these roles.

After training has been conducted to familiarize designated individuals with their roles and responsibilities, various types of exercises should provide more rigorous and focused opportunities to function in a HICS environment. Exercises should involve plausible scenarios based on the Hazard Vulnerability Analysis (HVA).

3.5 Exercises

Exercises should be based on specific objectives that include mitigated plans or deficiencies identified during previous exercises, drills or actual responses. The Homeland Security Exercise and Evaluation Program (HSEEP) is one example of methodology available for use. HSEEP is a standardized approach to exercise design, development, implementation and evaluation. The use of HSEEP provides a low-risk environment to test and evaluate plans and capabilities; identify gaps and areas for improvement; and comply with accreditation and regulatory guidelines.

The HSEEP website provides useful information and tools, including templates to assist hospitals in HSEEP compliance. HSEEP's Toolkit includes materials describing exercise design, implementation, and evaluation that can be helpful toward meeting exercise related federal funding requirements. Materials available within HSEEP provide tools for

identifying objectives and evaluating exercises through a standardized approach. The After Action Report (AAR) and Improvement Plan (IP) provide a comprehensive actionable summary of exercise performance, timelines, and assignments to complete the recommended corrective actions. The use of HSEEP is consistent with accrediting organizations and regulatory emergency management guidance documentation.

3.6 Integration with Community Emergency Response Partners

The authority for managing an emergency usually rests with the governmental agencies that have jurisdictional authority relevant to the incident. This led to the adoption of the Incident Command System (ICS) by the National Incident management System (NIMS) as a means of unifying the operational response structure when more than one agency was involved in an incident (e.g., fire and law enforcement) or when an incident crossed jurisdictional lines (e.g., involved multiple municipalities, regions, counties or states). Because ICS is the accepted standard practice among governmental response agencies, it is important that HICS remain consistent with ICS as it relates to coordination with community partners.

The highest operational priority in any emergency is saving lives. The field-level first responders (e.g., emergency medical services [EMS], fire service, and hazardous materials [HazMat] teams), hospitals, and other healthcare facilities must be prepared to integrate successfully within the community's emergency response system. It is important to predetermine in advance the manner in which hospitals will coordinate within the community's emergency response structure (i.e., in accordance with local policies and procedures).

3.6.1 Integration of HICS with external Incident Command System (ICS)

In many cases, a hospital responding to an incident will not do so alone. However, each facility should be prepared to manage without assistance for several hours or even days. This may require curtailing of services, rationing of supplies and resources or conducting partial of full evacuations. Depending on availability and the nature and extent of the incident, a wide variety of agencies will likely be engaged to some degree in the response effort. When possible, a hospital should integrate early into the community response, including the overall incident command structure. The integration process will be improved if there is regular and joint participation in community preparedness meetings, training, and exercises. These sessions lay the groundwork for mutual understanding of

roles and responsibilities, incident management principles, resource allocation, and effective communication and information sharing practices.

Depending on the situation, the incident may be managed overall by a single agency. For example, at the scene of a multiple-vehicle accident, the fire department is in charge and other response agencies support the overall response; or in a prison riot, law enforcement officers are in charge until order is restored. Hospitals involved must integrate into the community's emergency response structure through advance planning with emergency response partners, including the local or state Emergency Management Agency (EMA). The chosen approach is likely to depend on a number of factors relative to the community's emergency response structure and the nature and scope of the emergency and will vary according to local policies and procedures. Below are some examples:

1) If an incident is **internal** to a hospital and governmental agencies **have not** established an Incident Command Post (ICP) or activated the Emergency Operations Centers (EOC) – the hospital should respond as the primary agency having jurisdiction consistent with its Emergency Operations Plan (EOP). This may involve the activation of the Hospital Command Center (HCC), the Incident Commander, and specific Hospital Incident Management Team (HIMT) positions as necessary to manage the incident. Information regarding the incident and hospital status should be shared with others in the community (including emergency medical services [EMS], fire, law enforcement, local health department, or the local emergency management agency [EMA], and other hospitals, etc.) as dictated by applicable laws and regulations and local policies and procedures.

2) If an incident is either **internal** or **external** to a hospital and governmental agencies **have** established an Incident Command Post (ICP) or activated the Emergency Operations Center (EOC) – the hospital should respond consistent with its Emergency Operations Plan (EOP) as identified above and coordinate with the involved community agencies through the ICP or local EOC. Among the options:

- The hospital sends an Agency Representative to the ICP
- The hospital sends an Agency Representative to the jurisdictional EOC

- The hospital sends a representative to the Operations Section of the jurisdictional EOC

To reduce potential confusion and enhance coordination at a time when it is most needed, hospitals should consider the title "<Hospital Name> Incident Commander" or "<Hospital Name> Incident Action Plan", as should other types of healthcare facilities.

Large scale disasters are likely to produce widespread impact involving numerous hospitals, particularly in densely populated areas. It is important to predetermine in advance the manner in which hospitals will coordinate within the community's emergency response structure (i.e., in accordance with local policies and procedures). In such situations, it may be preferable to have individuals that represent hospital coalitions/consortia/associations integrate with the community's emergency management structure. Such a representative would serve as a bi-directional conduit of information regarding situation status and resource needs (i.e., serve as a connection between various HCCs and the field-level ICP or jurisdictional EOC).

3.6.2 Unified Command

When emergencies involve multiple agencies from the same jurisdiction with legal responsibility, or agencies from multiple jurisdictions, the National Incident Management System (NIMS) specifies that a Unified Command structure be established to allow the involved partners to coordinate in a cohesive fashion. The establishment of Unified Command in no way affects each agency's authority, responsibility or accountability, but provides a mechanism for unified coordination. If an incident causes a hospital to activate HICS, the hospital should coordinate with the jurisdictional Incident Command or Unified Command.

The agency responsible for on scene coordination will establish an Incident Command Post (ICP) that is generally located near the incident site. If more than one agency has responsibility for an incident, it is likely that the involved agencies will establish a Unified Command structure at the ICP. If an incident requires further support and coordination, it is likely that jurisdictional emergency operations centers (EOC) will activate using Unified Command to support the field-level response.

3.7 Integration with Corporate Healthcare Systems

Nearly 50% of America's 6,000 hospitals are part of a corporate healthcare system. This can provide those facilities several benefits, including access to a wide of array of resources, standardized policies and procedures, and financial support.

Member hospitals should coordinate their planning and response activities with the appropriate administrative section(s) within the corporate system. This effort may be supported by having a system-wide Emergency Management Committee composed of representatives from each hospital and affiliate organizations. The Emergency Management Committee should meet on a regular basis to discuss plans, procedures, exercises, strategies, deficiencies, education, and training.

Membership in a larger corporate healthcare system may involve:

- Participation in corporate-led emergency preparedness activities, including development of a system-wide Hazard Vulnerability Analysis (HVA), corporate Emergency Operations Plan (EOP), and corporate resource inventory
- Attendance at meetings of hospital emergency managers and corporate leadership
- Understanding how individual Hospital Command Center (HCC) operations integrate with a corporate incident management team structure and it's health system command center
- Following standardized policies and procedures regarding incident notification, situation status reporting, and communication of resource needs to corporate leadership during and after an incident
- Coordinated tabletop, functional, and full scale exercises that allow member hospitals to test and refine their processes and plans

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CHAPTER 4

Hospital Incident Management Team Overview

OBJECTIVES

- Describe the structure and roles of the Hospital Incident Management Team (HIMT).
- Describe five key additional HICS practices including:
  - Chain of Command and Unity of Command
  - HIMT Identification
  - HIMT Depth
  - Job Action Sheet (JAS)
  - Departmental Level Leadership

4.1 The Hospital Incident Management Team (HIMT)

The complete Hospital Incident Management Team (HIMT) is displayed on Figure 2 on page 45. It identifies the five primary management components (Command, Operations, Planning, Logistics, and Finance/Administration) and the associated branches, units and Technical Specialists. Positions are assigned only as indicated by an assessment of the scope and magnitude of the particular situation and the availability of trained personnel to assume a role.

Table 1 on page 46 and Appendix D-Potential Candidates for HICS Command and General Staff Positions identify positions within a hospital's organizational structure that may be appropriate candidates for HIMT positions. These positions are only suggestions, as the optimal selection of candidates is dependent on the unique needs of the event and the successful completion of the incident objectives.

4.1.1 Efficient Transfer of Command

HICS allows for the efficient transfer of command by recognizing that personnel initially assuming a command position may be relieved by someone with more experience as additional personnel arrive and share the incident command workload, or at shift change. The transfer of command begins with a transition meeting in which the outgoing commander briefs the replacement on the current situation, response actions, available resources, and the role of external agencies in support of the hospital. Health, medical, and safety concerns are addressed and, if relevant, political sensitivities and business continuity capabilities may also be discussed. After the transfer of command is completed, proper documentation is prepared and, where appropriate, broadly communicated to staff. It is important that the Incident Commander ensures each appointed Command/General Staff member is properly briefed on response issues and objectives. This should be clearly documented in both the Incident Action Plan (IAP) (HICS 201, 202, 203, 204, and 215A) and individual Activity Log (HICS 214).

Figure 2. Hospital Incident Management Team (HIMT)

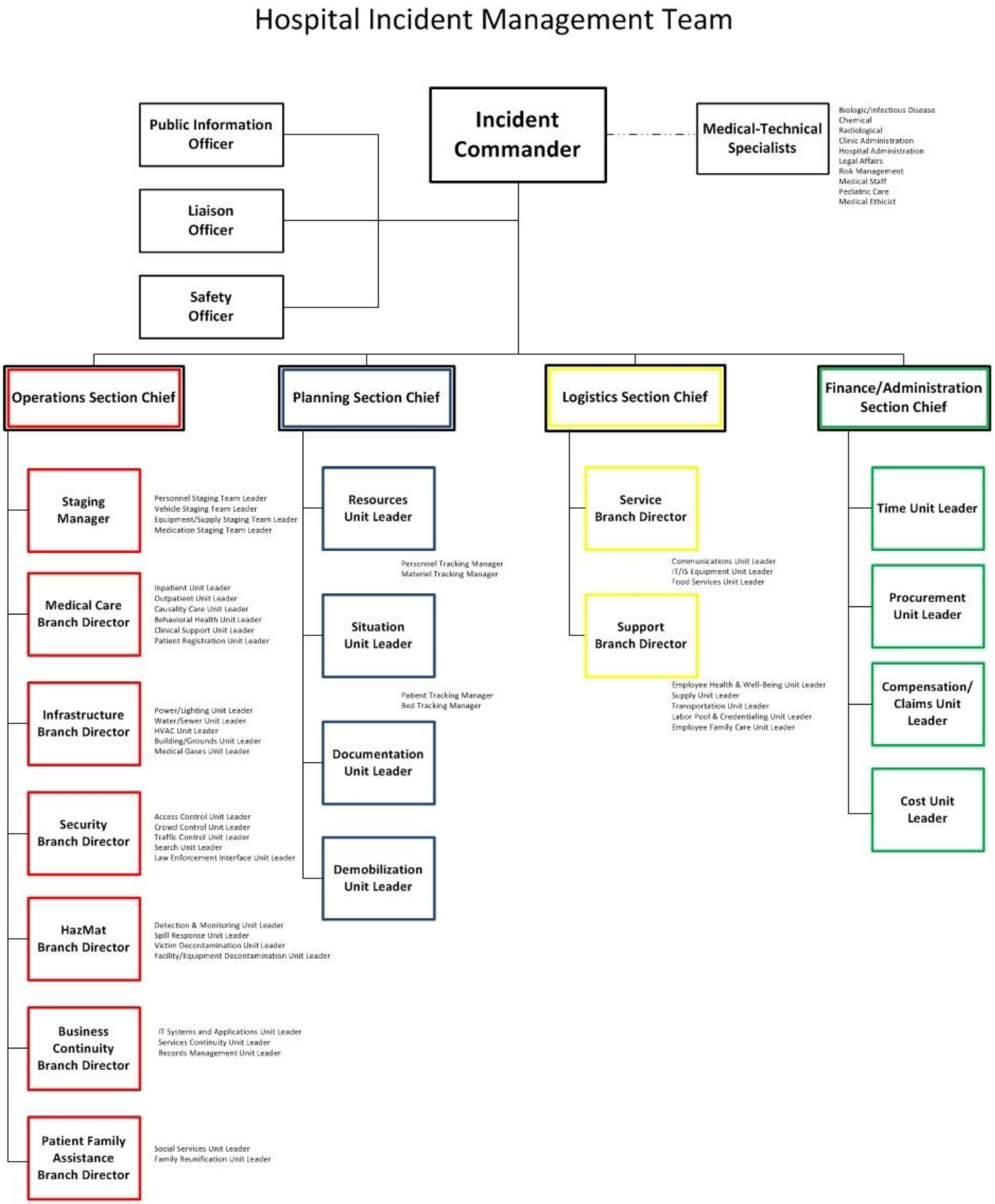

Table 1. Potential Candidates for HIMT Positions

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

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

4.2 Command

4.2.1 Incident Commander

The Incident Commander (IC) is the only position always activated in HICS. The IC is responsible for the management of the incident within the hospital. The Incident Commander directs all of the activities within the Hospital Command Center (HCC), sets the operational periods, and devises strategies and priorities to address those objectives that are communicated in the Incident Action Plan (IAP).

4.2.2 Command Staff

The Incident Commander may appoint other Command Staff to assist.

- The ***Public Information Officer*** (PIO) is responsible for coordinating information sharing inside and outside the hospital. He/she serves as a conduit for information to internal personnel and external stakeholders, including the media or other organizations/agencies.
- The ***Liaison Officer*** is the hospital's primary contact for external agencies assigned to support the hospital during incident response. In some cases, a Liaison Officer may be assigned to the Hospital Command Center (HCC) and a Deputy Liaison Officer or Assistant (or an Agency Representative) assigned to represent the hospital at the field Incident Command Post (ICP) or local emergency operations center (EOC).
- The ***Safety Officer*** monitors hospital response operations to identify and correct unsafe practices. He/she institutes measures for assuring the safety of all assigned personnel.
- ***Medical-Technical Specialists*** are persons with specialized expertise in areas such as infectious disease, legal affairs, risk management, medical ethics, etc., who may be asked to provide the HIMT staff with needed insight and recommendations. Medical-Technical Specialists may be assigned anywhere in the HICS structure as needed.

4.2.3 General Staff/Sections

Depending on the event, other General Staff positions (e.g., Operations, Planning, Logistics, and Finance/Administration Section Chiefs) may be activated by the Incident

Commander having legal jurisdiction. Qualified personnel assigned to serve as Section Chiefs receive a briefing, their names are recorded on the HIMT chart (see Appendix C: Hospital Incident Management Team), and their appointment is announced as outlined in the hospital's Emergency Operations Plan (EOP). If necessary, qualified **Deputy Chiefs** may be appointed to assist the Section Chiefs perform specific tasks or serve in the Chief's absence from the Hospital Command Center (HCC).

4.3 Operations Section

The Operations Section manages all incident tactical activities and implements the Incident Action Plan (IAP). This section is typically the largest due to the role of management and coordination of immediate resources needed to respond to the incident. Figure 3 represents how authority and responsibility is distributed within the Operations Section.

Branches and units are implemented as needed to maintain a manageable span of control and streamline the organizational management. The number of positions activated depends on situational needs and the availability of qualified staff.

The Medical Care, Infrastructure, Security, Hazardous Materials (HazMat), Business Continuity, and Patient Family Assistance Branches are included in the Operations Section because each of these areas provides services that are essential for supporting the mission of delivering patient care in the challenging circumstances of the immediate incident and not simply routine day-to-day logistical support. For example, the facilities (engineering) personnel in the Infrastructure Branch are providing for the utility needs for the incident; security personnel are maintaining order; and the information technology and business continuity personnel are keeping the computerized systems operational for information sharing and record keeping among various areas of the hospital. In some internal emergencies (e.g., child abduction, water outage, or computer system failure) the function of one or more of these areas becomes an essential part of restoring normal operations.

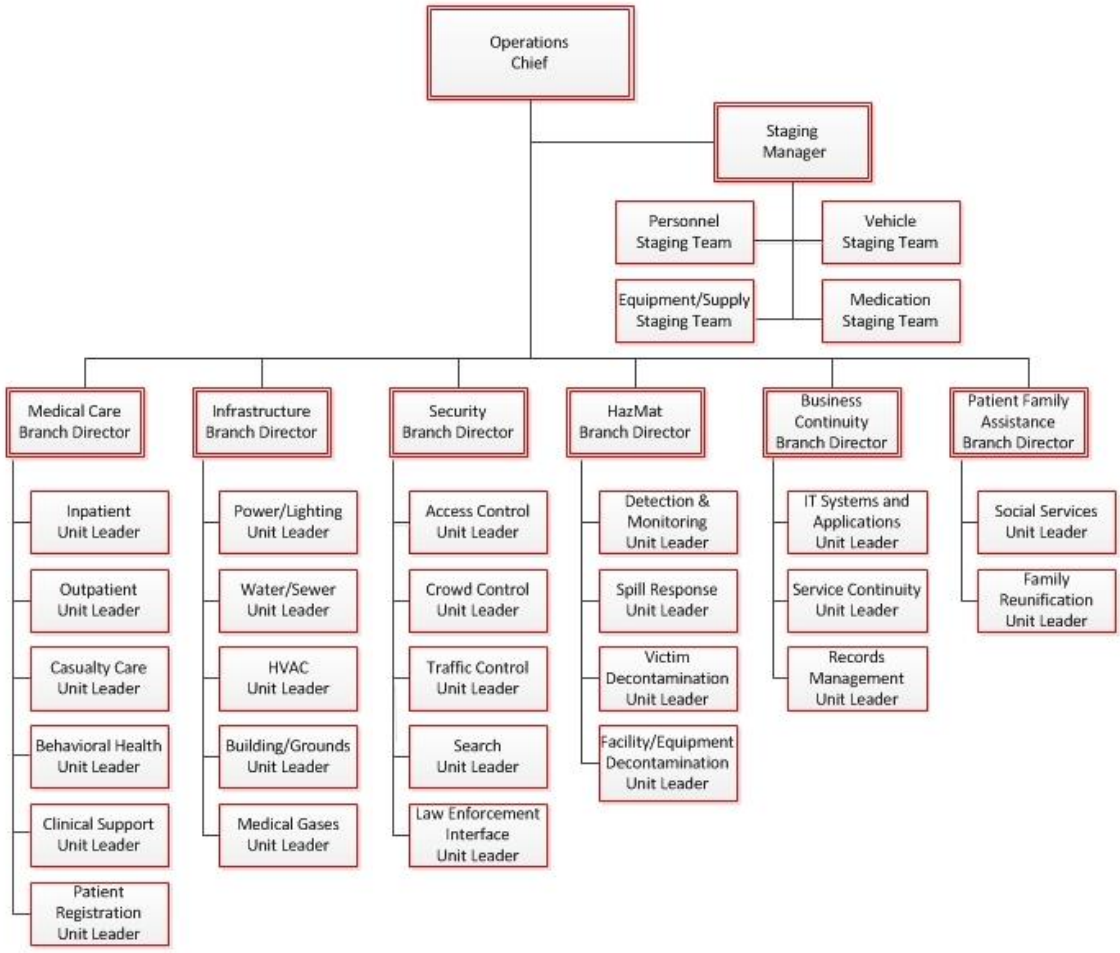

Figure 3. Distribution of Authority and Responsibility within Operations Section

The Staging Manager works closely with the Logistics Section to learn what is needed and ensure that the requested item(s) are delivered to the correct location as soon as possible. In turn, the Logistics Section works to obtain those needed items and directs their arrival to the Staging Area as outlined in the Emergency Operations Plan (EOP) and/or at the request of the Staging Manager. In situations where the number of staged items is too great or must be kept in separate locations, a team leader can be assigned to coordinate each type of asset being staged (e.g., Personnel Staging Team Leader, Vehicle Staging Team Leader, Equipment/Supply Staging Team Leader, and Medication Staging Team Leader).

The Operations Section Chief or Medical Care Branch Director is responsible for determining the need to assign resources in support of specific mission objectives. HICS allows for the deployment and supervision of single resources, task forces, and strike teams. Once those objectives are met, the team may be given a new assignment or deactivated. Examples of these resources include:

- A ***Single Resource*** is an asset such as a stretcher, a medicine cart, or a nurse
- A ***Task Force*** is a combination of like resources (e.g., Intensive Care Unit [ICU]–trained Registered Nurses (RNs), ICU technicians, and an ICU station secretary) that have been assembled and given a specific assignment under the direction of a leader
- A ***Strike Team*** is an assembly of the same kind and type of resources (e.g., 7 ICU RNs) that operate under direction of a leader

4.3.1 Patient Care Operations

The Medical Care Branch is responsible for providing care to the incident victims, non-incident related arrivals, as well as patients already within the hospital.

The Casualty Care Unit Leader is often located in the emergency department but can appoint additional personnel to coordinate triage and treatment activities elsewhere on the campus. These activities are conducted in accordance with the hospital's Emergency Operations Plan (EOP) (e.g., separation of victims into triage categories such as Immediate, Delayed, and Minor treatment areas).

Patients arriving at the hospital must be quickly triaged to a treatment location for expedited medical care. If activated, the Triage Unit Leader's treatment priority (triage category) should be plainly identified on a patient's tag or band (see Chapter 4.3.7 Additional Branch Options). A quick but reliable registration process should be implemented by the Patient Registration Unit to avoid delays in medical care and facilitate patient tracking. The daily registration process can be reinstituted once the incident is stabilized and staffing allows.

Patients contaminated with hazardous materials (HazMat) often arrive unannounced by private vehicle and should be received by properly trained and protected personnel (see Chapter 4.3.4 Hazardous Materials [HazMat] Branch) using a standardized and well-practiced decontamination procedure before they are allowed into the main hospital. In

this situation, only lifesaving interventions should be rendered prior to or during decontamination, with definitive care provided in the hospital after decontamination is completed to prevent the unnecessary exposure of staff and patients to any hazardous contaminant(s).

The Medical Care Branch also coordinates inpatient services (Inpatient Unit), outpatient services (Outpatient Unit), behavioral/mental health services (Behavioral Health Unit), clinical support services (Clinical Support Services Unit), and patient registration services (Patient Registration Unit).

The Medical Care Branch Director works with the Logistics Branch to ensure needed personnel, equipment, medication, and supplies are requested (through the Staging Manager when activated) for delivery to needed areas. Making prudent decisions is crucial when needed resources are in short supply. Guidance comes from the Command Section in the Hospital Command Center (HCC) who consults a plan devised before the incident to manage this challenging situation. Any needed outside resources may be requested by the Liaison Officer through the local emergency operations centers (EOC).

The medical care rendered should be uniform as often as possible across the healthcare system. The local health department or emergency medical services agency (or other coordinating body such as a Regional Hospital Coordination Center [RHCC] or equivalent) can provide guidance for area hospitals in this regard.

4.3.2 Infrastructure Operations

The maintenance of overall hospital facility operations support activities to meet the medical care needs of the patients and protect staff. The responsibility for maintaining facility operations primarily rests with the Infrastructure Branch in the Operations Section. Maintenance of the normal operational capability of the facility includes power and lighting (Power/Lighting Unit), water and sewer (Water/Sewer Unit), heating, ventilation, and air-conditioning (HVAC Unit), medical gases (Medical Gases Unit), and building/grounds (Building/Grounds Damage Unit). This branch is responsible for maintaining or potentially expanding operating capacity as well as identifying and fixing utility service delivery failures. The acquisition of equipment, parts, or outside contractors is coordinated with the Support Branch in the Logistics Section.

Maintaining business operations and supporting or repairing information technology equipment is managed by the Business Continuity Branch (see Chapter 4.3.5 Business

Continuity Operations) with logistical support coming from the Information Technology/Information Services (IT/IS) Equipment Unit Leader in the Service Branch in the Logistics Section.

4.3.3 Security Operations

The Security Branch coordinates all activities related to patient, staff, and hospital security. A significant number of actions should be considered early in an incident:

- Secure and restrict access
- Supplemental security staffing
- Traffic control
- Personal belongings management
- Evidence collection and chain-of-custody considerations

Secure and Restrict Access

Each incident has unique security-related issues. In the past, insufficient consideration was given to the hospital being a secondary or even a primary target for a harmful event. Hospitals cannot afford a passive security approach. Workplace violence, criminal activities, and potential terrorist threats are reasons for having a robust Security Plan. Comprehensive planning and training are needed to identify and mitigate growing threats such as hospital workplace violence, including gun-related incidents.

The decision to restrict access must be made early in the event by the Incident Commander in conjunction with leadership and the Security Branch Director. If access is to be restricted, the decision should be implemented quickly according to the Emergency Operations Plan (EOP). Assistance from local law enforcement should be requested as needed. After any security restrictions are announced to the staff and public, personnel will be assigned to re-route pedestrian and vehicular traffic. Signs may be posted and doors locked manually or electronically (Access Control Unit). Locked doors should ideally be monitored to prevent door blocking and ensure no unauthorized entrance or exit occurs.

Internal and external signage (in multiple languages if needed) indicating the doors are not to be opened (and where appropriate, redirecting would-be entrants) should be posted as soon as possible. Such signage can be created in advance and stored near

doors for rapid deployment. It is important to involve life-safety engineers and qualified representatives familiar with the American Disabilities Act requirements in planning and response to ensure adequate egress in the event of a fire or other internal emergency.

Heightened surveillance procedures may need to be implemented, including:

- Inspecting suspicious packages
- Closer scrutiny of personnel at checkpoints, including verification that each individual, including staff, is wearing a proper identification badge
- Assigning properly protected personnel at patient arrival points (Crowd Control Unit), especially the decontamination sector if activated

Certain areas (e.g., the emergency department, pharmacy, administration and Hospital Command Center [HCC]) should receive enhanced security support. Steps may need to include restricting staff entry into certain areas because of security concerns, unsafe conditions, or because no additional staff is needed.

Because off-site staff may not always have their hospital identification with them when responding, security staff should have a current list of employees and the ability to quickly provide temporary identification. Leadership can direct staff to carry their identification badges with them when off-duty; this may also aid in navigating law enforcement blockades.

Supplemental Security Staffing

Supplemental personnel may be needed to assist the on-duty security staff, depending on the type and length of the incident. This need may be met by calling personnel in from home, reassigning other non-security personnel to select tasks, and requesting help from local law enforcement (Law Enforcement Interface Unit). Planning should address when law enforcement will be able to assist and how they will be integrated into hospital operations and the HICS. Their deployment assignments, pertinent response procedures, rules of engagement, and what support they will require (e.g., personal protective equipment [PPE], phone access) can be discussed in the planning sessions. In addition to using local law enforcement to supplement staffing shortfalls, consideration should be given to having a contingency contract(s) with local or national private security firms to provide trained personnel during an emergency. Hospitals that are part of a corporate healthcare system may be able to receive security assistance from other corporate

hospitals. Planning must address the deployment, supervision, support, and financial reimbursement for any supplemental personnel.

Traffic Control

Depending on the situation, victims may be arriving by private vehicles or ambulances accompanied by family and friends. The media will also be arriving at some point and requesting special parking locations for their outside interviews and "live shots." Traffic patterns may need to be revised to optimize emergency medical services (EMS) and other emergency vehicle arrivals and exits. The area in front of the emergency department should be kept clear, along with areas assigned for decontamination. All available parking areas should be opened and consideration given to suspending gate-entry systems and fee payments.

Planning should address situations such as abandoned vehicles, including those with possible chemical contamination, and how they should be removed from outside the emergency department and other critical locations. The hospital Security Branch should also anticipate law enforcement requests for vehicle information (license/tag number, make and model of the car, and location) for the patients being seen.

As time goes on, supplier and service deliveries may need special inspections, alternative routing, or cancellation. The implications of all of these actions should not be taken lightly and will require careful planning and coordination.

Personal Belongings Management

Routine daily procedures for managing the personal belongings of patients may need to be modified. The arrival of a large number of patients will present challenges in rapidly and accurately cataloging and securing belongings. Contaminated patient belongings require special care to avoid cross-contamination as well as to preserve the chain of custody if the incident was deliberate. Thus, incident plans must be comprehensive and address the security of patient belongings as well as the process for determining when and how they will be returned to the rightful owner (Security Branch).

Evidence Collection and Chain-of-Custody Considerations

For suspicious incidents, specific evidence collection policies and chain-of-custody procedures must be followed as identified in the Emergency Operations Plan (EOP). These procedures should address everything from handling a patient's personal effects

to packaging and transfer of laboratory specimens. Local law enforcement and prosecutorial authorities should be consulted when developing these procedures to ensure they are consistent with accepted practice. During an incident it will be important for the Security Branch to identify what procedures are to be employed and quickly disseminate easily understood instructions.

4.3.4 Hazardous Materials (HazMat) Branch

In situations involving a hazardous material (HazMat) release (internal or external) the Incident Commander may choose to activate the HazMat Branch per the Emergency Operations Plan (EOP). The HazMat Branch will have the personnel and equipment to address agent identification (Detection and Monitoring Unit), spill response (Spill Response Unit), victim decontamination (Victim Decontamination Unit), and decontamination of equipment and the hospital (Facility/Equipment Decontamination Unit).

All responding staff should be trained and use proper personal protective equipment (PPE) and decontamination procedures. In addition, designating a decontamination area that can be quickly established and is suitable in size and flow to accommodate patient processing needs is vital. Designated staff should be familiar with procedures for the decontamination of ambulatory, non-ambulatory, and patients with special needs. Agreements for wastewater removal and remediation of the decontamination area or other contaminated parts of the hospital should be arranged in advance. Medical monitoring of decontamination team personnel should be effectively conducted and medical records for each team member completed and submitted for physician review per Occupational Safety and Health Administration (OSHA) and/or other state and federal agency guidance (see Appendix I: Resources and References; OSHA Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances).

4.3.5 Business Continuity Operations

The function of the Business Continuity Branch is to assist impacted hospital functions, departments and areas to maintain, restore, or augment critical business functions, and meet the designated recovery objectives and recovery strategies outlined in the Incident Action Plan (IAP). The Business Continuity Branch:

- Ensures the continued effective and efficient operation of the hospital's information system and information technology through the Information Technology (IT) Systems and Application Unit Leader and Services Continuity Unit Leader.
- Facilitates the acquisition of and access to essential recovery resources, including business records (e.g., patient medical records, purchasing contracts) through the Records Management Unit Leader.
- Supports the Infrastructure and Security Branches with needed movement or relocation to alternate business operation sites.
- Coordinates with the Logistics Section Communications Unit Leader, Information Technology/Information Services (IT/IS) Equipment Unit Leader, and the impacted area(s) to expand and/or restore business functions and review technology requirements.
- Maintains and repairs information technology equipment with logistical support from the IT/IS Equipment Unit Leader in the Service Branch of the Logistics Section.
- Assists other branches and impacted areas with the restoration and resumption of normal operations.

4.3.6 Patient Family Assistance Branch

When large numbers of patients are being received at a hospital the Patient Family Assistance Branch may be activated to assist in meeting their needs. Family support should be provided in a secure location suitable in size to accommodate the number of families being assisted. Refreshments for their consumption should be obtained from the Food Services Unit Leader and the availability of phones should be coordinated with the Communications Unit Leader. The Social Services Unit Leader will work with the families to address their behavioral health needs and other general support requirements. The Family Reunification Unit Leader will take the lead in assisting a family to locate their loved one or friend through the hospital's patient tracking program (working with the Planning Section's Patient Tracking Manager) or the community's patient location system (working with the Liaison Officer or other designee).

4.3.7 Additional Branch Options

Unique situations, usually involving internal emergencies, may occur that require the creation of additional operational branches. For example, evacuation and/or sheltering in place may be necessary for a fire, tornado, or severe snowstorm. The Incident Commander will appoint a qualified individual to be the Branch Director; the title should be consistent with activity being facilitated (e.g., Evacuation Branch, Shelter-in-Place Branch). This individual would exercise command over the unique response activities associated with the situation, working with other position leaders in that branch as appropriate to meet the mission objectives.

4.4 Planning Section

The Planning Section collects, evaluates, and disseminates situational information and intelligence regarding incident operations and assigned resources, conducts planning meetings, and prepares the Incident Action Plan (IAP) for each operational period. The effectiveness of the Planning Section has a direct impact on the availability of information needed for the critical strategic decision-making done by the Incident Commander and the other General Staff positions. There are four principal units in the Planning Section, each of which is directed by a Unit Leader (Figure 4).

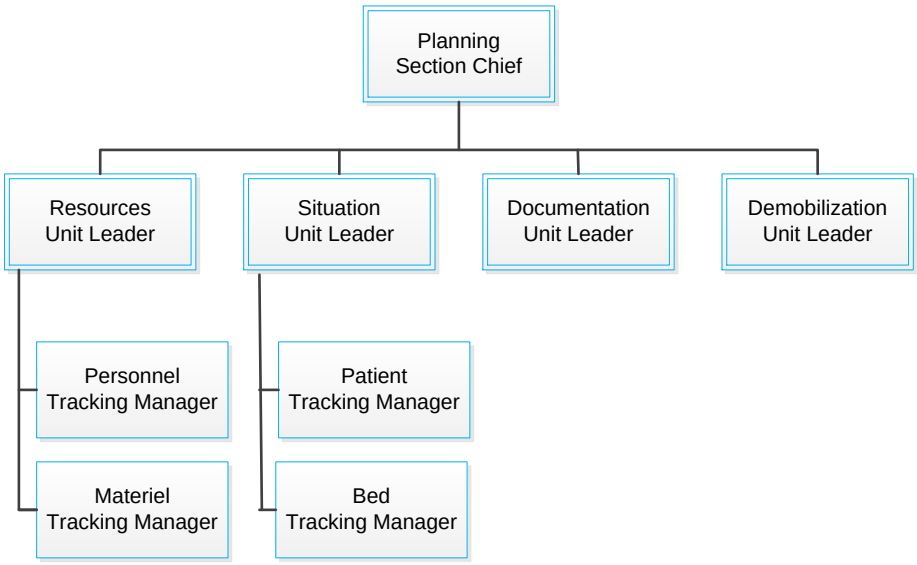

Figure 4. Distribution of Authority and Responsibility within Planning Section

The Resources Unit Leader tracks the status of personnel and material resources that are being utilized in various locations of the hospital. Personnel Tracking and Materiel Tracking Managers may be appointed to assist when necessary.

The Situation Unit Leader is responsible for writing and maintaining situational updates based on internal and external events (e.g., information displays), including those related to patient tracking (Patient Tracking Manager) and bed tracking (Bed Tracking Manager). These managers maintain current patient location assignments/bed capacity and make this information available to Hospital Incident Management Team (HIMT) personnel as well as the local emergency operations centers (EOC) and other appropriate external agencies through the Liaison Officer. Monitoring the media (TV, radio, and print) will also provide needed situational awareness and should be performed by the Situation Unit Leader unless assigned to other personnel. Important information may be displayed using tracking boards, chart pads, or computer software programs.

The Documentation Unit Leader completes the Incident Action Plans (IAPs) and other supporting documents and archives them based on instructions from the Incident Commander or the Emergency Operations Plan (EOP).

The Demobilization Unit Leader is responsible for developing demobilization activities (e.g., a Demobilization Plan) for approval by the Incident Commander, presenting the plan to designated Command Staff and revising the plan as needed once implementation is underway. The HICS 221: Demobilization Check-Out may be used as part of demobilization activities, as indicated by the Incident Commander. The HICS 221 is distribution to the Hospital Incident Management Team (HIMT) personnel designated by the Incident Commander then delivered to the Demobilization Unit Leader. The information is assimilated into the Demobilization Plan and approved by the Planning Section Chief prior to distribution to Command Staff. Archiving is completed by the Documentation Unit Leader (see Chapter 5.12 Demobilization).

A helpful resource to guide planners is the National Incident Management System (NIMS) Intelligence/Investigations Function Guidance and Field Operations Guide (October 2013) (see Appendix I: Resources and References: National Reference Documents).

4.4.1 Documentation

Incident-related information must be clearly documented. This information may originate from the incident scene, local emergency operations centers (EOC), other external sources or within the hospital's operating service areas, Hospital Command Center (HCC), etc. Although the Planning Section takes the lead in coordinating documentation efforts, the Documentation Unit Leader relies on all members of the Hospital Incident Management Team (HIMT) to support documentation efforts.

Multiple documentation methods may be used during an incident. Written documentation will be the primary method of information recording. The Job Action Sheets (JAS) have been designed to allow the user to write down the dates and times actions are taken. The HICS Form, HICS 213: General Message Form, should be used within the HCC to share key information as well as by other areas of the hospital. Disciplined use of the HICS 213 will help ensure messages are received and the resulting action is documented. The sender should be advised of any action taken. Each HIMT position is tasked with maintaining their own log of issues, actions, and outcomes with the HICS 214: Activity Log. Some personnel experienced in serving in HIMT positions have found it helpful to dictate information into a portable recording device and later go back and transcribe the information.

Actual information recording may be hardcopy (paper) or softcopy using electronic word-processing, database, or spreadsheet programs. Among the advantages of electronic based documentation is easy readability, ability to immediately transmit the information to other locations, and archiving convenience. Certain emergency management software vendors have developed information management programs specifically for use by hospitals.

Video conference software and recording devices may be used during meetings to provide additional opportunity for others not present to see or hear what was said and to document relevant incident information.

Forms

HICS uses specific forms to facilitate emergency management. Each form is intended to assist hospitals in identifying the various types of information to record and archive during an incident.

The forms are of two principal types:

- Federal Emergency Management Agency (FEMA) has created a set of standardized Incident Command System (ICS) forms that emergency responders are asked to use and maintain. Many of these FEMA ICS forms have been modified for use in the healthcare environment.
- Special forms have also been created for use by hospitals and have been adapted into the HICS.

Examples of information that is collected and recorded include:

- Details about the actual incident as they are collected (e.g., fire, plane crash, widespread illness) (HICS 201: Incident Briefing)
- Organization and branch assignments (HICS 203: Organization Assignment List, HICS 204: Assignment List)
- Critical problems encountered and incident command actions taken (HICS 202: Incident Objectives, HICS 213: General Message Form, HICS 214: Activity Log)
- Safety problems encountered and/or addressed (HICS 215A: Incident Action Plan [IAP] Safety Analysis)
- Patient location (HICS 254: Disaster Victim/Patient Tracking)

- Patient evacuation tracking (HICS 255: Master Patient Evacuation Tracking, HICS 260: Patient Evacuation Tracking)
- Casualty/fatality information (HICS 254: Disaster Victim/Patient Tracking, HICS 259: Hospital Casualty/Fatality Report)
- Resources on hand and requests for supplementation (HICS 256: Procurement Summary Report, HICS 257: Resource Accounting Record)
- Resource directory (HICS 258: Hospital Resource Directory)
- Personnel time and accountability (HICS 252: Section Personnel Time Sheet, HICS 253: Volunteer Registration)
- Communications list (internal and external) (HICS 205A: Communications List)
- Facility status (HICS 251: Facility System Status Report)
- Demobilization (HICS 221: Demobilization Check-Out)

Each form is accompanied by instructions regarding the purpose of the form, and by whom and how it should be completed. Certain forms are designed to reflect a chronology of decisions, whereas others are used for reporting information or making resource requests. Once completed, the forms should be duplicated and distributed according to the directions provided.

Archiving

The Planning Section is generally responsible for maintaining a complete file on all incident management information for archival purposes.

The Planning Section (Documentation Unit Leader) is responsible for maintaining a record of the hospital's Incident Action Plans (IAPs) and other incident management forms so they are available for future reference.

Sharing Information with External Agencies

The local emergency operations center (EOC) or healthcare system command center may request that hospitals submit their situation status reports and Incident Action Plans (IAPs) at designated times. This information will help community emergency response officials better understand the issues facing hospitals and what future assistance may be requested. Other information such as patient data, resource availability (e.g., personnel,

equipment/supplies, medications) and response cost information may also be requested from the local and/or state EOCs.

In some communities, the information shared with local and state EOCs may be transmitted via specially designed emergency response software programs; others may use methods such as fax machines, email, or phone reporting. It is important that assigned Hospital Incident Management Team (HIMT) personnel are familiar with the expected reporting frequencies/schedules, methodologies, and redundant systems that are in place in case technical problems are encountered.

4.5 Logistics Section

The Logistics Section provides for all the support needs of the incident. These responsibilities include acquiring resources from internal and external sources, using standard and emergency acquisition procedures as well as requests to other hospitals, corporate partners, and the local emergency operations centers (EOC) or the Regional Hospital Coordination Center (RHCC) or equivalent. Each resource request from an area in the hospital should be reported to the Logistics Section using ordering procedures outlined in the Emergency Operations Plan (EOP). When requesting resources from outside sources the hospital must specify exactly what the need is, not try to identify how that need can be met; that decision will be made at the local EOC or RHCC (or equivalent). In addition, the hospital must be familiar with how the requests are to be made (e.g., electronically, fax, phone).

The Logistics Section can be subdivided into two branches as the situation warrants. The *Service Branch* is responsible for supporting communication (Communications Unit); information technology/information services resource needs (Information Technology/Information Services [IT/IS] Equipment Unit); and food services for patients and staff (Food Services Unit). The *Support Branch* is responsible for acquiring needed supplies (Supply Unit); coordinating internal and external transportation (Transportation Unit); acquiring and credentialing additional personnel (Labor Pool and Credentialing Unit); employee health and behavioral health (Employee Health and Well-Being Unit); and staff family care (Employee Family Care Unit).

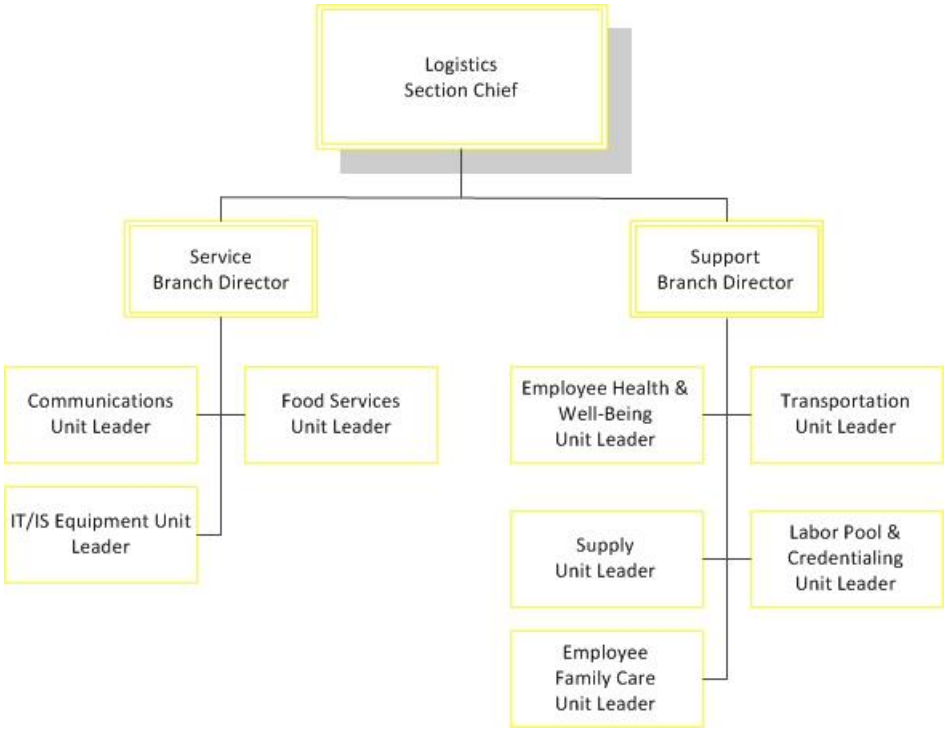

Figure 5. Distribution of Authority and Responsibility within Logistics Section

4.6 Finance/Administration Section

The Finance/Administration Section coordinates personnel time (Time Unit); orders items and initiates contracts (Procurement Unit); arranges personnel-related payments and Workers' Compensation (Compensation/Claims Unit); and tracks response and recovery costs and payment of invoices (Cost Unit). Figure 6 indicates how authority and responsibility are distributed within the Finance/Administration Section.

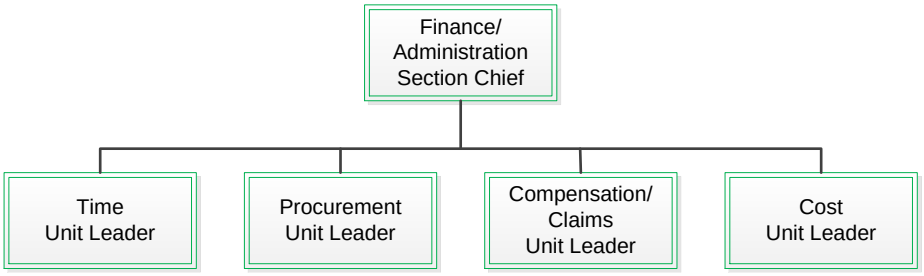

Figure 6. Distribution of Authority and Responsibility within Finance/Administration Section

The Federal Emergency Management Agency (FEMA) may reimburse some hospitals for specific allowed costs associated with emergency response to declared emergencies in accordance with FEMA reimbursement guidelines. The costs associated with the response must be recorded and accounted for from the beginning of the incident. These costs may include staff overtime, loss of revenue-generating activities, as well as repair, replacement, or rebuilding expenses. Daily financial reporting requirements are likely to be modified and new requirements outlined by state and federal officials.

State and federal reporting requirements should be clearly understood before an incident occurs so that documentation will meet expectations. Planning efforts should identify what state and federal financial aid documents must be completed to receive reimbursement. In addition to tracking patient care costs, vendor expenses, mutual aid financial remuneration, and personnel claims should also be tracked. Photographic and video documentation of damaged or broken equipment or locations within a damaged facility provides helpful supporting information.

4.7 Additional HICS Practices

4.7.1 Chain of Command and Unity of Command

HICS establishes a chain of command with the Incident Commander as the overall leader. Each Hospital Incident Management Team (HIMT) position reports to a designated immediate supervisor within the HICS organizational structure. An individual assigned to any position, during the term of their HICS assignment, reports to only a single HIMT supervisor. In other words, an individual assigned to the HICS organizational structure should not be expected to simultaneously perform their normal job duties in addition to the duties associated with their HIMT position, as this would violate the “Unity of Command” principle. The individual should notify his or her usual supervisor of their HIMT assignment.

4.7.2 Identifying Hospital Incident Management Team (HIMT) Members

All personnel assigned to an incident management role should wear identification that correctly communicates his or her role. Many hospitals use a vest for this purpose. Each vest should clearly identify the HIMT position title on the front and back in both normal and low-light conditions. The vests may also be color-coded to the Hospital Incident Management Team (HIMT) chart (white – Command; red – Operations; blue – Planning;

yellow – Logistics; and green – Finance/Administration). These vests should contain large pockets for holding a portable radio, tablet, pens, markers, Job Action Sheet (JAS), and HICS 214: Activity Log. They should be readily available, stored in a secure location, and regularly inspected.

4.7.3 Building Hospital Incident Management Team (HIMT) Depth

There should be at least 3 trained staff for each Hospital Incident Management Team (HIMT) position. The possibility of extended operations cannot be discounted and staff must receive adequate rest and days off to continue functioning at optimal levels.

In addition to training adequate numbers of their own staff, hospital planning should address the integration of qualified personnel from sources such as other hospitals or state and federal response teams.

Training and exercises should be used as a means of preparing personnel to assume one or more roles based on situational need and available resources. In addition to training, completion of the specified National Incident Management System (NIMS) courses or equivalents - either online or through classroom instruction - will help to prepare those individuals likely to assume management roles.

4.7.4 Job Action Sheets (JAS)

The Job Action Sheet (JAS) is an incident management tool designed to familiarize the user with critical aspects of the management position he or she is assuming. Information provided on a JAS includes the position title and mission, to whom the position reports, and critical action considerations. These tasks are intended to prompt the Hospital Incident Management Team (HIMT) members to take needed actions related to their roles and responsibilities. The JAS have been extensively revised and include action steps sectioned into time frames. The JAS format allows for personnel to document each action taken at specific times. The JAS also depicts the position within the HIMT and highlights reporting relationships. The JAS for each position should be readily available and ideally paired with other needed items such as those listed in the Document/Tools section of the JAS. Each JAS should be available for use in every operational period and collected by the Planning Section when the work period has been completed and maintained as part of the incident file.

4.7.5 Department Level Leadership

Providing leadership at the department level is an important part of the hospital's overall response. The Emergency Operations Plan (EOP) should address the role and responsibilities of each department for the various scenarios identified from the Hazard Vulnerability Analysis (HVA). The leadership of each department should be identified in the EOP, along with 24-hour/7-day-per-week contact information. Items that should be available for immediate access include:

- Job Action Sheets (JAS)
- Position identification vests (or other preferred identification method)
- Radios/phones/computers
- HICS Forms
- Pre-designated resources in a rapidly deployable storage bin. (e.g., phone lists, phone book, procedures manuals, office supplies, maps, keys)

Leadership should provide periodic briefings to staff members to decrease fear and anxiety, reduce rumors, and promote commitment to the tasks at hand.

Each hospital department or unit should have access to the equipment and supplies necessary to respond to internal emergencies such as hazardous materials (HazMat) spills, loss of power or water, etc. These items include:

- Personal protective equipment (PPE)
- Flashlights and chemical light sticks
- Bottled water
- Signs in multiple languages if needed (e.g., restroom closed, do not enter, directional, instructional)
- Chemical or standard portable toilets and toilet paper
- Hand-washing foam, disinfectant wipes
- Evacuation chairs, stretchers, backboards

Deployment of needed equipment and supplies should be effectively managed, and replacement needs should be reported to the Hospital Command Center (HCC).

Following the response phase, arrangements can be made during demobilization for the items to be replaced and returned to a ready state.

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CHAPTER 5

Incident Response: Putting It All Together

OBJECTIVES

- Describe key response and recovery activities.
- Describe evaluation processes and the importance of organizational learning to system improvement.

5.1 Alerts and Notification

The initial response to an incident begins with the recognition that an incident may occur or has occurred and that the impact is likely to disrupt normal hospital operations.

Advance warning information comes from several sources, including law enforcement, emergency medical services (EMS), local health department, or the local emergency management agency (EMA). Hospitals may receive three types of notifications through a central dispatch:

- *Advisory* indicates no system response is needed but the potential for a response exists.
- *Alert* indicates a response is likely or imminent and should prompt an elevated level of response readiness.
- *Activation* indicates a response is required.

Unfortunately, hospitals often receive little or no warning of an incident (i.e., "no notice" incidents). The first indication may be via EMS radio communication providing preliminary incident details, media presentation of a "breaking news story" or early-arriving victims providing incident information from their perspective. Early information quality may be sporadic or even erroneous although a more complete and accurate operating picture should rapidly evolve.

Important information to obtain as soon as possible includes:

- Type of incident, including the specific hazard/agent, if known

- Location of incident
- Number and types of injuries
- Special actions being taken (e.g., decontamination)
- Estimated time of arrival of first-arriving EMS units

It is important that hospital staff understand the plan for protecting themselves and their co-workers (including training and access to personal protective equipment [PPE]) and that key personnel are appropriately notified. The information sharing process should take into account the possibility that an incident occurs after normal business hours and incorporate the use of redundant communication methods. Personnel pagers (including two-way pagers allowing for text messaging back and forth) and overhead paging provide simple yet rapid means of announcing a response whether using a unique code nomenclature (e.g., Code Orange) or explicit wording ("the Mass Casualty Plan is now in effect"). Cell phone, email, and other appropriate personal contact information should be kept secure but readily available for on-duty supervisory personnel and telecommunication specialists to access when needed.

Staff contact information should be reviewed and updated on a regular basis to ensure notification methods succeed when needed. After-hours contact procedures should take into account the need to contact staff by telephone because many persons will not have their pagers available during off hours (e.g., while sleeping).

For certain incidents, such as a foodborne illness or infectious disease outbreak, the hospital may be first to recognize the incident due to the number and symptoms of patients arriving in the emergency department. Under such circumstances, internal notifications are important but external notifications are also needed. External notifications depend on the particular circumstances and could include EMS, fire, law enforcement, local health department, or the local emergency management agency (EMA), and other hospitals. Hospital plans should document what conditions should trigger the notification of specific external agencies.

Increasingly, active and passive surveillance systems are used to discover biologic/infectious disease outbreaks. For example, hospital patient data may be sent via the intranet to a central location where the information is aggregated and analyzed for trends or local pharmaceutical sales and other supplies from drug stores and grocery stores monitored to identify trends of interest. Suspicious data trends lead local health

departments or the local emergency management agency (EMA) officials and/or infectious disease specialists to investigate and make appropriate notifications if warranted.

5.2 Situation Assessment, Reporting and Monitoring

Situation reports may be received by the hospital from several sources. Emergency Medical Services (EMS) agencies may provide incident reports by radio, cell phone or mobile web device and EMS personnel transporting patients to the hospital also may verbally provide incident information. Some EMS agencies transmit incident information by wireless communication, including photographs and other pertinent data. Arriving patients may also provide relevant information. Periodic situation status updates may be received from the Regional Hospital Coordination Center (RHCC) or Medical and Health Branch (i.e., Emergency Support Function [ESF] #8 – Public Health and Medical Services) at the local emergency operations center (EOC) if activated.

Once a hospital becomes aware of an incident, it should determine if a field-level Incident Command Post (ICP) or jurisdictional EOC has been established. The hospital may determine this by contacting the local dispatch center, EOC (or local emergency management agency [EMA]) or RHCC if activated. With proper pre-incident collaborative planning, local policies and procedures should emphasize the integration of hospitals in the information sharing process. Once this is determined, the hospital should integrate with community response entities in accordance with local policies and procedures.

The bi-directional sharing of situation information should occur between the hospital and other response agencies, including the local EOC (see Figure 1 on page 83).

When available, closed circuit television (CCTV) or video cameras positioned to observe critical areas can provide useful information. Alternatively, staff may record critical areas and replay information for the Hospital Command Center (HCC). Monitoring media coverage can also provide useful information.

5.3 Emergency Operations Plan (EOP) Activation

Following the initial notification process, the next step is to determine the appropriate response actions based on available information. Options include partial or full activation of the Emergency Operations Plan (EOP) and Hospital Command Center (HCC), recruitment of additional clinical and non-clinical staff to augment operations, and

advance preparations in the emergency department and other functional units within the hospital.

Many hospitals routinely respond to "emergencies" with no significant alteration of their normal business practices. Within certain limits, hospitals can adequately respond using day-to-day processes (e.g., call in additional staff, coordinate with EMS to divert incoming patients, etc.). Hospital capacity is dependent on many factors, including the size of the facility, availability of additional staff, training, etc. However, every hospital has a point beyond which its capability and/or capacity to properly care for existing and incoming patients will be exceeded. The hospital should activate its EOP and initiate HICS well before this occurs. The purpose of HICS is to support the maintenance of the hospital's mission and patient care capability during emergencies.

The EOP identifies who has decision-making authority along with the criteria or triggers that should assist those in charge with making early decisions. Key decision-makers typically include the administrator on call, nursing supervisor, senior emergency department physician, or charge nurse on duty.

Once the decision is made to activate the HCC, the only position that must be activated is the Incident Commander. Additional positions are dependent on the needs of the situation. The personnel that are needed should be rapidly notified to report to the HCC at the hospital.

Once the HCC is activated, steps should be taken to establish the appropriate number of HCC workstations, implement a Communication Plan, establish a check-in station for incoming personnel, and prepare to distribute needed materials such as Job Action Sheets (JAS) and HICS Forms.

5.4 Activating HICS

Early activation of the HICS should be considered if there is indication that the incident is large and/or complex. After the decision has been made to activate HICS, the Incident Commander determines the initial management objectives and priorities. Based on this assessment and in accordance with the Emergency Operations Plan (EOP), additional Command and General Staff are activated, as determined according to the size and/or complexity of the incident, to assume Hospital Incident Management Team (HIMT) positions.

The HIMT positions being activated may initially have to be filled by in-house mid-level staff until more senior personnel arrive. For small or medium size hospitals, or any hospital after hours, some individuals may have to simultaneously perform several roles throughout the response or until additional assistance arrives. The functional needs of the hospital response and availability of qualified personnel drive which HIMT positions are activated by the Incident Commander.

The Incident Commander should ensure that Command and General Staff receive an initial briefing (HICS 201: Incident Briefing). This provides an overview of the general response priorities and preliminary problems being addressed as well as answers to any initial questions or concerns. It is also necessary to provide updated operational briefings at regular intervals.

5.5 Building the HICS Structure

Those personnel who have completed the recommended incident command training specified by the federal government, such as the National Incident Management System (NIMS), and other hospital or corporate requirements, should be appointed to a Hospital Incident Management Team (HIMT) position. Some individuals, by virtue of their background and training, might be capable of performing in more than one position. Table 1 on page 46 and Appendix D-Potential Candidates for HICS Command and General Staff Positions contain a suggested list of common hospital administrative and clinical positions that might be suitable for positions within the HIMT. Each hospital should maintain a sufficient cadre of trained personnel to ensure the capability to operate for extended periods of time.

A list of the qualified personnel should be maintained and immediately available in the Hospital Command Center (HCC) for the Incident Commander to use. An alternative system would be to assign teams of personnel, with each team taking an “on call” time period; if an incident occurred on their duty day, they would be the first response team members activated. The other teams would fill in positions that are vacant because of illness or vacation and be the second-shift and relief teams.

In larger incidents the Incident Commander will activate the Command Staff positions of Public Information Officer (PIO), Liaison Officer and Safety Officer, along with the General Staff positions of Operations Section Chief, Planning Section Chief, and Logistics Section Chief. The Finance/Administration Section Chief can be appointed as the

situation warrants and available resources allow. If the situation requires specialized expertise, a Medical-Technical Specialist(s) may be assigned. This may include experts in clinical areas such as infectious disease, radiation or chemical emergencies, or nonclinical expertise such as risk management, legal affairs, and hospital administration. These individuals typically provide assistance with situational assessment and response recommendations to the Incident Commander or Planning Section.

Along with the development of the HIMT at the HCC, other hospital operational areas (emergency department, surgery, registration, etc.) should follow the Emergency Operations Plan (EOP).

As the HIMT positions are activated, a written record is crucial to document who is assuming which role. This information is posted in the HCC for everyone to see, using projection or wall charts (see Appendix C: Hospital Incident Management Team). Noting the Command Staff, Section Chiefs, Branch Directors, and Unit Leaders names and contact information is important. In addition, the appropriate organization assignment forms (see Appendix H: HICS Forms; e.g., HICS 203, 204, and 207) should be maintained and widely distributed through all appropriate means (print format, intranet, email, etc.).

In most cases, the Incident Commander may not be the Chief Executive Officer (CEO) for the hospital. That individual may be away or assume other duties according to the EOP (e.g., agency executive or represent the hospital at the local emergency operations center [EOC] or elsewhere). The Incident Commander must ensure that the CEO and other senior administrators (including the board of directors) who are not directly involved in managing the incident are kept properly informed and consulted when needed.

5.6 Establishing the Hospital Command Center (HCC)

The effectiveness of the Hospital Incident Management Team (HIMT) is greatly enhanced when the members have access to a convenient location that accommodates the coordination of response activities.

5.6.1 Design Features

The Hospital Command Center (HCC) location and design should reflect the following characteristics:

- *Accessibility* – The area can be easily reached from any area of the hospital 24/7 but is not in the middle of critical operations or public access areas.
- *Flexibility* – Sufficient space to house equipment, furniture, supplies, and technology to accommodate the Hospital Incident Management Team (HIMT).
- *Sustainability* – Infrastructure support for emergency operations 24/7 without interruption, including access to emergency power circuits, outlets, lighting, computer systems, etc.
- *Security* – Protection of the facility, occupants, communications systems and equipment, and sensitive information. Only authorized persons are allowed to enter the area.
- *Survivability* – Ability to withstand the effects of local hazards and avoidance of typical internal risk areas.
- *Interoperability* – Technological capability to exchange routine and time-sensitive information with other HCCs or emergency operations centers (EOCs).

Space should ideally be designated to include:

- *Main operations room* for coordination among Hospital Incident Management Team (HIMT) members. The location of Command and General Staff should be clearly identified via table tent cards or overhead signage.
- *HIMT positions* should have access to adequate work space and access to the tools identified on their Job Action Sheet (JAS).
- *Enclosed nearby conference room(s)* for private meetings or executive briefings.
- *Communications area(s)* for television, radio, multiple telephones, amateur radio, and support equipment.
- *Areas for electronic and written displays* for scribing and projecting key response data and decision-making information.
- *Storage closet* for plans, reference manuals, resource directories, maps, supplies, and HIMT kits when not in use.

5.6.2 Equipment and Supplies

To ensure the Hospital Incident Management Team (HIMT) members are able to exchange information with internal hospital departments and external response

agencies, the Hospital Command Center (HCC) should be equipped with redundant communication capabilities.

- *Voice systems* include telephones (land, cellular, satellite) and radio (amateur, commercial, and public safety 2-way radios). Antennas, repeaters, etc., should be provided as needed.
- *Data systems* include computers with modems on analog/digital lines, computers on a local or wide area network, and computers with wireless cards. Multiple data ports should be provided so all computers have internal connectivity in addition to external information sharing sites.
- *Equipment for receiving public broadcasts* is necessary, including multiple televisions or a large screen capable of showing multiple channels simultaneously and AM/FM and weather radios.
- *Equipment for visual display of incident information* is also critical and includes large projection screens, whiteboards, maps, charts, and chart pads on easels.
- *Miscellaneous office supplies* in addition to preprinted HICS forms and general supplies, a fax machine and multiple photocopiers are necessary equipment.

It is important to periodically verify that the HCC equipment is functioning properly and that needed supplies are available on site. Information technology/information systems personnel should also verify that the computer software is updated and functioning as expected along with the primary and back-up communication systems.

5.6.3 Staffing

The number of staff in the Hospital Command Center (HCC) should expand and contract according to the size and/or complexity of the incident. The Incident Commander determines the level of staffing for the Hospital Incident Management Team (HIMT). Generally, the next level of expansion includes the Command and General Staff. Additional staff may be accommodated in the HCC if space is available; otherwise, nearby or adjacent rooms could be used. Under such circumstances, each section's team can be cohorted in nearby space or operate from their normal offices. In addition, Medical-Technical Specialists and external Agency Representatives may be located in the HCC, if space permits, or a nearby site. An adequate number of supporting administrative staff should be available to assist senior management personnel with documentation and communication activities, thereby freeing them to address critical issues. Some

hospitals call these personnel "Incident Management Support Team" members. These individuals should be selected in advance and receive training appropriate to their role.

5.6.4 Alternate Hospital Command Center (HCC)

If the primary Hospital Command Center (HCC) becomes non-functional or inaccessible, an alternate site should be available. The alternative HCC site should be pre-established and identified in the Emergency Operations Plan (EOP). If space is not available in the main building, consideration should be given to nearby buildings on campus or nearby external sites.

Some hospitals have developed a "plug and play" approach that includes storing position-specific materials (e.g., vests, Job Action Sheets [JAS], laptop computers, paper, pens, EOP) in heavy-duty roller boxes or bags that can be easily transported to the HCC site. Radios and other portable technology may be stored and transported in similar fashion. Exercises should include activation of the alternate HCC to promote familiarization and ensure functional dependability.

5.7 Incident Action Planning

Incident action planning is an essential component of HICS and directly reflects the Management by Objectives (MBO) characteristic. The Incident Action Plan (IAP) may be considered the single most important document produced during response operations (See Chapter 7 Incident Action Planning).

The Incident Commander will identify the response actions associated with preparing the IAP. Each Section Chief and Branch Director will be given an electronic or manual form to complete (see Appendix H: HICS Forms; HICS 204: Assignment List) with the assistance of others in their section as necessary. The completed form should be submitted to the Planning Section Chief by the announced deadline. The Planning Section will assimilate the forms received into a single IAP and present it to the Incident Commander. In turn, the Incident Commander will make any modifications as appropriate and subsequently brief the Command Staff on the document at the Planning Meeting.

During that meeting with Command Staff, the IAP can be modified as needed. The initial IAP should be developed as soon as possible once the Hospital Command Center (HCC) is operational. The initial IAP provides preliminary guidance for the response effort for a defined operational period. The Incident Commander, or at his or her direction, the

Planning Section Chief will establish the times when subsequent IAPs are to be submitted. Generally, the deadline should be a minimum of 2 hours before the end of the work shift. This allows the Planning Section time to develop the composite IAP that will be used by the Incident Commander to brief the oncoming Command and General Staff.

Another critical part of successfully managing an incident is conducting various meetings involving key personnel. These meetings will generally be of three types:

- *Planning Meetings*, in which the Command and General Staff decide upon response objectives, strategies, tactics, and response assignments. (In some situations where the development of tactical objectives and delineation of actual tactics is too complex to accomplish during the planning meeting, a special tactics meeting can be held before the planning meeting.)
- *Operations Briefings* to impart information to all parts of the hospital's Command and General Staff and discuss critical issues.
- *Command and General Staff Meetings*, which begin the next planning cycle and include reassessing and revising management objectives on the basis of information received throughout the operational period.

Each of the meetings should be well facilitated. Participants' comments should be brief and on topic. The decisions reached are then recorded on appropriate documents and shared with other HIMT personnel and hospital staff as appropriate.

5.8 Communications and Coordination

5.8.1 Internal

Gathering and sharing information with the hospital staff is critical to successfully managing the incident. Effective internal communication will be accomplished using the following strategies and technologies when available:

- Obtaining information from different departments collected via phone, intranet, email, or fax (e.g., HICS Forms; HICS 213: General Message Form)
- Using radios assigned to specific areas with assigned channels; (see Appendix H: HICS Forms; HICS 205A: Communications List)

- Staff completion and return of designated forms downloaded from the intranet/internet or provided in hardcopy format (e.g., HICS Forms; 251: Facility System Status Report and 259: Hospital Casualty/Fatality report)
- Sending out regular situation updates, response guidance, and requests for assistance via radio, intranet/internet, hardcopy material, or face-to-face meetings

Two-way pagers, cell phones, handheld mobile web devises and tablet computers are examples of technology increasingly being used to relay information between multiple individuals or groups and can be a means to confirm message receipt when necessary. Teleconferencing and video conferencing have also proven useful for communication and should be employed when available.

Depending on the circumstances surrounding the incident, conducting a "town hall meeting" with the hospital staff before or during a shift can be useful. Involving key Command Staff and Medical-Technical specialists can help ensure that correct information is being given to the staff, dispelling and assuaging rumors or concerns.

Hospitals that are part of a healthcare system must give early notification to their corporate officials and update them periodically as needed. Close communication with other system facilities should be undertaken as outlined in the hospital and organizational Emergency Operations Plans (EOP).

Keeping patients and visitors properly informed is another important communication requirement. Providing insight on what happened and what is being done to address these issues can be done via overhead page announcements, personal reassurance from the staff, using the hospital's television channel (if available) to provide the news, information updates strategically posted throughout the hospital, and printed material put on individual meal trays.

5.8.2 External

Communication with a number of external response partners is essential. If situations unfold without initial notification from EMS, fire, or law enforcement, they must be called when appropriate (e.g., patient with chemical contamination, child abduction) and apprised of the situation and any assistance requests.

Periodic information sharing and joint decision-making should occur among all hospitals receiving victims. In some communities, situation information is provided according to a Communication Plan which may be transmitted via radio (e.g., VHF, UHF), telephone (including satellite phones when land lines or cellular service isn't available), and the intranet/internet, using predetermined forms or tables. Each of these technologies has limitations and system redundancy is important to ensure that functional communication capabilities exist.

When available, amateur radio can also be used for communication. Many communities have found their local amateur radio operators to be reliable, skillful, and possessing very dependable communication equipment. However, amateur radio, like most public safety radios, is usually not secure, and unintended recipients such as the media and the public may overhear these messages.

Teleconferencing and video conferencing are also useful tools for hospitals to consider. A successful teleconference will typically require:

- Timely notification to area hospitals that a teleconference will be held, the time for the call, and the correct call-in number
- A facilitator from one of the hospitals or a respected outsider who will keep to the agenda and focus the discussion
- Meeting rules, such as the reporting order and content, announced at the outset of the call and strictly adhered to during the call
- One spokesperson per participating hospital, although others may listen to what is being said
- Pertinent comments being concisely made by the participants
- Announced time for next teleconference or issue-specific discussions, when appropriate. Hospitals will also continue to communicate with other external partners as the situation unfolds. Maintaining a regularly updated resource directory of external agencies and vendors (see Appendix H: HICS Forms; HICS 258: Hospital Resource Directory) will assist in rapidly identifying contact information.

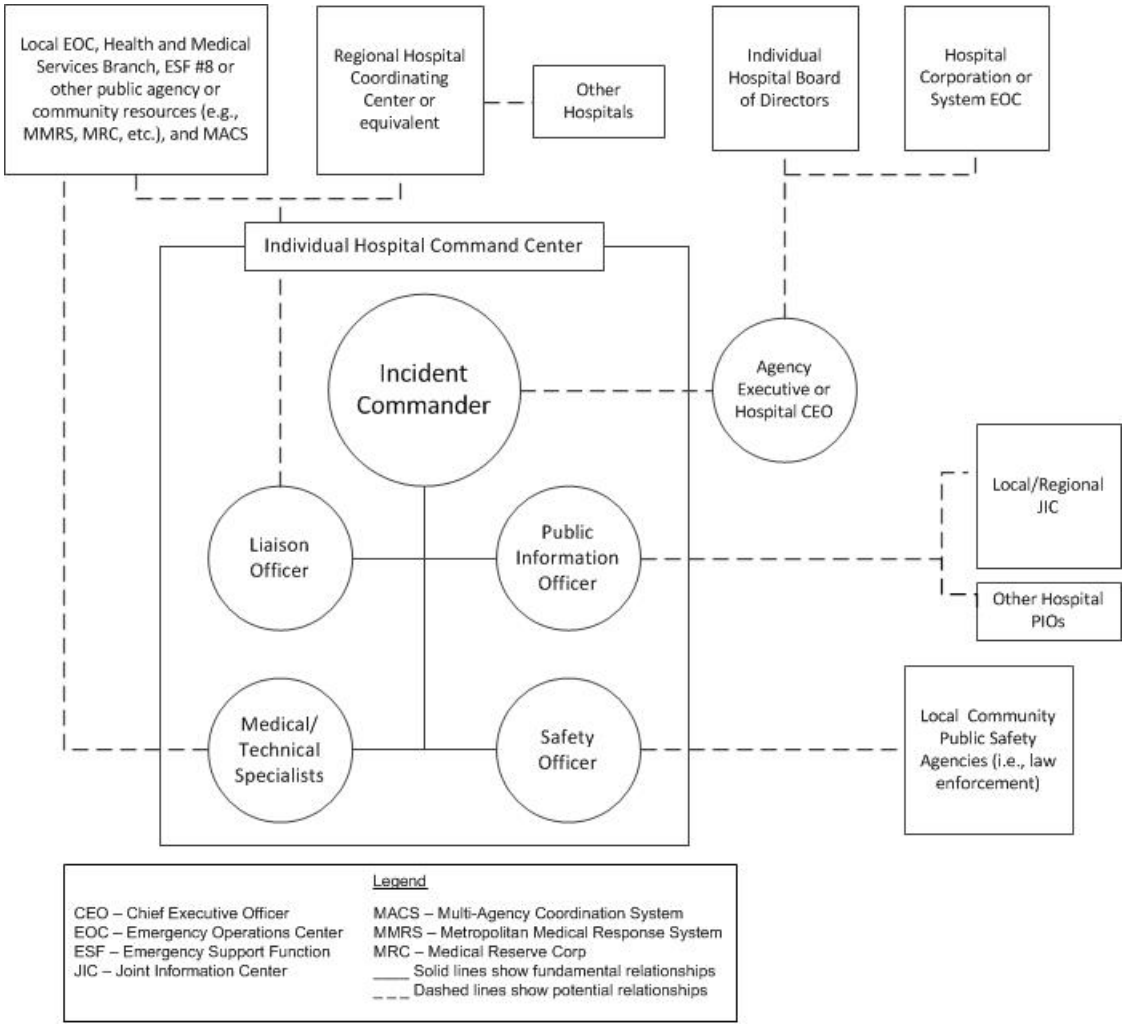
Information received from the outset of the incident should be followed by updated operational briefings based on a set timeline or on an as-needed basis in accordance with local, regional and/or state medical and health policies and procedures. The federal

Emergency Support Function (ESF) #8 – Public Health and Medical Services will be periodically requesting updated information from state medical and health partners. The local emergency operations centers (EOC) may ask the hospital to submit certain reports at designated times. There will be a primary point of contact for each hospital when specific resources are needed (e.g., medications, staffing, and transportation). Among the information requested will be an Incident Action Plan (IAP) and patient-tracking forms (HICS 254: Disaster Victim/Patient Tracking and HICS 255: Master Patient Evacuation Tracking). Effective planning identifies the forms to be completed and indicate the likely timeline for reporting.

In some communities, the Regional Hospital Coordination Center (RHCC) or equivalent is another response partner to which hospitals might be providing information. Depending on the community response plan, these centers may be the central point for hospital requests for resources (staff, supplies, food, water, etc.). When activated, the RHCC or equivalent will often focus on the hospital's medical care operations, and the local EOC will assist with non-medical issues. To be effective, there will need to be close coordination between the local EOC and RHCC or equivalent.

The Liaison Officer is the hospital's principal contact with all outside agencies and will often be the conduit for 2-way communication between the Hospital Command Center (HCC) and local EOC, the RHCC or equivalent. The Liaison Officer is among the busiest positions in the HCC and may require administrative assistance to ensure information flows in a timely, effective, and accurate manner.

Figure 1.External Communication



5.9 Staff Health and Safety

Protecting the health and safety of staff is the highest priority during any emergency response. The Safety Officer is primarily responsible for identifying, evaluating and resolving health and safety matters within the response structure.

The Incident Commander's efforts to provide timely, accurate, and concise information updates are important to maintaining the staff's willingness to work under difficult conditions. Staff members who become ill or injured should be cared for immediately through the Logistics Section's Employee Health and Well-Being Unit. Workers' compensation issues are addressed through the Compensation/Claims Unit Leader in the Finance/Administration Section.

5.9.1 Personal Protective Equipment (PPE)

Only authorized personnel who have received necessary training and medical clearance should wear personal protective equipment (PPE) for chemical, biological, or radiation-related incidents. Training consistent with state and federal guidance, including annual refresher training, will help ensure continued capability. Appropriate sizes and quantities of PPE should be available for use as needed. These items should be properly maintained in a safe, secure, and environmentally controlled storage location close to where they will be needed.

Persons wearing PPE should be monitored for signs of illness, injury, and fatigue. Appropriately trained personnel should ensure all equipment is being worn safely and correctly. Proper personnel and equipment decontamination, disinfection, or disposal is important to minimize cross-contamination and comply with state and federal regulations. The Safety Officer works closely with the Operations Section, in particular the Medical Care Branch Director and Hazardous Materials (HazMat) Branch Director, to ensure staff are provided with frequent rest periods and medical surveillance (i.e., observing for signs and symptoms of fatigue and heat exhaustion, emotional stress, and vital sign measurements). The Infrastructure Branch Director and Support Branch Director will take the lead in ensuring needed equipment and supplies are available and impacted areas are ready for routine operations following decontamination. They will coordinate with the Safety Officer to ensure proper disposal of hazardous waste materials by authorized contractors.

5.9.2 Infectious Disease

As soon as possible during a contagious biological event, hospitals should receive appropriate health and safety precautions from the local emergency management agency (EMA) and the local health department in collaboration with their infection control professionals. This information should be shared with staff, particularly those that may be directly exposed to patients meeting infectious disease case definitions. The Safety Officer should collaborate with Medical-Technical Specialists, (e.g., Biological/Infectious Disease) to determine what information and protective measures are required. Instructions should be communicated to staff and patients and regularly updated as additional information becomes available.

The hospital Emergency Operations Plan (EOP) should include an annex that addresses mass prophylaxis and medication distribution to staff or patients. This comprehensive plan should address issues such as medication and vaccination distribution to on-duty and off-duty staff (and as appropriate, their families), adverse-outcome reporting, medication acquisition using standard vendor lists, documentation and tracking, and working with the local health department or emergency medical services agency, or the local EMA officials to procure additional medications, if necessary, from the state and federal government.

5.9.3 Stress Management

Planning should address post-incident medical/psychological evaluation of staff after working in the decontamination area or with patients with contagious illnesses. Medical monitoring, including documentation must meet state and federal guidance (e.g., Occupational Safety and Health Administration [OSHA]).

The Command and General Staff should maintain close vigilance for signs of fatigue and psychological stress. The Logistics Section, primarily the Support Branch Director is responsible for addressing staff issues in conjunction with the Operations Section. Personnel demonstrating signs of illness or stress must be cared for properly to prevent additional adverse health impacts. The Employee Health and Well-Being Unit Leader will provide leadership in this effort. Maintaining reasonable work periods with periodic days off (Planning Section) and ensuring the availability of healthy nutrition (Service Branch) are a priority.

5.10 Extended Operations

Many of the most common incidents that hospitals face are short-lived, lasting only several hours. However, the Toronto Severe Acute Respiratory Syndrome (SARS) outbreak in 2003, the results of the Hurricane Sandy in 2012, and wildland fires in the West in 2011 and 2012 reinforce the importance of being prepared for the possibility that response operations may continue for days, weeks, or possibly longer. To help meet this possibility, hospitals may consider creating multiple Hospital Incident Management Teams (HIMT) (e.g., Team A, Team B, Team C) with the intent that they will work a rotating schedule until the hospital returns to normal operations.

5.10.1 Issues Related to Extended Operations/Large Scale Incidents

Numerous issues related to extended operations and large scale incidents must be addressed in planning. Among them are:

Personnel

- Loss of staff who evacuate or become victims of the event
- Lack of adequate staff
- Longer work shifts
- Staff fatigue leading to slower delivery of, or compromise in, patient care
- Permanent loss of staff who accept new employment elsewhere due to prolonged hospital closure
- Absenteeism
- Fear
- Concerns for family or personal situations
- Need for time off to assess and manage home situations
- Integration of outside relief personnel/volunteers into daily operations and Incident Command structure

Patient Care

- Lack of needed staff/expertise
- Overwhelming number of patients
- Need to alter the standard of care (i.e., crisis standards of care)
- Documentation demands while caring for greater than normal patient volume
- Difficulty moving patients due to elevator failures and facility damage

Equipment and Supplies

- Increased demand
- Lack of needed equipment, medication, and supplies
- Elevator failures and facility damage making movement of cumbersome/heavy items up/down stairs difficult
- Repair and replacement issues
- Staff not being familiar with provided or borrowed equipment
- Inundation by unsolicited donations, including blood donors

Behavioral Health

- Increased acute and long-term demand for limited behavioral health resources
- Natural fear, anxiety, and apprehension among patients, staff, and family members
- Rumors
- Preventing post-traumatic stress disorder

Security

- Implementing and sustaining enhanced security measures
- Staff and visitor compliance with adjusted or stricter security procedures being used
- Increased risk of patient or visitor violence from impatience or dissatisfaction with service delivery
- Parking needing to be controlled and supplemented
- Controlling media access

Infrastructure Support

- Structural engineering evaluation to determine safety of buildings
- Meeting and sustaining increased demand on various clinical and nonclinical services
- Recovery of utility services; operating under reduced capability in the interim
- Unavailability or delay in receiving needed assistance (e.g., fuel, repairs, replacement parts, medical gases, etc.)
- Increased need for food/water supplies and meal preparation
- Routine and hazardous waste pick-up
- Clean-up from damage

Information Sharing

- Need to keep patients, staff, and family members informed of the situation (on site and at off-site locations)
- Establishing, maintaining, integrating, and interpreting multiple databases, files, and reports
- Meeting information management needs when daily information technology/information services (IT/IS) are compromised
- Responding to multiple information requests (local, state, tribal, and federal)

Media/Public Relations

- Requests for information, interviews with patients and staff, and filming
- Family members making media statements
- Efforts of media attempting to infiltrate a secure hospital
- Monitoring and reacting as appropriate to social media postings
- Need for risk communication to inform the public on pertinent response/health-related issues
- Integrating efforts with Public Information Officers (PIOs) from community partners

5.10.2 Planning

The Planning Section must address the issues mentioned above and others that arise, in part through utilization of the Incident Action Plan (IAP). These planning efforts should also be coordinated where appropriate with others, such as corporate headquarters, other area hospitals, and the local emergency operations center (EOC).

Although responding to the incident is a priority, maintaining appropriate delivery of daily inpatient and outpatient services (including off-site locations) is also important and must be simultaneously addressed. This may be done by continuing routine management practices (using managers separate from those involved in the incident management) or having the Hospital Command Center (HCC) assume responsibility for coordination. Based on the initial and ongoing situation, decisions need to be made on operational issues such as canceling elective admissions/procedures, non-emergent surgeries, and other nonessential scheduled activities (e.g., meetings, medical rounds, special events, etc.). Clinic and physician office hours may need to be expanded, reduced, or temporarily canceled. Pre-incident planning efforts should address the decision-making processes to be employed and the procedures to be followed for all of these situations.

Planning for the relief of hospital staff must be a priority; it is also important that rotation of Hospital Incident Management Team (HIMT) personnel is effectively managed.

Another vital part of short-range and long-range planning is completing required documentation (see Chapter 4.4.1 Documentation).

5.11 Legal and Ethical Considerations

The response requirements of a particular disaster may include addressing a number of important medical and legal issues. For example:

- A surge in patient-volume that exceeds available resources could result in the need to employ crisis standards of care. This results in a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives (population based), in contrast to the traditional focus on saving individuals (individual based).[2]
- Patient information may be requested by family members, various governmental (e.g., local health department), or non-governmental (e.g., American Red Cross) agencies, and the media. Trained Public Information Officers (PIOs) should be available and promptly disseminate relevant information approved for release.
- Adherence to the Health Insurance Portability and Accountability Act (HIPAA) and Emergency Medical Treatment and Active Labor Act (EMTALA) requirements including modifications or waivers during declared local, state, and/or federal disasters.
- Compliance with federal and/or state Environmental Protection Agency directives.
- Potential modification to existing scope-of-practice guidelines may need to be requested to accommodate unusual demand with limited resources.
- The arrival of solicited and unsolicited volunteers necessitates a plan that includes credentialing, privileging, utilization, and supervision.
- Responsibility for a patient who dies from naturally occurring disease and/or accidental injury versus illness or injury related to terrorism.
- A deliberate act of harm or terrorism will require that a chain of custody be established by law enforcement for such things as personal effects and laboratory specimens.
- Investigative medication procedures normally followed may need to be revised or abandoned.

[2] (Barbera, Macintyre, et al. Emergency Management Principles and Practices for Healthcare Systems. Veterans Health Administration (VHA): June 2006; and Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. Institute of Medicine (IOM); March 2012).

The Emergency Management Committee should consider including the hospital's legal department, medical ethicist, and risk management to provide guidance in preplanning these issues and should address their availability to provide advice if needed during an actual incident.

5.12 Demobilization

Planning for demobilization should begin early in the response. The Planning Section Demobilization Unit Leader is tasked with developing preliminary activities (e.g., Demobilization Plan) for when and how demobilization is to occur and revising the plan as needed once implementation is underway. The decision to move from response to demobilization will be made by the Incident Commander.

Depending on the situation, not all areas of the hospital will begin demobilization at the same time. Planning should address not only when the demobilization process is to begin but also how it will be implemented.

When the decision to demobilize has been made, it should be communicated by the Planning Chief or Demobilization Unit Leader to hospital staff and by the Liaison Officer to appropriate external agencies (e.g., EMS, fire, law enforcement, local health department, and emergency management). Select information may need to be shared with the patients and their families. The Public Information Officer (PIO) should also determine the need to share information with the general public, particularly in situations where hospital operations have been curtailed and will subsequently be resumed (see Chapter 7.5.12 Demobilize and Recover).

5.13 Recovery

A hospital's return to day-to-day operations may be progressive. Planning should take into account that ramped-up methods to accommodate medical surge will be dismantled as patient care activities allow. Extra equipment, supplies, and medications will return to the pre-incident "just-in-time" inventory levels as soon as the opportunity permits.

The supplemental staffing levels needed during the response may continue to be maintained for certain patient care and support service areas. However, even these areas will eventually return to previous operational levels. Any individual or group that was asked to augment a hospital response during an incident should be debriefed by management. Furthermore, suitable expressions of appreciation should be offered, such

as a recognition gift (a certificate or an item with the hospital name on it), a gathering in their honor, or a simple letter of appreciation. These small gestures will have great importance both to hospital staff and volunteers.

Recovery efforts will also need to address various other personnel issues. Personnel who donned personal protective equipment (PPE) should complete medical surveillance forms that become part of their personnel/employee health record. They should also receive an appropriate health debriefing including signs or symptoms to watch for and response actions to subsequent health effects.

The staff members who become ill or injured while on duty will have financial, psychological, and medical-care issues that can be coordinated by the Finance/Administration Section's Compensation/Claims Unit. The possibility of a line-of-duty death occurring should be addressed by use of a specific annex to the Emergency Operations Plan (EOP) and be implemented through the combined efforts of the Logistics Section, Finance/ Administration Section, Operations Section, the Safety Officer, and the Public Information Officer (PIO). The wide impact a staff member illness and death can have on the remaining staff cannot be underestimated and must be given proper attention for the duration of an incident.

Experience has shown that the intensity of the response, perceived dangers related to doing the job, and family concerns may lead to staff absenteeism or even resignation during or following the incident. Although there is no guaranteed strategy to avoid these problems; regular, effective, and candid communication with the staff, while also providing for their health and safety during an incident, is critical to minimizing their occurrence. The importance of planning for family care and support during these types of emergency situations should be emphasized prior to an incident as part of the hospital's overall preparedness efforts. Planning guidance is available from the Federal Emergency Management Agency (FEMA) and the American Red Cross (ARC) (see Appendix I: Resources and References).

The Logistic Section's Support Branch plays an important coordination role for all matters pertaining to staff and family support. Psychological debriefing should be provided for staff and volunteers, as determined by the Support Branch Director.

Restoration of the hospital's physical plant will vary by incident. At a minimum, all patient-care areas and equipment will have to be thoroughly cleaned and inspected. Depending on the area involved, this effort may be time-consuming and costly. The

Operations Section Chief will primarily be responsible for coordination of this activity, along with the Medical Care and Infrastructure Branches. The actual cleanup work may be done using normal environmental services personnel or, to reduce recovery time, general hospital staff when they are available, or contractors when needed.

For hazardous materials (HazMat) or biological-related incidents, cleanup efforts may require special cleaning agents and procedures to be used including the use of specialized contractors. Licensed, bonded, and insured contractors should properly dispose of hazardous waste, including the collected runoff from decontamination operations. The HazMat Branch and the Infrastructure Branch should coordinate supervision of the cleanup of contaminated areas with assistance coming from the Support Branch.

For legal reasons and/or the reassurance of patients, staff, and the general public, it may be necessary to have a health inspector or other qualified professional conduct a survey of the hospital and confirm that it has been safely cleaned or disinfected.

The costs associated with a hospital's response to any incident can be significant. This is especially true if documentation is not collected properly and submitted within deadlines set by the local, state, tribal, federal governments, and insurance carriers. From the outset, the Finance/Administration Section has the responsibility to track the various costs associated with the response including personnel, patient care, resources, equipment repair and replacement, and hospital repair/operations. The tracking of these costs should be done according to daily practices and/or special procedures as outlined in the Emergency Operations Plan (EOP). Hospitals that are part of a corporate healthcare system should also comply with corporate directives and avail themselves of the fiscal, administrative, and personnel resources a corporate incident management team can offer. In some cases, normal reimbursement methods will be used and third-party insurance companies invoiced for the entire patient care services rendered. However, in other situations involving state or federally declared disasters, hospitals may be eligible to recover additional response monies not otherwise being reimbursed. To be considered for reimbursement, hospitals will have to submit special applications that require detailed explanations and accurate records. Thus, members of the Hospital Incident Management Team (HIMT) must be familiar with which forms must be used, the degree of detail necessary, to whom the completed forms must be sent, and reporting deadlines. Ideally, this knowledge should be obtained prior to an incident in order to best ensure that all recordkeeping will optimize the chance for restitution to be made.

Normally, hospitals enjoy the trust of the communities they serve. However, this trust may be shaken when performance during an incident is below public expectations. In addition, there may be concerns about a hospital's capability for providing patient care if there has been noticeable damage or if the cleanliness and safety of the hospital has been compromised by the perceived presence of HazMat or a dangerous pathogen. The hospital must remain responsive to these issues and proactive in allaying fears and, if necessary, rebuilding the public trust.

5.14 Response Evaluation and Organizational Learning

During an incident personnel should be performing their assigned roles. However, in many cases this may be expanded to additional responsibilities. One of the most important recovery activities will be capturing the lessons learned from individual and collective response efforts.

During the incident, as determined by the Incident Commander or designee, a quick "time out" can be taken to assess what is going well and what could be improved. On the basis of the information shared, adjustments can be made to improve response activities.

Following the termination of the response, a series of debriefing meetings or "hot washes" should be held at various levels to provide involved staff with the chance to share information on what worked well and possible improvement options. These comments should be formally recorded and reflected as part of the After Action Report (AAR) and Corrective Action and Improvement Plan (IP) process for the incident.

The format for the AAR process should be decided and a principal author(s) assigned to write a draft report for submission to the Emergency Management Committee and other groups identified by the Incident Commander or hospital administration. After a final draft with accompanying improvement recommendations is approved, the Emergency Management Committee should make the needed revisions in the Emergency Operations Plan (EOP) or annex, and ensure the staff receives needed training on the changes.

Hospitals should also be prepared to participate in the community AAR process, which may include conducting both closed meetings and public hearings. These meetings may be among single disciplines (e.g., meetings involving just the hospitals themselves or the general healthcare community) or more widely inclusive of all the response community

at the local, state, and federal levels. Hospitals must participate regularly in these meetings, not only to share their own opinions on the response and system, but also to ensure their interests are being represented and needs met.

Depending on the incident, hospitals may be asked to have representatives speak at local, state, or even federal conferences and forums. Making these presentations is an important way for hospitals throughout the United States or abroad to learn from the experience. Experience has shown that, depending on the situation, the volume of invitations can be daunting and require careful selection. Developing a standardized presentation will reduce the time requirement, diversify who can make the presentation, and ensure presentation consistency.

In addition to formal public presentations, publication in professional journals (e.g., standard print journals or web publications) is another opportunity that can be helpful for sharing response actions. Social media is another area to consider publishing response actions and experiences and an increasingly popular place to discuss lessons learned.

The California Emergency Medical Services Authority would like to receive copies of AAR and presentations on the use of HICS. This information will aid future revisions. Address these informative documents to the HICS Coordinator via email HICS@EMSA.CA.GOV

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CHAPTER 6

The HICS Toolkit

OBJECTIVES

- Discuss the purpose and use of the:
    - Incident Planning Guides (IPGs)
    - Incident Response Guides (IRGs)
    - Hospital Incident Management Team (HIMT) Activation Chart
    - Job Action Sheets (JAS)
    - HICS Forms

6.1 Use of Incident Planning Guides (IPGs) and Incident Response Guides (IRGs)

Incident Planning Guides (IPGs) and Incident Response Guides (IRGs) are tools hospitals and healthcare partners may use to evaluate and improve their level of preparedness (see Appendix E: Incident Planning Guides and Appendix F: Incident Response Guides). IPGs outline strategic considerations for hospitals to assess when writing their response plans. IRGs develop incident-specific response guides for the hazards that may impact the hospital. The guides include the following:

- The Incident Scenario
- The Incident Planning Guide (IPG)
- The Incident Response Guide (IRG)
- A recommended list of Documents and Tools, including HICS Forms
- A recommended Hospital Incident Management Team (HIMT) Activation Chart for each response period

Each of these sections will be discussed in this chapter. In addition, guidance on how to develop IPGs and IRGs for an incident not addressed in this guidance is outlined in Chapter 8 Customizing HICS (see Chapter 8.1 Creating and Modifying HICS Tools).

The IPGs and IRGs have been reformatted and consolidated or expanded for improved application among hospitals. Table 2 below and Table 3 on page 98 provide a crosswalk of the HICS 2006 Scenarios to the HICS 2014 Scenarios which the IPGs and IRGs included in Appendices E and F are based.

Table 2: Crosswalk of HICS 2006 Internal Scenarios to HICS 2014 Scenarios

	HICS 2006 Scenarios – Internal	Revision Action	HICS 2014 Scenarios
1	Bomb Threat	Consolidated	Explosive Incident
2	Evacuation, Complete or Partial Facility	Expanded	Evacuation, Shelter-in-Place, & Hospital Abandonment
3	Fire	Consolidated	Evacuation, Shelter-in-Place, & Hospital Abandonment
4	Hazardous Material Spill	Consolidated	Chemical Incident /Evacuation, Shelter-in-Place, & Hospital Abandonment
5	Hospital Overload		Staff Shortage/Mass Casualty Incident
6	Hostage/Barricade		Hostage or Barricade Incident
7	Infant/Child Abduction	Expanded	Missing Person
8	Internal Flooding	Consolidated	Utility Failure
9	Loss of Heating/Ventilation/Air Conditioning (HVAC)	Consolidated	
10	Loss of Power	Consolidated	
11	Loss of Water	Consolidated	
12	Severe Weather	Expanded	Severe Weather with Warning /Tornado
13	Work Stoppage		Staff Shortage

Table 3: Crosswalk of HICS 2006 External Scenarios to HICS 2014 Scenarios

	HICS 2006 Scenarios – External	Revision Action	HICS 2014 Scenarios
1	Nuclear Detonation - 10-Kiloton Improvised Nuclear Device		Radiation Incident
2	Biological Attack - Aerosol Anthrax	Consolidated	Infectious Disease
3	Biological Disease Outbreak - Pandemic Influenza	Consolidated	
4	Biological Disease Outbreak - Plague	Consolidated	
5	Chemical Attack - Blister Agent	Consolidated	Chemical Incident
6	Chemical Attack - Toxic Industrial Chemicals	Consolidated	
7	Chemical Attack - Nerve Agent	Consolidated	
8	Chemical Attack - Chlorine Tank Explosion	Consolidated	
9	Natural Disaster - Major Earthquake		Earthquake
10	Natural Disaster - Major Hurricane		Severe Weather with Warning
11	Radiological Attack - Radiological Dispersal Devices		Radiation Incident
12	Explosives Attack - Improvised Explosive Device	Consolidated	Explosive Incident
13	Biological Attack - Food Contamination	Consolidated	Infectious Disease
14	Cyber Attack		Information Technology (IT) Failure

6.2 Incident Scenarios

Each guide includes a sample scenario which the Incident Planning Guide (IPG) and Incident Response Guide (IRG) are based upon. The scenarios may be customized, expanded, or revised by individual hospitals to meet their unique needs and strengths. The scenarios may be used to launch planning activities or as exercise scenarios for the hospital.

6.3 Incident Planning Guide (IPG)

The Incident Planning Guide (IPG) identifies potential actions or strategies the hospital may use in preparing for the identified hazard. The IPG actions are grouped into the four phases of emergency management: mitigation, preparedness, response, and recovery. This allows the emergency manager to ensure that activities within each of the emergency management phases are considered during plan development. The IPG should be viewed as a template, with hospitals carefully considering the recommended actions for their customized plans.

Hospitals may use the IPG in a variety of ways, including:

Develop strategies and actions to reduce the impact of the event or threat

The Federal Emergency Management Agency (FEMA) defines hazard mitigation as "any sustained action taken to reduce or eliminate long-term risk to people and property from hazards and their effects[3]." Mitigation actions should reduce the impact of the threat on the hospital, avoid or minimize unnecessary disruptions or unplanned downtime and strengthen the capability of the hospital to maintain all operations.

Each IPG contains questions to promote actions and strategies to mitigate the impact of the event on the hospital. If actions listed in the mitigation section have been undertaken and are in place, the overall impact on the hospital may be less than previously identified and may be reflected in the scoring of the annual Hazard Vulnerability Analysis (HVA). The mitigation strategies and actions should be reflected in the overall emergency management program as goals and objectives within the annual review of the Emergency Management Plan.

[3] U.S., FEMA. (1995a). National Mitigation Strategy: Partnerships for Building Safer Communities. Washington, D.C., Federal Emergency Management Agency, pg. 3.

Assess current plans and identify gaps in planning

Within each IPG, recommended actions are listed in the preparedness, response, and recovery phases. A hospital may use the IPGs to assess their current hazard-specific plans, serving as a quality management tool for plan assessment and annual review. The thorough analysis and review of each IPG may identify gaps or challenges within individual hospital plans that may be considered in revisions.

Develop or customize event-specific response guides for the hospital

The IPG serves as a starting point for event-specific plans. As a hospital uses an IPG to develop their planning and response actions, the guide should be customized to their specific needs and capabilities. For example, the mitigation actions undertaken at a large hospital may vary from those of a small or rural hospital with limited resources. If actions identified in the preparedness section are not applicable to the mission of the hospital, they may be removed from the IPG or identified as not applicable.

6.4 Incident Response Guide (IRG)

The Incident Response Guide (IRG) identifies actions that may be undertaken in the Immediate, Intermediate, Extended, and Demobilization/System Recovery phases of an event. These actions are suggestions and should be reviewed by the hospital for applicability to their unique needs and capabilities. IRGs are meant to be customized by the hospital, including the insertion of hospital specific actions for each identified hazard. For example, the names and contact numbers of hospital leadership or external partners may be added to the guide. Hospital specific terminology for activation codes, the location of exit and entry points, communications systems and technology used by the hospital, and the location of critical response assets can be included in the IRG. Additionally, actions listed in the IRG that are not applicable to the hospital should be deleted during the review and customization process. The actions listed are suggestions and may not include all possible actions or suggest activities the hospital may have already identified or will identify during the planning process.

If a hospital identifies a threat or risk that has not been developed into an Incident Planning Guide (IPG) or IRG template within this guidebook, Chapter 9 provides guidance on how to develop and customize the IPGs and IRGs.

6.4.1 Hospital Incident Management Team (HIMT) Activation Chart

The final section of the Incident Response Guide (IRG) is a sample Hospital Incident Management Team (HIMT) Activation chart with recommended staffing of specific positions to manage the incident response and recovery. The activated positions vary with each event and throughout each phase of the activation. Individual hospitals may consider these as guidelines and customize to their own capabilities, based on the scope of the event, available staffing, response actions, and impact on the hospital. The Incident Commander may deactivate any position when objectives are met.

6.5 Use of Job Action Sheets (JAS)

The Job Action Sheets (JAS) are an incident management tool designed to familiarize the user with critical aspects of the management position he or she is assuming. The JAS have been developed for each of the positions (activated only as needed) in the full Hospital Incident Management Team (HIMT) chart and are, by design, generic to the position and should be complemented by the hazard-specific Incident Response Guide (IRG). JAS are intended to be handed-off to the next person assuming the position and/or upon shift change (see Appendix G: Job Action Sheets).

6.5.1 Title and Location

Each Job Action Sheet (JAS) contains the position title and mission, then a content box at the top of the first page. Within this box is the reporting structure, location of the Hospital Command Center (HCC) or other location of duty, assigned radio channel, telephone and fax contact information. This is an area of the JAS that the user may customize. Position titles, as a rule, should not be changed unless positions are deliberately being combined (see Chapter 9.1.1 Approach to Effectively Combining HIMT Positions). The logo of the hospital may be added to JAS, if desired.

6.5.2 Tasks and Documentation

The Job Action Sheet (JAS) is a running compilation across multiple operational periods or staffing assignments. The list of tasks identified as the responsibility for the position is sectioned into time frames. These tasks are intended to prompt the Hospital Incident Management Team (HIMT) members to take needed actions related to their roles and responsibilities. Each action step has a box for documenting the time the task was

completed and the initials of the person who carried out the action. The JAS format allows for personnel to document each action taken at specific times.

It is beneficial to use the JAS for all exercises, training, and actual events. Persons assigned to the position should use the JAS as a trigger for actions to be undertaken in the role as well as for documentation of those actions. In the post-event phase, the JAS may be reviewed for time of completion, additional information documented on the form, and actions not taken as a means to review and to refine the JAS and to prepare an AAR. For example, if a task identified in the Immediate Response phase was not carried out until the Extended Response phase, the reasoning should be determined and revisions to the JAS made and/or education provided for the users of the JAS. During the post event review, any additional information documented on the JAS should be considered for inclusion in the revision (e.g., tasks not on the JAS but unique to the hospital).

6.5.3 Documents and Tools

The final box on the Job Action Sheet (JAS) identifies the recommended documents, tools, and equipment the person assigned to the Hospital Incident Management Team (HIMT) position may need. As with the rest of the JAS, the list of tools should be reviewed and customized by the hospital. Hospital specific tools (e.g., laptops, notebooks, voice recorders, etc.) that are distributed with the JAS should be listed.

6.6 Use of HICS Forms

HICS Forms are for use within the hospital's operating service areas and the Hospital Incident Management Team (HIMT) positions. Although the Planning Section takes the lead in coordinating documentation efforts, the Documentation Unit Leader relies on all members of the HIMT to provide clear incident-related information.

Documentation during an incident should include the following:

- Incident situation/status
- Actions and precautions taken
- Decisions made
- Assignments made
- Information shared

- Resources utilized
- Financial costs and implications

Having a standardized form used by all responders provides a familiar and consistent method of documenting an incident and ease in sharing information. Local and federal agencies have adopted standardized forms with the use of Federal Emergency Management Agency (FEMA) Incident Command System (ICS) forms. HICS has modified select FEMA ICS forms (2010 edition) to reflect hospital functions. Where possible, HICS has maintained the intent and layout of the FEMA forms. Not every FEMA ICS form is applicable to a hospital; in that case, the FEMA form has not been utilized by HICS. There are additional functions performed by hospitals that are not addressed by FEMA forms, so additional hospital based forms have been developed to fill those needs. Appendix H: HICS Forms provides a list of the complete collection of HICS Forms.

Table 4 on page 104 provides a listing of the HICS Forms in numerical order, including which HIMT position is most likely to complete the form and when the form is utilized. Five HICS Forms are combined together (HICS 201, 202, 203, 204, 215A) to make up the core of the Incident Action Plan (IAP). (See Chapter 7 Incident Action Planning for additional information on the use of HICS Forms for the creation of the IAP).

A new HICS Form has been developed, the HICS IAP Quick Start. Often there are limited resources or time to complete multiple forms or the incident may be small in scope, requiring less documentation. The HICS IAP Quick Start was developed to provide a shorter, more concise documentation tool. As the incident expands or additional assistance is available, the information can be expanded onto the full version of the complementing HICS Form.

HICS Forms may be customized by a hospital. The title, core, and intent of the form should remain the same. Hospital names can and should be added. Additional data items that are desired can be added to the form as well.

Instructions for each form are provided and can be printed on the back of the form. The instructions accompanying each form include who is responsible for originating the form and to whom the form is distributed once completed. The forms may be completed as hardcopies or electronic versions. Hardcopies of the forms should always be available. When forms are completed by hand they should be written neatly to ensure readability.

Table 4: HICS Forms

#	Name	Responsible for Completion	When Completed
200	**Incident Action Plan (IAP) Cover Sheet**	Incident Commander or Planning Section Chief	Optional form used each operational period to list forms used in the Incident Action Plan (IAP)
IAP Quick Start	**Incident Action Plan (IAP) Quick Start**	Incident Commander or Planning Section Chief	Optional form for documenting an IAP for a smaller incident or to quickly start the documentation for any event
201	**Incident Briefing**	Incident Commander	Prior to briefing in the current operational period
202	**Incident Objectives**	Planning Section Chief	Prior to briefing in the current operational period
203	**Organization Assignment List**	Resources Unit Leader or Planning Section Chief	At the start of the first operational period, prior to each subsequent operational period, and as additional positions are staffed
204	**Assignment List**	Each Section Chief or Branch Director activated	At the start of each operational period
205A	**Communications List**	Communications Unit Leader	Whenever possible prior to an event, at the start of each operational period, and as changes are made
206	**Staff Medical Plan**	Employee Health and Well-Being Unit Leader	At the start of each operational period
207	**Hospital Incident Management Team (HIMT) Chart**	Incident Commander or designee	Whenever possible prior to an event, displayed using projection or wall chart at the start of each operational period, and updated as changes are made
213	**General Message Form**	All personnel	When intended receiver is unavailable to speak with the sender or when a communication includes specific details for which accuracy needs to be ensured

#	Name	Responsible for Completion	When Completed
214	**Activity Log**	All HIMT personnel	Continuously as a tool used to record major decisions (and critical details as needed) at all levels, from activation through demobilization
215A	**Incident Action Plan (IAP) Safety Analysis**	Safety Officer	Prior to safety briefing and is part of shift briefings conducted for all staff at the start of each operational period
221	**Demobilization Check-Out**	HIMT personnel designated by the Incident Commander	Documents personnel and resources checking out of the incident as they are released
251	**Facility System Status Report**	Infrastructure Branch Director	At start of operational period, as conditions change, or more frequently as indicated by the situation
252	**Section Personnel Timesheet**	HIMT personnel as directed by Incident Commander or the appropriate Section Chief	Throughout activation
253	**Volunteer Registration**	Labor Pool and Credentialing Unit Leader	Throughout activation
254	**Disaster Victim/Patient Tracking**	Patient Tracking Manager or team	Hourly and at end of each operational period, upon arrival of the first patient and until the disposition of the last
255	**Master Patient Evacuation Tracking**	Situation Unit Leader or designee (Patient Tracking Manager)	As decisions are made and as information is determined concerning patient disposition during an evacuation
256	**Procurement Summary Report**	HIMT personnel as directed by the Procurement Unit Leader	Prior to the end of the operational period and as procurements are completed
257	**Resource Accounting Record**	HIMT personnel as directed by the appropriate Section Chiefs	Prior to the end of the operational period or as needed

#	Name	Responsible for Completion	When Completed
258	**Hospital Resource Directory**	Resources Unit Leader	Whenever possible prior to an event, at the start of each operational period, and as changes are made
259	**Hospital Casualty/ Fatality Report**	Patient Tracking Manager or team	Prior to briefing in the next operational period
260	**Patient Evacuation Tracking**	Inpatient Unit Leader, Outpatient Unit Leader, and/or Casualty Care Unit Leader	As patients are identified for evacuation

Table 5 includes the Hospital Incident Command System (HICS) Forms User's Reference and provides a listing of forms grouped according to function. The form also provides the position(s) responsible for completing the form and a brief description of the intent of the form.

Table 6 on page 109 provides a crosswalk between FEMA ICS forms and HICS Forms. The FEMA ICS and HICS Forms are listed by number and name, in addition to the rationale for inclusion, modification or exclusion of FEMA ICS forms as part of HICS.

Table 5: HICS Forms User's Reference (Grouped According to Function)

HICS Form	Completed By	Notes
HICS assigned roles		
HICS 213 - General Message Form	All personnel	• To convey status information, assignments made, requests, etc.
HICS 214 - Activity Log	All HIMT personnel	• To log information received, actions taken and decisions made
HICS 221 - Demobilization Check-Out	HIMT personnel designated by the Incident Commander	• Provides a checklist for the demobilization, to assure that all activities are accomplished
HICS 252 - Section Personnel Timesheet	HIMT personnel as directed by Incident Commander or the appropriate Section Chief	• Provides an accounting of personnel time and activities

HICS Form	Completed By	Notes
For Completion of the Incident Action Plan (IAP)		
HICS 200 - Incident Action Plan (IAP) Cover Sheet	Incident Commander or Planning Section Chief	• Optional form to act as a cover sheet for each operational period IAP
HICS IAP Quick Start - Incident Action Plan (IAP) Quick Start	Incident Commander or Planning Section Chief	• Combination of HICS 201, 202, 203, 204, and 215A • Optional form for smaller incidents, or to quickly begin documentation for any incident
HICS 201 - Incident Briefing	Incident Commander	• Summary of status of incident situation and allocated resources • Can be utilized for briefing of Hospital Incident Management Team (HIMT) and oncoming Incident Commander
HICS 202 - Incident Objectives	Planning Section Chief	• Describes the basic incident objectives and safety considerations
HICS 203 - Organization Assignment List	Resources Unit Leader or Planning Section Chief	• Documentation of assigned positions and personnel
HICS 204 - Assignment List	Each Section Chief or Branch Director activated	• Documents the strategies of each section/branch, the resources/tactics needed to accomplish them, and the composition of the units
HICS 215A - Incident Action Plan (IAP) Safety Analysis	Safety Officer	• Replaces the 2006 HICS 261 • An operational risk assessment to prioritize hazards, safety, and health issues, and to assign the mitigation activities
Hospital Command Center (HCC) Management		
HICS 205A - Communications List	Communications Unit Leader	• Internal and external communications and contact information
HICS 206 - Staff Medical Plan	Employee Health and Well-Being Unit Leader	• Documents healthcare staff treatment areas
HICS 207 - Hospital Incident Management Team (HIMT) Chart	Incident Commander or designee	• Lists assignments of personnel to the HIMT positions • Optional form for distribution or display (projection or wall mounting) in the Hospital Command Center (HCC)
HICS 258 - Hospital Resource Directory	Resources Unit Leader	• Lists contact information for external resources

HICS Form	Completed By	Notes
Casualty/Victim Care		
HICS 254 - Disaster Victim/Patient Tracking	Patient Tracking Manager or team	• Disaster victim patient tracking
HICS 259 - Hospital Casualty/Fatality Report	Patient Tracking Manager or team	• Casualty/Fatality report
Event Logistics and Finance		
HICS 251 - Facility System Status Report	Infrastructure Branch Director	• Provides a checklist to document status of facility operating status
HICS 252 - Section Personnel Timesheet	HIMT personnel as directed by Incident Commander or the appropriate Section Chief	• Provides an accounting of personnel time and activities
HICS 253 - Volunteer Registration	Labor Pool and Credentialing Unit Leader	• Documents information and sign-in of people who volunteer for each operational period
HICS 256 - Procurement Summary Report	HIMT personnel as directed by the Procurement Unit Leader	• Provides an accounting list of items procured
HICS 257 - Resource Accounting Record	HIMT personnel as directed by the appropriate Section Chiefs	• Provides an accounting of resources utilized
Evacuation		
HICS 255 - Master Patient Evacuation Tracking	Situation Unit Leader or designee (Patient Tracking Manager)	• Records information concerning patient disposition during an evacuation
HICS 260 - Patient Evacuation Tracking	Inpatient Unit Leader, Outpatient Unit Leader and/or Casualty Care Unit Leader	• Detail and account for patients transferred to another facility

Table 6: Crosswalk of FEMA ICS and HICS Forms

FEMA Form	FEMA Form Title	HICS Form	HICS Form Title	Revisions/Explanations
		HICS 200	Incident Action Plan (IAP) Cover Sheet	• Optional form • New tool, to provide a cover sheet for each operational period IAP
			HICS Action Plan (IAP) Quick Start	• Optional form • New tool, to provide a short version of an IAP, or at the beginning of an incident when resources may be limited
ICS 201	Incident Briefing	**HICS 201**	Incident Briefing	• Revised to align with the FEMA form, reordered for hospitals • More sections added to provide summary of resource usage
ICS 202	Incident Objectives	**HICS 202**	Incident Objectives	• Slight revisions to content • Most significant change: removal of the term "Control" objectives, there will only be one type of objective referred to: "Incident Objectives" • Added section for "Site Safety Plan Required" for hazardous materials (HazMat) incidents
ICS 203	Organization Assignment List	**HICS 203**	Organization Assignment List	• Content remains the same • Added a column for contact information
ICS 204	Assignment List	**HICS 204**	Assignment List	• Name slightly changed to align with FEMA • Significant changes to content from HICS 2006 • Most divergent from the FEMA form; intended to define the activities in the hospital as opposed to the field

FEMA Form	FEMA Form Title	HICS Form	HICS Form Title	Revisions/Explanations
ICS 205	Incident Radio Communications Plan		N/A	• Opted not to use, focuses mostly on radio communications
ICS 205A	Communications List	**HICS 205A**	Communications List	• This replaces the HICS 2006 version of 205 internal and external, to promote compliance with FEMA form
ICS 206	Medical Plan	**HICS 206**	Staff Medical Plan	• Updated format
ICS 207	Incident Organization Chart	**HICS 207**	Hospital Incident Management Team (HIMT) Chart	• Name from FEMA to HICS is different • Intended to be projected or wall mounted in the Hospital Command Center (HCC), to promote compliance with FEMA form
ICS 208	Safety Message/Plan		N/A	• Opted not to use
ICS 209	Incident Status Summary		N/A	• Opted not to use, not adaptable to hospitals
ICS 210	Resource Status Change		N/A	• Opted not to use, not adaptable to hospitals
ICS 211	Incident Check-In List		N/A	• Opted not to use, not adaptable to hospitals
ICS 213	General Message	**HICS 213**	General Message Form	• Name and format changed to align with FEMA
ICS 214	Activity Log	**HICS 214**	Activity Log	• Name change to align with FEMA • Content remains the same
ICS 215	Operational Planning Worksheet		N/A	• Opted not to use, not adaptable to hospitals
ICS 215A	Incident Action Plan Safety Analysis	**HICS 215A**	Incident Action Plan (IAP) Safety Analysis	• Number change to align with FEMA • Content remains the same
ICS 218	Support Vehicle/ Equipment Inventory		N/A	• Opted not to use, not adaptable to hospitals

FEMA Form	FEMA Form Title	HICS Form	HICS Form Title	Revisions/Explanations
ICS 219-1 to ICS 219-10	Resource Status Cards		N/A	• Opted not to use, not adaptable to hospitals
ICS 220	Air Operations Summary Worksheet		N/A	• Opted not to use, not adaptable to hospitals
ICS 221	Demobilization Check-Out	**HICS 221**	Demobilization Check-Out	• New tool, to provide demobilization planning checklist and documentation
ICS 225	Incident Personnel Performance Rating		N/A	• Opted not to use, not adaptable to hospitals
	N/A	**HICS 251**	Facility System Status Report	• Updated format
	N/A	**HICS 252**	Section Personnel Timesheet	• Content remains the same • Updated format • Updated instructions for use by HIMT personnel as directed
	N/A	**HICS 253**	Volunteer Registration	• Removed "Staff" from title • Updated format
	N/A	**HICS 254**	Disaster Victim/Patient Tracking	• Updated format
	N/A	**HICS 255**	Master Patient Evacuation Tracking	• Updated format
	N/A	**HICS 256**	Procurement Summary Report	• Updated format • Updated instructions for use by HIMT personnel as directed
	N/A	**HICS 257**	Resource Accounting Record	• Updated format
	N/A	**HICS 258**	Hospital Resource Directory	• Updated format
	N/A	**HICS 259**	Hospital Casualty/Fatality Report	• Updated format

FEMA Form	FEMA Form Title	HICS Form	HICS Form Title	Revisions/Explanations
	N/A	**HICS 260**	Patient Evacuation Tracking	• Updated format
		HICS 261	Incident Action Plan Safety Analysis	• See 215A - number change

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CHAPTER 7

Incident Action Planning

OBJECTIVES

- Describe the importance of incident action planning.
- Describe the steps necessary to develop a hospital Incident Action Plan (IAP).
- Discuss when and how to use the IAP.
- Describe forms that are associated with the IAP.

7.1 Benefits of Incident Action Planning

Incident action planning is a core concept for a successful response and recovery from any incident. Developing and utilizing an Incident Action Plan (IAP) provides the goals, strategies, and tactics to facilitate the Management by Objectives (MBO) and ensures understanding of the strategic direction. The planning process is effective for both smaller, short-term incidents and more complicated long-term incidents and the IAP is scalable (e.g., HICS IAP Quick Start versus a fully documented IAP). Incident action planning provides the following benefits:

- Provides the organization's strategic direction
- Maximizes available resources
- Reduces omissions and duplication of efforts
- Reduces cost
- Gathers and disseminates information
- Improves and enhances communication
- Provides a historical record of the incident

The incident action planning process includes:

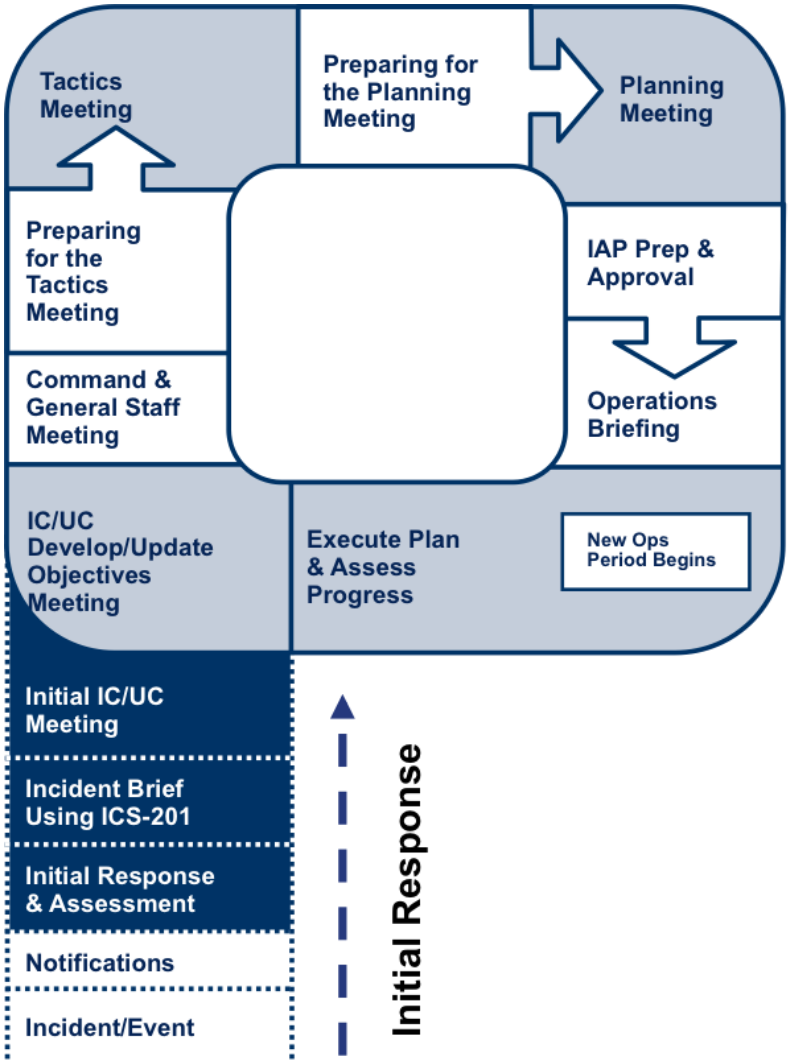
- Activating the hospital's Emergency Operations Plan (EOP) and implementing the HICS
- Rapidly gathering, verifying, and validating critical information relating to the incident, status of hospital systems, and capacity for operations
- Establishing incident objectives, providing direction and establishing priorities.
- Assigning Hospital Incident Management Team (HIMT) positions based on the most qualified personnel available
- Determining incident objectives that are SMART: Specific; Measurable; Action Oriented; Realistic; and Time sensitive
- Developing strategies and tactics: the general plan and actions that will be taken to accomplish objectives
- Projecting and assigning resource requirements based on on-going situational assessments
- Initiating appropriate community alerts and notifications
- Establishing communications and response links with appropriate community response partners

7.2 The Planning "P"

The Federal Emergency Management Agency (FEMA) has developed the Planning "P" concept to provide a visual guide to the planning process for an incident. The process described in this document is modified for use in the healthcare environment.

The base or leg of the P describes the Initial Response period: Notifications, Initial Response and Assessment, Incident Briefing using HICS 201: Incident Briefing, and Initial Incident Command (IC)/Unified Command (UC) Meeting.

Figure 7. FEMA's Planning "P"



The first operational period begins at the top of the base or leg of the P. In this circular sequence, the steps are

Incident Command/Unified Command Develop/Update Objectives Meeting; Command and General Staff Meeting; *Preparing for the Tactics Meeting; Tactics Meeting*; *Preparing for the Planning Meeting*; *Planning Meeting*; *IAP Prep and Approval*; *Operations Briefing*; *Execute the Plan and Asses Progress*. The current operational period ends, and the *New Operation Period* begins.

The cycle starts over (while skipping the Initial Response portion or leg of the P). Recognize that except for the FIRST operational period, where there were no prior

response activities, the cycle of meetings is to keep the planning process one step ahead of the response.

Listed below are the components, meetings, and processes to assist in developing the Incident Action Plan (IAP).

7.3 Section Responsibilities

Command

- Develops overall incident objectives and strategy
- Determines the operational period
- Approves resource orders and (later) demobilization
- Approves the Incident Action Plan (IAP)

Operations

- Assists with developing strategy
- Identifies, assigns, and supervises the resources needed to accomplish the incident objectives

Planning

- Provides status reports
- Tracks resources and identifies shortages
- Manages the planning process
- Develops the Incident Action Plan (IAP)

Logistics

- Orders resources
- Assists in the development of the transportation, communications, and medical plans

Finance/Administration

- Develops cost analyses to help ensure that the Incident Action Plan (IAP) is within the financial limits established by the Incident Commander

- Develops contracts, procures, and pays for the resources
- Reports costs

7.4 Meetings

Command and General Staff Meeting

- Leader: Incident Commander
- Attendees: Agency Executive, Command Staff (Public Information Officer [PIO], Liaison Officer, Safety Officer, Medical-Technical Specialist), and General Staff (Operations, Planning, Logistics, and Finance/Administration Chiefs), scribe for Incident Commander
- Purpose: Provides an opportunity for Command and General Staff to clarify the Incident Commander's objectives/intent; agree on current situation and main objectives (overall direction); and review main accomplishments and failures of last Incident Action Plan (IAP)
- Documents: HICS 201: Incident Briefing, HICS 202: Incident Objectives

Tactics Meeting Preparation

The Operations Section Chief should ensure the following actions take place prior to the Tactics Meeting:

Develop a Strategy:

- Generate a list of potential strategies (plans)
- Select the strategy that:
    - Is within acceptable safety norms
    - Makes good sense (is feasible, practical, and suitable)
    - Is cost effective
    - Is consistent with sound environmental practices
    - Meets political and public relations considerations

Develop Tactics (actions) for each Operations Branch:

- Describe what must be done to support a selected strategy

Tactics Meeting

- Leader: Operations Section Chief
- Attendees: Safety Officer, General Staff, Operations Branch Directors, Planning Section Chief, Resource Unit Leader (Planning), other leaders with pertinent responsibilities
- Purpose: Develop/review strategies and tactics to accomplish current objectives; assign resources to accomplish/support these objectives; identify methods for monitoring tactics and resources
- Documents: HICS 203: Organization Assignment List, HICS 204: Assignment List, HICS 215A: Incident Action Plan (IAP) Safety Analysis

Planning Meeting Preparation

The Planning Section Chief should ensure the following actions take place prior to the initial Planning Meeting:

- Evaluate the current situation and decide whether the current operation plan is adequate for the remainder of the operational period (i.e., until the next plan takes effect)
- Advise the Incident Commander and the Operations Section Chief of any suggested revisions to the current plan, as necessary
- Establish a planning cycle for the incident
- Participate in the Tactics Meeting, if held, to review the tactics developed by the Operations Section Chief
- Establish the location and time for the Planning Meeting
- Ensure that planning boards and forms are available
- Notify necessary support staff about the meeting and their assignments
- Ensure that a current situation and resource briefing will be available for the meeting
- Obtain an estimate of resource availability for use in planning for the next operational period

- Obtain necessary hospital policy, legal, or fiscal constraints for use in the Planning Meeting
- Documents: HICS 201: Incident Briefing, HICS 202: Incident Objectives, HICS 215A Incident Action Plan (IAP) Safety Analysis

Planning Meeting

- Leader: Planning Section Chief
- Attendees: Command and General Staff
- Purpose: Review and validate the operational plan proposed by the Operations Section Chief; determine objectives for the next operational period; submit to the Incident Commander for approval
- Documents: HICS 202: Incident Objectives, HICS 204: Assignment List, HICS 205A: Communications List, HICS 206: Staff Medical Plan, and HICS 215A: Incident Action Plan (IAP) Safety Analysis and all other necessary forms, attachments, maps, etc., depending on the complexity of the incident

Operations Briefing

- Leader: Operations Section Chief
- Attendees: Operations Section supervisors (branch, division, unit), and other leaders with pertinent responsibilities
- Purpose: Present the IAP to clarify staff responsibilities

Documents: All forms used in development of the IAP. The IAP will include HICS 201: Incident Briefing, HICS 202: Incident Objectives, HICS 204: Assignment List(s), HICS 215A: Incident Action Plan (IAP) Safety Analysis and other all other necessary forms, attachments, maps, etc., depending on the complexity of the incident

7.5 Develop the Incident Action Plan (IAP)

A hospital's Incident Action Plan (IAP) is a written document that provides the hospital's incident objectives, anticipated obstacles, and needed resources during the operational period. For the following sections describing the Incident Action Plan (IAP) sequences, see Figure 7 FEMA's Planning P on page 116.

7.5.1 Assess the Situation and Initial Response Actions

Situational Assessment

Situational assessment is the first step in the Incident Action Planning (IAP) process. This assessment should include the size, scope, and current and potential effect/impact of the incident on the hospital and its safety and operational systems. Factors to consider in situational assessment may include:

- Is the incident internal or external to the hospital?
- Will current clinical operations be impacted?
- Will there be delayed impact on hospital operations?
- Will business operations be impacted?
- Will the incident limit access to the hospital? To the campus?
- Is there a projected length of time for the incident (e.g., power failure, hazardous materials [HazMat] spill, law enforcement action, traffic accident, pandemic)?

Initial Response and Documentation

The initial information and actions taken should be clearly documented. Documentation is critical to develop the chronology of the incident and the initial key actions that guide the response that follows.

The documentation begins when the Incident Commander conducts the initial incident assessment from the information gathered and completes HICS 201: Incident Briefing. The form documents critical information including:

- Type of incident, location, magnitude, and possible duration
- Ongoing hazards and safety concerns
- Initial priorities based on:
    - Life saving
    - Incident stabilization
    - Property preservation
- Incident name
- Operational period date and time

- Situation status summary
- Health and safety briefing
- Current Hospital Incident Management Team (HIMT) staffing
- Incident objectives
- Summary of current and planned actions
- Summary of resources requested and assigned
- Incident Commander signature and position title
- Date of briefing
- Time of briefing
- Hospital name

If the incident is internal to the hospital and impacts only the facility, the Incident Commander may name the incident. If the incident begins externally or the response incorporates other jurisdictional agencies that establish Incident Command/Unified Command, the incident will be named by the on-scene Incident Commander or by local emergency management. The incident name is important to the hospital and its response partners to ensure that information, objectives, and tactics are coordinated. In addition, the ability to seek reimbursement during the recovery phase may be impacted if actions taken by a single entity cannot be clearly tied to the incident.

The Incident Commander distributes copies of the completed HICS 201: Incident Briefing and/or HICS Incident Action Plan (IAP) Quick Start to the Command and General Staff and the Documentation Unit Leader, who document initial situation and response information noting actions taken at start-up. The HICS 201 may also be shared with response partners and/or coordinating agencies. The distribution of the HICS 201 should be determined during the planning stage, and clearly documented on the HICS 201 and in policy.

An alternative to traditional IAP documentation is utilizing the HICS IAP Quick Start. The IAP Quick Start provides a short-form version of the HICS Forms 201, 202, 203, 204, and 215A to begin an incident prior to migrating to the basic forms, or for complete documentation of a minor incident.

The IAP Quick Start is prepared by the Incident Commander and/or Planning Chief and duplicated/distributed to the activated Command and General Staff positions. The HICS

201 or IAP Quick Start assists with documentation of the first step and leads to the next step in the incident action planning process.

7.5.2 Establish Operational Period

The operational period is the time period in which chosen objectives are to be met and identified strategies and tactics are carried out. This time period is flexible, may be of various lengths, and is determined by the Incident Commander according to the needs of the incident. The length of the operational period varies, usually between 2 and 24 hours. The operational period does not need to correspond to hospital shift times and may be shortened or extended based on situational response and incident progression.

7.5.3 Determine Safety Priorities and Establish Incident Objectives

Initial priorities are based on life safety, incident stabilization, and property preservation. The Incident Commander determines the initial incident objectives. The incident objectives are documented on the HICS 201: Incident Briefing and the HICS 202: Incident Objectives. Individual sections, branches and units will identify strategies and tactics for their response (HICS 204: Assignment List) based on these objectives set by the Incident Commander.

The Planning Section Chief initiates the HICS 202: Incident Objectives which includes:

- Incident name
- Operational period date and time
- Incident objectives, as obtained from the Incident Commander (including alternatives)
- Weather and environmental implications for the operational period to include as appropriate (e.g., forecast, wind speed and direction, daylight, etc.)
- Factors to consider (refer to the HICS 215A: Incident Action Plan (IAP) Safety Analysis)
- Date prepared
- Time prepared
- Incident Commander approval

As stated, life safety, incident stabilization, and property preservation are the foundation of the response. To ensure safety of patients, staff, and visitors, the Safety Officer assesses the hazards, determines strategies to mitigate the hazards, and assigns personnel to carry out the tactics. This information is recorded on the HICS 215A: Incident Action Plan (IAP) Safety Analysis.

The Safety Officer initiates the HICS 215A: Incident Action Plan (IAP) Safety Analysis, which includes:

- Incident name
- Operational period date and time
- Identification of hazards (potential and actual)
- Actions to be taken to reduce risk and ensure safety
- Assignments for mitigation activities listed
- Date prepared
- Time prepared
- Facility name
- Incident Commander approval

7.5.4 Determine Additional Section/Branch Incident Objectives

Additional incident objectives will be identified by Section Chiefs and/or Branch Directors to be addressed in the specified operational period. These incident objectives will comprise a section/branch/unit–specific set of strategies, tactical actions, and resources identified to address the priorities for the operational period and accomplish the incident objectives. Documentation includes:

- Section Chiefs and/or Branch Directors complete the HICS 204: Assignment List stating section/branch/unit-specific incident objectives
- The HICS 204: Assignment Lists are submitted to the Planning Section and distributed to Command, General Staff, and Documentation Unit Leader as part of the Incident Action Plan (IAP)

7.5.5 Determine Strategies and Tactics

Strategies are the general plans or directions selected to accomplish incident objectives for individual sections. Tactics are the short-term, specific actions taken to complete, or satisfy, the incident objectives (e.g., the directing/deployment of resources during an incident). The Section Chiefs and Branch Directors document strategies and tactics on the HICS 204: Assignment List.

7.5.6 Determine Needed Resources

The next step in Incident Action Plan (IAP) development is to determine the needed resources for the incident. After the objectives have been determined and strategies and tactics are developed, needed resources must be identified. Examples of needed resources include personnel, equipment, supplies, pharmaceuticals, and vehicles. Just as in daily operations, there are many components to resource identification, requisition, distribution, and restocking.

The following must be ensured:

- Section Chiefs coordinate with Branch Directors and Unit Leaders to determine needed resources within their specific section
- Logistics Section Chief confers with Operations Section Chief to coordinate obtaining the resources
- Finance/Administration Section Chief confers with Logistics and Operations Section Chiefs to assure appropriate financial tracking as individual sections identify resource needs

Documentation includes:

- HICS 204: Assignment Lists are used to document specific resources needed within the section/branch/unit
- Logistic Section Communication Unit Leader completes the HICS 205A: Communications List to identify communication resources and designate equipment and channels to be used within the hospital and for coordination with internal and external partners

- Logistic Section Employee Health and Well-Being Unit Leader completes the HICS 206: Staff Medical Plan to outline resources for medical care of injured/ill hospital personnel, as needed

7.5.7 Issue Assignments

The next step is for the Section Chiefs, Branch Directors, and Unit Leaders to make staff assignments specific to response action (e.g., Triage, Evacuation, Decontamination, Security). This step includes completion and distribution of the following:

- HICS 204: Assignment List documents specific assignments within each section/branch/unit activated
- The Planning Section Chief, or designee (Resource Unit Leader) completes the HICS 203: Organization Assignment List and distributes to Command and General Staff, Branch Directors and Documentation Unit Leader

The Planning Chief then compiles the forms of the Incident Action Plan (IAP). At a minimum, the IAP will include

- HICS 201: Incident Briefing
- HICS 202: Incident Objectives
- HICS 204: Assignment List(s)
- HICS 215A: Incident Action Plan (IAP) Safety Analysis

Many other components can be added depending on the complexity of the incident, such as the HICS 200: Incident Action Plan (IAP) Cover Sheet, the HICS 203: Organization Assignment List, Traffic Plan, Incident Map, Communication Plan, facility grids or blueprints, and Site Safety Plan. In addition hospital specific documents, such as press releases, Material Safety Data Sheets (MSDS), or medical guidelines, may be added to the IAP as needed by the hospital. Use of these additional documents should be noted on the HICS 201: Incident Briefing form and the HICS 200: Incident Action Plan (IAP) Cover Sheet.

The Incident Commander will approve the IAP for each operational period and direct its distribution by the Planning Section to Command and General Staff, Branch Directors, and the Documentation Leader. This information is presented in the Operations Briefing. Section Chiefs and the HIMT then execute the IAP. The completed plan may be shared

with outside response partners through the Liaison Officer if directed/authorized by the Incident Commander.

7.5.8 Implement Actions

The next step is to implement actions. Following the Operations Briefing, supervisors meet with their staff for a detailed briefing on their assignments using the approved Incident Action Plan (IAP). Staff members are directed to complete their assignments and to report their activities.

7.5.9 Evaluate and Revise Plans

As the Incident Action Plan (IAP) is used in the response, there is ongoing assessment of the effectiveness of strategies and tactics. Plans should be continually reassessed and revised. The revision of the plan does not have to wait for the next operational period. Adjustments in assignments, activation of additional branches or units, and revised safety plans should be documented and distributed to the HIMT as needed. The Section Chiefs evaluate the response and share the information with the Command and General Staff and make corrective actions.

7.5.10 Plan for the Next Operational Period

As an operational period is concluding, the Incident Action Plan (IAP) process sets off again, beginning with an updated situational assessment/review of the objectives to direct planning activities within sections and identification of continuing activities and objectives for the next operational period using a new set of forms and documents. The staffing of positions, the assignment of resources, and other critical information should be developed for this new operational period (and/or oncoming HIMT). The IAP will serve as the guidance for what is to be done during this next operational period.

7.5.11 Share the Incident Action Plan

The Incident Action Plan (IAP) should be communicated internally. The entire Hospital Incident Management Team (HIMT) benefits from knowing the strategic direction and plan. In addition, depending on the incident, the organization may share the IAP externally with other responders, partners, and outside agencies if directed/authorized by the Incident Commander.

7.5.12 Demobilize and Recover

Demobilization and recovery is a planned process that occurs as objectives are met and resources no longer needed are released and returned (or replaced). Demobilization activities should be part of the planning at the beginning of an incident, including how the hospital will return to normal, or "new normal," operations. Demobilization activities include:

- Specific responsibilities
- Release priorities
- Release procedures
- Checklists
- Continuity of Operations (COOP) Plans or Business Continuity Plans
- General information

Demobilization responsibilities include:

- Operations Section: identifies operational resources that are, or will be, in excess for the incident and prepares lists for Demobilization Unit Leader
- Planning Section: develops and implements demobilization activities (e.g., a Demobilization Plan); Demobilization Unit coordinates documentation completion
- Logistics Section: ensures the return, retrieval, and restocking of equipment and supplies
- Finance/Administration Section: processes claims, time records, and incident costs; assists in release priorities
- Incident Commander: approves release of resources and demobilization

Utilization of the HICS 221: Demobilization Check-Out can assist in the planning and response for demobilization of the incident. The HICS 221 is completed by Hospital Incident Management Team (HIMT) personnel designated by the Incident Commander then forwarded to the Demobilization Unit Leader for assimilation into the Demobilization Plan. The Demobilization Plan is then approved by the Section Planning Chief prior to distribution to Command Staff.

7.6 Forms for the Incident Action Plan (IAP)

The suggested forms to compose the Incident Action Plan (IAP) are found in Appendix H: HICS Forms. The HICS Forms may be customized, but the current formats follow the suggested content requirements of the National Incident Management System (NIMS). An electronic version can immediately be transferred to the Hospital Command Center (HCC) via the intranet/internet and allows for rapid revisions to be made if necessary; print versions should be available for use when computers are not available. The basic forms included in incident action planning include:

- HICS 200: Incident Action Plan (IAP) Cover Sheet
- HICS 201: Incident Briefing
- HICS 202: Incident Objectives
- HICS 204: Assignment List
- HICS 215A: Incident Action Plan (IAP) Safety Analysis

Additional forms and information may include:

- HICS – Incident Action Plan (IAP) Quick Start
- HICS 203: Organization Assignment List
- HICS 205A: Communications List
- HICS 206: Staff Medical Plan
- HICS 221: Demobilization Check-Out
- Incident Map, hospital and campus floor plans, maps, and evacuation routes, facility grids or blueprints
- Traffic Plan, Communication Plan, and Site Safety Plan(s)

Hospital specific documents, such as press releases, Material Safety Data Sheets (MSDS), or medical guidelines, may also be added to the IAP as needed by the hospital.

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CHAPTER 8
Customizing HICS

OBJECTIVE

- Discuss how the HICS tools may be modified to accommodate hospital size and mission.
- Discuss how the HICS may be used to provide direction to unique situational needs using the tenants of the National Incident Management System (NIMS) to modify the basic Hospital Incident Management Team (HIMT).

8.1 Creating and Modifying HICS Tools

In addition to the information contained in the HICS Guidebook, a number of tools have been created to assist the hospital in implementing HICS. The HICS Toolkit provided within the Appendices contains tools intended for individual review and modification by hospitals. This includes:

- Appendix C: Hospital Incident Management Team (HIMT)
- Appendix E: Scenarios and Incident Planning Guides
- Appendix F: Incident Response Guides
- Appendix G: Job Action Sheets, and
- Appendix H: HICS Forms

The review of each HICS tool should be deliberate and thoughtful, understanding that HICS is based on a standardized incident management system that has proven to be successful across many disciplines. Minor modifications are acceptable to fit the mission and resources of the hospital; however, significant variations should be approached with caution. Substantial deviation from accepted Incident Command System (ICS) principles may result in a system that is not recognized by other response partners and could potentially have an adverse impact on the coordination that is necessary during large scale disasters.

Examples of customization include placement of the hospital logo on materials prior to printing; customized document placement on a designated intranet location for electronic data collection; pre-populating key forms for use during incident response; and adding hospital specific information to internal Job Action Sheets (JAS) and Incident Planning Guides (IPGs) and Incident Response Guides (IRGs).

Additional data items, (e.g., communication instructions) that are desired should be determined and added as well. All customized tools should be evaluated by the hospital's Emergency Program Manager and the Emergency Management Committee for relevance to a particular hospital's situation. As a rule, the title, core, and intent of the tool should always remain the same.

Individual hospitals and planning partners may also choose to develop IPGs and Incident Response Guides (IRGs) beyond those developed within the HICS Toolkit. For example, in the annual Hazard Vulnerability Analysis (HVA) the hospital may identify a threat for which a planning or response guide has not yet been developed. Examples range from rail or airplane crashes to pest infestation or volcanic eruptions.

8.1.1 Creating Incident Planning Guides (IPGs)

The Incident Planning Guide (IPG) is designed for use by the Emergency Program Manager, the Emergency Management Committee or local planning partners to identify strategies and actions specific to the hospital in reducing the impact of the threat while preparing the hospital to respond and recover. The IPG includes all 4 phases of emergency management: Mitigation, Preparedness, Response, and Recovery. The following sections provide guidance on identifying actions, strategies and tasks toward developing the IPG.

Mitigation

For threats to the physical facility and overall operations, two types of mitigation should be considered, structural and non-structural mitigation.

Structural mitigation is reinforcing, bracing, anchoring, bolting, strengthening, or replacing any portion of the building that may become damaged and cause injury such as:

- Exterior walls (e.g., wind-resistant design for tornados or hurricanes)
- Exterior doors (e.g., noncombustible materials for wildfires or urban fires)

- Exterior windows (e.g., shutters on windows for tornados or hurricanes)
- Foundation (e.g., bracing, anchoring, or bolting the facility for earthquakes)
- Exterior columns/pilasters/corbels (e.g., steel or concrete columns)
- Roof (e.g., noncombustible materials for wildfires or urban fires)

Nonstructural mitigation reduces the threat to safety posed by the effects of an incident that causes interruption or failure of such nonstructural elements as building contents, internal utility systems, interior glass, and decorative architectural walls and ceilings. Nonstructural mitigation includes:

- Retrofit – refers to various methods for securing nonstructural items. Retrofitting methods are bracing, securing, tying down (tethers or leashes), bolting, and anchoring
- Replace – replacing the item with a new one that is resistant to the hazard
- Relocate – moving items from a hazardous location to a non-hazardous one (e.g., relocation of back-up generators and switching equipment out of hospital basements that are at risk for flooding)
- Communications (e.g., telecommunication systems)
- Critical systems and elements (e.g., computer systems, patient alarms, patient call systems) that are essential to operations
- Emergency power-generating equipment; water and sewage; and heating, ventilation, and air-conditioning (HVAC)
- Fire protection and detection systems – fire sprinklers and distribution lines, emergency water tank or reservoir, and alarms
- Medical equipment – diagnostic equipment (x-ray, CT, MRI, ultrasound, etc.), ventilators, monitors, refrigeration units to store pharmaceuticals and blood
- Hazardous materials (HazMat) – chemicals restrained on shelves, containers stored on braced storage rack or tall stacks, gas tanks with flexible connections, gas tank legs anchored to a concrete footing or slab
- Security target hardening (e.g., installation of closed circuit television (CCTV) or video cameras, key card access, and automatic locks)
- Purchase of redundant equipment to ensure a sufficient supply for operations

- Access to specialized supplies, equipment, personnel, and pharmaceuticals to reduce the impact from a hazard or event

Preparedness

Preparedness refers to those measures taken to prepare to respond to a given incident. Items to consider when creating the preparedness section of the IPG include:

- Status of current plans
- Frequency of maintenance, education, testing, and exercising
- Business Continuity Plans
- Insurance and Reimbursement Plans
- Availability of alternative sources for critical supplies and services
- Time to marshal response from internal and external sources
- Scope of current capability
- Historical evaluation of response and response success
- Time to prepare and mitigate (can be event-specific)
- Mission of the hospital to support the community in the identified hazard or event

Assessment of internal resources:

- Volume and type of redundant supplies on-site
- Staff availability and capability to surge
- Alternate care sites (ACS) to enable clinical operations as well as business continuity
- Availability of back-up systems/components
- Resource ability to withstand direct impact from the hazard or event

Availability of external resources:

- Coordination within corporate healthcare systems
- Agreements with community partners/other healthcare organizations
- Coordination with state and local agencies

- Coordination with regional healthcare organizations
- Community resources
- Alternate care sites (ACS) to enable clinical operations as well as business continuity
- Current memorandums of understanding to support the hospital
- Volunteer management

Response

In the response section of the IPG, consider all the activities your hospital undertakes to respond to a given incident. The actions are designed with strategies and actions to be activated during the emergency. Questions should be developed that are specific to the event and the mission of the hospital to respond to that event, including current and surge capabilities.

Extended Operations and System Recovery

When creating the extended operations and system recovery sections of the IPG, consider all activities the hospital may require to return to complete business operations. Short-term actions assess damage and return vital life-support operations to minimum operating conditions. Long-term actions focus on returning all hospital operations back to normal or an improved state of operations.

8.1.2 Creating Incident Response Guides (IRGs)

The Incident Response Guide (IRG) is designed to address your hospital's response to the incident. It is a document that provides the Incident Commander an overview of activities that should be taking place at any given time during the response. The IRG should be designed to address the most likely activities for a given response and is not intended to be all-inclusive. The hospital must customize the IRG to its unique capabilities as well as provide concrete actions to be taken by the Hospital Incident Management Team (HIMT).

Mission Statement

The Mission Statement reflects the overall response purpose for the incident. The Mission Statement is broad and overarching. For example, the Mission Statement for a

Missing Person Incident is "To manage the process of locating and recovering a lost or abducted person, whether infant, child, or an adult from the hospital."

Incident Objectives

Incident objectives are statements of guidance and direction necessary for selecting one or more appropriate strategies and the tactical direction of resources. These must be met in order to be successful in achieving the Mission Statement. Management by Objectives (MBO) is a management approach that involves a 4-step process (setting goals; assigning resources; developing plans, procedures, protocols; monitoring progress/revising objectives as needed). The objectives should be relatively broad and apply directly to the accomplishment of the goals. In developing the Incident Action Plan (IAP), the Incident Commander may use these as the overarching objectives in the event.

For example, in keeping with the example of the Missing Person Incident, the Incident Objectives for that incident are as follows:

- Ensure the safety of patients, staff, and visitors while initiating search procedures
- Coordinate with law enforcement in the response to and recovery of a missing person
- Provide behavioral health services to patients, staff, and families

Response Guide

The guide is broken up into four periods and a resources section:

- Immediate Response (0 – 2 hours)
- Intermediate Response (2 – 12 hours)
- Extended Response (greater than 12 hours)
- Demobilization/System Recovery
- Documents and Tools

Each period is arbitrarily set and may vary depending on the scope and complexity of the incident that will be described later within this chapter. However, for consistency, each period is structured in a table format that includes the Command, Operations, Planning, Logistics, and Finance/Administration Sections (when applicable; sometimes the Finance/Administration Section does not require activation during a portion of the

response), and the response measures that should be occurring in those sections during that period. The Command Section is further divided into the Command Staff responsibilities (Public Information, Liaison, Safety, and sometimes Technical Specialists). If necessary, the items discussed in the Incident Planning Guide (IPG) will be addressed in this section of the document along with any other concerns or response issues that could arise. Within the IRG, sections names are colored to further reinforce section identification. In addition, the IRG can be used as a documentation tool: a box is provided to document the time an action was completed and the initials of the person completing the action.

The actions within each section may be assigned to a branch or unit. Remember that if branches or units are not activated, the Section Chief is responsible to carry out the task.

Response Period refers to the period from the time of the onset of the incident. It provides a reference timeframe for response activities. The *Operational Period* is a designated time interval during incident operations in which organizational strategies and tactics are guided by objectives that are specific for that time period, usually not more than 24 hours, and reflected in the IAP.

- Immediate Response refers to the start of the incident (usually 0 – 2 hours from onset of incident, but this time frame may vary). This is the period when the response is getting set up, and it is important to remember what needs to happen and why.
- Intermediate Response refers to the middle of the incident (usually 2 – 12 hours into the incident, but this time frame may vary). This is the period when the response is in progress, but there are always further issues to address.
- Extended Response refers to the response near the end of the incident (usually more than 12 hours into the response, but this time frame may vary). This section is devoted to ensuring the response is adequate while planning for Demobilization and System Recovery.
- Demobilization and System Recovery refers to the actions taken to shut down the incident response and return the organization to normal operations. This includes debriefing response personnel and compiling the response documentation.

Documents and Tools

The Documents and Tools section of the IRG lists the plans, documents, HICS Forms, and other tools (e.g., hospital and campus maps, blueprints, and floor plans) that can help the hospital respond to the incident.

Hospital Incident Management Team (HIMT) Activation

The matrix of activated positions illustrates suggested Hospital Incident Management Team (HIMT) positions to consider during the operational period. Sections are colored to further reinforce section identification.

The color-filled sections marked with an "X" indicate a position that might be activated at each specific response period. Activation of any position depends on the scope of the incident, specific community or organizational needs, and the specific resources available to effectively respond and recover from the incident. Activated positions may or may not align with these recommendations; however they should remain fairly similar to the matrix for any hospital response. The Incident Commander may deactivate any position when objectives are met.

Table 7: Hospital Incident Management Team Activation: Missing Person

Position	Immediate	Intermediate	Extended	Recovery
Incident Commander	X	X	X	X
Public Information Officer	X	X	X	X
Liaison Officer	X	X	X	X
Safety Officer	X	X	X	X
Operations Section Chief	X	X	X	X
Medical Care Branch Director	X	X	X	X
Security Branch Director	X	X	X	X
Patient Family Assistance Branch Dir.		X	X	X
Planning Section Chief	X	X	X	X
Resources Unit Leader		X	X	X
Situation Unit Leader	X	X	X	X
Documentation Unit Leader		X	X	X
Logistics Section Chief	X	X	X	X
Support Branch Director	X	X	X	X
Finance /Administration Section Chief		X	X	X
Time Unit Leader		X	X	X

8.1.3 Customizing HICS Forms

The forms provided in Appendix H: HICS Forms have been made available in Microsoft Word and Adobe, to encourage customization among individual organizations and are of two principal types:

- Federal Emergency Management Agency (FEMA) ICS forms have been modified for use in the healthcare environment.
- Special forms have also been created for use by hospitals and have been adapted into the HICS.

Further modifications are acceptable to fit the mission and resources of the hospital. As a rule; the title, core, and intent of the HICS Forms should remain the same. Hospital names should be added. Additional data items that are desired can be added to the form as well. Examples of customization to the HICS Forms include placement of the hospital

logo on materials prior to distribution and customized instructions such as document placement on a designated intranet location for electronic data collection.

8.1.4 Customizing Job Action Sheets (JAS)

The Job Action Sheets (JAS) have been developed for each of the positions (activated only as needed) in the full Hospital Incident Management Team (HIMT) chart (see Appendix G: Job Action Sheets). The list of tasks and critical action considerations identified as the responsibility for the position is sectioned into time frames. The JAS is a running compilation across multiple operational periods or staffing assignments. It is beneficial to use the JAS for all exercises, training, and actual events. In the post-event phase, the JAS may be reviewed for time of completion, additional information documented on the form, and actions not taken as a means to review and to refine the JAS and to prepare an After Action Report. For example, if a task identified in the Immediate Response phase was not carried out until the Extended Response phase, the reasoning should be determined and revisions to the JAS made and/or education provided for the users of the JAS. During the post event review, any additional information documented on the JAS should be considered for inclusion in the revision (e.g., tasks not on the JAS but unique to the hospital).

As with the rest of the JAS, the list of tools should be reviewed and customized by the hospital. Hospital specific tools (e.g., laptops, notebooks, voice recorders, etc.) that are distributed with the JAS should also be listed.

Some hospitals practice the use of pocket-size, durable Field Operations Guides (FOGs) based on the HICS JAS. These condensed versions of the JAS include the position title and mission, to whom the position reports, and critical actions and documentation that are relevant to the four phases of emergency management: mitigation, preparedness, response, and recovery. These pocket-size guides do not replace the use of the full JAS, but act as a quick reference guide for the application of the specific HIMT position during exercises, training, and actual events.

8.2 Adapting HICS to Meet Unique Response Needs

Because the Hospital Incident Command System (HICS) embraces the National Incident Management System (NIMS) foundations of flexibility, scalability, and adaptability, hospitals of all missions and sizes can take the principle design outlined in earlier chapters and modify them to meet their unique situations. The following are samples of

situations hospitals may encounter that require variation in the basic Hospital Incident Management Team (HIMT) design. HICS can be successfully used to provide needed direction to unique situational needs, using the tenants of NIMS to modify the basic HIMT design when needed. There could be other ideas for an HIMT configuration for the situations presented as well as other response situations not included where change is warranted. It is important to follow the standard ICS naming of positions and reporting structure when making any adaptations. Each hospital must decide for itself, as part of their incident preplanning, what HIMT positions will be most needed for the preplanned events and response incidents they will likely encounter and work to insure the persons assigned to those positions have been trained and are equipped to succeed.

8.2.1 Nursing Home Incident Command System (NHICS)

The California Association of Health Facilities (CAHF) and the American Health Care Association introduced the revised Nursing Home Incident Command System (NHICS), based on previous efforts by the Florida Healthcare Association. The NHICS model leverages the structure of the Hospital Incident Command System (HICS).

The NHICS guidance was developed with the acknowledgement that, regardless of staff size or resident population, limited resources may be available for incident response and recovery. To further encourage standardization in response and collaboration, other NHICS tools were developed and customized based upon those already available within HICS. These include Incident Planning Guides (IPGs) and Incident Response Guides (IRGs) and documentation forms that can be used in incident action planning and other response and recovery activities. Nursing homes should review all of the NHICS materials and utilize those that best apply to their mission and capabilities, customizing them where appropriate to account for their mission and capabilities (see Appendix I: Resources and References; Nursing Home Incident Command System).

8.2.2 Mobile Field Hospitals (MFH) and Alternate Care Sites (ACS)

Recently, many states and communities have reviewed the issue of creating mobile field hospitals (MFH) and alternate care sites (ACS). Whether prepackaged in trailers deployed to decimated communities with little or no healthcare or by using an office building located next to an overwhelmed hospital for seeing injured or ill patients, these alternate care delivery models will need to operate using an incident command system.

The Hospital Incident Command System (HICS) can be modified to meet these needs just as it can for the hospital itself. If the facility will operate as a stand-alone site, then the Hospital Incident Management Team (HIMT) design should begin with an Incident Commander followed by a suitably abridged HIMT design. Positions such as Safety Officer, Operations, Logistics and Planning Section Chiefs will be important and should be appointed as soon as qualified staff is available to fill them. How the branches and units below each Section Chief (if appointed–otherwise these positions may report to the Incident Commander) are designed should correlate with the mission of the facility and available personnel to fill them. In situations where the temporary facility is closely tied to another hospital then the supported facility's HIMT assignments may address the other functions such as Liaison Officer, Public Information Officer (PIO), or Finance/ Administration Section Chief.

8.2.3 HICS Use in Austere Conditions

Over the past several years, hospitals and other emergency response partners have looked at how to address the issues related to large-scale incidents, ranging from an influenza pandemic to the detonation of an improvised nuclear device, resulting in casualties that may exceed healthcare resources. The Institute of Medicine (IOM) as well as other public and private organizations have published guidance to help emergency planners identify the critical issues and outlined potential action steps that might be undertaken.

In a situation involving austere conditions, the Hospital Incident Management Team (HIMT) will face both medical and non-medical issues that affect the delivery of patient care.

Examples of non-medical issues include legal and bioethical considerations, and resource management (i.e., allocation, equipment and supply acquisition and tracking, Information Technology/Information Systems [IT/IS] supplementation, communication, etc.). To help address these types of issues, a hospital will ideally have access to subject matter experts (e.g., Medical-Technical Specialists: Medical Ethicists, Risk Management, Legal Affairs, etc.) who can make specific recommendations and provide guidance and assistance where needed. These individuals may already be on staff or be consultants secured by pre-incident agreement and available during a crisis in person or virtually. As an example of varying the HIMT design to address resource management issues, the Logistics Section may need to be bolstered by adding personnel to existing branches and

units to manage the increased workload or adding additional branches or units to support management of specific items. This may include management of resources such as ventilators (i.e., Ventilator Unit Leader) or medications for staff distribution (i.e., Staff Medication Unit Leader) or to coordinate distribution of shelter in place materials (i.e., Shelter in Place Unit Leader).

The medical issues that might occur may also require modification in the typical HIMT appointments made to address special needs such as medical staff assignments, creation or revision of clinical management protocols, bed expansion planning or ventilator assignment management. These changes most likely will add or modify positions in the Operations Section. Examples could include positions such as Critical Care Triage Officer, and Telemedicine Branch or Unit Leader. Additional personnel staffing in the Planning and Finance/Administration Sections may be needed to insure their responsibilities are met and they are able to keep pace with support needs in the Operations and Logistics Sections.

Planning that is done for surge situations should include addressing as comprehensively as possible the potential for shortfalls of one kind or another and the altered (expanded or abridged) HIMT that might be appointed to deal with these issues should also be outlined. Preplanning should include crafting Incident Response Guides (IRGs), developing Job Action Sheets (JAS) and identification (e.g., command vests, etc.) for all new positions. Implementing a work schedule that will use these personnel in the most efficient manner possible will also be important.

8.2.4 Hazardous Materials (HazMat) Response

Another area in which some hospitals or healthcare systems may choose to revise the basic HIMT design is response to a hazardous material (HazMat) incident.

While remaining part of the Operations Section, the HazMat Branch itself could be modified to address each individual aspect of the operation. For example, Unit Leaders could be assigned under the HazMat Branch Director for facilities (prepare and maintain the site operations, donning and doffing personal protective equipment (PPE) and medical surveillance), Decontamination (including triage, patient de-clothing, patient washer and rinser, and patient transport) and Rapid Intervention Team and Decontamination Team Rehabilitation. Like any other situation, the design of the HazMat Branch should take into account the need for safety, the availability of trained personnel

to perform in a command role versus the number of trained personnel needed to perform decontamination, and the duration of the response.

8.2.5 Large Scale Disaster Behavioral Health Response

Another critical situation where the basic design of the Hospital Incident Management Team (HIMT) may be modified is an incident where the hospital is mounting a response to provide a robust behavioral health response. If needed, the standard Behavioral Health Unit could be replaced with a Behavioral Health Branch led by a Branch Director under the Operations Section. Unit Leaders could be assigned to address Inpatient Behavioral Health, Outpatient Behavioral Health and Staff Behavioral Health needs. The persons providing direct care in each of these areas would be staff from Pastoral-Spiritual Care, Psychiatry or Psychology Department(s) or external qualified healthcare professionals who have been asked to assist. As with any other HIMT role, those persons assuming these behavioral health leadership roles would have Job Actions Sheets (JAS) and be trained to perform their responsibilities.

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CHAPTER 9

Implementing HICS Off Hours and at Small/ Rural Hospitals

OBJECTIVE

- Describe how Hospital Incident Management Team (HIMT) positions can be efficiently staffed during off hours or at small/rural hospitals.

9.1 HICS Implementation during Off Hours and at Small/Rural Hospitals

The same HICS principles that make it useful for large hospitals apply to small hospitals as well. In addition, hospitals of all sizes must be able to apply HICS to crises that occur during off hours and on holidays and weekends.

Small hospitals will benefit from the use of HICS, but some have found it difficult to make needed adaptations. The same problem exists for all hospitals operating at night, on the weekend, or during holidays. The successful use of HICS depends in part on only activating the Hospital Incident Management Team (HIMT) positions that the situation requires. For a small hospital, successful adaptation requires the blending of some job roles into single Job Action Sheets (JAS). For example, staff at Critical Access Hospitals routinely perform multiple job roles on a daily basis. During an emergency, those same people will need to assume more than one position on the HIMT, at least initially. During nights, weekends, and holidays, hospitals of medium and large size will likely have to begin to build their HIMT in a similar fashion.

Some positions are more easily combined than others. It's not uncommon for the Incident Commander to assume the role of the Public Information Officer (PIO) and even the Liaison Officer. However, some positions, such as the Safety Officer or Medical-Technical Specialists, should not be combined with other job responsibilities unless absolutely necessary.

9.1.1 Approach to Effectively Combining HIMT Positions

The following steps have been used by several community hospitals to modify HICS for primary or off hours use:

1. Identify essential positions for the hospital response from the Hospital Incident Management Team (HIMT) chart. This should be done in light of the Hazard Vulnerability Assessment (HVA) and the potential personnel available for use in the HIMT.

2. Create new combined Job Action Sheets (JAS) while retaining the structure and intent of HICS. In doing so, identify key actions for positions not likely to be activated immediately due to limited available personnel.

3. Add priority tasks to the appropriate Command, Section Chief, and Branch Director JAS, creating a "blended" JAS which prompts key actions that should be taken even with limited resources. The positions associated with those key actions, depending on the nature of the event, should be the first to be activated in expanding the HIMT once qualified personnel begin to arrive in the Hospital Command Center (HCC).

4. Attach to the blended JAS the original Hospital Incident Management Team (HIMT) JASs. This will allow for easy expansion of the HIMT when resources and time allow. For example, in the sample blended Incident Commander JAS to follow, activities listed include the additional duties of three Command Staff positions. The priority and urgent duties that would usually be performed by these positions have been added to the revised, blended Incident Commander JAS version. This provides the Incident Commander a JAS with both their normally expected activities and additional priority tasks that they may need to complete.

The off hours/small/rural hospital HICS adaptation can be expanded or condensed to meet the needs of the incident while accounting for the availability of Hospital Incident Management Team (HIMT) positions. Consistent with the overall HICS system, the only position that is always activated is the Incident Commander; all other positions are activated as needed and as available personnel permit.

As with the full scale system, the off hours/small/rural hospital's system approach should include each position having the needed tools identified on the JAS readily available.

Training should be provided both on the role and responsibility for the blended positions and on the appropriate use of the identified tools.

EXAMPLE of combined JAS:

INCIDENT COMMANDER

(BLENDED WITH PUBLIC INFORMATION OFFICER, LIAISON OFFICER, AND SAFETY OFFICER)

Mission: Organize and direct the Hospital Command Center (HCC). Give overall strategic direction for hospital incident management and support activities, including emergency response and recovery. Approve the Incident Action Plan (IAP) for each operational period.

ESSENTIAL POSITION

Position Reports to: **Executive Administration** Command Location: _____ Position Contact Information: Phone: ( ) - Radio Channel: _____ Hospital Command Center (HCC): Phone: ( ) - Fax: ( ) -		
Position Assigned to:	Date: / /	Start: ____:____ hrs.
Signature:	Initials:	End: ____:____ hrs.
Position Assigned to:	Date: / /	Start: ____:____ hrs.
Signature:	Initials:	End: ____:____ hrs.
Position Assigned to:	Date: / /	Start: ____:____ hrs.
Signature:	Initials:	End: ____:____ hrs.

Immediate Response (0 – 2 hours)	Time	Initial
Receive appointment • Gather intelligence, information and likely impact from the sources providing event notification • Assume role of Incident Commander and activate the Hospital Command Center (HCC) • Review this Job Action Sheet • Put on position identification (e.g., position vest) • Notify your usual supervisor and the Hospital Chief Executive Officer (CEO) of the incident, activation of HICS, and your assignment		

Assess the operational situation
• Activate the Hospital Emergency Operations Plan (EOP) and applicable Incident Specific Plans or Annexes
• Brief Command Staff, as activated, on objectives and issues, including:
  ○ Size and complexity of the incident
  ○ Expectations
  ○ Involvement of outside agencies, stakeholders, and organizations
  ○ The situation, incident activities, and any special concerns
• Seek feedback and further information		

Determine the incident objectives, tactics, and assignments
• Determine incident objectives for the operational period
• Determine which Command Staff and Section Chiefs need to be activated, assigning multiple roles to available personnel if required:
  ○ Safety Officer
  ○ Liaison Officer
  ○ Public Information Officer
• ***For any Command Staff positions not activated, complete the priorities summarized in the blue-shaded area below***
• Determine the impact on affected departments and gather additional information from the Liaison Officer
• Appoint a Planning Section Chief to develop an Incident Action Plan (IAP)
• Appoint an Operations Section Chief to provide support and direction to affected areas
• Appoint a Logistics Section Chief to provide support and direction to affected areas
• Appoint a Finance Section Chief to provide support and direction to affected areas
• Determine the need for, and appropriately appoint or ensure appointment of Medical-Technical Specialists
• Make assignments and distribute corresponding Job Action Sheets and position identification
• Ensure hospital and key staff are notified of the activation of the Hospital Command Center (HCC)
• Identify the operational period and any planned Hospital Incident Management Team (HIMT) staff shift changes
• Conduct a meeting with HIMT staff to receive status reports from Section Chiefs and Command Staff to determine appropriate response and recovery levels, then set the time for the next briefing		

Activities • Ensure all activated positions are documented in the IAP and on status boards • Obtain current patient census and status from the Planning Section Chief • Determine the need to activate surge plans based on current patient status and injury projections • If additional beds are needed, authorize a patient prioritization assessment for the purposes of designating appropriate early discharge • If applicable, receive an initial hospital damage survey report from the Operations Section Infrastructure Branch and evaluate the need for evacuation		
Documentation • Incident Action Plan (IAP) Quick Start • HICS 200: Consider whether to use the Incident Action plan (IAP) Cover Sheet • HICS 201: Initiate the Incident Briefing Form • HICS 204: Assign or complete the Assignment List as appropriate • HICS 207: Assign or complete the HIMT Chart for assigned positions to be displayed • HICS 213: Document all communications on a General Message Form • HICS 214: Document all key activities, actions, and decisions in an Activity Log on a continual basis • HICS 252: Distribute the Section Personnel Time Sheet to Command and Medical-Technical Specialist Staff and ensure time is recorded appropriately		
Resources • Assign one or more clerical personnel from current staffing or make a request for staff to the Logistics Section Chief, if activated, to function as Hospital Command Center (HCC) recorders		
Communication *Hospital to complete: Insert communications technology, instructions for use and protocols for interface with external partners*		
Safety and security • Ensure that appropriate safety measures and risk reduction activities are initiated • Ensure that HICS 215A – Incident Action Plan Safety Analysis is completed and distributed • Ensure that a hospital damage survey is completed if the incident warrants		
Priority Tasks from Reporting Positions Job Action Sheets <u>Public Information Officer:</u> • Establish a designated media staging and media briefing area located away from the Hospital Command Center (HCC) and patient care activity areas, coordinating with the Safety Officer and Operations Section Security Branch Director as needed		

• Inform on site media of the physical areas to which they have access and those that are restricted
• Contact external Public Information Officers (PIOs) from community and governmental agencies to ascertain and collaborate on public information and media messages being developed by those entities and ensure consistent and collaborative messages from all entities
• Consider assigning a public relations staff member to the Joint Information Center (JIC), if activated
• Monitor, or assign personnel to monitor and report to you, incident and response information from sources such as the internet, radio, television, and newspapers
• Develop public information and media messages for release to the news media and the public
• Provide critical information through signage, TV messaging, and emails to hospital personnel, visitors, and media as needed
 	
<u>Liaison Officer:</u>
• Obtain initial status and information from the Planning Section Chief to provide surge capacity status; provide an update to external stakeholders and agencies
• Establish communication for information sharing with other hospitals and local agencies (e.g., emergency medical services, fire, law, public health, and emergency management)
• Respond to information and or resource inquiries from other hospitals and response agencies and organizations
• Provide information on local hospitals, community response activities, and Liaison goals to the Incident Action Plan (IAP)
• Report to appropriate authorities the following minimum data on HICS 259: Hospital Casualty/Fatality Report:
  ○ Number of casualties received and types of injuries treated
  ○ Current patient capacity and census
  ○ Number of patients admitted, discharged home, or transferred to other hospitals
  ○ Number deceased
  ○ Individual casualty data: name or physical description, sex, age, address, seriousness of injury or condition
 	
<u>Safety Officer:</u>
• Determine safety risks of the incident and response activities to patients, hospital personnel, and visitors as well as to the hospital and the environment
• Advise the Hospital Incident Management Team (HIMT) of any unsafe conditions and corrective recommendations
• Evaluate the building or incident hazards and identify vulnerabilities
• Specify the type and level of personal protective equipment (PPE) to be used by hospital personnel to ensure their protection, based on the incident or hazard
• Post non-entry signage around unsafe or restricted areas, as needed
• Attend all briefings and Incident Action Plan (IAP) meetings to gather and share incident and hospital safety requirements
• Monitor operational safety of decontamination operations, if applicable
• Ensure that safety team members, if assigned, identify and report all hazards and unsafe conditions		

• Assess hospital operations and practices of staff; terminate and report any unsafe operation or practice; recommend corrective actions to ensure safe service delivery		

Intermediate Response (2 – 12 hours)	**Time**	**Initial**

Activities
• Transfer the Incident Commander role, if appropriate
  ○ Conduct a transition meeting to brief your replacement on the current situation, response actions, available resources and the role of external agencies in support of the hospital
  ○ Address any health, medical, or safety concerns
  ○ Address political sensitivities, when appropriate
  ○ Instruct your replacement to complete the appropriate documentation and ensure that appropriate personnel are briefed on response issues and objectives (see HICS Forms 203, 204, 214, and 215A)
• Schedule regular briefings with Hospital Incident Management Team (HIMT) staff to identify and plan to:
  ○ Ensure a patient tracking system is established and linked with appropriate outside agencies and the local Emergency Operations Center (EOC)
  ○ Develop, review, and revise the Incident Action Plan (IAP), or its elements, as needed
  ○ Approve the IAP revisions if developed by the Planning Section Chief, then ensure that the approved plan is communicated to HIMT staff
  ○ Ensure that safety measures and risk reduction activities are ongoing and re-evaluate if necessary
• Consider deploying a Public Information Officer to the local Joint Information Center (JIC), if applicable		

Documentation • HICS 204: Document assignments and operational period objectives on Assignment List • HICS 213: Document all communications on a General Message Form • HICS 214: Document actions, decisions, and information received on Activity Log • HICS 215A: Complete the Incident Action Plan (IAP) Safety Analysis; document identified safety issues, mitigation strategies and assignments • HICS 259: Report data from the Hospital Casualty/Fatality Report		
Resources • Authorize resources as needed or requested by Command Staff or Section Chiefs		
Communication *Hospital to complete: Insert communications technology, instructions for use and protocols for interface with external partners*		

Safety and security • Ensure that patient and personnel safety measures and risk reduction actions are followed		

Extended Response (greater than 12 hours)	**Time**	**Initial**

Activities
• Transfer the Incident Commander role, if appropriate
  ○ Conduct a transition meeting to brief your replacement on the current situation, response actions, available resources and the role of external agencies in support of the hospital
  ○ Address any health, medical, or safety concerns
  ○ Address political sensitivities, when appropriate
  ○ Instruct your replacement to complete the appropriate documentation and ensure that appropriate personnel are briefed on response issues and objectives (see HICS Forms 203, 204, 214, and 215A)
• Evaluate or re-evaluate the need for deploying a Public Information Officer to the local Joint Information Center (JIC) and a Liaison Officer to the local Emergency Operations Center (EOC), if applicable
• Ensure that an Incident Action Plan (IAP) is developed for each operational period, approved, and provided to Section Chiefs for operational period briefings
• With Section Chiefs, determine the recovery and reimbursement costs and ensure documentation of financial impact
• Ensure staff, patient, and media briefings are being conducted regularly		

Documentation • HICS 214: Document all key activities, actions, and decisions in an Activity Log on a continual basis		
Resources • Authorize resources as needed or requested by Command Staff and Section Chiefs		
Communication *Hospital to complete: Insert communications technology, instructions for use and protocols for interface with external partners*		
Safety and security • Observe all staff and volunteers for signs of stress and inappropriate behavior and report concerns to the Safety Officer and the Logistics Section Employee Health and Well-Being Unit Leader • Provide for personnel rest periods and relief		

• Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques		

Demobilization/System Recovery	**Time**	**Initial**

Activities
• Transfer the Incident Commander role, if appropriate
  ○ Conduct a transition meeting to brief your replacement on the current situation, response actions, available resources and the role of external agencies in support of the hospital
  ○ Address any health, medical, or safety concerns
  ○ Address political sensitivities, when appropriate
  ○ Instruct your replacement to complete the appropriate documentation and ensure that appropriate personnel are briefed on response issues and objectives (see HICS Forms 203, 204, 214, and 215A)
• Assess the plan developed by the Planning Section Demobilization Unit and approved by the Planning Section Chief for the gradual demobilization of the Hospital Command Center and emergency operations according to the progression of the incident and hospital status
• Demobilize positions in the Hospital Command Center (HCC) and return personnel to their normal jobs as appropriate, in coordination with the Planning Section Demobilization Unit
• Brief staff, administration, and Board of Directors
• Approve notification of demobilization to the hospital staff when the incident is no longer active or can be managed using normal operations
• Participate in community and governmental meetings and other post-incident discussion and after action activities
• Ensure post-incident media briefings and hospital status updates are scheduled and conducted
• Ensure implementation of stress management activities and services for staff
• Ensure that staff debriefings are scheduled to identify accomplishments, response, and improvement issues		

Documentation • HICS 221- Demobilization Check-Out • Ensure all Hospital Command Center documentation is provided to the Planning Section Documentation Unit		

Documents and Tools
❑ Incident Action Plan (IAP) Quick Start ❑ HICS 200 - Incident Action Plan (IAP) Cover Sheet ❑ HICS 201 - Incident Briefing Form ❑ HICS 203 - Organization Assignment List ❑ HICS 204 - Assignment List ❑ HICS 205A - Communications List ❑ HICS 213 - General Message Form ❑ HICS 214 - Activity Log ❑ HICS 215A - Incident Action Plan (IAP) Safety Analysis ❑ HICS 221 - Demobilization Check-Out ❑ HICS 252 - Section Personnel Time Sheet ❑ HICS 258 - Hospital Resource Directory ❑ HICS 259 - Hospital Casualty/Fatality Report ❑ Hospital Emergency Operations Plan (EOP) ❑ Incident Specific Plans or Annexes ❑ Hospital organization chart ❑ Hospital telephone directory ❑ Telephone/cell phone/satellite phone/internet/amateur radio/2-way radio for communication

Appendices are separately attached